

**Introduced by Committee on Budget and Fiscal Review**

January 23, 2025

---

~~An act relating to the Budget Act of 2025.~~ *An act to amend Sections 1276.4, 1276.66, 1280.15, 1280.19, 1342.2, 1374.55, 1385.002, 1385.004, 1385.006, 1417.2, 1418.22, 120956, 120960, 127672, 127672.9, 127825, and 150900 of, to amend the heading of Article 6.1 (commencing with Section 1385.001) of Chapter 2.2 of Division 2 of, to amend and repeal Sections 1265.9 and 1385.005 of, to add Sections 1356.3, 1385.008, 1385.009, 1385.0010, 1385.0011, 1385.0012, 1385.0013, 1385.0014, 1385.0015, 1385.0016, 1385.0017, 1385.0018, 1385.0019, 1385.0020, 1385.0021, 1385.0022, 1385.0023, 1385.0024, 1385.0025, 1385.026, and 127673.05 to, and to repeal and add Sections 1385.001 and 127697 of, the Health and Safety Code, to amend Section 10119.6 of, and to add Section 10125.2 to, the Insurance Code, to amend Section 1026 of the Penal Code, and to amend Sections 5961.2, 14006, 14006.01, 14006.15, 14006.2, 14006.5, 14006.6, 14007.5, 14007.65, 14007.8, 14015, 14126.033, 14132, 14132.36, 14132.171, 14165.57, 14184.200, 14197.7, and 14199.128 of, to amend and repeal Sections 14000, 14005.11, 14005.20, 14005.40, 14005.401, 14006.3, 14006.4, 14007.9, 14009.6, 14009.7, 14011, 14013.3, 14051, 14051.5, 14105.33, 14126.024, 14133.85, 14148.5, and 14166.17 of, to amend, repeal, and add Sections 14005.62, 14105.436, and 14132.100 of, to add Sections 14107.115 and 14132.994 to, to repeal Section 14006.1 of, to repeal Chapter 16.5 (commencing with Section 18998) of Part 6 of Division 9 of, and to repeal and add Section 14105.38 of, the Welfare and Institutions Code, and to amend Section 83 of Chapter 40 of the Statutes of 2024, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.*

## LEGISLATIVE COUNSEL'S DIGEST

SB 116, as amended, Committee on Budget and Fiscal Review.  
~~Budget Act of 2025. Health omnibus trailer.~~

*(1) Existing law provides for the licensure and regulation of health facilities, including general acute care hospitals, acute psychiatric hospitals, and special hospitals, by the State Department of Public Health. Existing law requires the department to adopt regulations that establish minimum, specific, and numerical licensed nurse-to-patient ratios by licensed nurse classification and by hospital unit for all general acute care hospitals, acute psychiatric hospitals, and special hospitals. Existing law requires the regulations adopted by the department for acute psychiatric hospitals that are not operated by the State Department of State Hospitals to take into account the special needs of the patients served in the psychiatric units. Existing law generally makes a willful violation of those licensing provisions a crime.*

*Under existing law, on and after July 1, 2015, any acute psychiatric hospital that submits a completed application and is operated by the State Department of State Hospitals may be approved by the State Department of Public Health to offer, as a supplemental service, an Enhanced Treatment Program (ETP) that meets certain conditions, including sufficient and documented evaluation of violence risk of the patient. Existing law requires an ETP to meet certain requirements relating to staffing and patient room features and to implement certain policies and procedures on patient care.*

*Under existing law, those ETP provisions remain in effect for each pilot ETP until January 1 of the 5th calendar year after each pilot ETP site has admitted its first patient, and the provisions are repealed as of January 1 of the 5th calendar year after each pilot ETP site has admitted its first patient. Existing law requires the State Department of State Hospitals to post a declaration on its internet website regarding the timing of that repeal condition.*

*This bill would delete the above-described provisions regarding ETP repeal. The bill would instead repeal those provisions on January 1, 2030, as specified. To the extent that the bill would extend the operation of certain ETP sites, and by extending ETP requirements, the violation of which would be a crime, the bill would impose a state-mandated local program.*

*This bill would specify regulations for acute psychiatric hospitals not operated by the State Department of State Hospitals are deemed to be*

*an emergency and necessary for the immediate preservation of the public peace, health and safety, and general welfare, and would require the department to adopt emergency regulations for these facilities no later than January 31, 2026, and permanent regulations thereafter, as specified. The bill would authorize the department to readopt the emergency regulations, as specified. The bill would authorize the emergency regulations to include, among other things, staffing standards specific to acute psychiatric hospitals.*

*(2) Existing law requires the State Department of Public Health to use the direct care staffing level data it collects to determine whether a skilled nursing facility has met its nursing hours or direct care service hours per patient per day requirements, as specified. Existing law requires the department to assess specified administrative penalties on skilled nursing facilities that fail to meet these requirements and establishes an administrative process that skilled nursing facilities may use to appeal determinations or assessments made by the department. Existing law continues in the Special Deposit Fund the Skilled Nursing Facility Minimum Staffing Penalty Account and requires the administrative penalties described above to be deposited into that account. Under existing law, the account is continuously appropriated to the department to support the implementation of these provisions.*

*This bill would remove the Skilled Nursing Facility Minimum Staffing Penalty Account from the Special Deposit Fund. The bill would, notwithstanding any other law, authorize the State Controller to use the funds in the Skilled Nursing Facility Minimum Staffing Penalty Account for cash flow loans to the General Fund, as specified.*

*(3) Existing law requires a clinic, health facility, home health agency, or hospice to prevent unlawful or unauthorized access to, and use or disclosure of, patients' medical information, as defined. Existing law requires the clinic, health facility, home health agency, or hospice to report any unlawful or unauthorized access to, or use or disclosure of, a patient's medical information to the State Department of Public Health and to the affected patient or the patient's representative, as specified. Existing law authorizes the department to assess administrative penalties for violation of these provisions and gives the department discretion to consider all factors when determining the amount of a penalty. Existing law requires these and other specified penalty moneys to be deposited into the Internal Departmental Quality Improvement Account, which is established within the Special Deposit Fund. Upon appropriation by the Legislature, existing law requires the moneys in the account to be*

*expended for internal quality improvement activities in the Licensing and Certification Program.*

*This bill would remove the Internal Departmental Quality Improvement Account from the Special Deposit Fund and, notwithstanding specified provisions of law, require all interest earned on the moneys deposited in the account to be retained in the account. The bill would also, notwithstanding any other law, authorize the State Controller to use the funds in the Internal Departmental Quality Improvement Account for cash flow loans to the General Fund, as specified.*

*(4) Existing law also establishes the Internal Health Information Integrity Quality Improvement Account. Existing law requires all administrative fines assessed by the State Department of Public Health for unlawful disclosures of confidential medical information, as specified, to be deposited in that account. Upon appropriation by the Legislature, existing law requires money in the account to be used for purposes of supporting quality improvement activities of the department.*

*The bill would, effective July 1, 2025, abolish the Internal Health Information Integrity Quality Improvement Account and transfer all moneys in the account to the Internal Departmental Quality Improvement Account. The bill would require all remaining balances, assets, liabilities, and encumbrances of the Internal Health Information Integrity Quality Improvement Account as of July 1, 2025, to be transferred to, and become part of, the Internal Departmental Quality Improvement Account. The bill would require the administrative fines assessed for unlawful disclosures of confidential medical information described above to be deposited in the Internal Departmental Quality Improvement Account. The bill would, upon appropriation by the Legislature, require money in the account to be used for purposes of supporting quality improvement activities of the Licensing and Certification Program. The bill would also, notwithstanding any other provision of law, authorize the State Controller to use the funds in the account for cash flow loans to the General Fund, as specified.*

*(5) Existing law provides for the licensure of long-term health care facilities by the State Department of Public Health. Existing law establishes the State Health Facilities Citation Penalties Account and the Federal Health Facilities Citation Penalties Account in the Special Deposit Fund into which moneys from civil penalties for violations of state and federal law, respectively, are deposited. Existing law requires the moneys in those accounts to be used, upon appropriation by the*

*Legislature, in accordance with state and federal law for the protection of health or property of residents of long-term health care facilities, as specified.*

*This bill would remove the State Health Facilities Citation Penalties Account and the Federal Health Facilities Citation Penalties Account from the Special Deposit Fund.*

*(6) Existing law requires a skilled nursing facility, by January 1, 2026, to have an alternative source of power, as defined, to protect resident health and safety, as defined, for no fewer than 96 hours during any type of power outage. Existing law imposes specific compliance requirements based on whether a skilled nursing facility uses a generator as its alternative source of power, or batteries or a combination of batteries in tandem with a renewable electrical generation facility.*

*This bill would instead require a skilled nursing facility to comply with these provisions on or after January 1, 2026, commencing on the first day of the Medi-Cal skilled nursing facility rate year for which the State Department of Health Care Services publishes a written notice on its internet website that the Legislature has appropriated sufficient funds for the express purpose of providing an add-on to the Medi-Cal skilled nursing facility per diem rate for the projected Medi-Cal cost compliance, as specified. The bill would authorize the State Department of Health Care Services to implement these requirements by means of provider bulletins, policy letters, or other similar instructions, without taking regulatory action.*

*(7) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance.*

*Existing law requires a pharmacy benefit manager under contract with a health care service plan to, among other things, register with the Department of Managed Health Care.*

*This bill would instead require a pharmacy benefit manager contracting with a health care service plan or health insurer to secure a license from the Department of Managed Health Care on or after January 1, 2027, or the date on which the department has established the licensure process, whichever is later. The bill would establish application requirements, and would require a pharmacy benefit manager applying for licensure to reimburse the Director of the*

*Department of Managed Health Care for the actual cost of processing the application, including overhead, up to an amount not to exceed \$25,000. The bill would require a pharmacy benefit manager to submit financial statements to the department at specified intervals, and would require those statements and other proprietary information to be kept confidential, as specified. The bill would authorize the director to suspend or revoke a pharmacy benefit manager license, but would provide that, once issued, a license remains in effect until revoked or suspended. The bill would authorize a pharmacy benefit manager whose license has been revoked, or suspended for more than one year to petition the director to reinstate the license, and would authorize the director to prescribe a fee, not to exceed \$500, for the actual cost of processing the petition. The bill would create the Pharmacy Benefit Manager Fund in the State Treasury, into which fees, fines, penalties, and reimbursements collected from pharmacy benefit managers would be deposited, except fines and administrative penalties for specified acts or omissions would be deposited into the newly created Pharmacy Benefit Manager Administrative Fines and Penalties Fund in the State Treasury. Because a violation of these provisions would be a crime, the bill would impose a state-mandated local program.*

*Existing law requires the Department of Health Care Access and Information to implement and administer the Health Care Payments Data System to learn about and seek to improve public health, population health, social determinants of health, and the health care system.*

*This bill would require a pharmacy benefit manager to provide specified data to the Department of Health Care Access and Information regarding drug pricing, fees, and other information. The bill would require a licensed health care service plan to pay an annual fee for the 2025–26 and 2026–27 fiscal years for the reasonably necessary expenses of the Department of Health Care Access and Information to fund the Health Care Payments Data Program. The bill would also require a licensed pharmacy benefit manager to pay amounts twice per year to fund the actual and reasonably necessary expenses of the department to implement pharmacy benefit manager licensing and the actual and reasonably necessary expenses of the Department of Health Care Access and Information pertaining to data reporting by pharmacy benefit managers. The bill would require the Health Care Payments Data Program advisory committee to include pharmacy benefit managers.*

(8) Existing law requires large group health care service plan contracts and disability insurance policies issued, amended, or renewed on or after July 1, 2025, to provide coverage for the diagnosis and treatment of infertility and fertility services, including a maximum of 3 completed oocyte retrievals with unlimited embryo transfers, as specified. Existing law also requires small group health care service plan contracts and disability insurance policies issued, amended, or renewed on or after July 1, 2025, to offer coverage for the diagnosis and treatment of infertility and fertility services.

This bill would instead require compliance with the above-described provisions by large and small group health care service plan contracts and disability insurance policies issued, amended, or renewed on or after January 1, 2026. The bill would authorize the Director of the Department of Managed Health Care and the Insurance Commissioner to issue guidance regarding these provisions until January 1, 2027, and would require the departments to consult with each other and stakeholders in issuing that guidance.

(9) 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.

Existing law authorizes the State Department of Public Health, to the extent that the activities are an allowable use of funds, to spend up to \$23,000,000 from the ADAP Rebate Fund to implement certain programs, including an allocation of \$5,000,000 annually for 3 years, beginning on July 1, 2024, to the Transgender, Gender Nonconforming, and Intersex (TGI) Wellness and Equity Fund to fund services related to care and treatment for eligible individuals living with HIV and AIDS.

Under existing law, expenditure from the ADAP Rebate Fund also includes an allocation of \$5,000,000, in the 2024–25 fiscal year, available until June 30, 2027, to distribute funding to a community-based organization to make internal and external condoms available, if Senate Bill 954 of the 2023–24 Regular Session becomes effective, aimed at preventing the transmission of HIV and sexually transmitted infections.

This bill would additionally allow the moneys allocated to the TGI Wellness and Equity Fund to fund services related to HIV prevention, and would have the allocation begin instead on July 1, 2025. With

regard to funding for condoms, the bill would remove the condition that Senate Bill 954 become effective, and would authorize the allocation until June, 30, 2028. This bill would authorize the State Department of Public Health to spend up to \$75,000,000 from the ADAP Rebate Fund to support current or eligible HIV services and programs, as specified. The bill would specify the allocation of those funds, including by authorizing up to \$65,000,000 of that \$75,000,000 to be spent to supplement or fund services, programs, or initiatives for which federal funding has been reduced or eliminated. By adding to the purposes of the ADAP Rebate Fund, and by extending the terms of certain allocations, the bill would make an appropriation.

(10) Existing law requires the Office of Health Equity within the State Department of Public Health to administer the TGI Wellness and Equity Fund for purposes of funding grants to create programs, or funding existing programs, focused on coordinating trans-inclusive health care for individuals who identify as transgender, gender nonconforming, or intersex.

This bill would instead refer only to the State Department of Public Health, without specifying the office, for purposes of administering the fund.

Existing law authorizes use of the moneys in the fund, upon appropriation, to fund grants for certain purposes, including grants to TGI-serving organizations for the purpose of facilitating therapeutic arts programs, such as dancing, painting, or writing.

This bill would restructure that specific purpose by having the grants be made available to TGI-serving organizations for facilitating evidence-based therapeutic arts programs. The bill would make conforming changes to related provisions.

(11) Existing law, the California Affordable Drug Manufacturing Act of 2020, requires the California Health and Human Services Agency (CHHSA) to enter into partnerships, in consultation with other state departments as necessary, to, among other things, increase patient access to affordable drugs. Existing law authorizes CHHSA to enter into partnerships regarding over-the-counter naloxone products to allow the development, manufacturing, or distribution of those products by an entity that is authorized to do so under federal or state law.

This bill, subject to an appropriation by the Legislature, would additionally authorize CHHSA to enter into partnerships to increase competition, lower prices, and address supply shortages for generic or brand name drugs to address emerging health concerns, for the



*development, production, procurement, or distribution of vaccines, as specified, and for the manufacture, purchase, or distribution of medical supplies or medical devices.*

*(12) Existing law requires, when a defendant pleads not guilty by reason of insanity, that a jury determine whether the defendant was sane or insane at the time the offense was committed. Under existing law, if a defendant is found to be not guilty by reason of insanity, the court is required to commit the person to the State Department of State Hospitals or any other appropriate public or private treatment facility, as specified. If a defendant is confined in a state hospital or other treatment facility as an inpatient, existing law requires the medical director of the facility to submit a report, at 6-month intervals, to the court and the community program director of the county of commitment setting forth the status and progress of the defendant.*

*This bill would instead require the above-described report to be submitted every 12 months.*

*(13) Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Existing law sets forth a schedule of benefits under the Medi-Cal program, including prescribed drugs subject to the Medi-Cal list of contract drugs.*

*Existing law requires a specified health care service plan contract, including a Medi-Cal managed care plan, to cover the costs for COVID-19 diagnostic and screening testing, as provided, regardless of whether the services are provided by an in-network or out-of-network provider. Existing law prohibits this coverage from being subject to copayment, coinsurance, deductible, or any other form of cost sharing. Existing law also prohibits a health care service plan from imposing prior authorization or any other utilization management requirements on COVID-19 diagnostic and screening testing. Existing law requires the State Department of Health Care Services to seek any federal approval it deems necessary to implement those provisions regarding COVID-19.*

*This bill would require a Medi-Cal managed care plan, as defined, to cover COVID-19 screening, testing, immunizations, and therapeutics in accordance with applicable statutes, regulations, all plan letters, the Medi-Cal provider manual, Medi-Cal managed care plan contracts with the department, as specified, and other guidance. The bill would*

*exclude Medi-Cal managed care plans from the above-described prohibitions against cost sharing and utilization management by a health care service plan for COVID-19 diagnostic and screening testing. The bill would remove the above-described requirement on the State Department of Health Care Services to seek federal approval.*

*(14) Existing law sets forth a schedule of benefits covered under the Medi-Cal program, including hospice service that is certified under the federal Medicare Program, subject to utilization controls. Under existing law, coverage is available only to the extent that no additional net program costs are incurred. Under existing law, prior authorization is not required for hospice services, with exceptions in the case of any admission that violates federal law or for inpatient hospice services.*

*This bill would make the above-described restriction on prior authorization inoperative on July 1, 2026, and would repeal it as of January 1, 2027. Under the bill, hospice services would be covered under Medi-Cal in accordance with Medicare requirements and subject to utilization controls, while maintaining the condition on net program costs. The bill would condition implementation of this coverage on the availability of federal financial participation and receipt of any necessary federal approvals.*

*(15) Existing law authorizes the department to enter into contracts with manufacturers of single-source and multiple-source drugs, on a bid or nonbid basis, for drugs from each major therapeutic category. Existing law requires all pharmaceutical manufacturers to provide to the department a state rebate equal to an amount not less than 10% of the average manufacturer price based on Medi-Cal utilization data for any drug products that have been added to the Medi-Cal list of contract drugs under provisions relating to treatment of acquired immunodeficiency syndrome (AIDS) or an AIDS-related condition or to treatment of cancer. Existing law authorizes the department to restrict the availability of the drug products of certain manufacturers by requiring prior authorization when the department has not received a timely rebate payment, but authorizes a beneficiary to continue obtaining those drugs if the beneficiary qualifies for continuing care status. Continuing care status requires a beneficiary to have been taking the drug at the time the manufacturer is placed on prior authorization status and the department to receive a claim for the drug with a date of service that is within 100 days prior to the date the manufacturer was placed on prior authorization status.*

*This bill would delete the above-described provisions on continuing care status and, instead, beginning January 1, 2026, would authorize beneficiaries to continue to receive drugs previously prescribed but subject to prior authorization if their pharmacy provider or prescriber initiates a prior authorization request that is subsequently approved by the department. This bill would, effective January 1, 2026, for pharmaceutical manufacturers renewing or entering new state rebate agreements, require that the rebate amount be in an amount not less than 20% of the average manufacturer price if the federal rebate is less than 50% of that price, or an amount not less than 15% of that price if the federal rebate is 50% or greater of that price.*

*Under existing law, for purposes of the above-described drug products, if the pharmaceutical manufacturer does not enter into a supplemental rebate agreement within 60 days after the addition of the drug to the Medi-Cal list of contract drugs, the manufacturer is required to provide to the department a state rebate equal to not less than 20% of the average manufacturer price, as specified.*

*This bill would increase the state rebate minimum threshold to not less than 25% of the price. The bill would make a conforming change to a related provision.*

*Existing law establishes the Medi-Cal Drug Rebate Fund, into which nonfederal moneys collected by the department under the above-described rebate provisions are deposited. Under existing law, funds deposited into the Medi-Cal Drug Rebate Fund are continuously appropriated to the department for purposes of funding the nonfederal share of health care services for children, adults, seniors, and persons with disabilities enrolled in the Medi-Cal program.*

*By increasing the state rebate minimum threshold for the above-described drug products, the bill would make an appropriation.*

*Existing law requires the department, when it determines that a drug should be removed from the list of contract drugs, to conduct a public hearing to receive comment on the impact of removing the drug.*

*This bill would, instead of a public hearing, require the department to provide individual notice to impacted beneficiaries that the drug is only obtainable through the prior authorization process. The bill would require that the notice include a description of the beneficiary's right to a fair hearing and would encourage the beneficiary to consult a physician. The bill would require the department to also provide provider notice about the removal of the drug, as specified.*

*(16) Existing law requires, with exceptions, the temporary placement of a Medi-Cal provider under payment suspension upon receipt of a credible allegation of fraud for which an investigation is pending under the Medi-Cal program against the provider. Existing law sets forth related provisions regarding the department's collection of overpayments, appeal procedures afforded to the provider, offsetting of the overpayments to satisfy audit or appeal findings if the findings are against the provider, and return of the overpayments if the findings are in favor of the provider, as specified. Existing law authorizes the lifting of a payment suspension upon resolution of an investigation for fraud or abuse.*

*This bill would create the Medi-Cal Anti-Fraud Special Deposit Fund for the deposit of outstanding Medi-Cal payments intercepted as a result of a payment suspension. Under the bill, moneys would be continuously appropriated and allocated, but would remain in the fund until the department lifts the suspension, after which the department would be authorized to return the intercepted Medi-Cal payments to the provider or to offset the payments against any liabilities or restitution owed by the provider to the department.*

*(17) Existing law, the Medi-Cal Long-Term Care Reimbursement Act, requires the department to implement a facility-specific ratesetting system for certain skilled nursing facilities using a cost-based reimbursement rate methodology. Existing law requires the department, subject to any necessary federal approvals, for managed care rating periods that begin between January 1, 2023, and December 31, 2026, inclusive, to establish and implement the Workforce and Quality Incentive Program. Under that program, a network provider furnishing skilled nursing facility services to a Medi-Cal managed care enrollee is authorized to earn performance-based directed payments from the Medi-Cal managed care plan with which they contract, as specified, in addition to other certain payments. Existing law repeals the act on January 1, 2028, as specified.*

*This bill would instead apply the program to managed care rating periods that begin between January 1, 2023, and December 31, 2025, inclusive. The bill would make the provisions relating to the program inoperative on January 1, 2026, and authorize the department to conduct all necessary closeout activities applicable to any managed care rating period before January 1, 2026. The bill would repeal those provisions on January 1, 2027, or on the date that the Director of Health Care Services certifies to the Secretary of State that all necessary closeout*

*activities have been completed, whichever is later, but no later than January 1, 2028. The bill would delete a related provision regarding the supplementation of funds available for payments made under the program, as described above, for the 2026 calendar year.*

*(18) Existing law, subject to an appropriation by the Legislature for this purpose, expands the schedule of benefits to include an annual cognitive health assessment for Medi-Cal beneficiaries who are 65 years of age or older if they are otherwise ineligible for a similar assessment as part of an annual wellness visit under the Medicare Program. Existing law makes a Medi-Cal provider eligible to receive the payment for this benefit only if they comply with certain requirements, including completing cognitive health assessment training, as specified. Existing law requires the department, by January 1, 2024, and every 2 years thereafter, to consolidate and analyze data related to the benefit, and to post information on the utilization of, and payment for, the benefit on its internet website.*

*This bill would delete the requirement that a Medi-Cal provider complete specified cognitive health assessment training to be eligible to receive the payment. The bill would also delete the requirement that the department consolidate and analyze data and post information related to the benefit every 2 years.*

*(19) Existing law authorizes the Director of Health Care Services to terminate a contract or impose sanctions if the director finds that an entity that contracts with the department for the delivery of health care services, known as a contractor, fails to comply with contract requirements, state or federal law or regulations, or the state plan or approved waivers, or for other good cause. Existing law includes various entities as part of the definition of “contractor” for purposes of these provisions, including Medi-Cal managed care plans and Drug Medi-Cal organized delivery systems.*

*This bill would add, to the list of contractors subject to the above-described provisions, entities under the Home- and Community-Based Alternatives (HCBA) Waiver and the Program of All-Inclusive Care for the Elderly (PACE), as specified.*

*(20) Under existing law, to the extent that federal financial participation is available, federally qualified health center (FQHC) services and rural health clinic (RHC) services are covered Medi-Cal benefits. Under existing law, FQHC and RHC services are reimbursed on a per-visit basis, as defined.*

*This bill would, commencing July 1, 2026, require reimbursement for FQHC and RHC services that are eligible for federal financial participation. The bill would revise the definition of visit for purposes of this provision to mean a face-to-face encounter between an FQHC or RHC patient and specified health professionals that is eligible for federal financial participation or an encounter between an FQHC or RHC patient and specified health professionals using specified modalities, including, among others, video synchronous interaction, when services delivered through those modalities meet the applicable standard of care and are eligible for federal participation.*

*(21) Existing law requires the department to establish the Nondesignated Public Hospital Intergovernmental Transfer Program to provide supplemental payments to nondesignated public hospitals in a manner that maximizes federal financial participation in the resulting supplemental payments. Existing law authorizes a transferring entity, as defined, to agree to transfer its intergovernmental transfer (IGT) allocation, as defined, to the state in accordance with the program, and requires the state to deposit the transferred funds into the Medi-Cal Inpatient Payment Adjustment Fund, which is a continuously appropriated fund. Existing law authorizes the state to retain 9% of each intergovernmental transfer amount to reimburse the department, or transfer to the General Fund, for the administrative costs of operating the program and for the benefit of Medi-Cal children's health care programs.*

*This bill would require a nondesignated public hospital participating in the program to reimburse the department for specified administrative costs as a condition of receiving the above-described supplemental payments. Beginning with the 2026–27 fiscal year and every fiscal year thereafter, the bill would require the state to retain a percentage of each IGT amount associated with interim supplemental payments such that the total amount retained is equal to the projected administrative cost to the department, as specified. The bill would require the department to project the specified administrative costs each fiscal year to determine the percentage to be retained. To the extent the bill would continuously appropriate additional moneys, the bill would make an appropriation.*

*(22) Existing law establishes the Medi-Cal Hospital/Uninsured Care Demonstration Project Act, which revises hospital reimbursement methodologies under the Medi-Cal program to maximize the use of federal funds consistent with federal Medicaid law and stabilize the*

*distribution of funding for hospitals that provide care to Medi-Cal beneficiaries and uninsured patients. Existing law provides funding, in supplementation of Medi-Cal reimbursement, to various hospitals, including nondesignated public hospitals, in accordance with certain provisions relating to disproportionate share hospitals. Existing law establishes the Nondesignated Public Hospital Supplemental Fund, a continuously appropriated fund, in the State Treasury, and requires all amounts in the fund for a project year in excess of the amount necessary to make specified supplemental payments to be available for negotiation by the California Medical Assistance Commission, as provided.*

*For the 2025–26 fiscal year, this bill would require additional supplemental payments to be made to nondesignated public hospitals that meet certain criteria such that the specified payments made are equal to the prescribed amount transferred from the General Fund plus the applicable amount of federal financial participation that is available for the nonfederal share of payments. The bill would require the remaining amounts in the fund to be used for supplemental payments to nondesignated public hospitals pursuant to a methodology developed by the department, as specified. The bill would make these provisions inoperative on June 30, 2026, abolish the fund effective December 31, 2028, and repeal these provisions on July 1, 2030. The bill would authorize the department to conduct any necessary and remaining duties, as specified, even after these provisions become inoperative.*

*(23) The federal Medicaid program prohibits payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Existing state law extends Medi-Cal eligibility for the full scope of Medi-Cal benefits to an individual who does not have satisfactory immigration status if they are otherwise eligible for those benefits, as specified.*

*This bill would instead exclude an individual who is 19 years of age or older and does not have satisfactory immigration status from dental benefits under Medi-Cal, as specified and would, beginning no sooner than July 1, 2027, require individuals who are not pregnant and who are 19 to 59 years of age, inclusive, to pay a monthly premium of \$30, subject to certain exceptions. The bill would make an individual who is 19 years of age or older and does not have satisfactory immigration status and who applies for Medi-Cal on or after January 1, 2026, eligible only for pregnancy-related services and emergency medical treatment. The bill would delay the implementation of certain provisions*

*until the director makes specified communications to the Department of Finance. The bill would make other conforming changes. Because counties are required to make Medi-Cal eligibility determinations and this bill would alter Medi-Cal eligibility, the bill would impose a state-mandated local program.*

*(24) Existing law prohibits the use of an assets or resources test for individuals whose income eligibility for Medi-Cal is determined based on the application of a modified adjusted gross income (MAGI). Existing federal law authorizes a state to establish a non-MAGI standard for determining the eligibility of certain populations.*

*Existing law, subject to receipt of any necessary federal approvals, prohibits the use of resources, including property or other assets, to determine Medi-Cal eligibility for applicants or beneficiaries whose eligibility is not determined using the MAGI-based financial methods. Existing law requires the department to seek federal authority to disregard all resources as authorized by the flexibilities provided pursuant to federal law.*

*This bill would, commencing on January 1, 2026, remove the above-described prohibition on the use of resources for determining Medi-Cal eligibility in non-MAGI cases and implement a disregard of \$130,000 in nonexempt property for a case with one member and \$65,000 for each additional household member, up to a maximum of 10 members, as specified. As part of conforming changes, the bill would make certain provisions inoperative on January 1, 2026, and would repeal them as of January 1, 2027. The bill would make certain inoperative provisions operative for purposes of reinstating references to resources or assets.*

*The bill would make certain additional changes to the above-described provisions, including modifying the timeline of certain regulations and changing certain reporting requirements.*

*By creating new duties for counties relating to the consideration of resources for determining Medi-Cal eligibility, the bill would impose a state-mandated local program.*

*(25) Existing law establishes the Children and Youth Behavioral Health Initiative, administered by the California Health and Human Services Agency and its departments, with the purpose of transforming the state's behavioral health system into an innovative ecosystem in which all children and youth 25 years of age and younger, regardless of payer, are screened, supported, and served for emerging and existing behavioral health needs. Existing law requires, subject to an*



*appropriation, that the initiative include, among other things, grants to qualified entities to support implementation of the initiative for behavioral health services in schools and investments for behavioral health workforce, education, and training. Existing law authorizes the Department of Health Care Access and Information to award competitive grants to qualified entities and individuals to expand the supply of behavioral health counselors, coaches, peer supports, and other allied health care providers serving children and youth, including those at schoolsites.*

*Existing law defines a “behavioral health coach,” for purposes of those provisions, to mean a new category of behavioral health provider who, among other things, (A) is trained specifically to help address the unmet mental health and substance use needs of children and youth, (B) receives appropriate supervision from licensed staff, and (C) has training and qualifications, including psychoeducation, system navigation, crisis deescalation, safety planning, coping skills, and motivational interviewing.*

*This bill would revise these provisions to replace the term “behavioral health coach” with “certified wellness coach.” The bill would specify that a certified wellness coach receives appropriate supervision and coordination from staff who are licensed or who hold a pupil personnel services credential or school nurse services credential. The bill would add crisis referral to, and remove crisis deescalation and safety planning from, the list of a certified wellness coach’s training and qualifications.*

*(26) Existing law, as a component of the Children and Youth Behavioral Health Initiative, authorizes the State Department of Health Care Services to award competitive grants to entities that it deems qualified to, among other things, expand access to licensed medical and behavioral health professionals, counselors, peer support specialists, community health workers, and behavioral health coaches serving children and youth.*

*This bill would revise that provision to replace the term “behavioral health coaches” with “certified wellness coaches.”*

*(27) Existing law establishes a Department of Health Care Access and Information within the California Health and Human Services Agency.*

*Existing law requires the department, on or before July 1, 2023, to develop and approve statewide requirements for community health worker certificate programs and to approve the curriculum required for programs to certify community health workers. Existing law requires*

*the department, on or before July 1, 2023, to review, approve, or renew evidence-based curricula and community-defined curricula for core competencies, specialized programs, and training. Existing law requires an organization that seeks approval or renewal of a community health worker certificate program to submit a community health worker certificate program plan, submit to periodic reviews, and submit annual community health worker certificate program reports, as specified. Existing law authorizes the department, in consultation with stakeholders, to request that an individual who is either enrolled in, or who has completed, a community health worker certificate program submit specified workforce data. Existing law defines “community health worker” to, among other things, include nonlicensed health workers with the qualifications developed pursuant to these provisions.*

*This bill would repeal these provisions. The bill would make conforming changes to provisions defining “community health worker” by cross-reference to the above-described definition.*

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

*This bill would make legislative findings to that effect.*

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

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

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

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

~~*This bill would express the intent of the Legislature to enact statutory changes relating to the Budget Act of 2025.*~~

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

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

1     **SECTION 1.** *Section 1265.9 of the Health and Safety Code is*  
2 *amended to read:*

3     1265.9. (a) On and after July 1, 2015, any acute psychiatric  
4 hospital that submits a completed application and is operated by  
5 the State Department of State Hospitals may be approved by the  
6 State Department of Public Health to offer, as a supplemental  
7 service, an Enhanced Treatment Program (ETP) that meets the  
8 requirements of this section, Section 4144 of the Welfare and  
9 Institutions Code, and applicable regulations.

10     ~~(b) This section shall remain in effect for each pilot ETP until~~  
11 ~~January 1 of the fifth calendar year after each pilot ETP site has~~  
12 ~~admitted its first patient, and is repealed as of January 1 of the fifth~~  
13 ~~calendar year after each pilot ETP site has admitted its first patient,~~  
14 ~~unless a later enacted statute extending the program is enacted~~  
15 ~~prior to those dates. The State Department of State Hospitals shall~~  
16 ~~post a declaration on its Internet Web site when the condition for~~  
17 ~~repealing this section is met stating that this section is repealed.~~

18     (e)

19     (b) (1) Prior to the admission of the first patient into the last  
20 pilot ETP, the State Department of Public Health may adopt  
21 emergency regulations in accordance with the Administrative  
22 Procedure Act (Chapter 3.5 (commencing with Section 11340) of  
23 Part 1 of Division 3 of Title 2 of the Government Code) to  
24 implement this section. The adoption of an emergency regulation  
25 under this paragraph is deemed to address an emergency, for  
26 purposes of Sections 11346.1 and 11349.6 of the Government  
27 Code, and the State Department of Public Health is hereby  
28 exempted for this purpose from the requirements of subdivision  
29 (b) of Section 11346.1 of the Government Code.

30     (2) As an alternative to paragraph (1) and notwithstanding the  
31 rulemaking provisions of Administrative Procedures Act (Chapter  
32 3.5 (commencing with Section 11340) of Part 1 of Division 3 of  
33 Title 2 of the Government Code), the director of the State  
34 Department of Public Health may implement this section, in whole  
35 or in part, by means of an all facility letter or other similar  
36 instruction.

37     ~~(d)~~

38     (c) An ETP shall meet all of the following requirements:

- 1 (1) Maintain a staff-to-patient ratio of one to five.
- 2 (2) Limit each room to one patient.
- 3 (3) Each patient room shall allow visual access by staff 24 hours
- 4 per day.
- 5 (4) Each patient room shall have a toilet and sink in the room.
- 6 (5) Each patient room door shall have the capacity to be locked
- 7 externally. The door may be locked when clinically indicated and
- 8 determined to be the least restrictive treatment environment for
- 9 the patient's care and treatment pursuant to Section 4144 of the
- 10 Welfare and Institutions Code, but shall not be considered
- 11 seclusion, as defined ~~by~~ *in* subdivision (e) of Section 1180.1, for
- 12 purposes of Division 1.5 (commencing with Section 1180).
- 13 (6) Provide emergency egress for ETP patients.
- 14 (7) In the event *that* seclusion or restraints, as defined ~~by~~ *in*
- 15 Section 1180.1, are used in an ETP, all state licensing and
- 16 regulations shall be followed.
- 17 (8) A full-time independent patients' rights advocate who
- 18 provides patients' rights advocacy services shall be assigned to
- 19 each ETP.
- 20 ~~(e)~~
- 21 *(d)* The ETPs shall adopt and implement policies and procedures
- 22 necessary to encourage patient improvement, recovery, and a return
- 23 to a standard treatment environment, and to create identifiable
- 24 facility requirements and ~~benchmarks~~ *benchmarks*. The policies
- 25 and procedures shall also provide all of the following:
- 26 (1) Criteria and process for admission into an ETP pursuant to
- 27 Section 4144 of the Welfare and Institutions Code.
- 28 (2) Clinical assessment and review focused on behavior, history,
- 29 high risk of most dangerous behavior, and clinical need for patients
- 30 to receive treatment in an ETP as the least restrictive treatment
- 31 environment.
- 32 (3) A process for identifying an ETP along a continuum of care
- 33 that will best meet the patient's needs, including least restrictive
- 34 treatment environment.
- 35 (4) A process for creating and implementing a treatment plan
- 36 with regular clinical review and reevaluation of placement back
- 37 into a standard treatment environment and discharge and
- 38 reintegration planning as specified in subdivision (e) of Section
- 39 4144 of the Welfare and Institutions Code.
- 40 ~~(f)~~

(e) Patients who have been admitted to an ETP shall have the same rights guaranteed to patients not in an ETP with the exception set forth in paragraph (5) of subdivision ~~(d)~~. (c).

~~(g)~~

(f) For purposes of paragraph (1) of subdivision ~~(d)~~, (c), “staff” means licensed nurses and psychiatric technicians providing direct patient care.

(g) *This section shall remain in effect only until January 1, 2030, and as of that date is repealed, unless a later enacted statute that is enacted before January 1, 2030, deletes or extends that date.*

SEC. 2. *Section 1276.4 of the Health and Safety Code is amended to read:*

1276.4. (a) By January 1, 2002, the State Department of Public Health shall adopt regulations that establish minimum, specific, and numerical licensed nurse-to-patient ratios by licensed nurse classification and by hospital unit for all health facilities licensed pursuant to subdivision ~~(a)~~, ~~(b)~~, (a) or (f) of Section 1250. *No later than July 31, 2027, or one and one-half years after adoption of emergency regulations pursuant to subdivision (k), whichever is sooner, the State Department of Public Health shall adopt regulations pursuant 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), as specified in subdivision (k), that establish minimum, specific, and numerical licensed nurse-to-patient ratios for health facilities licensed pursuant to subdivision (b) of Section 1250.* The State Department of Public Health shall adopt these regulations in accordance with the department’s licensing and certification regulations as stated in Sections 70053.2, 70215, and 70217 of Title 22 of the California Code of Regulations, and the professional and vocational regulations in Section 1443.5 of Title 16 of the California Code of Regulations. The department shall review these regulations five years after adoption and shall report to the Legislature regarding any proposed changes. Flexibility shall be considered by the department for rural general acute care hospitals in response to their special needs. As used in this subdivision, “hospital unit” means a critical care unit, burn unit, labor and delivery room, postanesthesia service area, emergency department, operating room, pediatric unit, step-down/intermediate care unit, specialty care unit, telemetry unit, general medical care unit, subacute care

1 unit, and transitional inpatient care unit. The regulation addressing  
2 the emergency department shall distinguish between regularly  
3 scheduled core staff licensed nurses and additional licensed nurses  
4 required to care for critical care patients in the emergency  
5 department.

6 (b) These ratios shall constitute the minimum number of  
7 registered and licensed nurses that shall be allocated. Additional  
8 staff shall be assigned in accordance with a documented patient  
9 classification system for determining nursing care requirements,  
10 including the severity of the illness, the need for specialized  
11 equipment and technology, the complexity of clinical judgment  
12 needed to design, implement, and evaluate the patient care plan  
13 and the ability for self-care, and the licensure of the personnel  
14 required for care.

15 (c) “Critical care unit” as used in this section means a unit that  
16 is established to safeguard and protect patients whose severity of  
17 medical conditions requires continuous monitoring, and complex  
18 intervention by licensed nurses.

19 (d) All health facilities licensed under subdivision (a), (b), or  
20 (f) of Section 1250 shall adopt written policies and procedures for  
21 training and orientation of nursing staff.

22 (e) No registered nurse shall be assigned to a nursing unit or  
23 clinical area unless that nurse has first received orientation in that  
24 clinical area sufficient to provide competent care to patients in that  
25 area, and has demonstrated current competence in providing care  
26 in that area.

27 (f) The written policies and procedures for orientation of nursing  
28 staff shall require that all temporary personnel shall receive  
29 orientation and be subject to competency validation consistent  
30 with Sections 70016.1 and 70214 of Title 22 of the California Code  
31 of Regulations.

32 (g) Requests for waivers to this section that do not jeopardize  
33 the health, safety, and well-being of patients affected and that are  
34 needed for increased operational efficiency may be granted by the  
35 department to rural general acute care hospitals meeting the criteria  
36 set forth in Section 70059.1 of Title 22 of the California Code of  
37 Regulations.

38 (h) In case of conflict between this section and any provision  
39 or regulation defining the scope of nursing practice, the scope of  
40 practice provisions shall control.

1 (i) The regulations adopted by the department shall augment  
2 and not replace existing nurse-to-patient ratios that exist in  
3 regulation or law for the intensive care units, the neonatal intensive  
4 care units, or the operating room.

5 (j) The regulations adopted by the department shall not replace  
6 existing licensed staff-to-patient ratios for hospitals operated by  
7 the State Department of State Hospitals.

8 (k) (1) The regulations adopted by the department for health  
9 facilities licensed under subdivision (b) of Section 1250 that are  
10 not operated by the State Department of State Hospitals shall take  
11 into account the special needs of the patients served in the  
12 psychiatric units.

13 (2) *The department shall adopt emergency regulations pursuant*  
14 *to this subdivision no later than January 31, 2026. The department*  
15 *may readopt any emergency regulation authorized by this*  
16 *subdivision that is the same as, or substantially equivalent to, an*  
17 *emergency regulation previously adopted under this subdivision.*

18 (3) *The adoption of emergency regulations pursuant to this*  
19 *subdivision and two readoptions of emergency regulations shall*  
20 *be deemed an emergency and necessary for the immediate*  
21 *preservation of the public peace, health, safety, or general welfare.*  
22 *Emergency regulations and readoptions authorized by this section*  
23 *shall be exempt from review by the Office of Administrative Law.*  
24 *The emergency regulations and the readoptions authorized by this*  
25 *section shall be submitted to the Office of Administrative Law for*  
26 *filing with the Secretary of State. Notwithstanding any other*  
27 *provision of law, the adoption and readoptions of these emergency*  
28 *regulations shall be exempt from the requirements of subdivision*  
29 *(b) of Section 11346.1 of the Government Code and each shall*  
30 *remain in effect for no more than 180 days.*

31 (4) *The emergency regulations adopted pursuant to this*  
32 *subdivision may include, but are not limited to, the following:*

33 (A) *Staffing standards, including nurse-to-patient, specific to*  
34 *acute psychiatric hospitals.*

35 (B) *Requirements used to determine appropriate staffing based*  
36 *on patient acuity and care needs.*

37 (C) *Requirements that the State Department of Public Health*  
38 *deems necessary or relevant to staffing policies and procedures*  
39 *to promote patient safety.*

(l) The department may take into consideration the unique nature of the University of California teaching hospitals as educational institutions when establishing licensed nurse-to-patient ratios. The department shall coordinate with the Board of Registered Nursing to ensure that staffing ratios are consistent with the Board of Registered Nursing approved nursing education requirements. This includes nursing clinical experience incidental to a work-study program rendered in a University of California clinical facility approved by the Board of Registered Nursing provided there will be sufficient direct care registered nurse preceptors available to ensure safe patient care.

SEC. 3. *Section 1276.66 of the Health and Safety Code is amended to read:*

1276.66. (a) (1) ~~There is hereby continued in the Special Deposit Fund, established pursuant to Section 16370 of the Government Code, the Skilled Nursing Facility Minimum Staffing Penalty Account. The Skilled Nursing Facility Minimum Staffing Penalty Account is hereby established in the State Treasury.~~ The account shall contain all moneys deposited pursuant to subdivision (b).

(2) Notwithstanding Section 13340 of the Government Code or any other law, the Skilled Nursing Facility Minimum Staffing Penalty Account is hereby continuously appropriated, without regard to fiscal years, to the State Department of Public Health to support the implementation of this section.

(b) (1) The State Department of Public Health shall use the direct care staffing level data it collects to determine whether a skilled nursing facility has met the nursing hours or direct care service hours per patient per day requirements pursuant to Section 1276.5 or 1276.65, as applicable.

(2) (A) The State Department of Public Health shall assess a skilled nursing facility, licensed pursuant to subdivision (c) of Section 1250, an administrative penalty if the State Department of Public Health determines that the skilled nursing facility fails to meet the nursing hours or direct care service hours per patient per day requirements pursuant to Section 1276.5 or 1276.65, as applicable, as follows:

(i) Twenty-five thousand dollars (\$25,000) if the facility fails to meet the requirements for 5 percent or more of the audited days up to 49 percent.



1 (ii) Fifty thousand dollars (\$50,000) if the facility fails to meet  
2 the requirements for over 49 percent or more of the audited days.

3 (B) (i) If the skilled nursing facility does not dispute the  
4 determination or assessment, the penalties shall be paid in full by  
5 the licensee to the State Department of Public Health within 30  
6 days of the facility's receipt of the notice of penalty and deposited  
7 into the Skilled Nursing Facility Minimum Staffing Penalty  
8 Account.

9 (ii) The State Department of Public Health may, upon written  
10 notification to the licensee, request that the State Department of  
11 Health Care Services offset any moneys owed to the licensee by  
12 the Medi-Cal program or any other payment program administered  
13 by the State Department of Health Care Services to recoup the  
14 penalty provided for in this section.

15 (C) (i) If a facility disputes the determination or assessment  
16 made pursuant to this paragraph, the facility shall, within 30 days  
17 of the facility's receipt of the determination and assessment,  
18 simultaneously submit a request for appeal to both the State  
19 Department of Health Care Services and the State Department of  
20 Public Health. A request for an appeal may be made by a facility  
21 based upon a determination that does not result in an assessment.  
22 The request shall include a detailed statement describing the reason  
23 for appeal and include all supporting documents the facility will  
24 present at the hearing.

25 (ii) Within 30 days of the State Department of Public Health's  
26 receipt of the facility's request for appeal, the State Department  
27 of Public Health shall submit, to both the facility and the State  
28 Department of Health Care Services, its responsive arguments and  
29 all supporting documents that the State Department of Public  
30 Health will present at the hearing.

31 (D) The State Department of Health Care Services shall hear a  
32 timely appeal and issue a decision as follows:

33 (i) The hearing shall commence within 60 days from the date  
34 of receipt by the State Department of Health Care Services of the  
35 facility's timely request for appeal.

36 (ii) The State Department of Health Care Services shall issue a  
37 decision within 120 days from the date of receipt by the State  
38 Department of Health Care Services of the facility's timely request  
39 for appeal.

1 (iii) The decision of the State Department of Health Care  
2 Services' hearing officer, when issued, shall be the final decision  
3 of the State Department of Public Health.

4 (E) The appeals process set forth in this paragraph shall be  
5 exempt from Chapter 4.5 (commencing with Section 11400), and  
6 Chapter 5 (commencing with Section 11500), of Part 1 of Division  
7 3 of Title 2 of the Government Code. The provisions of Sections  
8 100171 and 131071 do not apply to appeals under this paragraph.

9 (F) If a hearing decision issued pursuant to subparagraph (D)  
10 is in favor of the State Department of Public Health, the skilled  
11 nursing facility shall pay the penalties to the State Department of  
12 Public Health within 30 days of the facility's receipt of the  
13 decision. The penalties collected shall be deposited into the Skilled  
14 Nursing Facility Minimum Staffing Penalty Account.

15 (c) The assessment of a penalty under this section shall not  
16 prohibit any state or federal enforcement action, including, but not  
17 limited to, State Department of Public Health's investigation  
18 process or issuance of deficiencies or citations under Chapter 2.4  
19 (commencing with Section 1417).

20 (d) Notwithstanding Chapter 3.5 (commencing with Section  
21 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
22 the State Department of Public Health may implement this section  
23 by means of all-facility letters or other similar instructions without  
24 taking regulatory action.

25 (e) In implementing this section, the State Department of Public  
26 Health may contract, as necessary, with California's Medicare  
27 Quality Improvement Organization, or other entities deemed  
28 qualified by the State Department of Public Health, not associated  
29 with a skilled nursing facility. The department may enter into  
30 exclusive or nonexclusive contracts, or amend existing contracts,  
31 on a bid or negotiated basis for purposes of implementing this  
32 subdivision. Contracts entered into or amended pursuant to this  
33 subdivision shall be exempt from Chapter 6 (commencing with  
34 Section 14825) of Part 5.5 of Division 3 of Title 2 of the  
35 Government Code, Part 2 (commencing with Section 10100) of  
36 Division 2 of the Public Contract Code, the State Administrative  
37 Manual, and the State Contracting Manual, and shall be exempt  
38 from the review or approval of any division of the State Department  
39 of General Services.

40 ~~(f) This section shall become operative on January 1, 2023.~~

1     (f) *Notwithstanding any other law, the State Controller may use*  
2     *the funds in the Skilled Nursing Facility Minimum Staffing Penalty*  
3     *Account for cash flow loans to the General Fund as provided in*  
4     *Sections 16310 and 16381 of the Government Code.*

5     SEC. 4. *Section 1280.15 of the Health and Safety Code is*  
6     *amended to read:*

7     1280.15. (a) A clinic, health facility, home health agency, or  
8     hospice licensed pursuant to Section 1204, 1250, 1725, or 1745  
9     shall prevent unlawful or unauthorized access to, and use or  
10    disclosure of, patients' medical information, as defined in Section  
11    56.05 of the Civil Code and consistent with Section 1280.18. For  
12    purposes of this section, internal paper records, electronic mail,  
13    or facsimile transmissions inadvertently misdirected within the  
14    same facility or health care system within the course of  
15    coordinating care or delivering services shall not constitute  
16    unauthorized access to, or use or disclosure of, a patient's medical  
17    information. The department, after investigation, may assess an  
18    administrative penalty for a violation of this section of up to  
19    twenty-five thousand dollars (\$25,000) per patient whose medical  
20    information was unlawfully or without authorization accessed,  
21    used, or disclosed, and up to seventeen thousand five hundred  
22    dollars (\$17,500) per subsequent occurrence of unlawful or  
23    unauthorized access, use, or disclosure of that patient's medical  
24    information. For purposes of the investigation, the department  
25    shall consider the clinic's, health facility's, agency's, or hospice's  
26    history of compliance with this section and other related state and  
27    federal statutes and regulations, the extent to which the facility  
28    detected violations and took preventative action to immediately  
29    correct and prevent past violations from recurring, and factors  
30    outside its control that restricted the facility's ability to comply  
31    with this section. The department shall have full discretion to  
32    consider all factors when determining whether to investigate and  
33    the amount of an administrative penalty, if any, pursuant to this  
34    section.

35    (b) (1) A clinic, health facility, home health agency, or hospice  
36    to which subdivision (a) applies shall report any unlawful or  
37    unauthorized access to, or use or disclosure of, a patient's medical  
38    information to the department no later than 15 business days after  
39    the unlawful or unauthorized access, use, or disclosure has been

1 detected by the clinic, health facility, home health agency, or  
2 hospice.

3 (2) Subject to subdivision (c), a clinic, health facility, home  
4 health agency, or hospice shall also report any unlawful or  
5 unauthorized access to, or use or disclosure of, a patient's medical  
6 information to the affected patient or the patient's representative  
7 at the last known address, or by an alternative means or at an  
8 alternative location as specified by the patient or the patient's  
9 representative in writing pursuant to Section 164.522(b) of Title  
10 45 of the Code of Federal Regulations, no later than 15 business  
11 days after the unlawful or unauthorized access, use, or disclosure  
12 has been detected by the clinic, health facility, home health agency,  
13 or hospice. Notice may be provided by email only if the patient  
14 has previously agreed in writing to electronic notice by email.

15 (c) (1) A clinic, health facility, home health agency, or hospice  
16 shall delay the reporting, as required pursuant to paragraph (2) of  
17 subdivision (b), of any unlawful or unauthorized access to, or use  
18 or disclosure of, a patient's medical information beyond 15  
19 business days if a law enforcement agency or official provides the  
20 clinic, health facility, home health agency, or hospice with a written  
21 or oral statement that compliance with the reporting requirements  
22 of paragraph (2) of subdivision (b) would likely impede the law  
23 enforcement agency's investigation that relates to the unlawful or  
24 unauthorized access to, and use or disclosure of, a patient's medical  
25 information and specifies a date upon which the delay shall end,  
26 not to exceed 60 days after a written request is made, or 30 days  
27 after an oral request is made. A law enforcement agency or official  
28 may request an extension of a delay based upon a written  
29 declaration that there exists a bona fide, ongoing, significant  
30 criminal investigation of serious wrongdoing relating to the  
31 unlawful or unauthorized access to, and use or disclosure of, a  
32 patient's medical information, that notification of patients will  
33 undermine the law enforcement agency's investigation, and that  
34 specifies a date upon which the delay shall end, not to exceed 60  
35 days after the end of the original delay period.

36 (2) If the statement of the law enforcement agency or official  
37 is made orally, then the clinic, health facility, home health agency,  
38 or hospice shall do both of the following:

39 (A) Document the oral statement, including, but not limited to,  
40 the identity of the law enforcement agency or official making the

1 oral statement and the date upon which the oral statement was  
2 made.

3 (B) Limit the delay in reporting the unlawful or unauthorized  
4 access to, or use or disclosure of, the patient's medical information  
5 to the date specified in the oral statement, not to exceed 30 calendar  
6 days from the date that the oral statement is made, unless a written  
7 statement that complies with the requirements of this subdivision  
8 is received during that time.

9 (3) A clinic, health facility, home health agency, or hospice  
10 shall submit a report that is delayed pursuant to this subdivision  
11 not later than 15 business days after the date designated as the end  
12 of the delay.

13 (d) If a clinic, health facility, home health agency, or hospice  
14 to which subdivision (a) applies violates subdivision (b), the  
15 department may assess the licensee a penalty in the amount of one  
16 hundred dollars (\$100) for each day that the unlawful or  
17 unauthorized access, use, or disclosure is not reported to the  
18 department or the affected patient, following the initial 15-day  
19 period specified in subdivision (b). However, the total combined  
20 penalty assessed by the department under subdivision (a) and this  
21 subdivision shall not exceed two hundred fifty thousand dollars  
22 (\$250,000) per reported event. For enforcement purposes, it shall  
23 be presumed that the facility did not notify the affected patient if  
24 the notification was not documented. This presumption may be  
25 rebutted by a licensee only if the licensee demonstrates, by a  
26 preponderance of the evidence, that the notification was made.

27 (e) In enforcing subdivisions (a) and (d), the department shall  
28 take into consideration the special circumstances of small and rural  
29 hospitals, as defined in Section 124840, and primary care clinics,  
30 as defined in subdivision (a) of Section 1204, in order to protect  
31 access to quality care in those hospitals and clinics. When assessing  
32 a penalty on a skilled nursing facility or other facility subject to  
33 Section 1423, 1424, 1424.1, or 1424.5, the department shall issue  
34 only the higher of either a penalty for the violation of this section  
35 or a penalty for violation of Section 1423, 1424, 1424.1, or 1424.5,  
36 not both.

37 (f) All penalties collected by the department pursuant to this  
38 section, Sections 1280.1, 1280.3, ~~and 1280.4~~, *and 1280.19*, shall  
39 be deposited into the Internal Departmental Quality Improvement  
40 Account, which is hereby ~~created within the Special Deposit Fund~~

~~under Section 16370 of the Government Code.~~ *established in the State Treasury. Notwithstanding Section 16305.7 of the Government Code, all interest earned on the moneys deposited into the account shall be retained in the account.* Upon appropriation by the Legislature, moneys in the account shall be expended for internal quality improvement activities in the Licensing and Certification Program.

(g) If the licensee disputes a determination by the department regarding a failure to prevent or failure to timely report unlawful or unauthorized access to, or use or disclosure of, patients' medical information, or the imposition of a penalty under this section, the licensee may, within 10 days of receipt of the penalty assessment, request a hearing pursuant to Section 131071. Penalties shall be paid when appeals have been exhausted and the penalty has been upheld.

(h) In lieu of disputing the determination of the department regarding a failure to prevent or failure to timely report unlawful or unauthorized access to, or use or disclosure of, patients' medical information, transmit to the department 75 percent of the total amount of the administrative penalty, for each violation, within 30 business days of receipt of the administrative penalty.

(i) For purposes of this section, the following definitions shall apply:

(1) "Reported event" means all breaches included in any single report that is made pursuant to subdivision (b), regardless of the number of breach events contained in the report.

(2) "Unauthorized" means the inappropriate access, review, or viewing of patient medical information without a direct need for medical diagnosis, treatment, or other lawful use as permitted by the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code) or any other statute or regulation governing the lawful access, use, or disclosure of medical information.

(j) *Notwithstanding any other provision of law, the State Controller may use the funds in the Internal Departmental Quality Improvement Account for cash flow loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code.*

SEC. 5. *Section 1280.19 of the Health and Safety Code is amended to read:*

1 1280.19. ~~The~~ (a) *Effective July 1, 2025, the Internal Health*  
2 *Information Integrity Quality Improvement Account is hereby*  
3 ~~created in the State Treasury.~~ *abolished. All moneys in the fund*  
4 *shall be transferred to the Internal Departmental Quality*  
5 *Improvement Account created pursuant to subdivision (f) of Section*  
6 *1280.15. Any remaining balance, assets, liabilities, and*  
7 *encumbrances of the Internal Health Information Integrity Quality*  
8 *Improvement Account as of July 1, 2025, shall be transferred to,*  
9 *and become part of, the Internal Departmental Quality*  
10 *Improvement Account. All administrative fines assessed by the*  
11 *department pursuant to Section 56.36 of the Civil Code shall be*  
12 ~~deposited in the Internal Health Information Integrity~~ *into the*  
13 *Internal Departmental Quality Improvement Account.*  
14 *Notwithstanding Section 16305.7 of the Government Code, all*  
15 *interest earned on the moneys deposited in the account shall be*  
16 *retained in the account. Upon appropriation by the Legislature,*  
17 ~~money~~ *moneys in the account shall be used for the purpose of*  
18 *supporting quality improvement activities in the—department.*  
19 *Licensing and Certification Program.*

20 (b) *Notwithstanding any other provision of law, the State*  
21 *Controller may use the funds in the Internal Departmental Quality*  
22 *Improvement Account for cash flow loans to the General Fund as*  
23 *provided in Sections 16310 and 16381 of the Government Code.*

24 SEC. 6. *Section 1342.2 of the Health and Safety Code is*  
25 *amended to read:*

26 1342.2. (a) *Notwithstanding any other law, a health care*  
27 *service plan contract that covers medical, surgical, and hospital*  
28 *benefits, excluding a specialized health care service plan contract,*  
29 *shall cover the costs for COVID-19 diagnostic and screening*  
30 *testing and health care services related to diagnostic and screening*  
31 *testing approved or granted emergency use authorization by the*  
32 *federal Food and Drug Administration for COVID-19, regardless*  
33 *of whether the services are provided by an in-network or*  
34 *out-of-network provider. Coverage required by this section shall*  
35 *not be subject to copayment, coinsurance, deductible, or any other*  
36 *form of cost sharing. Services related to COVID-19 diagnostic*  
37 *and screening testing include, but are not limited to, hospital or*  
38 *health care provider office visits for the purposes of receiving*  
39 *testing, products related to testing, the administration of testing,*  
40 *and items and services furnished to an enrollee as part of testing.*

1 Services related to COVID-19 diagnostic and screening testing do  
2 not include bonus payments for the use of specialized equipment  
3 or expedited processing.

4 (1) To the extent a health care provider would have been entitled  
5 to receive cost sharing but for this section, the health care service  
6 plan shall reimburse the health care provider the amount of that  
7 lost cost sharing.

8 (2) A health care service plan contract shall not impose prior  
9 authorization or any other utilization management requirements  
10 on COVID-19 diagnostic and screening testing.

11 (3) With respect to an enrollee, a health care service plan shall  
12 reimburse the provider of the testing according to either of the  
13 following:

14 (A) If the health plan has a specifically negotiated rate for  
15 COVID-19 diagnostic and screening testing with such provider in  
16 effect before the public health emergency declared under Section  
17 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such  
18 negotiated rate shall apply throughout the period of such  
19 declaration.

20 (B) If the health plan does not have a specifically negotiated  
21 rate for COVID-19 diagnostic and screening testing with such  
22 provider, the plan may negotiate a rate with such provider.

23 (4) For an out-of-network provider with whom a health care  
24 service plan does not have a specifically negotiated rate for  
25 COVID-19 diagnostic and screening testing and health care  
26 services related to testing, a plan shall reimburse the provider for  
27 all testing items or services in an amount that is reasonable, as  
28 determined in comparison to prevailing market rates for testing  
29 items or services in the geographic region where the item or service  
30 is rendered. An out-of-network provider shall accept this payment  
31 as payment in full, shall not seek additional remuneration from an  
32 enrollee for services related to testing, and shall not report adverse  
33 information to a consumer credit reporting agency or commence  
34 civil action against the enrollee.

35 (5) Beginning six months after the federal public health  
36 emergency expires, a health care service plan shall no longer be  
37 required to cover the cost sharing for COVID-19 diagnostic and  
38 screening testing and health care services related to testing when  
39 delivered by an out-of-network provider, except as otherwise



1 required by law. All other requirements of this subdivision shall  
2 remain in effect after the federal public health emergency expires.

3 (6) Changes to a contract between a health care service plan  
4 and a provider delegating financial risk for diagnostic and screening  
5 testing related to a declared public health emergency shall be  
6 considered a material change to the parties' contract. A health care  
7 service plan shall not delegate the financial risk to a contracted  
8 provider for the cost of enrollee services provided under this section  
9 unless the parties have negotiated and agreed upon a new provision  
10 of the parties' contract pursuant to Section 1375.7.

11 (b) (1) A health care service plan contract that covers medical,  
12 surgical, and hospital benefits shall cover without cost sharing any  
13 item, service, or immunization that is intended to prevent or  
14 mitigate COVID-19 and that is either of the following with respect  
15 to the individual enrollee:

16 (A) An evidence-based item or service that has in effect a rating  
17 of "A" or "B" in the current recommendations of the United States  
18 Preventive Services Task Force.

19 (B) An immunization that has in effect a recommendation from  
20 the Advisory Committee on Immunization Practices of the federal  
21 Centers for Disease Control and Prevention, regardless of whether  
22 the immunization is recommended for routine use.

23 (2) The item, service, or immunization covered pursuant to  
24 paragraph (1) shall be covered no later than 15 business days after  
25 the date on which the United States Preventive Services Task Force  
26 or the Advisory Committee on Immunization Practices of the  
27 federal Centers for Disease Control and Prevention makes a  
28 recommendation relating to the item, service, or immunization. A  
29 recommendation from the Advisory Committee on Immunization  
30 Practices of the federal Centers for Disease Control and Prevention  
31 is considered in effect after it has been adopted, or granted  
32 emergency use authorization, by the Director of the Centers for  
33 Disease Control and Prevention.

34 (3) (A) A health care service plan subject to this subdivision  
35 shall not impose any cost-sharing requirements, including a  
36 copayment, coinsurance, or deductible, for any item, service, or  
37 immunization described in paragraph (1), regardless of whether  
38 such service is delivered by an in-network or out-of-network  
39 provider.

1 (B) To the extent a health care provider would have been entitled  
2 to receive cost sharing but for this section, the health care service  
3 plan shall reimburse the health care provider the amount of that  
4 lost cost sharing.

5 (C) With respect to an enrollee, a health care service plan shall  
6 reimburse the provider of the immunization according to either of  
7 the following:

8 (i) If the health plan has a negotiated rate with such provider in  
9 effect before the public health emergency declared under Section  
10 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such  
11 negotiated rate shall apply throughout the period of such  
12 declaration.

13 (ii) If the health plan does not have a negotiated rate with such  
14 provider, the plan may negotiate a rate with such provider.

15 (D) A health care service plan shall not impose cost sharing for  
16 any items or services that are necessary for the furnishing of an  
17 item, service, or immunization described in paragraph (1),  
18 including, but not limited to, provider office visits and vaccine  
19 administration, regardless of whether the service is delivered by  
20 an in-network or out-of-network provider.

21 (E) (i) For an out-of-network provider with whom a health care  
22 service plan does not have a negotiated rate for an item, service,  
23 or immunization described in paragraph (1), a health care service  
24 plan shall reimburse the provider for all related items or services,  
25 including any items or services that are necessary for the furnishing  
26 of an item, service, or immunization described in paragraph (1),  
27 in an amount that is reasonable, as determined in comparison to  
28 prevailing market rates for such items or services in the geographic  
29 region in which the item or service is rendered. An out-of-network  
30 provider shall accept this payment as payment in full, shall not  
31 seek additional remuneration from an enrollee, and shall not report  
32 adverse information to a consumer credit reporting agency or  
33 commence civil action against the enrollee for items, services, and  
34 immunizations described in subdivision (b), including any items  
35 or services that are necessary for the furnishing of an item, service,  
36 or immunization described in paragraph (1).

37 (ii) Beginning six months after the federal public health  
38 emergency expires, a health care service plan shall no longer be  
39 required to cover the cost sharing for any item, service, or  
40 immunization described in paragraph (1) and to cover items or

1 services that are necessary for the furnishing of the items, services,  
2 or immunizations described in paragraph (1) when delivered by  
3 an out-of-network provider, except as otherwise required by law.  
4 All other requirements of this section shall remain in effect after  
5 the federal public health emergency expires.

6 (4) A health care service plan subject to this subdivision shall  
7 not impose prior authorization or any other utilization management  
8 requirements on any item, service, or immunization described in  
9 paragraph (1) or to items or services that are necessary for the  
10 furnishing of the items, services, or immunizations described in  
11 subparagraph (D) of paragraph (3).

12 (5) Changes to a contract between a health care service plan  
13 and a provider delegating financial risk for immunization related  
14 to a declared public health emergency, shall be considered a  
15 material change to the parties' contract. A health plan shall not  
16 delegate the financial risk to a contracted provider for the cost of  
17 enrollee services provided under this section unless the parties  
18 have negotiated and agreed upon a new provision of the parties'  
19 contract pursuant to Section 1375.7.

20 (c) The director may issue guidance to health care service plans  
21 regarding compliance with this section. This guidance shall not  
22 be subject to the Administrative Procedure Act (Chapter 3.5  
23 (commencing with Section 11340) of Part 1 of Division 3 of Title  
24 2 of the Government Code). The department shall consult with the  
25 Department of Insurance in issuing the guidance specified in this  
26 subdivision.

27 (d) This section, excluding subdivision (h), shall apply  
28 retroactively beginning from the Governor's declared State of  
29 Emergency related to the SARS-CoV-2 (COVID-19) pandemic  
30 on March 4, 2020. Notwithstanding Section 1390, this subdivision  
31 does not create criminal liability for transactions that occurred  
32 before January 1, 2022.

33 (e) For purposes of this section:

34 (1) "Diagnostic testing" means all of the following:

35 (A) Testing intended to identify current or past infection and  
36 performed when a person has signs or symptoms consistent with  
37 COVID-19, or when a person is asymptomatic but has recent  
38 known or suspected exposure to SARS-CoV-2.

39 (B) Testing a person with symptoms consistent with COVID-19.

40 (C) Testing a person as a result of contact tracing efforts.

1 (D) Testing a person who indicates that they were exposed to  
2 someone with a confirmed or suspected case of COVID-19.

3 (E) Testing a person after an individualized clinical assessment  
4 by a licensed health care provider.

5 (2) “Screening testing” means tests that are intended to identify  
6 people with COVID-19 who are asymptomatic and do not have  
7 known, suspected, or reported exposure to SARS-CoV-2. Screening  
8 testing helps to identify unknown cases so that measures can be  
9 taken to prevent further transmission. Screening testing includes  
10 all of the following:

11 (A) Workers in a workplace setting.

12 (B) Students, faculty, and staff in a school setting.

13 (C) A person before or after travel.

14 (D) At home for someone who does not have symptoms  
15 associated with COVID-19 and does not have a known exposure  
16 to someone with COVID-19.

17 (f) This section does not relieve a health care service plan from  
18 continuing to cover testing as required by federal law and guidance.

19 (g) The department shall hold health care service plans  
20 accountable for timely access to services required under this section  
21 and coverage requirements established under federal law,  
22 regulations, or guidelines.

23 (h) (1) This subdivision applies to a health care service plan  
24 contract issued, amended, or renewed on or after the operative date  
25 of this subdivision that covers medical, surgical, and hospital  
26 benefits, excluding a specialized health care service plan contract,  
27 with respect to therapeutics for COVID-19 covered under the  
28 contract, which shall include therapeutics approved or granted  
29 emergency use authorization by the federal Food and Drug  
30 Administration for treatment of COVID-19 when prescribed or  
31 furnished by a licensed health care provider acting within their  
32 scope of practice and the standard of care.

33 (2) A health care service plan shall reimburse a provider for the  
34 therapeutics described in paragraph (1) at the specifically  
35 negotiated rate for those therapeutics, if the plan and provider have  
36 negotiated a rate. If the plan does not have a negotiated rate with  
37 a provider, the plan may negotiate a rate with the provider.

38 (3) For an out-of-network provider with whom a health care  
39 service plan does not have a negotiated rate for the therapeutics  
40 described in paragraph (1), a health care service plan shall

reimburse the provider for the therapeutics in an amount that is reasonable, as determined in comparison to prevailing market rates for the therapeutics in the geographic region in which the therapeutic was delivered. An out-of-network provider shall accept this payment as payment in full, shall not seek additional remuneration from an enrollee, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee for therapeutics described in this subdivision.

(4) A health care service plan shall cover COVID-19 therapeutics without cost sharing, regardless of whether the therapeutics are provided by an in-network or out-of-network provider, and without utilization management. If a provider would have been entitled to receive cost sharing but for this section, the health care service plan shall reimburse the provider for the amount of that lost cost sharing. A provider shall accept this payment as payment in full, shall not seek additional remuneration from an enrollee, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee for therapeutics pursuant to this subdivision.

(5) Beginning six months after the federal public health emergency expires, a health care service plan shall no longer be required to cover the cost sharing for COVID-19 therapeutics delivered by an out-of-network provider, unless otherwise required by law. All other requirements of this subdivision shall remain in effect after the federal public health emergency expires.

~~(6) For purposes of this section, "health care service plan" includes This section does not apply to a Medi-Cal managed care plan that contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code. The State Department of Health Care Services shall seek any federal approvals it deems necessary to implement this section. This section applies to a Medi-Cal managed care plan contract only to the extent that the State Department of Health Care Services obtains any necessary federal approvals, and federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.~~

1     *SEC. 7. Section 1356.3 is added to the Health and Safety Code,*  
2     *immediately following Section 1356.2, to read:*

3     1356.3. (a) *For the 2025–26 to 2026–27 fiscal years, inclusive,*  
4     *a health care service plan licensed by the department shall be*  
5     *assessed an annual fee in an amount determined by the department,*  
6     *in consultation with the Department of Health Care Access and*  
7     *Information. The annual fee shall be limited to the amount*  
8     *necessary to fund the actual and reasonably necessary expenses*  
9     *of the department to implement Article 6.1 (commencing with*  
10    *Section 1385.001) and the actual and reasonably necessary*  
11    *expenses of the Department of Health Care Access and Information*  
12    *pertaining to data reporting by pharmacy benefit managers,*  
13    *including that portion of the Health Care Payments Data Program*  
14    *established by Section 127671.1 that concerns pharmacy benefit*  
15    *managers.*

16    (b) *The fees received pursuant to this section shall be transferred*  
17    *from the Managed Care Fund to the Pharmacy Benefit Manager*  
18    *Fund established by Section 1385.0017 and disbursed pursuant*  
19    *to that section, upon appropriation by the Legislature.*

20    *SEC. 8. Section 1374.55 of the Health and Safety Code is*  
21    *amended to read:*

22    1374.55. (a) (1) *A large group health care service plan*  
23    *contract, except a specialized health care service plan contract,*  
24    *that is issued, amended, or renewed on or after ~~July 1, 2025,~~*  
25    *January 1, 2026, shall provide coverage for the diagnosis and*  
26    *treatment of infertility and fertility services, including a maximum*  
27    *of three completed oocyte retrievals with unlimited embryo*  
28    *transfers in accordance with the guidelines of the American Society*  
29    *for Reproductive Medicine (ASRM), using single embryo transfer*  
30    *when recommended and medically appropriate.*

31    (2) *A small group health care service plan contract, except a*  
32    *specialized health care service plan contract, that is issued,*  
33    *amended, or renewed on or after ~~July 1, 2025,~~ January 1, 2026,*  
34    *shall offer coverage for the diagnosis and treatment of infertility*  
35    *and fertility services. This paragraph shall not be construed to*  
36    *require a small group health care service plan contract to provide*  
37    *coverage for infertility services.*

38    (3) *A health care service plan shall include notice of the*  
39    *coverage specified in this section in the plan's evidence of*  
40    *coverage.*

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

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

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

10 (3) The failure to establish a pregnancy or to carry a pregnancy  
11 to live birth after regular, unprotected sexual intercourse. For  
12 purposes of this section, “regular, unprotected sexual intercourse”  
13 means no more than 12 months of unprotected sexual intercourse  
14 for a person under 35 years of age or no more than 6 months of  
15 unprotected sexual intercourse for a person 35 years of age or  
16 older. Pregnancy resulting in miscarriage does not restart the  
17 12-month or 6-month time period to qualify as having infertility.

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

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

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

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

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

36 (e) Consistent with Section 1365.5, coverage for the treatment  
37 of infertility and fertility services shall be provided without  
38 discrimination on the basis of age, ancestry, color, disability,  
39 domestic partner status, gender, gender expression, gender identity,  
40 genetic information, marital status, national origin, race, religion,

1 sex, or sexual orientation. This subdivision shall not be construed  
2 to interfere with the clinical judgment of a physician and surgeon.

3 (f) This section does not apply to Medi-Cal managed care health  
4 care service plan contracts or any entity that enters into a contract  
5 with the State Department of Health Care Services for the delivery  
6 of health care services pursuant to Chapter 7 (commencing with  
7 Section 14000), Chapter 8 (commencing with Section 14200),  
8 Chapter 8.75 (commencing with Section 14591), or Chapter 8.9  
9 (commencing with Section 14700) of Part 3 of Division 9 of the  
10 Welfare and Institutions Code.

11 (g) This section shall not apply to a religious employer, as  
12 defined in Section 1367.25.

13 (h) This section shall not apply to a health care benefit plan or  
14 contract entered into with the Board of Administration of the Public  
15 Employees' Retirement System pursuant to the Public Employees'  
16 Medical and Hospital Care Act (Part 5 (commencing with Section  
17 22750) of Division 5 of Title 2 of the Government Code) until July  
18 1, 2027.

19 (i) (1) *Until January 1, 2027, the director may issue guidance*  
20 *regarding compliance with this section, and that guidance shall*  
21 *not be subject to the Administrative Procedure Act (Chapter 3.5*  
22 *(commencing with Section 11340) of Part 1 of Division 3 of Title*  
23 *2 of the Government Code).*

24 (2) *The department shall consult with the Department of*  
25 *Insurance and stakeholders in issuing the guidance specified in*  
26 *paragraph (1).*

27 *SEC. 9. The heading of Article 6.1 (commencing with Section*  
28 *1385.001) of Chapter 2.2 of Division 2 of the Health and Safety*  
29 *Code is amended to read:*

30  
31 Article 6.1. Pharmacy Benefit ~~Management Services~~ *Managers*

32  
33 *SEC. 10. Section 1385.001 of the Health and Safety Code is*  
34 *repealed.*

35 ~~1385.001. For the purposes of this article, "pharmacy benefit~~  
36 ~~manager" means a person, business, or other entity that, pursuant~~  
37 ~~to a contract with a health care service plan, manages the~~  
38 ~~prescription drug coverage provided by the health care service~~  
39 ~~plan, including, but not limited to, the processing and payment of~~  
40 ~~claims for prescription drugs, the performance of drug utilization~~



1 review, the processing of drug prior authorization requests, the  
2 adjudication of appeals or grievances related to prescription drug  
3 coverage, contracting with network pharmacies, and controlling  
4 the cost of covered prescription drugs. This definition shall not  
5 include a health care service plan licensed under this chapter or  
6 any individual employee of a health care service plan or its  
7 contracted provider, as defined in subdivision (i) of Section 1345,  
8 performing the services described in this section.

9 *SEC. 11. Section 1385.001 is added to the Health and Safety*  
10 *Code, to read:*

11 *1385.001. For the purposes of this article:*

12 (a) *“Department” means the Department of Managed Health*  
13 *Care.*

14 (b) *“Director” means the Director of the Department of*  
15 *Managed Health Care.*

16 (c) *“Drug” has the same meaning as defined in Section 4025*  
17 *of the Business and Professions Code.*

18 (d) *“Health insurer” means an entity licensed to provide health*  
19 *insurance, as defined in Section 106 of the Insurance Code.*

20 (e) *“Manufacturer” has the same meaning as defined in Section*  
21 *4033 of the Business and Professions Code.*

22 (f) *“Payer” means a health care service plan licensed by the*  
23 *department or a health insurer licensed by the Department of*  
24 *Insurance.*

25 (g) *“Pharmacist” has the same meaning as defined in Section*  
26 *4036 of the Business and Professions Code.*

27 (h) *“Pharmacy” has the same meaning as defined in Section*  
28 *4037 of the Business and Professions Code.*

29 (i) (1) *“Pharmacy benefit manager” means a person, business,*  
30 *or other entity that, either directly or through an intermediary,*  
31 *affiliate, or both, acts as a price negotiator or group purchaser*  
32 *on behalf of a payer, or manages the prescription drug coverage*  
33 *provided by the payer, including, but not limited to, the processing*  
34 *and payment of claims for prescription drugs, the performance of*  
35 *drug utilization review, the processing of drug prior authorization*  
36 *requests, the adjudication of appeals or grievances related to*  
37 *prescription drug coverage, contracting with network pharmacies,*  
38 *or controlling the cost of covered prescription drugs.*

(2) “Pharmacy benefit manager” includes an entity performing the duties specified in paragraph (1) that is under common ownership with, or control by, a payer.

(3) “Pharmacy benefit manager” does not include any of the following:

(A) An entity providing services pursuant to a contract authorized by Section 4600.2 of the Labor Code.

(B) A fully self-insured employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 (Public Law 93-406), as amended (29 U.S.C. Sec. 1001 et seq.).

(C) A health care service plan licensed pursuant to this chapter or an individual employee of a health care service plan.

(D) A health insurer licensed to provide health insurance, as defined in Section 106 of the Insurance Code, or an individual employee of a health insurer.

(E) A city or county that develops or manages drug coverage programs for uninsured patients for which no reimbursement is received.

(F) An entity exclusively providing services to patients covered by Part 418 (commencing with Section 418.1) of Subchapter B of Chapter IV of Title 42 of the Code of Federal Regulations.

(G) The State Department of Health Care Services, including any contracts between the State Department of Health Care Services and another entity related to the negotiation and collection of drug or medical supply rebates.

(j) “Plan participant” means an individual who is enrolled in health care coverage provided by a payer.

SEC. 12. Section 1385.002 of the Health and Safety Code is amended to read:

~~1385.002. (a) Except as specified in Section 1385.007, the requirements of this article shall become operative on January 1, 2020.~~

~~(b) Notwithstanding subdivision (a), the~~

1385.002. (a) The department has the authority to enforce the provisions of this article, including the authority to adopt, amend, or repeal any rules and regulations, not inconsistent with the laws of this state, as may be necessary for the protection of the public and to implement this article, including, but not limited to, the director’s enforcement authority under this chapter.

(e)

(b) Notwithstanding ~~subdivision (a) and~~ Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this article by means of all-plan letters or similar instructions to plans and pharmacy benefit managers, without taking regulatory action, until such time as regulations are adopted.

~~(d) The~~

(c) *Until June 30, 2028, for purposes of implementing this article, the department may contract with a consultant or consultants with expertise in this subject area to assist the department in developing guidance or instructions described in subdivision (e), or the report required pursuant to Section 1385.007. consultants, including information technology consultants and vendors, with relevant expertise to assist the department with implementing this article.* The department's contract with a consultant shall include conflict-of-interest provisions to prohibit a person from participating in any report in which the person knows or has reason to know ~~he or she~~ *the person* has a material financial interest, including, but not limited to, a person who has a consulting or other agreement with a person or organization that would be affected by the results of the report.

~~(e)~~

(d) Contracts entered into pursuant to the authority in this ~~article~~ *section* shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

*SEC. 13. Section 1385.004 of the Health and Safety Code is amended to read:*

1385.004. (a) A health care service plan that contracts with a pharmacy benefit manager for management of any or all of its prescription drug coverage shall require the pharmacy benefit manager to do all of the following:

(1) Comply with the provisions of Section 1385.003.

(2) Register with the department pursuant to the requirements of this ~~article.~~ *article, or, if licensure of the pharmacy benefit*

1 *manager is required pursuant to this article, obtain a license and*  
2 *keep it in good standing with the department.*

3 (3) Exercise good faith and fair dealing in the performance of  
4 its contractual duties to a health care service plan.

5 (4) Comply with the requirements of Chapter 9.5 (commencing  
6 with Section 4430) of Division 2 of the Business and Professions  
7 Code, as applicable.

8 (5) Inform all pharmacists under contract with or subject to  
9 contracts with the pharmacy benefit manager of the pharmacist's  
10 rights to submit complaints to the department under Section  
11 1371.39 and of the pharmacist's rights as a provider under Section  
12 1375.7.

13 *(b) Contracts issued, amended, or renewed on or after January*  
14 *1, 2026, between a health care service plan and a pharmacy benefit*  
15 *manager shall require the pharmacy benefit manager to submit*  
16 *to the Department of Health Care Access and Information all*  
17 *information required to be reported pursuant to Chapter 8.5*  
18 *(commencing with Section 127671) of Part 2 of Division 107.*

19 ~~(b)~~

20 (c) A pharmacy benefit manager shall notify a health care service  
21 plan in writing of any activity, policy, or practice of the pharmacy  
22 benefit manager that directly or indirectly presents a conflict of  
23 interest that interferes with the discharge of the pharmacy benefit  
24 manager's duty to the health care service plan to exercise good  
25 faith and fair dealing in the performance of its contractual duties  
26 pursuant to subdivision (a).

27 *SEC. 14. Section 1385.005 of the Health and Safety Code is*  
28 *amended to read:*

29 1385.005. (a) A pharmacy benefit manager required to register  
30 with the department pursuant to Section 1385.004 shall complete  
31 an application for registration with the department that shall  
32 include, but not be limited to, all of the information required by  
33 subdivision (c).

34 (b) A pharmacy benefit manager registration obtained pursuant  
35 to this section is not transferable.

36 (c) The department shall develop an application form for  
37 pharmacy benefit manager registration. The application form for  
38 a pharmacy benefit manager registration shall require the pharmacy  
39 benefit manager to submit the following information to the  
40 department:

1 (1) The name of the pharmacy benefit manager.

2 (2) The address and contact telephone number for the pharmacy  
3 benefit manager.

4 (3) The name and address of the pharmacy benefit manager's  
5 agent for service of process in the state.

6 (4) The name and address of each person beneficially interested  
7 in the pharmacy benefit manager.

8 (5) The name and address of each person with management or  
9 control over the pharmacy benefit manager.

10 (d) If the applicant is a partnership or other unincorporated  
11 association, a limited liability company, or a corporation, and the  
12 number of partners, members, or stockholders, as the case may  
13 be, exceeds five, the application shall so state, and shall further  
14 state the name, address, usual occupation, and professional  
15 qualifications of each of the five partners, members, or stockholders  
16 who own the five largest interests in the applicant entity. Upon  
17 request by the department, the applicant shall furnish the  
18 department with the name, address, usual occupation, and  
19 professional qualifications of partners, members, or stockholders  
20 not named in the application, or shall refer the department to an  
21 appropriate source for that information.

22 (e) The application shall contain a statement to the effect that  
23 the applicant has not been convicted of a felony and has not  
24 violated any of the provisions of this article. If the applicant cannot  
25 make this statement, the application shall contain a statement of  
26 the violation, if any, or shall describe the reasons that prevent the  
27 applicant from being able to comply with the requirements with  
28 respect to the statement.

29 (f) The department may set a fee for a registration required by  
30 this article. The application fee shall not exceed the reasonable  
31 costs of the department in carrying out its duties under this article.

32 (g) Within 30 days of a change in any of the information  
33 disclosed to the department on an application for a registration,  
34 the pharmacy benefit manager shall notify the department of that  
35 change in writing.

36 (h) For purposes of this section, "person beneficially interested"  
37 with respect to a pharmacy benefit manager means and includes  
38 the following:

39 (1) If the applicant is a partnership or other unincorporated  
40 association, each partner or member.

(2) If the applicant is a corporation, each of its officers, directors, and stockholders, provided that a natural person shall not be deemed to be beneficially interested in a nonprofit corporation.

(3) If the applicant is a limited liability company, each officer, manager, or member.

*(i) This section shall become inoperative on January 1, 2027, or the date on which the department has established the licensure process pursuant to Section 1385.009, whichever is later and, as of the following January 1 is repealed.*

*SEC. 15. Section 1385.006 of the Health and Safety Code is amended to read:*

1385.006. The failure by a health care service plan to comply with the contractual requirements *and to maintain appropriate oversight of a contracted pharmacy benefit manager to ensure the pharmacy benefit manager's compliance* pursuant to this article shall constitute grounds for disciplinary action. The director shall, as appropriate, investigate and take enforcement action against a health care service plan that fails to comply with these requirements and shall periodically evaluate contracts between health care service plans and pharmacy benefit managers to determine if any audit, evaluation, or enforcement actions should be undertaken by the department.

*SEC. 16. Section 1385.008 is added to the Health and Safety Code, to read:*

1385.008. *On or after January 1, 2027, or the date on which the department has established the licensure process pursuant to Section 1385.009, whichever is later, a person shall not engage in business as a pharmacy benefit manager for a payer in this state unless that person has first secured a license from the director. A license issued pursuant to this article is not transferable without the express and specific permission of the director.*

*SEC. 17. Section 1385.009 is added to the Health and Safety Code, to read:*

1385.009. *An application for licensure as a pharmacy benefit manager under this article shall be verified by an authorized representative of the applicant and shall be in a form prescribed by the department. To the extent applicable, the department may direct licensure applicants to use the forms and processes available to and required of health care service plan licensure applicants and licensees created pursuant to this chapter and its implementing*

1 regulations, including Section 1351 and the forms and exhibits  
2 described in regulations, as amended, implementing that section.  
3 The application for licensure as a pharmacy benefit manager shall  
4 be accompanied by the fee prescribed by Section 1385.0016 and  
5 shall set forth or be accompanied by all of the following:

6 (a) The basic organizational documents of the applicant, such  
7 as the articles of incorporation, articles of association, partnership  
8 agreement, trust agreement, or other applicable documents, and  
9 all amendments to those documents.

10 (b) A copy of the bylaws, rules and regulations, or similar  
11 documents regulating the conduct of the internal affairs of the  
12 applicant.

13 (c) A list of the names, addresses, and official positions of the  
14 persons who are to be responsible for the conduct of the affairs  
15 of the applicant, including all members of the board of directors,  
16 board of trustees, executive committee, or other governing board  
17 or committee, the principal officers, each shareholder with more  
18 than 5 percent interest in the case of a corporation, all partners  
19 or members in the case of a partnership or association, and each  
20 person who has loaned funds to the applicant for the operation of  
21 its business.

22 (d) A statement of whether, within the preceding 10 years, the  
23 applicant, its management company, an affiliate of the applicant,  
24 a controlling person, officer, director, or other person occupying  
25 a principal management or supervisory position in the pharmacy  
26 benefit manager, management company, or affiliate, or a person  
27 intended to hold that relationship or position, has been convicted  
28 of or pleaded nolo contendere to a felony, been held to have  
29 committed an act involving dishonesty, fraud, or deceit in a judicial  
30 or administrative proceeding to which the person was a party, or  
31 has had a license or certificate to operate as a pharmacy benefit  
32 manager denied or revoked in another jurisdiction.

33 (e) For an applicant not domiciled in this state, a power of  
34 attorney duly executed appointing the director the true and lawful  
35 attorney in fact of the applicant for the purposes of service of all  
36 lawful process in a legal action or proceeding against the  
37 pharmacy benefit manager on a cause of action arising in this  
38 state.

39 (f) Financial statements accompanied by a report, certificate,  
40 or opinion of an independent certified public accountant that

1 demonstrates the financial viability of the applicant. Submission  
2 of financial statements may, at the direction of the department, be  
3 completed using the same forms and processes as required for  
4 health care service plans licensed pursuant to this chapter.

5 (g) An affirmation that the applicant's business practices and  
6 contracts comply with the applicable provisions of this chapter,  
7 including the requirements of pharmacy benefit manager contracts  
8 and business practices set forth in this article.

9 (h) An affirmation that the applicant shall comply with all  
10 requirements for reporting data to the Department of Health Care  
11 Access and Information in accordance with this article and Chapter  
12 8.5 (commencing with Section 127671) of Part 2 of Division 107.

13 (i) A description of the business operations of the applicant,  
14 including descriptions of its services, facilities, and personnel.

15 (j) A list of all jurisdictions in which the applicant operates as  
16 a pharmacy benefit manager, including those in which the  
17 applicant holds a license, registration, or certification as a  
18 pharmacy benefit manager.

19 (k) The applicant's organization chart or charts that show the  
20 lines of responsibility and authority in the administration of the  
21 applicant's business as a pharmacy benefit manager. The applicant  
22 shall include a narrative explanation of the organization chart,  
23 including the responsibility and authority of each entity, board,  
24 committee, and position, and identify the persons who serve on  
25 the boards and committees and in those positions.

26 (l) A list of all pharmaceutical supply chain entities, including  
27 drug manufacturers, wholesalers, and distributors, that are  
28 contracted or affiliated with the applicant.

29 (m) A list of all health care providers, including pharmacies  
30 and pharmacists, that are contracted or affiliated with the  
31 applicant.

32 (n) A list of each payer with which the applicant is affiliated or  
33 has a contract for the provision of pharmacy benefit manager  
34 services, including a description of all services provided and the  
35 number of individual enrollees covered under the contract or  
36 contracts with each payer.

37 (o) A statement describing how the applicant shall provide for  
38 separation of medical and clinical decisionmaking from fiscal and  
39 administrative management to ensure that medical and clinical  
40 decisions shall not be unduly influenced by fiscal and



1 *administrative management, including a description of what*  
2 *controls will be put into place to assure compliance with this*  
3 *requirement.*

4 *SEC. 18. Section 1385.0010 is added to the Health and Safety*  
5 *Code, to read:*

6 *1385.0010. In addition to the requirements of Section 1385.009,*  
7 *and upon request of the director, an application shall be*  
8 *accompanied by authorization for disclosure to the director of*  
9 *financial records of each pharmacy benefit manager licensed under*  
10 *this chapter, pursuant to Section 7473 of the Government Code.*  
11 *For purposes of this chapter, the authorization for disclosure shall*  
12 *also include the financial records of an association, partnership,*  
13 *or corporation controlling, controlled by, or otherwise affiliated*  
14 *with the pharmacy benefit manager.*

15 *SEC. 19. Section 1385.0011 is added to the Health and Safety*  
16 *Code, to read:*

17 *1385.0011. (a) A pharmacy benefit manager shall submit to*  
18 *the department financial statements prepared as of the close of its*  
19 *fiscal year within 120 days after the close of the fiscal year. These*  
20 *financial statements shall be accompanied by a report, certificate,*  
21 *or opinion of an independent certified public accountant or*  
22 *independent public accountant. An audit shall be conducted in*  
23 *accordance with generally accepted auditing standards and the*  
24 *rules and regulations of the director.*

25 *(b) Within 45 days after the close of each quarter of its fiscal*  
26 *year, a pharmacy benefit manager shall submit its quarterly*  
27 *unaudited financial statement, prepared in accordance with*  
28 *generally accepted accounting principles and consisting of at least*  
29 *a balance sheet, statement of income, statement of cash flows,*  
30 *statement of changes in equity, and notes to financial statements*  
31 *as of the date and for the period specified by the director. The*  
32 *director may require the submission of these reports on a monthly*  
33 *or other periodic basis.*

34 *(c) A pharmacy benefit manager shall make special reports to*  
35 *the director as the director may require.*

36 *(d) For good cause and upon written request, the director may*  
37 *extend the time for compliance with subdivisions (a) to (c),*  
38 *inclusive.*

39 *(e) If the report, certificate, or opinion of the independent*  
40 *accountant required pursuant to subdivision (a) is qualified, the*

1 director may require the pharmacy benefit manager to take action  
2 that the director deems appropriate to permit an independent  
3 accountant to remove the qualification from the report, certificate,  
4 or opinion.

5 (f) The director may reject a financial statement, report,  
6 certificate, or opinion filed pursuant to this section by notifying  
7 the pharmacy benefit manager of the rejection and its cause. Within  
8 30 days after the receipt of the notice, the pharmacy benefit  
9 manager shall correct the deficiency, and the failure so to do shall  
10 be deemed a violation of this chapter. The director shall retain a  
11 copy of all rejected filings.

12 (g) The director may make rules and regulations specifying the  
13 form and content of the reports and financial statements required  
14 by this section, and may require that these reports and financial  
15 statements be verified by the pharmacy benefit manager in a  
16 manner as the director may prescribe. Revenue reported by  
17 pharmacy benefit managers shall include revenue from  
18 manufacturers, payers, and other sources, including from affiliates.  
19 Types of revenue reported shall be inclusive of rebates of any type  
20 or form. Expenses reported by pharmacy benefit managers shall  
21 include payments to pharmacies, claims processing, special  
22 programs, administrative costs, and all other expenses. The  
23 director may require the reporting of any additional revenue,  
24 expenses, or related information that the department requires to  
25 assist in determining the overall impact of pharmacy benefit  
26 manager business practices on the cost of drugs in this state.

27 (h) To the extent applicable, the department may direct licensure  
28 applicants to use the forms and processes available to and required  
29 of health care service plans and other entities reporting financial  
30 data created pursuant to this chapter and their implementing  
31 regulations, including Section 1384 and the forms and exhibits  
32 described in regulations, as amended, implementing that section.

33 (i) Financial and other records produced, disclosed, or  
34 otherwise made available by an organization pursuant to this  
35 section shall be received and maintained on a confidential basis  
36 and protected from public disclosure.

37 SEC. 20. Section 1385.0012 is added to the Health and Safety  
38 Code, to read:

39 1385.0012. (a) A pharmacy benefit manager licensed pursuant  
40 to this article shall submit to the Department of Health Care Access

1 *and Information all information required to be reported pursuant*  
2 *to Chapter 8.5 (commencing with Section 127671) of Part 2 of*  
3 *Division 107.*

4 *(b) The obligation of a pharmacy benefit manager to comply*  
5 *with this section shall not be waived if the pharmacy benefit*  
6 *manager delegates any of its services or business operations to*  
7 *another entity via a contractual relationship or otherwise.*

8 *(c) Failure by a pharmacy benefit manager to timely or*  
9 *completely submit required reporting to the Department of Health*  
10 *Care Access and Information shall be grounds for enforcement*  
11 *action by the department pursuant to this chapter.*

12 *SEC. 21. Section 1385.0013 is added to the Health and Safety*  
13 *Code, to read:*

14 *1385.0013. (a) (1) A licensed pharmacy benefit manager*  
15 *shall, within 30 days after a change in the information contained*  
16 *in its application, other than financial or statistical information,*  
17 *file an amendment to the application in the manner prescribed by*  
18 *rule by the director.*

19 *(2) Notwithstanding paragraph (1), if an association,*  
20 *partnership, or corporation is added in a controlling, controlled,*  
21 *or affiliated status relative to the pharmacy benefit manager, the*  
22 *pharmacy benefit manager shall file within 30 days an*  
23 *authorization for disclosure to the director of financial records of*  
24 *the person pursuant to Section 7473 of the Government Code.*

25 *(b) Before a material modification of its operations, a pharmacy*  
26 *benefit manager shall give notice of the change to the director,*  
27 *who shall approve, disapprove, suspend, or postpone the*  
28 *effectiveness of the change by order, within 20 business days or*  
29 *within additional time specified by the pharmacy benefit manager,*  
30 *subject to Section 1385.0014.*

31 *(c) A pharmacy benefit manager shall, within five days, give*  
32 *written notice to the director, in the form prescribed by rule by*  
33 *the director, of a change in the officers, directors, partners,*  
34 *controlling shareholders, principal creditors, or persons occupying*  
35 *similar positions or performing similar functions, of the pharmacy*  
36 *benefit manager, any parent company of the pharmacy benefit*  
37 *manager, or a management company of the pharmacy benefit*  
38 *manager or its parent company. The director may define by rule*  
39 *the positions, duties, and relationships that shall be reported*  
40 *pursuant to this subdivision.*

1     (d) *The fee for filing a notice of material modification pursuant*  
2 *to subdivision (b) shall be the actual cost to the director of*  
3 *processing the notice, including overhead, but shall not exceed*  
4 *seven hundred fifty dollars (\$750).*

5     (e) *Rules and regulations promulgated and amended by the*  
6 *department pursuant to this chapter relating to health care service*  
7 *plan license amendments and material modifications, including*  
8 *those promulgated to implement and make specific Section 1352,*  
9 *shall, to the extent applicable, apply to pharmacy benefit managers*  
10 *licensed pursuant to this article.*

11     SEC. 22. *Section 1385.0014 is added to the Health and Safety*  
12 *Code, to read:*

13     1385.0014. *Upon denial of an application for licensure, or the*  
14 *issuance of an order pursuant to Section 1385.0013 disapproving,*  
15 *suspending, or postponing a material modification, the director*  
16 *shall notify the applicant in writing, stating the reason for the*  
17 *denial and that the applicant has the right to a hearing if the*  
18 *applicant makes a written request within 30 days after the date of*  
19 *mailing of the notice of denial. Service of the notice required by*  
20 *this section may be made by certified mail addressed to the*  
21 *applicant at the latest address filed by the applicant in writing*  
22 *with the department.*

23     SEC. 23. *Section 1385.0015 is added to the Health and Safety*  
24 *Code, to read:*

25     1385.0015. *A pharmacy benefit manager license issued under*  
26 *this article shall remain in effect until revoked or suspended by*  
27 *the director.*

28     SEC. 24. *Section 1385.0016 is added to the Health and Safety*  
29 *Code, to read:*

30     1385.0016. (a) *A pharmacy benefit manager applying for*  
31 *licensure under this article shall reimburse the director for the*  
32 *actual cost of processing the application, including overhead, up*  
33 *to an amount not to exceed twenty-five thousand dollars (\$25,000).*  
34 *The cost shall be billed not more frequently than monthly and shall*  
35 *be remitted by the applicant to the director within 30 days of the*  
36 *date of billing. The director shall not issue a license to an applicant*  
37 *before receiving payment in full from that applicant for all amounts*  
38 *charged pursuant to this subdivision.*

39     (b) (1) *In addition to other fees, fines, penalties, and*  
40 *reimbursements required to be paid under this article, a licensed*

1 *pharmacy benefit manager shall pay to the director an amount*  
2 *estimated by the director, in consultation with the Department of*  
3 *Health Care Access and Information, to be necessary to fund the*  
4 *actual and reasonably necessary expenses of the department to*  
5 *implement this article and the actual and reasonably necessary*  
6 *expenses of the Department of Health Care Access and Information*  
7 *pertaining to data reporting by pharmacy benefit managers,*  
8 *including for any portion of the Health Care Payments Data*  
9 *Program established by Section 127671.1 that is necessary to*  
10 *implement the provisions of this article, for the ensuing fiscal year.*  
11 *The amount may be paid in two equal installments. The first*  
12 *installment shall be paid on or before August 1 of each year, and*  
13 *the second installment shall be paid on or before December 15 of*  
14 *each year.*

15 (2) *The total assessment cost for all licensed pharmacy benefit*  
16 *managers determined by the director pursuant to paragraph (1)*  
17 *shall be divided pro rata among licensees based upon each*  
18 *licensee's share of the aggregate number of claims adjudicated*  
19 *in this state by licensed pharmacy benefit managers. The aggregate*  
20 *number of claims adjudicated in this state and each licensee's*  
21 *share of that number shall be calculated based on the report that*  
22 *licensees are required to submit pursuant to paragraph (3).*

23 (3) *A licensed pharmacy benefit manager shall, by January 31*  
24 *of each year, file with the director a report stating the total number*  
25 *of claims it adjudicated for drugs in this state for the preceding*  
26 *calendar year. For purposes of this paragraph, adjudicated claims*  
27 *are claims for reimbursement for drugs dispensed by a provider*  
28 *to a beneficiary under the drug benefit administered by the*  
29 *pharmacy benefit manager for which payment was authorized and*  
30 *made by the pharmacy benefit manager. Reports submitted shall*  
31 *be in the form and manner directed by the department.*  
32 *Notwithstanding Chapter 3.5 (commencing with Section 11340)*  
33 *of Part 1 of Division 3 of Title 2 of the Government Code, the*  
34 *department may issue instructions on reporting without taking*  
35 *regulatory action.*

36 (4) *The amount paid by each pharmacy benefit manager shall*  
37 *be fixed by the director by notice to all licensed pharmacy benefit*  
38 *managers on or before June 15 of each year. A pharmacy benefit*  
39 *manager that is unable to report the number of adjudicated claims*  
40 *shall provide the director with an estimate of the number and the*

1 *method used for determining the estimate. The director may, upon*  
2 *giving written notice to the pharmacy benefit manager, revise the*  
3 *estimate if the director determines that the method used for*  
4 *determining the estimate was not reasonable.*

5 *(5) In determining the amount assessed, the director shall*  
6 *consider all appropriations from the Pharmacy Benefit Manager*  
7 *Fund for the support of the administration of this article and other*  
8 *relevant reimbursements provided for in this chapter.*

9 *(6) A refund or reduction of the amount assessed shall not be*  
10 *provided if a miscalculated assessment is based on a pharmacy*  
11 *benefit manager's overestimate of adjudicated claims.*

12 *SEC. 25. Section 1385.0017 is added to the Health and Safety*  
13 *Code, to read:*

14 *1385.0017. (a) To support the department in the administration*  
15 *of this article and the effective regulation of pharmacy benefit*  
16 *managers under this chapter, and to support the Department of*  
17 *Health Care Access and Information as it pertains to data*  
18 *regarding pharmacy benefit managers and the cost of drugs in*  
19 *this state, the Pharmacy Benefit Manager Fund, administered by*  
20 *the Department of Managed Health Care, is hereby established*  
21 *in the State Treasury.*

22 *(b) All revenues of the department received pursuant to this*  
23 *article, including fees, fines, penalties, and reimbursements, except*  
24 *those collected pursuant to Section 1385.0018, shall be deposited*  
25 *in the Pharmacy Benefit Manager Fund and subject to an*  
26 *appropriation by the Legislature.*

27 *(c) The department may transfer any revenues deposited into*  
28 *the Pharmacy Benefit Manager Fund to the Health Care Payments*  
29 *Data Fund, established pursuant to Section 127674, for use by the*  
30 *Department of Health Care Access and Information, upon*  
31 *appropriation by the Legislature, for the administration of the*  
32 *Health Care Payments Data System.*

33 *(d) In any fiscal year, the Pharmacy Benefit Manager Fund*  
34 *shall maintain not more than a prudent 5-percent reserve unless*  
35 *otherwise determined by the Department of Finance.*

36 *SEC. 26. Section 1385.0018 is added to the Health and Safety*  
37 *Code, to read:*

38 *1385.0018. (a) The director may, after appropriate notice and*  
39 *opportunity for a hearing, by order suspend or revoke a license*  
40 *issued under this article to a pharmacy benefit manager or assess*

1 *administrative penalties if the director determines that the licensee*  
2 *has committed an act or omission constituting grounds for*  
3 *disciplinary action.*

4 *(b) All of the following acts or omissions constitute grounds for*  
5 *disciplinary action by the director:*

6 *(1) The pharmacy benefit manager is operating at variance with*  
7 *basic organizational documents as filed pursuant to Section*  
8 *1385.009, or with its published plan, or in a manner contrary to*  
9 *that described in, and reasonably inferred from, the plan as*  
10 *contained in its application for licensure and annual report, or*  
11 *any modification thereof, unless amendments allowing the variation*  
12 *have been submitted to, and approved by, the director.*

13 *(2) The continued operation of the pharmacy benefit manager*  
14 *shall constitute a substantial risk to its subscribers and enrollees.*

15 *(3) The pharmacy benefit manager has violated, attempted to*  
16 *violate, or conspired to violate, directly or indirectly, or assisted*  
17 *in or abetted a violation or conspiracy to violate a provision of*  
18 *this chapter, a rule or regulation adopted by the director pursuant*  
19 *to this chapter, or an order issued by the director pursuant to this*  
20 *chapter.*

21 *(4) The pharmacy benefit manager has engaged in conduct that*  
22 *constitutes fraud, dishonest dealing, or unfair competition, as*  
23 *defined by Section 17200 of the Business and Professions Code.*

24 *(5) The pharmacy benefit manager has permitted, aided, or*  
25 *abetted a violation by an employee or contractor who is a holder*  
26 *of a certificate, license, permit, registration, or exemption issued*  
27 *pursuant to the Business and Professions Code or this code that*  
28 *would constitute grounds for discipline against the certificate,*  
29 *license, permit, registration, or exemption.*

30 *(6) The pharmacy benefit manager has permitted, aided, or*  
31 *abetted the commission of an illegal act.*

32 *(7) The pharmacy benefit manager, its management company,*  
33 *another affiliate of the pharmacy benefit manager, or a controlling*  
34 *person, officer, director, or other person occupying a principal*  
35 *management or supervisory position in the pharmacy benefit*  
36 *manager, management company, or affiliate, has been convicted*  
37 *of or pleaded nolo contendere to a crime, or committed an act*  
38 *involving dishonesty, fraud, or deceit, which crime or act is*  
39 *substantially related to the qualifications, functions, or duties of*  
40 *a person engaged in business in accordance with this chapter. The*

1 *director may revoke or deny a license hereunder irrespective of a*  
2 *subsequent order under Section 1203.4 of the Penal Code.*

3 *(8) The pharmacy benefit manager has been subject to a final*  
4 *disciplinary action taken by this state, another state, an agency of*  
5 *the federal government, or another country for an act or omission*  
6 *that would constitute a violation of this chapter.*

7 *(9) The pharmacy benefit manager violated the Confidentiality*  
8 *of Medical Information Act (Part 2.6 (commencing with Section*  
9 *56) of Division 1 of the Civil Code).*

10 *(10) The pharmacy benefit manager violated Chapter 8.5*  
11 *(commencing with Section 127671) of Part 2 of Division 107,*  
12 *including the data submission requirements of that chapter.*

13 *(c) The assessment of administrative penalties against a*  
14 *pharmacy benefit manager shall use the same factors described*  
15 *in subdivision (d) of Section 1386 for health care service plans.*

16 *(d) A pharmacy benefit manager shall be subject, if applicable,*  
17 *to all enforcement authority of the department set forth in Article*  
18 *8 (commencing with Section 1390), and civil penalties for violation*  
19 *of the licensure requirement of Section 1385.009.*

20 *(e) Fines and administrative penalties collected pursuant to this*  
21 *section shall be deposited into the Pharmacy Benefit Manager*  
22 *Administrative Fines and Penalties Fund established pursuant to*  
23 *Section 1385.0024. These fines and administrative penalties shall*  
24 *not be used to reduce the assessments imposed on pharmacy benefit*  
25 *managers pursuant to Section 1385.0016.*

26 *SEC. 27. Section 1385.0019 is added to the Health and Safety*  
27 *Code, to read:*

28 *1385.0019. (a) A pharmacy benefit manager whose license*  
29 *has been revoked, or suspended for more than one year, may*  
30 *petition the director to reinstate the license as provided by Section*  
31 *11522 of the Government Code. A petition shall not be considered*  
32 *if the petitioner is under criminal sentence for a violation of this*  
33 *chapter, or an offense that would constitute grounds for discipline*  
34 *or denial of licensure under this chapter, including any period of*  
35 *probation or parole.*

36 *(b) The petition for restoration shall be in the form prescribed*  
37 *by the director. The director may condition the granting of the*  
38 *petition upon additional information and undertakings as the*  
39 *director requires to determine if the person, if restored, would*  
40 *engage in business in full compliance with this chapter and the*



1 rules and regulations adopted by the director pursuant to this  
2 chapter.

3 (c) The director may prescribe a fee not to exceed five hundred  
4 dollars (\$500) for the filing of a petition for restoration pursuant  
5 to this section, which shall be the actual cost to the director of  
6 processing the petition. In addition, the director may condition  
7 the granting of a petition to a pharmacy benefit manager upon  
8 payment of the assessment due and unpaid pursuant to subdivision  
9 (b) of Section 1385.0016 as of December 15 in the preceding 12  
10 calendar months and, if the pharmacy benefit manager's  
11 suspension or revocation was in effect for more than 12 months,  
12 upon the filing of a new pharmacy benefit manager licensure  
13 application and the payment of the fee prescribed by subdivision  
14 (a) of Section 1385.0016.

15 SEC. 28. Section 1385.0020 is added to the Health and Safety  
16 Code, to read:

17 1385.0020. (a) Surrender of a pharmacy benefit manager  
18 license shall become effective 30 days after receipt of an  
19 application to surrender the license or within a shorter period of  
20 time as the director may determine to be in the public interest and  
21 not detrimental to the protection of subscribers, enrollees, or  
22 persons regulated under this chapter, unless a revocation or  
23 suspension proceeding is pending when the application is filed or  
24 a proceeding to revoke or suspend or to impose conditions upon  
25 the surrender is instituted within 30 days after the application is  
26 filed. If this proceeding is pending or instituted, surrender becomes  
27 effective at the time and upon the conditions as the director  
28 determines by order.

29 (b) If the director finds that a pharmacy benefit manager is no  
30 longer in existence, has ceased to do business, has failed to initiate  
31 business activity as a licensee within six months after licensure,  
32 or cannot be located after reasonable search, the director may,  
33 by order, summarily revoke the license of the pharmacy benefit  
34 manager.

35 (c) The director may summarily suspend or revoke the license  
36 of a pharmacy benefit manager upon failure to pay a fee required  
37 by this chapter within 15 days after notice by the director that the  
38 fee is due and unpaid or failure to file an amendment or report  
39 required under this article within 15 days after notice by the  
40 director that the report is due.

1 SEC. 29. Section 1385.0021 is added to the Health and Safety  
2 Code, to read:

3 1385.0021. (a) The director shall withhold from public  
4 inspection, pursuant to the applicable state or federal law,  
5 information received in connection with an application, including  
6 applications for interpretive opinions, submissions, or reports filed  
7 by a pharmacy benefit manager, if, in the opinion of the director,  
8 the public inspection of the information is not necessary for the  
9 purposes of the law under which the information was filed, and  
10 the information is reasonably shown to meet either of the following:

11 (1) The information is proprietary or of a confidential business  
12 nature, including trade secrets, the information has been  
13 confidentially maintained by the business entity, and the release  
14 of the information would be damaging or prejudicial to the business  
15 concern.

16 (2) The information is such that the private or public interest  
17 is served by withholding the information.

18 (b) Requests for confidentiality of information shall be submitted  
19 to and processed by the department consistent with regulations  
20 adopted and amended pursuant to this chapter relating to the  
21 request for confidentiality of information.

22 SEC. 30. Section 1385.0022 is added to the Health and Safety  
23 Code, to read:

24 1385.0022. A pharmacy benefit manager has a fiduciary duty  
25 to its payer client that includes a duty to be fair and truthful toward  
26 the payer, to act in the payer's best interests, and to perform its  
27 duties with care, skill, prudence, and diligence. This section does  
28 not limit a payer's obligations under applicable law with respect  
29 to the administration of health care coverage for plan participants.

30 SEC. 31. Section 1385.0023 is added to the Health and Safety  
31 Code, to read:

32 1385.0023. (a) The department may conduct periodic routine  
33 and nonroutine surveys of a pharmacy benefit manager. These  
34 surveys shall be conducted in accordance with Section 1380, as  
35 applicable.

36 (b) The department may conduct periodic routine and nonroutine  
37 examinations of the fiscal and administrative affairs of a pharmacy  
38 benefit manager. These examinations shall be conducted in  
39 accordance with Section 1382, as applicable.

1     (c) A complaint made by an enrollee that includes potential  
2     violations by a pharmacy benefit manager of the terms of this  
3     article shall be considered by the department to be a complaint  
4     against the health care service plan.

5     SEC. 32. Section 1385.0024 is added to the Health and Safety  
6     Code, to read:

7     1385.0024. (a) The Pharmacy Benefit Manager Administrative  
8     Fines and Penalties Fund is hereby created in the State Treasury.

9     (b) On and after July 1, 2025, the fines and administrative  
10    penalties collected pursuant to Section 1385.0018 shall be  
11    deposited into the Pharmacy Benefit Manager Administrative Fines  
12    and Penalties Fund.

13    (c) Fines and administrative penalties deposited into the  
14    Pharmacy Benefit Manager Administrative Fines and Penalties  
15    Fund may be transferred into the Health Care Payments Data  
16    Fund, established pursuant to Section 127674, for use by the  
17    Department of Health Care Access and Information, upon  
18    appropriation by the Legislature, for the administration of the  
19    Health Care Payments Data System.

20    (d) Fines and administrative penalties deposited into the  
21    Pharmacy Benefit Manager Administrative Fines and Penalties  
22    Fund may be transferred, subject to the annual budget process, to  
23    the Health Care Services Plan Fines and Penalties Fund,  
24    established pursuant to Section 15893 of the Welfare and  
25    Institutions Code.

26    (e) Fines and administrative penalties deposited into the  
27    Pharmacy Benefit Manager Administrative Fines and Penalties  
28    Fund shall not be used to reduce the assessments imposed on  
29    pharmacy benefit managers pursuant to Section 1385.0016.

30    SEC. 33. Section 1385.0025 is added to the Health and Safety  
31    Code, to read:

32    1385.0025. The provisions of this article are severable. If any  
33    provision of this article or its application is held invalid, that  
34    invalidity shall not affect other provisions or applications that can  
35    be given effect without the invalid provision or application.

36    SEC. 34. Section 1385.026 is added to the Health and Safety  
37    Code, to read:

38    1385.026. The Legislature finds and declares that Sections 19  
39    and 29 of this act, which add Sections 1385.0011 and 1385.0021,  
40    respectively, to the Health and Safety Code, impose a limitation

1 *on the public's right of access to the meetings of public bodies or*  
2 *the writings of public officials and agencies within the meaning*  
3 *of Section 3 of Article I of the California Constitution. Pursuant*  
4 *to that constitutional provision, the Legislature makes the following*  
5 *findings to demonstrate the interest protected by this limitation*  
6 *and the need for protecting that interest:*

7 *To balance the public's right to access records with the need to*  
8 *protect proprietary information received from pharmacy benefit*  
9 *managers, it is necessary that the information be kept confidential.*

10 *SEC. 35. Section 1417.2 of the Health and Safety Code is*  
11 *amended to read:*

12 1417.2. (a) Notwithstanding Section 1428, moneys collected  
13 as a result of state and federal civil penalties imposed under this  
14 chapter or federal law shall be deposited into ~~accounts that are~~  
15 ~~hereby established in the Special Deposit Fund created pursuant~~  
16 ~~to Section 16370 of the Government Code. These accounts are~~  
17 ~~titled the State Health Facilities Citation Penalties Account, hereby~~  
18 ~~established in the State Treasury, into which moneys derived from~~  
19 ~~civil penalties for violations of state law shall be deposited, and~~  
20 ~~the Federal Health Facilities Citation Penalties Account, hereby~~  
21 ~~established in the State Treasury, into which moneys derived from~~  
22 ~~civil penalties for violations of federal law shall be deposited.~~  
23 ~~Moneys from these accounts shall be used, notwithstanding Section~~  
24 ~~16370 of the Government Code, used upon appropriation by the~~  
25 ~~Legislature, in accordance with state and federal law for the~~  
26 ~~protection of health or property of residents of long-term health~~  
27 ~~care facilities, including, but not limited to, the following:~~

28 (1) Relocation expenses incurred by the department, in the event  
29 of a facility closure.

30 (2) Maintenance of facility operation pending correction of  
31 deficiencies or closure, such as temporary management or  
32 receivership, in the event that the revenues of the facility are  
33 insufficient.

34 (3) Reimbursing residents for personal funds lost. In the event  
35 that the loss is a result of the actions of a long-term health care  
36 facility or its employees, the revenues of the facility shall first be  
37 used.

38 (4) The costs associated with informational meetings required  
39 under Section 1327.2.

(5) Support for the Long-Term Care Ombudsman Program established pursuant to Chapter 11 (commencing with Section 9700) of Division 8.5 of the Welfare and Institutions Code in an amount appropriated from the State Health Facilities Citation Penalties Account for this purpose in the annual Budget Act.

(b) Notwithstanding subdivision (a), the balance in the State Health Facilities Citation Penalties Account shall not, at any time, exceed ten million dollars (\$10,000,000).

(c) Moneys from the Federal Health Facilities Citation Penalties Account may also be used, notwithstanding Section 16370 of the Government Code, upon appropriation by the Legislature, in accordance with state and federal law for the improvement of quality of care and quality of life for long-term health care facilities residents pursuant to Section 1417.3.

(d) The department shall post on its internet website, and shall update on a quarterly basis, all of the following regarding the funds in the State Health Facilities Citation Penalties Account and the Federal Health Facilities Citation Penalties Account:

(1) The specific sources of funds deposited into the account.

(2) The amount of funds in the account that have not been allocated.

(3) A detailed description of how funds in the account have been allocated and expended, including, but not limited to, the names of persons or entities that received the funds, the amount of salaries paid to temporary managers, and a description of equipment purchased with the funds. However, the description shall not include the names of residents.

*SEC. 36. Section 1418.22 of the Health and Safety Code is amended to read:*

1418.22. (a) The Legislature finds and declares that it is the public policy of this state to ensure the health and safety of highly vulnerable persons residing in skilled nursing facilities during power outages that may result from a public safety power shutoff, an emergency, a natural disaster, or other cause.

(b) (1) A skilled nursing facility shall have an alternative source of power to protect resident health and safety for no fewer than 96 hours during any type of power outage.

(2) For purposes of this section, “alternative source of power” means a source of electricity that is not received through an electric utility but is generated or stored onsite, which may include, but is

1 not limited to, emergency generators using fuel, large capacity  
2 batteries, and renewable electrical generation facilities.

3 (c) For purposes of this section, “resident health and safety”  
4 includes, but is not limited to, maintaining a safe temperature for  
5 residents, maintaining availability of life-saving equipment, and  
6 maintaining availability of oxygen-generating devices.

7 (d) A facility that uses a generator as its alternative source of  
8 power shall maintain sufficient fuel onsite to maintain generator  
9 operation for no less than 96 hours or make arrangements for fuel  
10 delivery for an emergency event. If fuel is to be delivered during  
11 an emergency event, the facility shall ensure that fuel will be  
12 available with no delays.

13 (e) A facility that uses batteries or a combination of batteries in  
14 tandem with a renewable electrical generation facility as its  
15 alternative source of power shall have sufficient storage or  
16 generation capacity to maintain operation for no fewer than 96  
17 hours. A facility shall also make arrangements for delivery of a  
18 generator and fuel in the event power is not restored within 96  
19 hours and the generation capacity of the renewable electrical  
20 generation facility is unable to provide sufficient power to comply  
21 with state requirements for long-term care facilities.

22 (f) *(1) A facility shall comply with the requirements of this*  
23 *section ~~by January 1, 2026~~ on or after January 1, 2026,*  
24 *commencing on the first day of the Medi-Cal skilled nursing facility*  
25 *rate year for which the State Department of Health Care Services*  
26 *publishes a written notice on its internet website that the*  
27 *Legislature has appropriated sufficient funds for the express*  
28 *purpose of providing an add-on to the Medi-Cal skilled nursing*  
29 *facility per diem rate for the projected Medi-Cal cost of complying*  
30 *with the requirements of this section, to the extent required by any*  
31 *of the following:*

32 (A) *The Medi-Cal Long-Term Care Reimbursement Act (Article*  
33 *3.8 (commencing with Section 14126) of Chapter 7 of Part 3 of*  
34 *Division 9 of the Welfare and Institutions Code).*

35 (B) *The California Medicaid State Plan.*

36 (C) *Any other applicable state or federal law or regulation.*

37 (2) *Notwithstanding the rulemaking provisions of Chapter 3.5*  
38 *(commencing with Section 11340) of Part 1 of Division 3 of Title*  
39 *2 of the Government Code, the State Department of Health Care*  
40 *Services may implement this subdivision by means of provider*

1 *bulletins, policy letters, or other similar instructions, without taking*  
2 *regulatory action.*

3 *SEC. 37. Section 120956 of the Health and Safety Code is*  
4 *amended to read:*

5 120956. (a) The AIDS Drug Assistance Program Rebate Fund  
6 is hereby created as a special fund in the State Treasury.

7 (b) All rebates collected from drug manufacturers on drugs  
8 purchased through the AIDS Drugs Assistance Program (ADAP)  
9 implemented pursuant to this chapter and, notwithstanding Section  
10 16305.7 of the Government Code, interest earned on these moneys  
11 shall be deposited in the fund exclusively to cover costs related to  
12 the purchase of drugs and services provided through ADAP and  
13 the HIV prevention programs as described in Sections 120972,  
14 120972.1, and 120972.2 and services related to *HIV prevention*  
15 *and* care and treatment for individuals living with HIV provided  
16 through the programs funded by the Transgender, Gender  
17 Nonconforming, and Intersex (TGI) Wellness and Equity Fund as  
18 described in Section 150900.

19 (c) Notwithstanding Section 13340 of the Government Code,  
20 moneys in the fund are continuously appropriated without regard  
21 to fiscal year to State Department of Public Health and available  
22 for expenditure for those purposes specified under this section.

23 *SEC. 38. Section 120960 of the Health and Safety Code is*  
24 *amended to read:*

25 120960. (a) The department shall establish uniform standards  
26 of financial eligibility for the drugs under the program established  
27 under this chapter.

28 (b) Nothing in the financial eligibility standards shall prohibit  
29 drugs to an otherwise eligible person whose modified adjusted  
30 gross income does not exceed 500 percent of the federal poverty  
31 level per year based on family size and household income.  
32 However, the director may authorize drugs for persons with  
33 incomes higher than 500 percent of the federal poverty level per  
34 year based on family size and household income if the estimated  
35 cost of those drugs in one year is expected to exceed 20 percent  
36 of the person's modified adjusted gross income. Beginning January  
37 1, 2025, or as soon as technically feasible thereafter, the financial  
38 eligibility standard in this section shall increase to 600 percent of  
39 the federal ~~poverty~~ *poverty* level per year based on family size and  
40 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. 39. Section 127672 of the Health and Safety Code is amended to read:*

127672. (a) (1) The Department of Health Care Access and Information shall convene a Health Care Payments Data Program



1 advisory committee, composed of health care stakeholders and  
2 experts, including, but not limited to, all of the following:

3 (A) Health care service plans, including specialized health care  
4 service plans.

5 (B) Insurers that have a certificate of authority from the  
6 Insurance Commissioner to provide health insurance, as defined  
7 in Section 106 of the Insurance Code.

8 (C) Suppliers, as defined in paragraph (3) of subdivision (b) of  
9 Section 1367.50.

10 (D) Providers, as defined in paragraph (2) of subdivision (b) of  
11 Section 1367.50.

12 (E) Self-insured employers.

13 (F) Multiemployer self-insured plans that are responsible for  
14 paying for health care services provided to beneficiaries or the  
15 trust administrator for a multiemployer self-insured plan.

16 (G) Businesses that purchase health care coverage for their  
17 employees.

18 (H) Organized labor.

19 (I) Organizations representing consumers.

20 (J) *Pharmacy benefit managers, as defined in Section*  
21 *127673.05.*

22 (2) The advisory committee shall consist of no fewer than ~~nine~~  
23 ~~10~~ and no more than ~~11~~ 12 persons.

24 (3) In addition to the members specified by paragraph (2), the  
25 director of the department, the director of the State Department of  
26 Health Care Services, and the executive director of the California  
27 Health Benefit Exchange, or their officially designated  
28 representatives, shall be nonvoting ex officio members of the  
29 advisory committee.

30 (4) Each appointed member shall serve a term of two years,  
31 except one-half of the initial appointments shall be for one year.  
32 Each appointed member shall serve at the discretion of the director  
33 and may be removed at any time.

34 (5) The chairperson of the advisory committee shall be an  
35 appointed member and shall be elected by a majority of the  
36 appointed members.

37 (6) The advisory committee shall meet at least quarterly or when  
38 requested by the director.

39 (7) The advisory committee shall assist and advise the director  
40 in formulating program policies regarding data collection,

1 management, use, and access, and development of public  
2 information to meet the goals of the program. The advisory  
3 committee shall, through its meetings, provide a forum for  
4 stakeholder and public engagement. Upon request of the director,  
5 the advisory committee may assist and advise on the department's  
6 other data programs.

7 (8) On or before July 1, 2024, the advisory committee shall  
8 make recommendations to the department on how existing state  
9 public health data functions may be integrated into the system.  
10 The advisory committee shall also recommend options for state  
11 public health data integration. These recommendations shall be  
12 published on the department's internet website.

13 (9) The advisory committee shall not have decisionmaking  
14 authority related to the administration of the system and shall not  
15 have a financial interest, individually or through a family member,  
16 in the recommendations made to the department. The advisory  
17 committee shall hold public meetings with stakeholders, solicit  
18 input, and set its own meeting agendas. Meetings of the advisory  
19 committee are subject to the Bagley-Keene Open Meeting Act  
20 (Article 9 (commencing with Section 11120) of Chapter 1 of Part  
21 1 of Division 3 of Title 2 of the Government Code).

22 (10) The members of the advisory committee appointed from  
23 outside government shall serve without compensation, but shall  
24 receive a per diem for each day's attendance at an advisory  
25 committee meeting. All members shall be reimbursed for any  
26 actual and necessary expenses incurred in connection with their  
27 duties as members of the committee.

28 (b) The department may convene other committees or  
29 workgroups as necessary to support effective operation of the  
30 system. These committees may be standing committees or  
31 time-limited workgroups, at the discretion of the director.

32 *SEC. 40. Section 127672.9 of the Health and Safety Code is*  
33 *amended to read:*

34 127672.9. ~~Until January 1, 2026;~~ *June 30, 2028*, for purposes  
35 of implementing this chapter, including, but not limited to, hiring  
36 staff and consultants, facilitating and conducting meetings,  
37 conducting research and analysis, and developing the required  
38 reports, the department may enter into exclusive or nonexclusive  
39 contracts on a bid or negotiated basis. Contracts entered into or  
40 amended pursuant to this section are exempt from Chapter 6

(commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and are exempt from the review or approval of any division of the Department of General Services.

*SEC. 41. Section 127673.05 is added to the Health and Safety Code, to read:*

*127673.05. (a) For purposes of this section, “pharmacy benefits manager” or “PBM” means an entity that is required to be licensed pursuant to Section 1385.008.*

*(b) Notwithstanding any other state law, for the purpose of providing information for inclusion in the system, PBMs shall provide to the department data regarding drug pricing, the fees paid for pharmacy benefit management services, payments or rebates to or from pharmacy benefits managers regarding drugs or services, and other information as needed to provide transparency on pricing and payments related to prescription drugs. This may include all of the following:*

*(1) Drug codes, names, therapeutic category, and manufacturer.*

*(2) Wholesale acquisition costs.*

*(3) Average wholesale prices.*

*(4) National average drug acquisition cost.*

*(5) Fees paid to pharmacy benefit managers by manufacturers, health care service plans, health insurers, employers, and pharmacies.*

*(6) Prescription counts.*

*(7) Member counts.*

*(8) Payment amounts collected and paid by pharmacy benefit managers.*

*(9) Discounts and rebate amounts collected and paid by pharmacy benefit managers.*

*(10) Information grouped by National Drug Code and Generic Product Identifier.*

*(11) Information grouped by pharmacies owned by, or under common control of, the pharmacy benefit manager and pharmacies not owned by, or under common control of, the pharmacy benefit manager.*

*(12) Information grouped by business relationship, including by exclusive relationships under a contract, agreement, or other arrangement between a pharmacy benefit manager and a*

1 *pharmaceutical manufacturer to exclusively dispense or provide*  
2 *a drug to a health care service plan's or health insurer's*  
3 *employees, enrollees, or insureds.*  
4 *(13) Information needed to calculate any of the following:*  
5 *(A) The number of participants or beneficiaries who filled a*  
6 *prescription.*  
7 *(B) Total out-of-pocket spending by participants or beneficiaries.*  
8 *(C) Total net price by drug.*  
9 *(D) Payer total net spending by drug.*  
10 *(E) Payer average net spending per 30-day and 90-day supply.*  
11 *(F) Percentage of prescriptions dispensed by pharmacies owned*  
12 *by, or under common control of, the pharmacy benefit manager.*  
13 *(G) Comparisons of the amounts charged to patients and payers*  
14 *by pharmacies owned by, or under common control of, the*  
15 *pharmacy benefit manager, with the amounts charged by*  
16 *pharmacies not owned by, or under common control of, the*  
17 *pharmacy benefit manager.*  
18 *(H) Average sales price of drugs dispensed at pharmacies owned*  
19 *by, or under common control of, the pharmacy benefit manager.*  
20 *(I) Average wholesale acquisition cost of drugs dispensed at*  
21 *pharmacies owned by, or under common control of, the pharmacy*  
22 *benefit manager.*  
23 *(J) Average drug acquisition cost per dosage unit of drugs*  
24 *dispensed at pharmacies owned by, or under common control of,*  
25 *the pharmacy benefit manager.*  
26 *(K) Average drug acquisition cost per 30-day and 90-day supply.*  
27 *(c) The department shall promulgate regulations for the purpose*  
28 *of carrying out this section, including regulations relating to the*  
29 *content, file formats, frequency, and timelines for data submission*  
30 *by pharmacy benefit managers. In the development of regulations,*  
31 *the department may consider national or regional standards and*  
32 *standards from other databases.*  
33 *(d) Until January 1, 2028, any necessary rules and regulations*  
34 *for the purpose of implementing this section may be adopted as*  
35 *emergency regulations in accordance with the Administrative*  
36 *Procedure Act (Chapter 3.5 (commencing with Section 11340) of*  
37 *Part 1 of Division 3 of Title 2 of the Government Code). The*  
38 *adoption of emergency regulations pursuant to this section shall*  
39 *be deemed to be an emergency and necessary for the immediate*

1 *preservation of the public peace, health and safety, or general*  
2 *welfare.*

3 *(e) Notwithstanding Chapter 3.5 (commencing with Section*  
4 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*  
5 *including subdivisions (e) and (h) of Section 11346.1 of the*  
6 *Government Code, an emergency regulation adopted pursuant to*  
7 *this section shall be repealed by operation of law unless the*  
8 *adoption, amendment, or repeal of the regulation is promulgated*  
9 *by the office pursuant to Chapter 3.5 (commencing with Section*  
10 *11340) of Part 1 of Division 3 of Title 2 of the Government Code*  
11 *within two years of the initial adoption of the emergency*  
12 *regulation.*

13 *(f) In its initial implementation of this section, the department*  
14 *shall seek historical data for three years before the effective date*  
15 *of the regulations described in subdivision (d).*

16 *(g) The provisions of this section are severable. If any provision*  
17 *of this section or its application is held invalid, that invalidity shall*  
18 *not affect other provisions or applications that can be given effect*  
19 *without the invalid provision or application.*

20 *SEC. 42. Section 127697 of the Health and Safety Code is*  
21 *repealed.*

22 ~~127697. Notwithstanding anything to the contrary in this~~  
23 ~~chapter, CHHSA may enter into partnerships regarding~~  
24 ~~over-the-counter naloxone products. Partnerships entered into~~  
25 ~~pursuant to this section may allow the development, manufacturing,~~  
26 ~~or distribution of over-the-counter naloxone products by any entity~~  
27 ~~that is authorized to do so under federal or state law.~~

28 *SEC. 43. Section 127697 is added to the Health and Safety*  
29 *Code, to read:*

30 *127697. In addition to partnerships authorized pursuant to*  
31 *Sections 127692 and 127693, the California Health and Human*  
32 *Services Agency may, subject to an appropriation by the*  
33 *Legislature, enter into partnerships to increase competition, lower*  
34 *prices, and address supply shortages under any of the following*  
35 *circumstances:*

36 *(a) For over-the-counter naloxone products. Partnerships*  
37 *entered into pursuant to this section may allow the development,*  
38 *manufacturing, or distribution of over-the-counter naloxone*  
39 *products by an entity that is authorized to do so under federal or*  
40 *state law.*

1 (b) For generic or brand name drugs to address emerging health  
2 concerns, including in reproductive health care or gender affirming  
3 health care.

4 (c) For the development, production, procurement, or  
5 distribution of vaccines, by an entity that is authorized to do so  
6 under federal or state law, with the intent that these vaccines be  
7 made widely available to public and private purchasers, providers,  
8 suppliers, and pharmacies.

9 (d) For the manufacture, purchase, or distribution of medical  
10 supplies or medical devices.

11 SEC. 44. Section 127825 of the Health and Safety Code is  
12 amended to read:

13 127825. (a) As a component of the Children and Youth  
14 Behavioral Health ~~Initiative~~ Initiative, established pursuant to  
15 Chapter 2 (commencing with Section 5961) of Part 7 of Division  
16 5 of the Welfare and Institutions Code, the office ~~is hereby~~  
17 ~~authorized to~~ may award competitive grants to the entities and  
18 individuals it deems qualified to expand the supply of behavioral  
19 health counselors, coaches, peer supports, and other allied health  
20 care providers serving children and youth, including ~~those~~  
21 individuals at schoolsites.

22 (b) For the purposes of this chapter, ~~“behavioral health~~ “certified  
23 wellness coach” means a new category of behavioral health  
24 provider trained specifically to help address the unmet mental  
25 health and substance use needs of children and youth. Recognizing  
26 that unmet mental health and substance use needs create learning  
27 barriers, ~~behavioral health~~ certified wellness coaches shall engage  
28 and support children and youth in cultural, linguistic, and  
29 age-appropriate ~~services~~, services with the ability to refer and link  
30 to higher levels of care, as needed. As ~~members~~ a member of a  
31 care team, a behavioral health ~~professionals~~ professional serving  
32 as a certified wellness coach ~~receive~~ receives appropriate  
33 supervision and coordination from ~~licensed staff~~. staff who are  
34 licensed or who hold a pupil personnel services credential pursuant  
35 to Section 44266 of the Education Code, or school nurse services  
36 credential pursuant to Section 44267.5 of the Education Code.  
37 Training and qualifications include, but are not limited to,  
38 psychoeducation, system navigation, crisis ~~deescalation~~, safety  
39 planning, referral, coping skills, and motivational interviewing.

1 (c) *This chapter shall be implemented in a manner that is*  
2 *consistent with Section 44270.2 of the Education Code and Section*  
3 *80049.1 of Title 5 of the California Code of Regulations.*

4 SEC. 45. *Section 150900 of the Health and Safety Code is*  
5 *amended to read:*

6 150900. (a) The Transgender, Gender Nonconforming, and  
7 Intersex (TGI) Wellness and Equity Fund is established in the State  
8 Treasury.

9 (b) The State Department of Public ~~Health's Office of Health~~  
10 ~~Equity Health~~ shall administer the TGI Wellness and Equity Fund  
11 for purposes of funding grants to create programs, or funding  
12 existing programs, focused on coordinating trans-inclusive health  
13 care for individuals who identify as transgender, gender  
14 nonconforming, or intersex.

15 (c) Upon appropriation by the Legislature, moneys in the TGI  
16 Wellness and Equity Fund may be used to fund grants for the  
17 following purposes:

18 (1) The grants shall be available to TGI-serving organizations  
19 for the purpose of increasing the capacity of health care  
20 professionals to effectively provide TGI health care and institute  
21 TGI-inclusive best practices. This includes the creation of  
22 educational materials or facilitation of capacity-building trainings.

23 (2) The grants shall be available to TGI-serving organizations  
24 for the purpose of ~~facilitating therapeutic arts programs, such as~~  
25 ~~dancing, painting, or writing.~~ *evidence-based therapeutic arts*  
26 *programs.*

27 (3) The grants shall be available to TGI-serving organizations  
28 for purposes of assisting, identifying, and referring TGI people to  
29 access supportive housing. This includes case management  
30 opportunities, financial assistance, and assisting TGI people in  
31 receiving and utilizing housing vouchers. If a TGI-serving  
32 organization has already implemented a TGI-specific housing  
33 program, funding may be utilized to maintain or expand existing  
34 housing programs.

35 (4) The grants shall be available to a hospital, health care clinic,  
36 or other medical provider that currently provides gender-affirming  
37 health care services, such as hormone therapy or gender  
38 reassignment surgery, to continue providing those services, or to  
39 a hospital, health care clinic, or other medical provider that will  
40 establish a program that offers gender-affirming health care

1 services and has an established relationship with a TGI-serving  
2 organization that will lead in establishing the program.

3 (d) A hospital, health care clinic, or other medical provider that  
4 applies for a grant must apply in partnership with a TGI-serving  
5 organization and consult with the TGI-serving organization  
6 throughout the process of creating and implementing its  
7 trans-inclusive health care program.

8 (e) This section does not limit or impact payer coverage  
9 requirements of health care or other social services.

10 (f) For purposes of this section, the following definitions apply:

11 (1) “Health care” means all of the following:

12 (A) Medical, behavioral, and spiritual care, which includes, but  
13 is not limited to, guided meditation and nondenominational therapy.

14 ~~(B) Therapeutic arts programs, which includes, but is not limited~~  
15 ~~to, dancing, painting, and writing classes.~~

16 (B) *Evidence-based therapeutic arts programs.*

17 (C) Services related to substance use disorder or substance  
18 abuse.

19 (D) Supportive housing as a mechanism to support  
20 TGI-identified individuals in accessing other social services.

21 (2) A “TGI-serving organization” means either of the following:

22 (A) A public or nonprofit organization with a mission statement  
23 that centers around serving transgender, gender nonconforming,  
24 and intersex people, and where at least 65 percent of the clients of  
25 the organization are TGI.

26 (B) A nonprofit that serves as the fiscal agent or sponsor for an  
27 organization described in subparagraph (A). A nonprofit that is  
28 serving as a fiscal agent or sponsor shall pass all funding to the  
29 organization, but may charge a reasonable or industry standard fee  
30 for administrative costs of not more than 16 percent.

31 (3) “Transgender” is broad and inclusive of all gender identities  
32 different from the gender *that* a person was assigned at birth.

33 (4) “Gender nonconforming” is an inclusive term used to  
34 describe individuals who may experience a gender that is neither  
35 exclusively male nor female or is in between or beyond both of  
36 those genders, including, but not limited to, nonbinary, gender  
37 fluid, agender or without gender, third gender, genderqueer, gender  
38 variant, Two-Spirit, Hijra, Kathoey, Mak nyah, Muxe, Waria,  
39 Māhū, and Fa’afafine.



1 (5) “Intersex” is an umbrella term referring to people whose  
2 anatomy, hormones, or chromosomes fall outside the strict male  
3 and female binary.

4 SEC. 46. Section 10119.6 of the Insurance Code is amended  
5 to read:

6 10119.6. (a) (1) A large group disability insurance policy,  
7 except a specialized disability insurance policy, that is issued,  
8 amended, or renewed on or after ~~July 1, 2025~~, January 1, 2026,  
9 shall provide coverage for the diagnosis and treatment of infertility  
10 and fertility services, including a maximum of three completed  
11 oocyte retrievals with unlimited embryo transfers in accordance  
12 with the guidelines of the American Society for Reproductive  
13 Medicine (ASRM), using single embryo transfer when  
14 recommended and medically appropriate.

15 (2) A small group disability insurance policy, except a disability  
16 insurance policy described in paragraph (4), that is issued,  
17 amended, or renewed on or after ~~July 1, 2025~~, January 1, 2026,  
18 shall offer coverage for the diagnosis and treatment of infertility  
19 and fertility services. This paragraph shall not be construed to  
20 require a small group disability insurance policy to provide  
21 coverage for infertility services.

22 (3) A disability insurer shall include notice of the coverage  
23 specified in this section in the insurer’s evidence of coverage.

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

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

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

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

36 (3) The failure to establish a pregnancy or to carry a pregnancy  
37 to live birth after regular, unprotected sexual intercourse. For  
38 purposes of this section “regular, unprotected sexual intercourse”  
39 means no more than 12 months of unprotected sexual intercourse  
40 for a person under 35 years of age or no more than 6 months of

1 unprotected sexual intercourse for a person 35 years of age or  
2 older. Pregnancy resulting in miscarriage does not restart the  
3 12-month or 6-month time period to qualify as having infertility.

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

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

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

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

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

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

25 (f) Consistent with Section 10140, coverage for the treatment  
26 of infertility and fertility services shall be provided without  
27 discrimination on the basis of age, ancestry, color, disability,  
28 domestic partner status, gender, gender expression, gender identity,  
29 genetic information, marital status, national origin, race, religion,  
30 sex, or sexual orientation. This subdivision shall not be construed  
31 to interfere with the clinical judgment of a physician and surgeon.

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

34 (h) This section shall not apply to a health care benefit plan or  
35 policy entered into with the Board of Administration of the Public  
36 Employees' Retirement System pursuant to the Public Employees'  
37 Medical and Hospital Care Act (Part 5 (commencing with Section  
38 22750) of Division 5 of Title 2 of the Government Code) until July  
39 1, 2027.

1     *(i) (1) Until January 1, 2027, the commissioner may issue*  
2     *guidance regarding compliance with this section, and that guidance*  
3     *shall not be subject to the Administrative Procedure Act (Chapter*  
4     *3.5 (commencing with Section 11340) of Part 1 of Division 3 of*  
5     *Title 2 of the Government Code).*

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

9     *SEC. 47. Section 10125.2 is added to the Insurance Code, to*  
10    *read:*

11    10125.2. *(a) A pharmacy benefit manager that contracts with*  
12    *a health insurer shall comply with Article 6.1 (commencing with*  
13    *Section 1385.001) of Chapter 2.2 of Division 2 of the Health and*  
14    *Safety Code, including Sections 1385.004 and 1385.006 of the*  
15    *Health and Safety Code.*

16    *(b) A complaint made by an insured that includes potential*  
17    *violations by a pharmacy benefit manager of the terms of Article*  
18    *6.1 (commencing with Section 1385.001) of Chapter 2.2 of Division*  
19    *2 of the Health and Safety Code shall be considered by the*  
20    *department to be a complaint against the health insurer.*

21    *SEC. 48. Section 1026 of the Penal Code is amended to read:*

22    1026. *(a) If a defendant pleads not guilty by reason of insanity,*  
23    *and also joins with it another plea or pleas, the defendant shall first*  
24    *be tried as if only the other plea or pleas had been entered, and in*  
25    *that trial the defendant shall be conclusively presumed to have*  
26    *been sane at the time the offense is alleged to have been committed.*  
27    *If the jury finds the defendant guilty, or if the defendant pleads*  
28    *only not guilty by reason of insanity, the question whether the*  
29    *defendant was sane or insane at the time the offense was committed*  
30    *shall be promptly tried, either before the same jury or before a new*  
31    *jury in the discretion of the court. In that trial, the jury shall return*  
32    *a verdict either that the defendant was sane at the time the offense*  
33    *was committed or was insane at the time the offense was*  
34    *committed. If the verdict or finding is that the defendant was sane*  
35    *at the time the offense was committed, the court shall sentence the*  
36    *defendant as provided by law. If the verdict or finding is that the*  
37    *defendant was insane at the time the offense was committed, the*  
38    *court, unless it appears to the court that the sanity of the defendant*  
39    *has been recovered fully, shall direct that the defendant be*  
40    *committed to the State Department of State Hospitals for the care*

1 and treatment of persons with mental health disorders or any other  
2 appropriate public or private treatment facility approved by the  
3 community program director, or the court may order the defendant  
4 placed on outpatient status pursuant to Title 15 (commencing with  
5 Section 1600) of Part 2.

6 (b) Prior to making the order directing that the defendant be  
7 committed to the State Department of State Hospitals or other  
8 treatment facility or placed on outpatient status, the court shall  
9 order the community program director or a designee to evaluate  
10 the defendant and to submit to the court within 15 judicial days of  
11 the order a written recommendation as to whether the defendant  
12 should be placed on outpatient status or committed to the State  
13 Department of State Hospitals or other treatment facility. A person  
14 shall not be admitted to a state hospital or other treatment facility  
15 or placed on outpatient status under this section without having  
16 been evaluated by the community program director or a designee.  
17 If, however, it appears to the court that the sanity of the defendant  
18 has been recovered fully, the defendant shall be remanded to the  
19 custody of the sheriff until the issue of sanity has been finally  
20 determined in the manner prescribed by law. A defendant  
21 committed to a state hospital or other treatment facility or placed  
22 on outpatient status pursuant to Title 15 (commencing with Section  
23 1600) of Part 2 shall not be released from confinement, parole, or  
24 outpatient status unless and until the court that committed the  
25 person, after notice and hearing, finds and determines that the  
26 person's sanity has been restored, or meets the criteria for release  
27 pursuant to Section 4146 of the Welfare and Institutions Code.  
28 This section does not prohibit the transfer of the patient from one  
29 state hospital to any other state hospital by proper authority. This  
30 section does not prohibit the transfer of the patient to a hospital in  
31 another state in the manner provided in Section 4119 of the Welfare  
32 and Institutions Code.

33 (c) If the defendant is committed or transferred to the State  
34 Department of State Hospitals pursuant to this section, the court  
35 may, upon receiving the written recommendation of the medical  
36 director of the state hospital and the community program director,  
37 or their designee, or, pursuant to Section 4360.5 of the Welfare  
38 and Institutions Code, the recommendation of the independent  
39 evaluation panel, that the defendant be transferred to a public or  
40 private treatment facility approved by the community program

1 director or their designee, or, pursuant to Section 4360.5 of the  
2 Welfare and Institutions Code, the independent evaluation panel,  
3 order the defendant transferred to that facility. If the defendant is  
4 committed or transferred to a public or private treatment facility  
5 approved by the community program director, the court may, upon  
6 receiving the written recommendation of the community program  
7 director, order the defendant transferred to the State Department  
8 of State Hospitals or to another public or private treatment facility  
9 approved by the community program director. If either the  
10 defendant or the prosecuting attorney chooses to contest either  
11 kind of order of transfer, a petition may be filed in the court  
12 requesting a hearing, which shall be held if the court determines  
13 that sufficient grounds exist. At that hearing, the prosecuting  
14 attorney or the defendant may present evidence bearing on the  
15 order of transfer. The court shall use the same procedures and  
16 standards of proof as used in conducting probation revocation  
17 hearings pursuant to Section 1203.2.

18 (d) Prior to making an order for transfer under this section, the  
19 court shall notify the defendant, the attorney of record for the  
20 defendant, the prosecuting attorney, and the community program  
21 director or a designee.

22 (e) If the court, after considering the placement recommendation  
23 of the community program director or independent evaluation  
24 panel required in subdivision (b), orders that the defendant be  
25 committed to the State Department of State Hospitals or other  
26 public or private treatment facility, the court shall provide copies  
27 of the following documents prior to the admission of the defendant  
28 to the State Department of State Hospitals or other treatment  
29 facility where the defendant is to be committed:

30 (1) The commitment order, including a specification of the  
31 charges.

32 (2) A computation or statement setting forth the maximum term  
33 of commitment in accordance with Section 1026.5.

34 (3) A computation or statement setting forth the amount of credit  
35 for time served, if any, to be deducted from the maximum term of  
36 commitment.

37 (4) State summary criminal history information.

38 (5) Any arrest reports prepared by the police department or other  
39 law enforcement agency.

1 (6) Any court-ordered psychiatric examination or evaluation  
2 reports.

3 (7) The community program director's placement  
4 recommendation report.

5 (8) Any medical records.

6 (f) If the defendant is confined in a state hospital or other  
7 treatment facility as an inpatient, the medical director of the facility  
8 shall, at ~~six-month~~ 12-month intervals, submit a report in writing  
9 to the court and the community program director of the county of  
10 commitment, or a designee, setting forth the status and progress  
11 of the defendant. The court shall transmit copies of these reports  
12 to the prosecutor and defense counsel.

13 (g) For purposes of this section and Sections 1026.1 to 1026.6,  
14 inclusive, "community program director" means the person,  
15 agency, or entity designated by the State Department of State  
16 Hospitals pursuant to Section 1605 of this code and Section 4360  
17 of the Welfare and Institutions Code.

18 *SEC. 49. Section 5961.2 of the Welfare and Institutions Code*  
19 *is amended to read:*

20 5961.2. (a) As a component of the initiative, the State  
21 Department of Health Care Services, or its contracted vendor, may  
22 award competitive grants to entities it deems qualified for the  
23 following purposes:

24 (1) To build partnerships, capacity, and infrastructure supporting  
25 ongoing school-linked behavioral health services for children and  
26 youth 25 years of age and younger.

27 (2) To expand access to licensed medical and behavioral health  
28 professionals, counselors, peer support specialists, community  
29 health workers, and ~~behavioral health~~ *certified wellness* coaches  
30 serving children and youth.

31 (3) To build a statewide, community-based organization provider  
32 network for behavioral health prevention and treatment services  
33 for children and youth, including those attending institutions of  
34 higher education.

35 (4) To enhance coordination and partnerships with respect to  
36 behavioral health prevention and treatment services for children  
37 and youth via appropriate data sharing systems.

38 (b) Subject to subdivision (c), entities eligible to receive grants  
39 pursuant to this section may include counties, city mental health  
40 authorities, tribal entities, local educational agencies, institutions

1 of higher education, publicly funded childcare and preschools,  
2 health care service plans, community-based organizations, and  
3 behavioral health providers.

4 (c) The department shall determine the eligibility criteria, grant  
5 application process, and methodology for the distribution of funds  
6 appropriated for the purposes described in this section to those  
7 entities it deems qualified.

8 (d) The department shall ensure that grant distribution includes,  
9 but is not limited to, rural, urban, and suburban regions and  
10 geographic distribution among different age cohorts. Allowable  
11 activities shall include, but not be limited to, the following:

12 (1) Addressing behavioral health disparities while providing  
13 linguistically and culturally competent services for children and  
14 youth who lack access to adequate behavioral health services or  
15 otherwise are difficult to reach.

16 (2) Supporting administrative costs, including planning, project  
17 management, training, and technical assistance.

18 (3) Linking plans, counties, and school districts with local social  
19 services and community-based organizations.

20 (4) Implementing telehealth equipment and virtual systems in  
21 schools or near schools.

22 (5) Implementing data-sharing tools, information technology  
23 interfaces, or other technology investments designed to connect  
24 to behavioral health services.

25 (e) Of the funds appropriated for purposes of this section to  
26 institutions of higher education, at least two-thirds shall be reserved  
27 for California Community Colleges.

28 (f) For purposes of this section, the following definitions shall  
29 apply:

30 (1) “Comprehensive risk contract” has the same meaning as set  
31 forth in Section 438.2 of Title 42 of the Code of Federal  
32 Regulations.

33 (2) “Health care service plan” has the same meaning as described  
34 in subdivision (f) of Section 1345 of the Health and Safety Code.

35 (3) “Institution of higher education” means the California  
36 Community Colleges, the California State University, or the  
37 University of California.

38 (4) “Local educational agency” means a school district, county  
39 office of education, charter school, the California Schools for the  
40 Deaf, and the California School for the Blind.

(5) “Tribal entity” means a federally recognized Indian tribe, tribal organization, or urban Indian organization.

*SEC. 50. Section 14000 of the Welfare and Institutions Code, as amended by Section 1 of Chapter 291 of the Statutes of 2022, is amended to read:*

14000. The purpose of this chapter is to afford to qualifying individuals health care and related remedial or preventive services, including related social services that are necessary for those receiving health care under this chapter.

The intent of the Legislature is to provide, to the extent practicable, through the provisions of this chapter, for health care for California residents who lack sufficient income to meet the costs of health care and whose other assets are so limited that their application toward the costs of that care would jeopardize the person or family’s future minimum self-maintenance and security. It is intended that, whenever possible and feasible, all of the following shall apply:

(a) The means employed shall allow, to the extent practicable, eligible persons to secure health care in the same manner employed by the public generally, and without discrimination or segregation based purely on their economic disability. The means employed shall include an emphasis on efforts to arrange and encourage access to health care through enrollment in organized, managed care plans of the type available to the general public.

(b) The benefits available under this chapter shall not duplicate those provided under other federal or state laws or under other contractual or legal entitlements of the person or persons receiving them.

(c) In the administration of this chapter and in establishing the means to be used to provide access to health care to persons eligible under this chapter, the department shall emphasize and take advantage of both the efficient organization and ready accessibility and availability of health care facilities and resources through enrollment in managed health care plans and new and innovative fee-for-service managed health care plan approaches to the delivery of health care services.

~~This section shall remain in effect only until subdivision (b) of Section 14005.62 is implemented, and as of that date is repealed.~~

(d) *This section shall become operative January 1, 2026.*



1     *SEC. 51. Section 14000 of the Welfare and Institutions Code,*  
2     *as added by Section 2 of Chapter 291 of the Statutes of 2022, is*  
3     *amended to read:*

4     14000. The purpose of this chapter is to afford to qualifying  
5     individuals health care and related remedial or preventive services,  
6     including related social services that are necessary for those  
7     receiving health care under this chapter.

8     The intent of the Legislature is to provide, to the extent  
9     practicable, through the provisions of this chapter, for health care  
10    for California residents who lack sufficient income to meet the  
11    costs of health care. It is intended that, whenever possible and  
12    feasible, all of the following shall apply:

13    (a) The means employed shall allow, to the extent practicable,  
14    eligible persons to secure health care in the same manner employed  
15    by the public generally, and without discrimination or segregation  
16    based purely on their economic disability. The means employed  
17    shall include an emphasis on efforts to arrange and encourage  
18    access to health care through enrollment in organized, managed  
19    care plans of the type available to the general public.

20    (b) The benefits available under this chapter shall not duplicate  
21    those provided under other federal or state laws or under other  
22    contractual or legal entitlements of the person or persons receiving  
23    them.

24    (c) In the administration of this chapter and in establishing the  
25    means to be used to provide access to health care to persons eligible  
26    under this chapter, the department shall emphasize and take  
27    advantage of both the efficient organization and ready accessibility  
28    and availability of health care facilities and resources through  
29    enrollment in managed health care plans and new and innovative  
30    fee-for-service managed health care plan approaches to the delivery  
31    of health care services.

32    ~~This section shall become operative on the date that subdivision~~  
33    ~~(b) of Section 14005.62 is implemented.~~

34    (d) *This section shall become inoperative on January 1, 2026,*  
35    *and as of that date is repealed.*

36    *SEC. 52. Section 14005.11 of the Welfare and Institutions*  
37    *Code, as amended by Section 1 of Chapter 707 of the Statutes of*  
38    *2023, is amended to read:*

39    14005.11. (a) To the extent required by federal law for  
40    qualified ~~Medicare beneficiaries,~~ *beneficiaries enrolled in the*

1 *federal Medicare Program*, the department shall pay the premiums,  
2 deductibles, and coinsurance for elderly and disabled persons  
3 entitled to benefits under Title XVIII of the federal Social Security  
4 Act, whose income does not exceed the federal poverty level and  
5 whose resources do not exceed 200 percent of the Supplemental  
6 ~~Security Income program standard.~~ *the amount specified in*  
7 *subdivision (a) of Section 14005.62.*

8 (b) The department ~~shall~~, *shall pay*, in addition to subdivision  
9 (a), ~~pay~~ applicable additional premiums, deductibles, and  
10 coinsurance for drug coverage extended to qualified ~~Medicare~~  
11 ~~beneficiaries.~~ *beneficiaries enrolled in the federal Medicare*  
12 *Program.*

13 (c) The deductible payments required by subdivision (b) may  
14 be covered by providing the same drug coverage as offered to  
15 categorically needy recipients, as defined in Section 14050.1.

16 (d) As specified in this section, it is the intent of the Legislature  
17 to assist in the payment of Medicare Part B premiums for qualified  
18 low-income Medi-Cal beneficiaries who are ineligible for federal  
19 sharing or federal contribution for the payment of those premiums.

20 (e) For a Medi-Cal beneficiary who has a spend down of excess  
21 income but who is ineligible for the assistance provided pursuant  
22 to subdivision (a), or who is ineligible for any other federally  
23 funded assistance for the payment of the beneficiary's Medicare  
24 Part B premium, the department shall pay for the beneficiary's  
25 Medicare Part B premium in the month following each month that  
26 the beneficiary's spend down of excess income has been met.

27 (f) When a county is informed that an applicant or beneficiary  
28 is eligible for ~~Medicare benefits,~~ *benefits under the federal*  
29 *Medicare Program*, the county shall determine whether that  
30 individual is eligible under the Qualified Medicare Beneficiary  
31 ~~(QMB)~~ program, the Specified Low-Income Medicare Beneficiary  
32 ~~(SLMB)~~ program, or the Qualifying Individual ~~program and~~  
33 *program, and shall* enroll the applicant or beneficiary in the  
34 appropriate program.

35 (g) (1) The department shall enter into a Medicare Part A buy-in  
36 agreement for qualified Medicare beneficiaries with the federal  
37 Centers for Medicare and Medicaid Services by submitting a state  
38 plan amendment with a proposed effective date in accordance with  
39 paragraph (2).

1 (2) Subject to paragraph (3), the Medicare Part A buy-in  
2 agreement described in this subdivision shall be effective on  
3 January 1, 2025, or the date the department communicates to the  
4 Department of Finance in writing that systems have been  
5 programmed for implementation of this subdivision, whichever  
6 date is later.

7 (3) This subdivision shall be implemented only to the extent  
8 that any necessary federal approvals are obtained and that federal  
9 financial participation is available and is not otherwise jeopardized.

10 (4) Notwithstanding Chapter 3.5 (commencing with Section  
11 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
12 the department, without taking any further regulatory action, may  
13 implement, interpret, or make specific this subdivision by means  
14 of all-county letters, plan letters, plan or provider bulletins, or  
15 similar instructions, until the time regulations are adopted.

16 (5) For purposes of this subdivision, “Medicare Part A buy-in  
17 agreement” means an agreement authorized by Section 1395v of  
18 Title 42 of the United States Code under which the state shall pay  
19 Medicare Part A premiums for qualified individuals who are  
20 enrolled in both the Medicare Program and the Medi-Cal program.

21 ~~(h) This section shall become inoperative on the later of either~~  
22 ~~January 1, 2024, or the date on which the determination of the~~  
23 ~~Director of Health Care Services is communicated in writing to~~  
24 ~~the Department of Finance pursuant to paragraph (2) of subdivision~~  
25 ~~(b) of Section 14005.62, and subject to implementation of Section~~  
26 ~~14005.62 pursuant to subdivision (d) of that section, and shall~~  
27 ~~remain inoperative for time periods in which the department has~~  
28 ~~obtained the necessary federal approvals to implement paragraph~~  
29 ~~(2) of subdivision (b) of Section 14005.62 for the applicable~~  
30 ~~population.~~

31 ~~(h) This section shall become operative on January 1, 2026.~~

32 *SEC. 53. Section 14005.11 of the Welfare and Institutions*  
33 *Code, as amended by Section 2 of Chapter 707 of the Statutes of*  
34 *2023, is amended to read:*

35 14005.11. (a) To the extent required by federal law for  
36 qualified beneficiaries enrolled in the Medicare Program, the  
37 department shall pay the premiums, deductibles, and coinsurance  
38 for elderly and disabled persons entitled to benefits under Title  
39 XVIII of the federal Social Security Act, whose income does not  
40 exceed the federal poverty level.

(b) The department shall pay, in addition to subdivision (a), applicable additional premiums, deductibles, and coinsurance for drug coverage extended to qualified beneficiaries enrolled in the Medicare Program.

(c) The deductible payments required by subdivision (b) may be covered by providing the same drug coverage as offered to categorically needy recipients, as defined in Section 14050.1.

(d) As specified in this section, it is the intent of the Legislature to assist in the payment of Medicare Part B premiums for qualified low-income Medi-Cal beneficiaries who are ineligible for federal sharing or federal contribution for the payment of those premiums.

(e) For a Medi-Cal beneficiary who has a spend down of excess income but who is ineligible for the assistance provided pursuant to subdivision (a), or who is ineligible for any other federally funded assistance for the payment of the beneficiary's Medicare Part B premium, the department shall pay for the beneficiary's Medicare Part B premium in the month following each month that the beneficiary's spend down of excess income has been met.

(f) When a county is informed that an applicant or beneficiary is eligible for benefits under the Medicare Program, the county shall determine whether that individual is eligible under the Qualified Medicare Beneficiary program, the Specified Low-Income Medicare Beneficiary program, or the Qualifying Individual program, and shall enroll the applicant or beneficiary in the appropriate program.

(g) (1) The department shall enter into a Medicare Part A buy-in agreement for qualified Medicare beneficiaries with the federal Centers for Medicare and Medicaid Services by submitting a state plan amendment with a proposed effective date in accordance with paragraph (2).

(2) Subject to paragraph (3), the Medicare Part A buy-in agreement described in this subdivision shall be effective on January 1, 2025, or the date the department communicates to the Department of Finance in writing that systems have been programmed for implementation of this subdivision, whichever date is later.

(3) This subdivision shall be implemented only to the extent that any necessary federal approvals are obtained and that federal financial participation is available and is not otherwise jeopardized.

(4) 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 subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, until the time regulations are adopted.

(5) For purposes of this subdivision, “Medicare Part A buy-in agreement” means an agreement authorized by Section 1395v of Title 42 of the United States Code under which the state shall pay Medicare Part A premiums for qualified individuals who are enrolled in both the Medicare Program and the Medi-Cal program.

~~(h) This section shall become operative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain operative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.~~

~~(h) This section shall become inoperative on January 1, 2026, and, as of January 1, 2027, is repealed.~~

SEC. 54. *Section 14005.20 of the Welfare and Institutions Code, as amended by Section 75 of Chapter 42 of the Statutes of 2023, is amended to read:*

14005.20. (a) ~~The State Department of Health Care Services~~ department shall adopt the option made available under Section 1902(a)(10)(A)(ii)(XII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XII)) to pay allowable ~~tuberculosis-related~~ *tuberculosis-related* services for persons infected with tuberculosis.

(b) (1) Except as provided in paragraph (2), the income and resources of these persons may not exceed the maximum amount for a disabled person as described in Section 1902(a)(10)(A)(i) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)).

~~(2) Effective January 1, 2014, the income and resources of individuals eligible under this section may not exceed the maximum amount for a disabled person as described in Section~~

1 1902(a)(10)(A)(i) of Title XIX of the federal Social Security Act  
2 (42 U.S.C. Sec. 1396a(a)(10)(A)(i)), as determined, counted, and  
3 valued in accordance with the requirements of Section 14005.64.

4 (e) ~~The amendments made by the act that added this subdivision~~  
5 ~~shall be implemented only if, and to the extent that, federal~~  
6 ~~financial participation is available and any necessary federal~~  
7 ~~approvals have been obtained.~~

8 (d) ~~This section shall become inoperative on the later of either~~  
9 ~~January 1, 2024, or the date on which the determination of the~~  
10 ~~Director of Health Care Services is communicated in writing to~~  
11 ~~the Department of Finance pursuant to paragraph (2) of subdivision~~  
12 ~~(b) of Section 14005.62, and subject to implementation of Section~~  
13 ~~14005.62 pursuant to subdivision (d) of that section, and shall~~  
14 ~~remain inoperative for time periods in which the department has~~  
15 ~~obtained the necessary federal approvals to implement paragraph~~  
16 ~~(2) of subdivision (b) of Section 14005.62 for the applicable~~  
17 ~~population.~~

18 (c) *This section shall become operative on January 1, 2026.*

19 SEC. 55. *Section 14005.20 of the Welfare and Institutions*  
20 *Code, as added by Section 76 of Chapter 42 of the Statutes of 2023,*  
21 *is amended to read:*

22 14005.20. (a) The department shall adopt the option made  
23 available under Section 1902(a)(10)(A)(ii)(XII) of Title XIX of  
24 the federal Social Security Act (42 U.S.C. Sec.  
25 1396a(a)(10)(A)(ii)(XII)) to pay allowable tuberculosis-related  
26 services for persons infected with tuberculosis.

27 (b) (1) Except as provided in paragraph (2), the income of these  
28 persons may not exceed the maximum amount for a disabled person  
29 as described in Section 1902(a)(10)(A)(i) of Title XIX of the  
30 federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)).

31 (2) Effective January 1, 2014, the income of individuals eligible  
32 under this section may not exceed the maximum amount for a  
33 disabled person as described in Section 1902(a)(10)(A)(i) of Title  
34 XIX of the federal Social Security Act (42 U.S.C. Sec.  
35 1396a(a)(10)(A)(i)), as determined, counted, and valued in  
36 accordance with the requirements of Section 14005.64.

37 (c) The amendments made by the act that added this subdivision  
38 shall be implemented only if, and to the extent that, federal  
39 financial participation is available and any necessary federal  
40 approvals have been obtained.

~~(d) This section shall become operative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain operative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.~~

*(d) This section shall become inoperative on January 1, 2026, and, as of January 1, 2027, is repealed.*

*SEC. 56. Section 14005.40 of the Welfare and Institutions Code, as amended by Section 80 of Chapter 42 of the Statutes of 2023, is amended to read:*

14005.40. (a) To the extent federal financial participation is available, the department shall exercise its option under Section 1902(a)(10)(A)(ii)(X) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(X)), to implement a program for aged and disabled persons as described in Section 1902(m) of the federal Social Security Act (42 U.S.C. Sec. 1396a(m)(1)).

(b) To the extent federal financial participation is available, the blind shall be included within the definition of disabled for the purposes of the program established in this section.

(c) An individual shall satisfy the financial eligibility requirement of this program if all of the following conditions are met:

(1) Countable income, as determined in accordance with Section 1902(m) of the federal Social Security Act (42 U.S.C. Sec. 1396a(m)), does not exceed an income level equal to 100 percent of the applicable federal poverty level.

(2) (A) ~~Until such time as~~ *the time that* the department obtains federal approval for the income disregard described in paragraph (3), countable income shall include an additional two hundred thirty dollars (\$230) for an individual or, in the case of a couple, three hundred ten dollars (\$310).

(B) Upon receipt of federal approval for, and implementation of, paragraph (3), this paragraph shall become inoperative. The director shall execute a declaration, which shall be retained by the director, stating that federal approval for paragraph (3) has been

1 obtained and the date ~~upon which~~ *that* paragraph (3) ~~will~~ *shall* be  
2 implemented. The director shall post the declaration on the  
3 department's internet website.

4 (3) (A) Pursuant to Section 1902(r)(2) of the federal Social  
5 Security Act (42 U.S.C. Sec. 1396a(r)(2)), all countable income  
6 over 100 percent of the federal poverty level, up to 138 percent of  
7 the federal poverty level, shall be disregarded, after taking all other  
8 disregards, deductions, and exclusions into account for those  
9 persons eligible pursuant to this section.

10 (B) The department shall seek federal approval to implement  
11 this paragraph.

12 (4) (A) For the purposes of calculating countable income under  
13 this section, an income exemption shall be applied as necessary  
14 to adjust the ~~SSI/SSP Supplemental Security Income/State~~  
15 ~~Supplementary Program for the Aged, Blind, and Disabled~~  
16 (SSI/SSP) payment level as used in this section so that it is the  
17 same as the SSI/SSP payment level that was in place on May 1,  
18 2009.

19 (B) This additional income exemption shall cease to be  
20 implemented when the SSI/SSP payment levels increase beyond  
21 those in effect on May 1, 2009.

22 (C) The income level determined pursuant to paragraphs (1)  
23 and (2) shall not be less than the SSI/SSP payment level the  
24 individual receives or would receive as a disabled or blind  
25 individual or, in the case of a couple, the SSI/SSP payment level  
26 the couple receives or would receive as a disabled or blind couple.

27 (5) Countable resources, as determined in accordance with  
28 ~~Section 1902(m) of the federal Social Security Act (42 U.S.C. Sec.~~  
29 ~~1396a(m))~~; *subdivision (a) of Section 14005.62*, do not exceed the  
30 maximum levels established in that section.

31 (d) The financial eligibility requirements provided in subdivision  
32 (c) may be adjusted upwards to reflect the cost of living in  
33 California, contingent upon appropriation in the annual Budget  
34 Act.

35 (e) (1) Notwithstanding Chapter 3.5 (commencing with Section  
36 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
37 the department, without taking any further regulatory action, shall  
38 implement, interpret, or make specific this section by means of  
39 all-county letters, plan letters, plan or provider bulletins, or similar  
40 instructions until regulations are adopted.



(2) The department shall adopt regulations by ~~July 1, 2023,~~  
*January 1, 2030*, in accordance with the requirements of Chapter  
3.5 (commencing with Section 11340) of Part 1 of Division 3 of  
Title 2 of the Government Code. The department shall provide a  
status report to the Legislature on a semiannual basis, in  
compliance with Section 9795 of the Government Code, until  
regulations are adopted.

(f) For purposes of calculating income under this section during  
any calendar year, increases in social security benefit payments  
under Title II of the federal Social Security Act (42 U.S.C. Sec.  
401 et seq.) arising from cost-of-living adjustments shall be  
disregarded commencing in the month that these social security  
benefit payments are increased by the cost-of-living adjustment  
through the month before the month in which a change in the  
federal poverty level requires the department to modify the income  
level described in subdivision (c).

(g) (1) For purposes of this section, the following definitions  
apply:

(A) “SSI” means the federal Supplemental Security Income  
program established under Title XVI of the federal Social Security  
Act.

(B) “Income level” means the applicable income level specified  
in subdivision (c).

(C) The board and care “personal care services” or “PCS”  
deduction refers to an income disregard that is applied to a resident  
in a licensed community care facility in lieu of the board and care  
deduction (equal to the amount by which the basic board and care  
rate exceeds the income level in subparagraph (B)) when the PCS  
deduction is greater than the board and care deduction.

(2) (A) For purposes of this section, the SSI recipient retention  
amount is the amount by which the SSI maximum payment amount  
to an individual residing in a licensed community care facility  
exceeds the maximum amount that the state allows community  
care facilities to charge a resident who is an SSI recipient.

(B) For the purposes of this section, the personal and incidental  
needs deduction for an individual residing in a licensed community  
care facility is ~~either~~ *one* of the following:

(i) If the board and care deduction is applicable to the individual,  
the amount, not to exceed the amount by which the SSI recipient  
retention amount exceeds twenty dollars (\$20), nor to be less than

1 zero, by which the sum of the amount that the individual pays to  
2 the individual's licensed community care facility and the SSI  
3 recipient retention amount exceed the sum of the individual's  
4 income level, the individual's board and care deduction, and twenty  
5 dollars (\$20).

6 (ii) If the PCS deduction specified in paragraph (1) of  
7 subdivision (g) is applicable to the individual, an amount, not to  
8 exceed the amount by which the SSI recipient retention amount  
9 exceeds twenty dollars (\$20), nor to be less than zero, by which  
10 the sum of the amount that the individual pays to the individual's  
11 community care facility and the SSI recipient retention amount  
12 exceed the sum of the individual's income level, the individual's  
13 PCS deduction, and twenty dollars (\$20).

14 (3) In determining the countable income under this section of  
15 an individual residing in a licensed community care facility, the  
16 individual shall have deducted from the individual's income the  
17 amount specified in subparagraph (B) of paragraph (2).

18 (h) No later than one month after the effective date of  
19 subdivision (g), the department shall submit to the federal Medicaid  
20 program administrator a state plan amendment seeking approval  
21 of the income deduction specified in paragraph (3) of subdivision  
22 (g), and of federal financial participation for the costs resulting  
23 from that income deduction.

24 (i) The deduction prescribed by paragraph (3) of subdivision  
25 (g) shall be applied no later than the first day of the fourth month  
26 after the month in which the department receives approval for the  
27 federal financial participation specified in subdivision (h). Until  
28 approval for federal financial participation is received, there shall  
29 be no deduction under paragraph (3) of subdivision (g).

30 (j) This section shall be implemented only if, and to the extent  
31 that, any necessary federal approvals have been obtained.

32 (k) Paragraph (3) of subdivision (c) shall be implemented after  
33 the director determines, and communicates that determination in  
34 writing to the Department of Finance, that systems have been  
35 programmed for implementation of paragraph (3) of subdivision  
36 (c), but no sooner than January 1, 2020.

37 ~~(l) This section shall become inoperative on the later of either~~  
38 ~~January 1, 2024, or the date on which the determination of the~~  
39 ~~Director of Health Care Services is communicated in writing to~~  
40 ~~the Department of Finance pursuant to paragraph (2) of subdivision~~

1 ~~(b) of Section 14005.62, and subject to implementation of Section~~  
2 ~~14005.62 pursuant to subdivision (d) of that section, and shall~~  
3 ~~remain inoperative for time periods in which the department has~~  
4 ~~obtained the necessary federal approvals to implement paragraph~~  
5 ~~(2) of subdivision (b) of Section 14005.62 for the applicable~~  
6 ~~population.~~

7 *(l) This section shall become operative on January 1, 2026.*

8 *SEC. 57. Section 14005.40 of the Welfare and Institutions*  
9 *Code, as added by Section 81 of Chapter 42 of the Statutes of 2023,*  
10 *is amended to read:*

11 14005.40. (a) To the extent federal financial participation is  
12 available, the department shall exercise its option under Section  
13 1902(a)(10)(A)(ii)(X) of the federal Social Security Act (42 U.S.C.  
14 Sec. 1396a(a)(10)(A)(ii)(X)), to implement a program for aged  
15 and disabled persons as described in Section 1902(m) of the federal  
16 Social Security Act (42 U.S.C. Sec. 1396a(m)(1)).

17 (b) To the extent federal financial participation is available, the  
18 blind shall be included within the definition of disabled for the  
19 purposes of the program established in this section.

20 (c) An individual shall satisfy the financial eligibility  
21 requirement of this program if all of the following conditions are  
22 met:

23 (1) Countable income, as determined in accordance with Section  
24 1902(m) of the federal Social Security Act (42 U.S.C. Sec.  
25 1396a(m)), does not exceed an income level equal to 100 percent  
26 of the applicable federal poverty level.

27 (2) (A) Until the time that the department obtains federal  
28 approval for the income disregard described in paragraph (3),  
29 countable income shall include an additional two hundred thirty  
30 dollars (\$230) for an individual or, in the case of a couple, three  
31 hundred ten dollars (\$310).

32 (B) Upon receipt of federal approval for, and implementation  
33 of, paragraph (3), this paragraph shall become inoperative. The  
34 director shall execute a declaration, which shall be retained by the  
35 director, stating that federal approval for paragraph (3) has been  
36 obtained and the date that paragraph (3) shall be implemented.  
37 The director shall post the declaration on the department's internet  
38 website.

39 (3) (A) Pursuant to Section 1902(r)(2) of the federal Social  
40 Security Act (42 U.S.C. Sec. 1396a(r)(2)), all countable income

1 over 100 percent of the federal poverty level, up to 138 percent of  
2 the federal poverty level, shall be disregarded, after taking all other  
3 disregards, deductions, and exclusions into account for those  
4 persons eligible pursuant to this section.

5 (B) The department shall seek federal approval to implement  
6 this paragraph.

7 (4) (A) For the purposes of calculating countable income under  
8 this section, an income exemption shall be applied as necessary  
9 to adjust the Supplemental Security Income/State Supplementary  
10 Program for the Aged, Blind, and Disabled (SSI/SSP) payment  
11 level as used in this section so that it is the same as the SSI/SSP  
12 payment level that was in place on May 1, 2009.

13 (B) This additional income exemption shall cease to be  
14 implemented when the SSI/SSP payment levels increase beyond  
15 those in effect on May 1, 2009.

16 (C) The income level determined pursuant to paragraphs (1)  
17 and (2) shall not be less than the SSI/SSP payment level the  
18 individual receives or would receive as a disabled or blind  
19 individual or, in the case of a couple, the SSI/SSP payment level  
20 the couple receives or would receive as a disabled or blind couple.

21 (5) Countable resources, including property or other assets, shall  
22 not be considered in determining eligibility.

23 (d) The financial eligibility requirements provided in subdivision  
24 (c) may be adjusted upwards to reflect the cost of living in  
25 California, contingent upon appropriation in the annual Budget  
26 Act.

27 (e) (1) Notwithstanding Chapter 3.5 (commencing with Section  
28 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
29 the department, without taking any further regulatory action, shall  
30 implement, interpret, or make specific this section by means of  
31 all-county letters, plan letters, plan or provider bulletins, or similar  
32 instructions until regulations are adopted.

33 (2) The department shall adopt regulations by July 1, 2023, in  
34 accordance with the requirements of Chapter 3.5 (commencing  
35 with Section 11340) of Part 1 of Division 3 of Title 2 of the  
36 Government Code. The department shall provide a status report  
37 to the Legislature on a semiannual basis, in compliance with  
38 Section 9795 of the Government Code, until regulations are  
39 adopted.

(f) For purposes of calculating income under this section during any calendar year, increases in social security benefit payments under Title II of the federal Social Security Act (42 U.S.C. Sec. 401 et seq.) arising from cost-of-living adjustments shall be disregarded commencing in the month that these social security benefit payments are increased by the cost-of-living adjustment through the month before the month in which a change in the federal poverty level requires the department to modify the income level described in subdivision (c).

(g) (1) For purposes of this section, the following definitions apply:

(A) “SSI” means the federal Supplemental Security Income program established under Title XVI of the federal Social Security Act.

(B) “Income level” means the applicable income level specified in subdivision (c).

(C) The board and care “personal care services” or “PCS” deduction refers to an income disregard that is applied to a resident in a licensed community care facility in lieu of the board and care deduction (equal to the amount by which the basic board and care rate exceeds the income level in subparagraph (B)) when the PCS deduction is greater than the board and care deduction.

(2) (A) For purposes of this section, the SSI recipient retention amount is the amount by which the SSI maximum payment amount to an individual residing in a licensed community care facility exceeds the maximum amount that the state allows community care facilities to charge a resident who is an SSI recipient.

(B) For the purposes of this section, the personal and incidental needs deduction for an individual residing in a licensed community care facility is one of the following:

(i) If the board and care deduction is applicable to the individual, the amount, not to exceed the amount by which the SSI recipient retention amount exceeds twenty dollars (\$20), nor to be less than zero, by which the sum of the amount that the individual pays to the individual’s licensed community care facility and the SSI recipient retention amount exceed the sum of the individual’s income level, the individual’s board and care deduction, and twenty dollars (\$20).

(ii) If the PCS deduction specified in paragraph (1) of subdivision (g) is applicable to the individual, an amount, not to

1 exceed the amount by which the SSI recipient retention amount  
2 exceeds twenty dollars (\$20), nor to be less than zero, by which  
3 the sum of the amount that the individual pays to the individual's  
4 community care facility and the SSI recipient retention amount  
5 exceed the sum of the individual's income level, the individual's  
6 PCS deduction, and twenty dollars (\$20).

7 (3) In determining the countable income under this section of  
8 an individual residing in a licensed community care facility, the  
9 individual shall have deducted from the individual's income the  
10 amount specified in subparagraph (B) of paragraph (2).

11 (h) No later than one month after the effective date of  
12 subdivision (g), the department shall submit to the federal Medicaid  
13 program administrator a state plan amendment seeking approval  
14 of the income deduction specified in paragraph (3) of subdivision  
15 (g), and of federal financial participation for the costs resulting  
16 from that income deduction.

17 (i) The deduction prescribed by paragraph (3) of subdivision  
18 (g) shall be applied no later than the first day of the fourth month  
19 after the month in which the department receives approval for the  
20 federal financial participation specified in subdivision (h). Until  
21 approval for federal financial participation is received, there shall  
22 be no deduction under paragraph (3) of subdivision (g).

23 (j) This section shall be implemented only if, and to the extent  
24 that, any necessary federal approvals have been obtained.

25 (k) Paragraph (3) of subdivision (c) shall be implemented after  
26 the director determines, and communicates that determination in  
27 writing to the Department of Finance, that systems have been  
28 programmed for implementation of paragraph (3) of subdivision  
29 (c), but no sooner than January 1, 2020.

30 ~~(l) This section shall become operative on the later of either~~  
31 ~~January 1, 2024, or the date on which the determination of the~~  
32 ~~Director of Health Care Services is communicated in writing to~~  
33 ~~the Department of Finance pursuant to paragraph (2) of subdivision~~  
34 ~~(b) of Section 14005.62, and subject to implementation of Section~~  
35 ~~14005.62 pursuant to subdivision (d) of that section, and shall~~  
36 ~~remain operative for time periods in which the department has~~  
37 ~~obtained the necessary federal approvals to implement paragraph~~  
38 ~~(2) of subdivision (b) of Section 14005.62 for the applicable~~  
39 ~~population.~~

1 *(l) This section shall become inoperative on January 1, 2026,*  
2 *and, as of January 1, 2027, is repealed.*

3 *SEC. 58. Section 14005.62 of the Welfare and Institutions Code*  
4 *is amended to read:*

5 14005.62. (a) (1) Notwithstanding any other law, for an  
6 applicant or beneficiary whose eligibility is not determined using  
7 the modified adjusted gross income (MAGI)-based financial  
8 methods, as specified in Section 1396a(e)(14) of Title 42 of the  
9 United States Code, ~~the department shall seek federal approval to~~  
10 ~~implement a disregard of one hundred thirty thousand dollars~~  
11 ~~(\$130,000) in nonexempt property for a case with one member~~  
12 ~~and sixty five thousand dollars (\$65,000) for each additional~~  
13 ~~household member, up to a maximum of ten members. resources,~~  
14 ~~including property or other assets, shall not be used to determine~~  
15 ~~eligibility under the Medi-Cal program to the extent permitted by~~  
16 ~~federal law. The department shall seek federal authority to~~  
17 ~~disregard all resources as authorized by the flexibilities provided~~  
18 ~~under Section 1396a(r)(2) of Title 42 of the United States Code~~  
19 ~~or other available authorities.~~

20 ~~(2) This subdivision shall be implemented only after the director~~  
21 ~~determines that systems have been programmed for the disregards~~  
22 ~~specified in paragraph (1) and they communicate that determination~~  
23 ~~in writing to the Department of Finance, and no sooner than July~~  
24 ~~1, 2022.~~

25 ~~(b) (1) Notwithstanding any other law, for an applicant or~~  
26 ~~beneficiary described in subdivision (a), resources, including~~  
27 ~~property or other assets, shall not be used to determine eligibility~~  
28 ~~under the Medi-Cal program to the extent permitted by federal~~  
29 ~~law. The department shall seek federal authority to disregard all~~  
30 ~~resources as authorized by the flexibilities provided under Section~~  
31 ~~1396a(r)(2) of Title 42 of the United States Code or other available~~  
32 ~~authorities.~~

33 ~~(2) This subdivision shall be implemented only after the director~~  
34 ~~determines that systems have been programmed for these disregards~~  
35 ~~and they communicate that determination in writing to the~~  
36 ~~Department of Finance, and no sooner than January 1, 2024.~~

37 ~~(e)~~

38 *(b) (1) Notwithstanding Chapter 3.5 (commencing with Section*  
39 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*  
40 *the department may implement this section by means of county*

1 letters, provider bulletins or notices, policy letters, or other similar  
2 instructions, without taking regulatory action.

3 (2) Within two years of implementing the requirements set forth  
4 in subdivision (b), the department shall do both of the following:

5 (A) Adopt, amend, or repeal regulations in accordance with the  
6 requirements of Chapter 3.5 (commencing with Section 11340) of  
7 Part 1 of Division 3 of Title 2 of the Government Code and this  
8 section.

9 (B) Update its notices and forms to delete any reference to  
10 limitations on resources or assets.

11 (c) *No sooner than August 1, 2025, the department shall convene*  
12 *a stakeholder workgroup to provide feedback and assist the*  
13 *department with activities related to the implementation of the*  
14 *version this section to be operative on January 1, 2026, including*  
15 *educational outreach in the form of flyers and factsheets and other*  
16 *public education strategies developed by the department in*  
17 *consultation with interested stakeholders, including, but not limited*  
18 *to, counties and consumer advocates.*

19 (d) This section shall only be implemented to the extent  
20 consistent with federal law, upon the department obtaining any  
21 necessary federal approvals, and to the extent federal financial  
22 participation under the Medi-Cal program is available and not  
23 otherwise jeopardized.

24 (e) *This section shall become inoperative on January 1, 2026,*  
25 *and as of that date is repealed.*

26 SEC. 59. *Section 14005.62 is added to the Welfare and*  
27 *Institutions Code, to read:*

28 14005.62. (a) (1) *Notwithstanding any other law, for an*  
29 *applicant or beneficiary whose eligibility is not determined using*  
30 *the modified adjusted gross income (MAGI)-based financial*  
31 *methods, as specified in Section 1396a(e)(14) of Title 42 of the*  
32 *United States Code, the department shall seek federal approval to*  
33 *implement a disregard of one hundred thirty thousand dollars*  
34 *(\$130,000) in nonexempt property for a case with one member*  
35 *and sixty five thousand dollars (\$65,000) for each additional*  
36 *household member, up to a maximum of 10 members.*

37 (2) *This subdivision shall be implemented only after the director*  
38 *determines that systems have been programmed for the disregards*  
39 *specified in paragraph (1) and they communicate that*  
40 *determination in writing to the Department of Finance.*



1     **(b) (1)** *Notwithstanding Chapter 3.5 (commencing with Section*  
2 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*  
3 *the department may implement this section by means of county*  
4 *letters, provider bulletins or notices, policy letters, or other similar*  
5 *instructions, without taking regulatory action. Such instructions*  
6 *shall include a list of all exempt property for use until such time*  
7 *that regulations are adopted.*

8     **(2)** *Within two years of implementing the requirements set forth*  
9 *in this subdivision, the department shall do both of the following:*

10     **(A)** *Adopt, amend, or repeal regulations in accordance with the*  
11 *requirements of Chapter 3.5 (commencing with Section 11340) of*  
12 *Part 1 of Division 3 of Title 2 of the Government Code and this*  
13 *section.*

14     **(B)** *Update its notices and forms to reflect the consideration of*  
15 *assets and resources as described in subdivision (a).*

16     **(c)** *Upon operation of subdivision (a), the department shall*  
17 *make available, on a quarterly basis data, the number of Medi-Cal*  
18 *enrollees who lost eligibility due to the asset limit. The department*  
19 *shall consult with stakeholders to determine the appropriate data*  
20 *elements and level of detail, including, but not limited to, the*  
21 *reasons for termination.*

22     **(d)** *This section shall only be implemented to the extent*  
23 *consistent with federal law, upon the department obtaining any*  
24 *necessary federal approvals, and to the extent federal financial*  
25 *participation under the Medi-Cal program is available and not*  
26 *otherwise jeopardized.*

27     **(e)** *This section shall become operative on January 1, 2026.*

28     **SEC. 60.** *Section 14005.401 of the Welfare and Institutions*  
29 *Code, as amended by Section 82 of Chapter 42 of the Statutes of*  
30 *2023, is amended to read:*

31     14005.401. **(a)** *The department shall seek a Medicaid state*  
32 *plan amendment or waiver to implement an income disregard that*  
33 *would allow an aged, blind, or disabled individual who becomes*  
34 *ineligible for benefits under the Medi-Cal program pursuant to*  
35 *Section 14005.40 because of the state's payment of the individual's*  
36 *Medicare Part B premiums to remain eligible for the Medi-Cal*  
37 *program under Section 14005.40 if their income and resources*  
38 *otherwise meet all eligibility requirements.*

39     **(b) (1)** *Notwithstanding Chapter 3.5 (commencing with Section*  
40 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*

1 the department may implement, interpret, or make specific this  
2 section by means of all-county letters, plan letters, plan or provider  
3 bulletins, or similar instructions until the time any necessary  
4 regulations are adopted.

5 (2) The department shall adopt regulations by ~~July 1, 2021,~~  
6 *January 1, 2030*, in accordance with the requirements of Chapter  
7 3.5 (commencing with Section 11340) of Part 1 of Division 3 of  
8 Title 2 of the Government Code.

9 ~~(3) Commencing six months after the effective date of this~~  
10 ~~section, and notwithstanding Section 10231.5 of the Government~~  
11 ~~Code, the department shall provide a status report to the Legislature~~  
12 ~~on a semiannual basis, in compliance with Section 9795 of the~~  
13 ~~Government Code, until regulations have been adopted.~~

14 (c) This section shall be implemented only if, and to the extent  
15 that, federal financial participation is available and necessary  
16 federal approvals have been obtained.

17 ~~(d) This section shall become inoperative on the later of either~~  
18 ~~January 1, 2024, or the date on which the determination of the~~  
19 ~~Director of Health Care Services is communicated in writing to~~  
20 ~~the Department of Finance pursuant to paragraph (2) of subdivision~~  
21 ~~(b) of Section 14005.62, and subject to implementation of Section~~  
22 ~~14005.62 pursuant to subdivision (d) of that section, and shall~~  
23 ~~remain inoperative for time periods in which the department has~~  
24 ~~obtained the necessary federal approvals to implement paragraph~~  
25 ~~(2) of subdivision (b) of Section 14005.62 for the applicable~~  
26 ~~population.~~

27 *(d) This section shall become operative on January 1, 2026.*

28 *SEC. 61. Section 14005.401 of the Welfare and Institutions*  
29 *Code, as added by Section 83 of Chapter 42 of the Statutes of 2023,*  
30 *is amended to read:*

31 14005.401. (a) The department shall seek a Medicaid state  
32 plan amendment or waiver to implement an income disregard that  
33 would allow an aged, blind, or disabled individual who becomes  
34 ineligible for benefits under the Medi-Cal program pursuant to  
35 Section 14005.40 because of the state's payment of the individual's  
36 Medicare Part B premiums to remain eligible for the Medi-Cal  
37 program under Section 14005.40 if their income otherwise meets  
38 all eligibility requirements.

39 (b) (1) Notwithstanding Chapter 3.5 (commencing with Section  
40 11340) of Part 1 of Division 3 of Title 2 of the Government Code,

1 the department may implement, interpret, or make specific this  
2 section by means of all-county letters, plan letters, plan or provider  
3 bulletins, or similar instructions until the time any necessary  
4 regulations are adopted.

5 (2) The department shall adopt regulations by July 1, 2021, in  
6 accordance with the requirements of Chapter 3.5 (commencing  
7 with Section 11340) of Part 1 of Division 3 of Title 2 of the  
8 Government Code.

9 (3) Commencing six months after the effective date of this  
10 section, and notwithstanding Section 10231.5 of the Government  
11 Code, the department shall provide a status report to the Legislature  
12 on a semiannual basis, in compliance with Section 9795 of the  
13 Government Code, until regulations have been adopted.

14 (c) This section shall be implemented only if, and to the extent  
15 that, federal financial participation is available and necessary  
16 federal approvals have been obtained.

17 ~~(d) This section shall become operative on the later of either~~  
18 ~~January 1, 2024, or the date on which the determination of the~~  
19 ~~Director of Health Care Services is communicated in writing to~~  
20 ~~the Department of Finance pursuant to paragraph (2) of subdivision~~  
21 ~~(b) of Section 14005.62, and subject to implementation of Section~~  
22 ~~14005.62 pursuant to subdivision (d) of that section, and shall~~  
23 ~~remain operative for time periods in which the department has~~  
24 ~~obtained the necessary federal approvals to implement paragraph~~  
25 ~~(2) of subdivision (b) of Section 14005.62 for the applicable~~  
26 ~~population.~~

27 *(d) This section shall become inoperative on January 1, 2026,*  
28 *and, as of January 1, 2027, is repealed.*

29 *SEC. 62. Section 14006 of the Welfare and Institutions Code*  
30 *is amended to read:*

31 14006. (a) This section applies to medically needy persons,  
32 medically needy family persons, and state-only Medi-Cal persons.

33 (b) For the purposes of this section, the term “principal  
34 residence” means the home, including a multiple-dwelling unit,  
35 in which the individual resides or formerly resided. The home will  
36 continue to be considered the principal residence if any of the  
37 following is applicable:

38 (1) During any absence, the individual intends to return to the  
39 home.

1 (2) The individual lives in a nursing facility or a medical  
2 institution and intends to return home.

3 (3) The individual's spouse or a dependent relative of the  
4 individual continues to reside in the home during the individual's  
5 absence.

6 (4) The individual does not have the right, authority, power, or  
7 legal capacity to liquidate the property, but a bona fide effort is  
8 being made to attain the right, authority, power, or legal capacity  
9 to liquidate the property.

10 (5) The property cannot readily be converted to cash but a bona  
11 fide effort is being made to sell the property, in which case the  
12 state shall, subject to notice and an opportunity for a hearing, have  
13 a lien against the property, to the extent permitted by federal law,  
14 for the cost of medical services.

15 The lien shall be recorded, and from the date of recording, shall  
16 have the force, effect, and priority of a judgment lien.

17 (6) If it is a multiple-dwelling unit, one unit of which is occupied  
18 by the applicant or recipient, any unit not occupied by the applicant  
19 or recipient is producing income for the individual or family  
20 reasonably consistent with its value.

21 (7) It is inhabited by any sibling or child of the recipient who  
22 has continuously resided in the property since at least one year  
23 prior to the date the owner entered a nursing facility, or in a medical  
24 institution.

25 For purposes of this subdivision, "bona fide effort" means that  
26 the property shall be listed with a licensed real estate broker at the  
27 value determined to be the fair market value by a qualified real  
28 estate appraiser and the applicant or recipient provides evidence  
29 that a continuous effort is being made to sell the property, offers  
30 at fair market value are accepted, and all offers are reported.

31 (c) For purposes of determining eligibility under this part,  
32 ~~resources shall be determined, defined, counted, and valued in~~  
33 ~~accordance with the federal law governing resources under Title~~  
34 ~~XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et~~  
35 ~~seq.); countable resources shall be determined in accordance with~~  
36 ~~subdivision (a) of Section 14005.62.~~ Resources exempt under Title  
37 XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et  
38 seq.) shall not be considered in determining eligibility. A  
39 community spouse may retain nonexempt resources to the  
40 maximum extent permitted under Title XIX of the federal Social

1 Security Act (42 U.S.C. Sec. 1396 et seq.). Medically needy  
2 individuals and families may retain nonexempt resources to the  
3 extent permitted under Title XIX of the federal Social Security  
4 Act (42 U.S.C. Sec. 1396 et seq.). In addition, the principal  
5 residence as defined in subdivision (b) shall be exempt.

6 (d) The director, to meet the requirements of the federal Social  
7 Security Act and to ensure the highest percentage of federal  
8 financial participation in the program provided by this chapter,  
9 may decrease or increase the amounts set forth herein.

10 (e) (1) If the holdings are in the form of real property, the value  
11 shall be the assessed value, determined under the most recent  
12 county property tax assessment, less the unpaid amount of any  
13 encumbrance of record.

14 (2) If the real property other than the home is not producing  
15 income reasonably consistent with its value, the applicant or  
16 recipient shall be allowed reasonable time to begin producing such  
17 income from the property. If the property cannot produce  
18 reasonable income or be sold based on the market value, the  
19 applicant or recipient shall be allowed to submit evidence from a  
20 qualified real estate appraiser that indicates the value for which  
21 the property can be adequately utilized or sold. If the applicant or  
22 recipient provides evidence that the only method of adequately  
23 utilizing the property is sale, and the property has not been sold at  
24 market value during a reasonable period of time, the property shall  
25 be considered to be adequately utilized provided it is listed with  
26 a licensed real estate broker at the value determined to be the fair  
27 market value by a qualified real estate appraiser and the applicant  
28 or recipient provides evidence that a bona fide and continuous  
29 effort is being made to sell the property.

30 (3) If federal requirements permit a person to whom this  
31 subdivision applies to own an automobile of greater value than is  
32 permitted in determining eligibility for aid under Chapter 3  
33 (commencing with Section 12000), the department shall adopt  
34 regulations authorizing that higher allowance.

35 (f) Any mortgage or note secured by a deed of trust shall be  
36 deemed real property if its value does not exceed six thousand  
37 dollars (\$6,000) and it is obtained by the applicant or recipient, or  
38 in combination with their spouse, through the sale of such real  
39 property.

(g) If the holdings consist of money on deposit, the value shall be the actual amount thereof. If the holdings are in any other form of personal property or investment, except life insurance, the value shall be the conversion value as of the date of application or the anniversary date of such application. If the holdings are in the form of life insurance, the value shall be the cash value as of the policy anniversary nearest the date of such application.

(h) The value of property holdings shall be determined as of the date of application and, if the person is found eligible, this determination shall establish the amount of such holdings to be considered during the ensuing 12 months except a new determination to govern during the succeeding 12 months shall be made on the first anniversary date of the application or such alternate date as may be established following the acquisition of additional holdings as provided in the following paragraph and on each succeeding anniversary date thereafter.

(i) If any person shall by gift, inheritance, or other manner, acquire additional holdings during any such interval, other than from their own earnings, they shall immediately report such acquisition, and the anniversary date shall become the date of such acquisition.

(j) If any provision of this section does not comply with federal requirements, the provision shall become inoperative to the extent that it is not in compliance with federal requirements pursuant to Section 11003.

~~(k) This section shall become inoperative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain inoperative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.~~

*(k) This section shall become operative on January 1, 2026.*

*SEC. 63. Section 14006.01 of the Welfare and Institutions Code is amended to read:*

14006.01. (a) This section applies to any individual who is residing in a continuing care retirement community, as defined in

paragraph (10) of subdivision (c) of Section 1771 of the Health and Safety Code, pursuant to a continuing care contract, as defined in paragraph (8) of subdivision (c) of Section 1771 of the Health and Safety Code, or pursuant to a life care contract, as defined in subdivision (l) of Section 1771 of the Health and Safety Code, that collects an entrance fee from its residents upon admission.

(b) In determining an individual's eligibility for Medi-Cal benefits, the individual's entrance fee shall be considered a resource available to the individual if all of the following apply:

(1) The individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care if other resources or income of the individual are insufficient to pay for care.

(2) The individual is eligible for a refund of any remaining entrance fee when they die or terminate their contract with, and leave, the continuing care retirement community.

(3) The entrance fee does not confer an ownership interest in the continuing care retirement community.

(c) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), and any regulations adopted pursuant to that act, and only to the extent required by federal law, and only to the extent that federal financial participation is available.

(d) To the extent that regulations are necessary to implement this section, the department shall promulgate regulations using the nonemergency regulatory process described in Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of the Government Code.

(e) It is the intent of the Legislature that the provisions of this section shall apply prospectively to any individual to whom the act applies commencing from the date regulations adopted pursuant to this act are filed with the Secretary of State.

~~(f) This section shall become inoperative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain inoperative for time periods in which the department has obtained the necessary federal approvals to implement paragraph~~

~~(2) of subdivision (b) of Section 14005.62 for the applicable population.~~

~~(f) This section shall become operative on January 1, 2026.~~

~~SEC. 64. Section 14006.1 of the Welfare and Institutions Code is repealed.~~

~~14006.1. (a) The State Director of Health Services shall adopt emergency regulations pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code to implement subdivision (b) of Section 14006. The adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health or safety. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, emergency regulations adopted by the Department of Health Services in order to implement subdivision (b) of Section 14006 shall not be subject to the review and approval of the Office of Administrative Law. These regulations shall become effective immediately upon filing with the Secretary of State.~~

~~(b) Any provision of Section 14006 that is in conflict with any federal statute or regulation shall be inapplicable to the extent of this conflict, but the provision and the remainder of the provisions shall be unaffected to the extent that no conflict exists.~~

~~(c) This section shall become inoperative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain inoperative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.~~

~~SEC. 65. Section 14006.15 of the Welfare and Institutions Code is amended to read:~~

~~14006.15. (a) For the purposes of this section, “equity interest” means the lesser of the following:~~

~~(1) The assessed value of the principal residence determined under the most recent tax assessment, less any encumbrances of record.~~



1 (2) The appraised value of the principal residence determined  
2 by a qualified real estate appraiser who has been retained by the  
3 applicant or beneficiary, less any encumbrances of record.

4 (b) Notwithstanding subdivisions (b) and (c) of Section 14006,  
5 and except as provided in subdivision (c), an individual is not  
6 eligible for medical assistance for home and facility care if their  
7 equity interest in the principal residence exceeds seven hundred  
8 fifty thousand dollars (\$750,000). No later than December 31,  
9 2011, and each year thereafter, this amount shall be increased  
10 based on the percentage increase in the consumer price index for  
11 all urban consumers (all items, United States city average), rounded  
12 to the nearest one thousand dollars (\$1,000).

13 (c) This section does not apply to an individual if any of the  
14 following circumstances exist:

15 (1) The spouse of the individual or the individual's child, who  
16 is under 21 years of age, or who is blind or who is disabled, as  
17 defined in paragraph (3) of subsection (a) of Section 1382c of Title  
18 42 of the United States Code, is lawfully residing in the individual's  
19 home.

20 (2) The individual was determined eligible for medical assistance  
21 for home and facility care based on an application filed before  
22 January 1, 2006.

23 (3) The department determines that ineligibility for medical  
24 assistance for home and facility care would result in demonstrated  
25 hardship on the individual. For purposes of this section,  
26 demonstrated hardship shall include, but need not be limited to,  
27 any of the following circumstances:

28 (A) The individual was receiving home and facility care prior  
29 to January 1, 2006.

30 (B) The individual has been determined to be eligible for  
31 medical assistance for home and facility care based on an  
32 application filed on or after January 1, 2006, and before the date  
33 that regulations adopted pursuant to this section are certified with  
34 the Secretary of State.

35 (C) The individual purchased and received benefits under a  
36 long-term care insurance policy certified by the department's  
37 California Partnership for Long-Term Care Program, established  
38 by Division 12 (commencing with Section 22000).

39 (D) The individual's equity interest in the principal residence  
40 exceeds the equity interest limit as provided in subdivision (b),

1 but would not exceed the equity interest limit under that subdivision  
2 if it had been increased by using the quarterly House Price Index  
3 (HPI) for California, published by the Office of Federal Housing  
4 Enterprise Oversight (OFHEO).

5 (E) The applicant or beneficiary has been denied a home equity  
6 loan by at least three lending institutions, or is ineligible for any  
7 one Federal Housing Administration (FHA) approved loan or  
8 reverse mortgage.

9 (F) The applicant or beneficiary, with good cause, is unable to  
10 provide verification of the equity value.

11 (G) The applicant or beneficiary meets the criteria set forth in  
12 subdivision (b) of Section 14015.1.

13 ~~(d) To the extent that federal financial participation is~~  
14 ~~unavailable to cover the costs associated with subparagraph (C)~~  
15 ~~of paragraph (3) of subdivision (c), state general funds shall be~~  
16 ~~used.~~

17 ~~(e)~~

18 ~~(d)~~ This section shall be implemented pursuant to the  
19 requirements of Title XIX of the federal Social Security Act (42  
20 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to  
21 that act, and ~~except for subparagraph (C) of paragraph (3) of~~  
22 ~~subdivision (c), and subdivision (d),~~ only to the extent that federal  
23 financial participation is available.

24 ~~(f)~~

25 ~~(e)~~ To the extent that regulations are necessary to implement  
26 this section, the department shall promulgate regulations using the  
27 nonemergency regulatory process described in Article 5  
28 (commencing with Section 11346) of Chapter 3.5 of Part 1 of  
29 Division 3 of the Government Code.

30 ~~(g)~~

31 ~~(f)~~ It is the intent of the Legislature that the provisions of this  
32 section shall apply prospectively to any individual to whom the  
33 act applies commencing from the date regulations adopted pursuant  
34 to this act are filed with the Secretary of State.

35 ~~(h) This section shall become inoperative on the later of either~~  
36 ~~January 1, 2024, or the date on which the determination of the~~  
37 ~~Director of Health Care Services is communicated in writing to~~  
38 ~~the Department of Finance pursuant to paragraph (2) of subdivision~~  
39 ~~(b) of Section 14005.62, and subject to implementation of Section~~  
40 ~~14005.62 pursuant to subdivision (d) of that section, and shall~~

1 ~~remain inoperative for time periods in which the department has~~  
2 ~~obtained the necessary federal approvals to implement paragraph~~  
3 ~~(2) of subdivision (b) of Section 14005.62 for the applicable~~  
4 ~~population.~~

5 *(g) This section shall become operative on January 1, 2026.*

6 *SEC. 66. Section 14006.2 of the Welfare and Institutions Code*  
7 *is amended to read:*

8 14006.2. (a) In determining the eligibility of a married  
9 individual, pursuant to Section 14005.4 or 14005.7, who, in  
10 accordance with Title XIX of the federal Social Security Act (42  
11 U.S.C. Sec. 1396 et seq.) and regulations adopted pursuant thereto,  
12 is considered to be living separately from their spouse, the  
13 individual shall be considered to have made a transfer of resources  
14 for full and adequate consideration under Section 14006 or 14015  
15 by reason of either of the following:

16 (1) Having entered into a written agreement with their spouse  
17 dividing their nonexempt community property into equal shares  
18 of separate property. Property so agreed to be separate property  
19 shall be considered by the department to be the separate property  
20 of the spouse who, pursuant to the agreement, is the owner of the  
21 property. Only in cases in which separate property owned by one  
22 spouse is actually made available to the other spouse, may the  
23 department count the separate property in the eligibility  
24 determination of the nonowner spouse.

25 (2) Having transferred to their spouse all of their interest in a  
26 home, whether the transfer was made before or after the individual  
27 became a resident in a nursing facility in accordance with and to  
28 the extent permitted by Title XIX of the federal Social Security  
29 Act and regulations promulgated pursuant thereto.

30 (b) The department shall furnish to all Medi-Cal applicants a  
31 clear and simple statement in writing advising them that (1) in the  
32 case of an individual who is an inpatient in a nursing facility, if  
33 the individual or the individual's conservator transferred to the  
34 individual's spouse all of the interest in a home, the individual  
35 shall not be considered ineligible for Medi-Cal by reason of the  
36 transfer; and that (2) if the individual and the individual's spouse  
37 execute a written interspousal agreement that divides and  
38 transmutes nonexempt community property into equal shares of  
39 separate property, the separate property of the individual's spouse  
40 shall not be considered available to the individual and need not be

1 spent by the spouse for the individual's care in a nursing facility  
2 or other medical institution. The statement provided for in this  
3 subdivision shall also be furnished to each individual admitted to  
4 a nursing facility, along with, but separately from, the statement  
5 required under Section 72527 of Title 22 of the California Code  
6 of Regulations.

7 (c) In order to qualify for Medi-Cal benefits pursuant to Section  
8 14005.4 or 14005.7, a married individual who resides in a nursing  
9 facility, and who is in a Medi-Cal budget unit separate from that  
10 of their spouse, shall be required to expend their other resources  
11 for their own benefit, so that the amount that remains does not  
12 exceed the ~~limit established pursuant to subdivision (c) of Section~~  
13 ~~14006~~ *maximum levels established pursuant to subdivision (a) of*  
14 *Section 14005.62*. In the event that the married individual expends  
15 their resources for expenses associated with or for improvements  
16 to property, those expenditures shall be considered to be for their  
17 own benefit only to the extent that the expenditures are  
18 proportionate to the ownership interest the individual has in the  
19 property. For purposes of this section, the term "their other  
20 resources" shall be limited to the following:

21 (1) All of their separate property that would not have been  
22 exempt under applicable Medi-Cal laws and regulations at the time  
23 when they entered a nursing facility, or at the date of execution of  
24 the agreement referred to in this section, whichever is earlier. For  
25 purposes of this paragraph, the mere change of residence from one  
26 facility to another shall not be deemed to be a new entry.

27 (2) One-half of all the community property, or the proceeds  
28 from the sale or exchange of that property, that would not have  
29 been exempt at the time described in paragraph (1).

30 (d) For purposes of subdivision (c), in the absence of an  
31 agreement such as that referred to in subdivision (a), there shall  
32 be a presumption, rebuttable by either spouse, that all property  
33 owned by either spouse was community property.

34 (e) The statement furnished pursuant to subdivision (b) shall  
35 advise all persons entering a long-term care facility, and all  
36 Medi-Cal applicants that only their half of the community property  
37 shall be taken into account in determining their eligibility for  
38 Medi-Cal, whether or not they execute the written interspousal  
39 agreement referred to in the statement.

40 (f) This section shall not apply to an institutionalized spouse.

(g) This section shall apply to the full extent to an institutionalized spouse if Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is amended to authorize the consideration of state community property law in determining eligibility under this chapter, or the federal government authorizes the state to apply community property laws in making that determination.

(h) (1) Subdivision (f) shall become inoperative if the federal government amends Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) to allow state community property laws to be considered for Medi-Cal eligibility purposes, or the federal government authorizes the state to apply community property laws in making that determination.

(2) The department shall report to the appropriate committees of the Legislature upon the occurrence of the amendment of federal law or receipt of federal authorization as specified in paragraph (1).

~~(i) This section shall become inoperative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain inoperative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.~~

*(i) This section shall become operative on January 1, 2026.*

*SEC. 67. Section 14006.3 of the Welfare and Institutions Code, as amended by Section 92 of Chapter 42 of the Statutes of 2023, is amended to read:*

14006.3. (a) The department, at the time of application or the assessment pursuant to Section 14006.6, and any nursing facility enrolled as a provider in the Medi-Cal program, ~~prior to before~~ admitting any person, shall provide a clear and simple statement, in writing, in a form and language specified by the department, to that person, and that person's spouse, legal representative, or agent, if any, that explains the resource and income requirements of the Medi-Cal program, including, but not limited to, certain exempt resources, certain protections against spousal impoverishment, and

1 certain circumstances under which an interest in a home may be  
2 transferred without affecting Medi-Cal eligibility.

3 ~~(b) This section shall become inoperative on the later of either~~  
4 ~~January 1, 2024, or the date on which the determination of the~~  
5 ~~Director of Health Care Services is communicated in writing to~~  
6 ~~the Department of Finance pursuant to paragraph (2) of subdivision~~  
7 ~~(b) of Section 14005.62, and subject to implementation of Section~~  
8 ~~14005.62 pursuant to subdivision (d) of that section, and shall~~  
9 ~~remain inoperative for time periods in which the department has~~  
10 ~~obtained the necessary federal approvals to implement paragraph~~  
11 ~~(2) of subdivision (b) of Section 14005.62 for the applicable~~  
12 ~~population.~~

13 *(b) This section shall become operative on January 1, 2026.*

14 SEC. 68. Section 14006.3 of the Welfare and Institutions Code,  
15 as added by Section 93 of Chapter 42 of the Statutes of 2023, is  
16 amended to read:

17 14006.3. (a) The department, at the time of application or the  
18 assessment pursuant to former Section 14006.6, and any nursing  
19 facility enrolled as a provider in the Medi-Cal program, before  
20 admitting any person, shall provide a clear and simple statement,  
21 in writing, in a form and language specified by the department, to  
22 that person, and that person's spouse, legal representative, or agent,  
23 if any, that explains the income requirements of the Medi-Cal  
24 program, including, but not limited to, certain protections against  
25 spousal impoverishment.

26 ~~(b) This section shall become operative on the later of either~~  
27 ~~January 1, 2024, or the date on which the determination of the~~  
28 ~~Director of Health Care Services is communicated in writing to~~  
29 ~~the Department of Finance pursuant to paragraph (2) of subdivision~~  
30 ~~(b) of Section 14005.62, and subject to implementation of Section~~  
31 ~~14005.62 pursuant to subdivision (d) of that section, and shall~~  
32 ~~remain operative for time periods in which the department has~~  
33 ~~obtained the necessary federal approvals to implement paragraph~~  
34 ~~(2) of subdivision (b) of Section 14005.62 for the applicable~~  
35 ~~population.~~

36 *(b) This section shall become inoperative on January 1, 2026,*  
37 *and, as of January 1, 2027, is repealed.*

38 SEC. 69. Section 14006.4 of the Welfare and Institutions Code,  
39 as amended by Section 94 of Chapter 42 of the Statutes of 2023,  
40 is amended to read:

1 14006.4. (a) The statement required by Sections 14006.2 and  
2 14006.3 shall be in the following form:

3  
4 “NOTICE REGARDING STANDARDS FOR MEDI-CAL  
5 ELIGIBILITY  
6

7 If you or your spouse is in or is entering a nursing facility, read  
8 this important message!

9 You or your spouse do not have to use all your resources, such  
10 as savings, before Medi-Cal might help pay for all or some of the  
11 costs of a nursing facility.

12 You should be aware of the following to take advantage of these  
13 provisions of the law:

14  
15 UNMARRIED RESIDENT  
16

17 An unmarried resident is financially eligible for Medi-Cal  
18 benefits if they have less than (insert amount of individual’s  
19 resource allowance) in available resources. A home is an exempt  
20 resource and is not considered against the resource limit, as long  
21 as the resident states on the Medi-Cal application that they intend  
22 to return home. Clothes, household furnishings, irrevocable burial  
23 plans, burial plots, and an automobile are examples of other exempt  
24 resources.

25 If an unmarried resident is financially eligible for Medi-Cal  
26 reimbursement, they are allowed to keep from their monthly  
27 income a personal allowance of (insert amount of personal needs  
28 allowance) plus the amount of health insurance premiums paid  
29 monthly. The remainder of the monthly income is paid to the  
30 nursing facility as a monthly deductible called the “Medi-Cal  
31 long-term care patient liability.”

32  
33 MARRIED RESIDENT  
34

35 If one spouse lives in a nursing facility, and the other spouse  
36 does not live in a nursing facility, the Medi-Cal program will pay  
37 some or all of the nursing facility costs as long as the couple  
38 together does not have more than (insert amount of Community  
39 Spouse Resource Allowance plus individual’s resource allowance)  
40 in available assets. The couple’s home will not be counted against

1 this (insert amount of Community Spouse Resource Allowance  
2 plus individual's resource allowance), as long as one spouse or a  
3 dependent relative, or both, lives in the home, or the spouse in the  
4 nursing facility states on the Medi-Cal application that they intend  
5 to return to the couple's home to live.

6 If a spouse is eligible for Medi-Cal payment of nursing facility  
7 costs, the spouse living at home is allowed to keep a monthly  
8 income of at least their individual monthly income or (insert  
9 amount of Minimum Monthly Maintenance Needs Allowance),  
10 whichever is greater. Of the couple's remaining monthly income,  
11 the spouse in the nursing facility is allowed to keep a personal  
12 allowance of (insert amount of personal needs allowance) plus the  
13 amount of health insurance premiums paid monthly. The remaining  
14 money, if any, generally must be paid to the nursing facility as the  
15 Medi-Cal long-term care patient liability. The Medi-Cal program  
16 will pay remaining nursing facility costs.

17 Under certain circumstances, an at-home spouse can obtain an  
18 order from an administrative law judge that will allow the at-home  
19 spouse to retain additional resources or income. Such an order can  
20 allow the couple to retain more than (insert amount of Community  
21 Spouse Resource Allowance plus individual's resource allowance)  
22 in available resources, if the income that could be generated by  
23 the retained resources would not cause the total monthly income  
24 available to the at-home spouse to exceed (insert amount of  
25 Monthly Maintenance Needs Allowance). Such an order also can  
26 allow the at-home spouse to retain more than (insert amount of  
27 Monthly Maintenance Needs Allowance) in monthly income, if  
28 the extra income is necessary "due to exceptional circumstances  
29 resulting in significant financial duress."

30 An at-home spouse also may obtain a court order to increase the  
31 amount of income and resources that they are allowed to retain,  
32 or to transfer property from the spouse in the nursing facility to  
33 the at-home spouse. You should contact a knowledgeable attorney  
34 for further information regarding court orders.

35 The paragraphs above do not apply if both spouses live in a  
36 nursing facility and neither previously has been granted Medi-Cal  
37 eligibility. In this situation, the spouses may be able to hasten  
38 Medi-Cal eligibility by entering into an agreement that divides  
39 their community property. The advice of a knowledgeable attorney  
40 should be obtained prior to the signing of this type of agreement.



1 Note: For married couples, the resource limit ((insert amount of  
2 Community Spouse Resource Allowance plus individual's resource  
3 allowance) in (insert current year)) and income limit ((insert  
4 amount of Minimum Monthly Maintenance Needs Allowance) in  
5 (insert current year)) generally increase a slight amount on January  
6 1 of every year.

7  
8 TRANSFER OF HOME FOR BOTH A MARRIED AND AN  
9 UNMARRIED RESIDENT  
10

11 A transfer of a property interest in a resident's home will not  
12 cause ineligibility for Medi-Cal reimbursement if either of the  
13 following conditions is met:

14 (a) At the time of transfer, the recipient of the property interest  
15 states in writing that the resident would have been allowed to return  
16 to the home at the time of the transfer, if the resident's medical  
17 condition allowed them to leave the nursing facility. This provision  
18 shall only apply if the home has been considered an exempt  
19 resource because of the resident's intent to return home.

20 (b) The home is transferred to one of the following individuals:

21 (1) The resident's spouse.

22 (2) The resident's minor or disabled child.

23 (3) A sibling of the resident who has an equity interest in the  
24 home, and who resided in the resident's home for at least one year  
25 immediately before the resident began living in institutions.

26 (4) A child of the resident who resided in the resident's home  
27 at least two years before the resident began living in institutions,  
28 and who provided care to the resident that permitted the resident  
29 to remain at home longer.

30 This is only a brief description of the Medi-Cal eligibility rules,  
31 for more detailed information, you should call your county welfare  
32 department. You will probably want to consult with the local  
33 branch of the state long-term care ombudsman, an attorney, or a  
34 legal services program for seniors in your area.

35 I have read the above notice and have received a copy.

36 Dated: \_\_\_\_\_ Signature: \_\_\_\_\_"

37 (b) The statement required by subdivision (a) shall be printed  
38 in at least 10-point type, shall be clearly separate from any other  
39 document or writing, and shall be signed by the person to be  
40 admitted and that person's spouse, and legal representative, if any.

(c) Any nursing facility that willfully fails to comply with this section shall be subject to a class “B” citation, as defined by Section 1424 of the Health and Safety Code.

(d) The department may revise this statement as necessary to maintain its consistency with state and federal law.

~~(e) This section shall become inoperative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain inoperative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.~~

*(e) This section shall become operative on January 1, 2026.*

*SEC. 70. Section 14006.4 of the Welfare and Institutions Code, as added by Section 95 of Chapter 42 of the Statutes of 2023, is amended to read:*

14006.4. (a) The statement required by Section 14006.3 shall be in the following form:

“NOTICE REGARDING STANDARDS FOR MEDI-CAL  
ELIGIBILITY

If you or your spouse is in or is entering a nursing facility, read this important message!

You or your spouse do not have to use all your resources, such as savings, before Medi-Cal might help pay for all or some of the costs of a nursing facility.

You should be aware of the following to take advantage of these provisions of the law:

UNMARRIED RESIDENT

An unmarried resident is financially eligible for Medi-Cal benefits if they meet income requirements. Resources, including property and assets, are not considered in determining Medi-Cal eligibility.

1 If an unmarried resident is financially eligible for Medi-Cal  
2 reimbursement, they are allowed to keep from their monthly  
3 income a personal allowance of (insert amount of personal needs  
4 allowance) plus the amount of health insurance premiums paid  
5 monthly. The remainder of the monthly income is paid to the  
6 nursing facility as a monthly deductible called the “Medi-Cal share  
7 of cost.”

8  
9 **MARRIED RESIDENT**

10  
11 If one spouse lives in a nursing facility, and the other spouse  
12 does not live in a nursing facility, the Medi-Cal program will pay  
13 some or all of the nursing facility costs as long as the couple  
14 together meets income requirements. Resources, including property  
15 and assets, are not considered in determining Medi-Cal eligibility.

16 If a spouse is eligible for Medi-Cal payment of nursing facility  
17 costs, the spouse living at home is allowed to keep a monthly  
18 income of at least their individual monthly income or (insert  
19 amount of Minimum Monthly Maintenance Needs Allowance),  
20 whichever is greater. Of the couple’s remaining monthly income,  
21 the spouse in the nursing facility is allowed to keep a personal  
22 allowance of (insert amount of personal needs allowance) plus the  
23 amount of health insurance premiums paid monthly. The remaining  
24 money, if any, generally must be paid to the nursing facility as the  
25 Medi-Cal share of cost. The Medi-Cal program will pay remaining  
26 nursing facility costs.

27 Under certain circumstances, an at-home spouse can obtain an  
28 order from an administrative law judge that will allow the at-home  
29 spouse to retain additional income. That order may allow the  
30 at-home spouse to retain more than (insert amount of Monthly  
31 Maintenance Needs Allowance) in monthly income, if the extra  
32 income is necessary “due to exceptional circumstances resulting  
33 in significant financial duress.”

34 An at-home spouse also may obtain a court order to increase the  
35 amount of income that they are allowed to retain. You should  
36 contact a knowledgeable attorney for further information regarding  
37 court orders.

38 Note: For married couples, the income limit ((insert amount of  
39 Minimum Monthly Maintenance Needs Allowance) in (insert

1 current year)) generally increase a slight amount on January 1 of  
2 every year.

3 This is only a brief description of the Medi-Cal eligibility rules,  
4 for more detailed information, you should call your county welfare  
5 department. You will probably want to consult with the local  
6 branch of the state long-term care ombudsman, an attorney, or a  
7 legal services program for seniors in your area.

8 I have read the above notice and have received a copy.

9 Dated: \_\_\_\_\_ Signature: \_\_\_\_\_”

10 (b) The statement required by subdivision (a) shall be printed  
11 in at least 10-point type, shall be clearly separate from any other  
12 document or writing, and shall be signed by the person to be  
13 admitted and that person’s spouse, and legal representative, if any.

14 (c) Any nursing facility that willfully fails to comply with this  
15 section shall be subject to a class “B” citation, as defined by  
16 Section 1424 of the Health and Safety Code.

17 (d) The department may revise this statement as necessary to  
18 maintain its consistency with state and federal law.

19 ~~(e) This section shall become operative on the later of either~~  
20 ~~January 1, 2024, or the date on which the determination of the~~  
21 ~~Director of Health Care Services is communicated in writing to~~  
22 ~~the Department of Finance pursuant to paragraph (2) of subdivision~~  
23 ~~(b) of Section 14005.62, and subject to implementation of Section~~  
24 ~~14005.62 pursuant to subdivision (d) of that section, and shall~~  
25 ~~remain operative for time periods in which the department has~~  
26 ~~obtained the necessary federal approvals to implement paragraph~~  
27 ~~(2) of subdivision (b) of Section 14005.62 for the applicable~~  
28 ~~population.~~

29 *(e) This section shall become inoperative on January 1, 2026,*  
30 *and, as of January 1, 2027, is repealed.*

31 *SEC. 71. Section 14006.5 of the Welfare and Institutions Code,*  
32 *as amended by Section 96 of Chapter 42 of the Statutes of 2023,*  
33 *is amended to read:*

34 14006.5. (a) The department shall include training regarding  
35 the treatment of separate and community income and resources in  
36 determining eligibility for Medi-Cal benefits, as part of the ongoing  
37 training offered to county welfare departments.

38 ~~(b) This section shall become inoperative on the later of either~~  
39 ~~January 1, 2024, or the date on which the determination of the~~  
40 ~~Director of Health Care Services is communicated in writing to~~

the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain inoperative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.

(b) Commencing January 1, 2026, the department shall also include training regarding the applicability of the lookback period outlined in Section 14015, which only applies to people seeking home- and facility-based care as described in subdivision (c) of Section 1396p of Title 42 of the United States Code, as part of the ongoing training offered to county welfare departments.

SEC. 72. Section 14006.6 of the Welfare and Institutions Code is amended to read:

14006.6. (a) To the extent required by Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and regulations adopted pursuant thereto, upon the request of either an institutionalized spouse or a community spouse, and upon receipt of relevant documentation of resources, the department shall promptly assess and document the total value of the couple's resources to the extent either the institutionalized spouse or the community spouse has an ownership interest. Upon completion of the assessment and documentation, the department shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment.

(b) If the assessment is not part of an application for Medi-Cal, the department may, as a condition of providing the assessment, require payment of a fee not to exceed the reasonable expenses of providing and documenting the assessment.

(c) For purposes of completing the assessment, resources shall be determined, defined, counted, and valued in accordance with subdivision (c) of Section ~~14006~~. 14006, and subject to the maximum resource levels specified in subdivision (a) of Section 14005.62.

(d) At the time of providing the copy of the assessment to the couple, the department shall include a notice indicating that either spouse will have a right to a fair hearing to the extent required by federal law.

(e) (1) This section shall remain operative only until Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is amended to authorize the consideration of state community property law in determining eligibility under this chapter, or the federal government authorizes the state to apply community property laws in making that determination.

(2) The department shall report to the appropriate committees of the Legislature upon the occurrence of the amendment of federal law or the receipt of federal authorization to apply community property law, as specified in paragraph (1).

~~(f) This section shall become inoperative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain inoperative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.~~

*(f) This section shall become operative on January 1, 2026.*

*SEC. 73. Section 14007.5 of the Welfare and Institutions Code is amended to read:*

14007.5. (a) Persons who are not citizens or nationals of the United States shall be eligible for Medi-Cal, whether federally funded or state-funded, only to the same extent as permitted under federal law and regulations for receipt of federal financial participation under Title XIX of the federal Social Security Act, except as otherwise provided in this section and elsewhere in this chapter.

(b) In accordance with Section 1903(v)(1) of the federal Social Security Act (42 U.S.C. Sec. 1396b(v)(1)), a person who is not a citizen or a national of the United States shall only be eligible for the full scope of Medi-Cal benefits if the person ~~has been lawfully admitted for permanent residence, or is otherwise permanently residing in the United States under color of law.~~ *an immigration status described in Section 1641(b) of Title 8 of the United States Code.* For purposes of this section, persons who are not citizens or nationals of the United States and who are “permanently residing in the United States under color of law” shall be interpreted to

1 include all persons who are not citizens or nationals of the United  
2 States residing in the United States with the knowledge and  
3 permission of the United States Department of Homeland Security  
4 and whose departure the United States Department of Homeland  
5 Security does not contemplate enforcing and with respect to whom  
6 federal financial participation is *not* available under Title XIX of  
7 the federal Social Security Act.

8 ~~(e) Any person whose immigration status has been adjusted~~  
9 ~~either to lawful temporary resident or lawful permanent resident~~  
10 ~~in accordance with the provisions of Section 210, 210A, or 245A~~  
11 ~~of the federal Immigration and Nationality Act, and who meets all~~  
12 ~~other eligibility requirements, shall be eligible only for care and~~  
13 ~~services under Medi-Cal for which the person is not disqualified~~  
14 ~~pursuant to those sections of the federal act.~~

15 *(c) A person who has an immigration status described in Section*  
16 *1641(b) of Title 8 of the United States Code, but who is subject to*  
17 *the limitation described in Section 1613(a) of Title 8 of the United*  
18 *States Code, or a person who is otherwise permanently residing*  
19 *in the United States under color of law, shall be eligible for the*  
20 *full scope, except as described in subdivision (l), of Medi-Cal*  
21 *benefits.*

22 (d) Any person who is not a citizen or national of the United  
23 States who is otherwise eligible for Medi-Cal services, but who  
24 does not meet the requirements under subdivision (b) or (c), shall  
25 only be eligible for care and services that are necessary for the  
26 treatment of an emergency medical condition and medical care  
27 directly related to the emergency, as defined in federal-law: law,  
28 *except as described in Sections 14007.65, 14007.7, and 14007.8.*  
29 For purposes of this section, the term “emergency medical  
30 condition” means a medical condition manifesting itself by acute  
31 symptoms of sufficient severity, including severe pain, such that  
32 the absence of immediate medical attention could reasonably be  
33 expected to result in any of the following:

- 34 (1) Placing the patient’s health in serious jeopardy.
- 35 (2) Serious impairment to bodily functions.
- 36 (3) Serious dysfunction to any bodily organ or part. It is the  
37 intent of this section to entitle eligible individuals to inpatient and  
38 outpatient services that are necessary for the treatment of the  
39 emergency medical condition in the same manner as administered

1 by the department through regulations and provisions of federal  
2 law.

3 *(e) (1) No sooner than July 1, 2027, except for individuals*  
4 *under 19 years of age, individuals over 59 years of age, and*  
5 *pregnant women, all individuals described in subdivisions (c) and*  
6 *(d) shall be required to pay a monthly premium as a condition of*  
7 *eligibility for the full scope of Medi-Cal benefits, if they are*  
8 *otherwise eligible for benefits under this chapter.*

9 *(2) Monthly premiums imposed under this subdivision shall be*  
10 *thirty dollars (\$30) per beneficiary.*

11 *(3) An individual required to pay premiums pursuant to this*  
12 *subdivision, after no more than 90 days of nonpayment of the*  
13 *monthly premium, is only eligible for medically necessary*  
14 *pregnancy-related services, and care and services necessary for*  
15 *the treatment of an emergency medical condition and medical care*  
16 *directly related to the emergency, as defined in federal law. All*  
17 *outstanding premium balances shall be paid in full as a condition*  
18 *of continued eligibility for the full scope of Medi-Cal benefits.*

19 ~~(e)~~

20 *(f) Pursuant to Section 14001.2, each county department shall*  
21 *require that each applicant for, or beneficiary of, Medi-Cal,*  
22 *including a child, shall provide their social security number account*  
23 *number, or numbers, if they have more than one social security*  
24 *number.*

25 ~~(f)~~

26 *(g) (1) In order to be eligible for benefits under subdivision (b)*  
27 *or (c), an applicant or beneficiary shall present United States*  
28 *Citizenship and Immigration Services registration documentation*  
29 *or other proof of satisfactory immigration status from the United*  
30 *States Citizenship and Immigration Services.*

31 *(2) Any person who meets all other program requirements but*  
32 *who lacks documentation of United States Citizenship and*  
33 *Immigration Services registration or other proof of satisfactory*  
34 *immigration status shall be provided a reasonable opportunity to*  
35 *submit the evidence. For purposes of this paragraph, “reasonable*  
36 *opportunity” means 30 days or the time it actually takes the county*  
37 *to process the Medi-Cal application, whichever is longer.*

38 *(3) During the reasonable opportunity period under paragraph*  
39 *(2), the county department shall process the applicant’s application*



1 for medical assistance in a manner that conforms to its normal  
2 processing procedures and timeframes.

3 ~~(g)~~

4 (h) (1) The county department shall grant only the Medi-Cal  
5 benefits set forth in subdivision (d) of this section or in Section  
6 ~~14007.7~~ 14007.65, 14007.7, or 14007.8 to any individual who,  
7 after 30 calendar days or the time it actually takes the county to  
8 process the Medi-Cal application, whichever is longer, has failed  
9 to submit documents constituting reasonable evidence indicating  
10 a satisfactory immigration status for Medi-Cal purposes, or who  
11 is reported by the United States Citizenship and Immigration  
12 Services to lack a satisfactory immigration status for Medi-Cal  
13 purposes.

14 (2) If a person who is not a citizen or national of the United  
15 States has been receiving Medi-Cal benefits based on eligibility  
16 established prior to the effective date of this section and that  
17 individual, upon redetermination of eligibility for benefits, fails  
18 to submit documents constituting reasonable evidence indicating  
19 a satisfactory immigration status for Medi-Cal purposes, the county  
20 department shall discontinue the Medi-Cal benefits, except for the  
21 care and services set forth in subdivision (d) of this section or in  
22 Section ~~14007.7~~: 14007.65, 14007.7, or 14007.8. The county  
23 department shall provide adequate notice to the individual of any  
24 adverse action and shall accord the individual an opportunity for  
25 a fair hearing if the individual requests one.

26 ~~(h)~~

27 (i) To the extent permitted by federal law and regulations, a  
28 person who is not a citizen or national of the United States applying  
29 for services under subdivisions (b) and (c) shall be granted  
30 eligibility for the scope of services to which they would otherwise  
31 be entitled if, at the time the county department makes the  
32 determination about their eligibility, the person meets either of the  
33 following requirements:

34 (1) The person has not had a reasonable opportunity to submit  
35 documents constituting reasonable evidence indicating satisfactory  
36 immigration status.

37 (2) The person has provided documents constituting reasonable  
38 evidence indicating a satisfactory immigration status, but the  
39 county department has not received timely verification of the

1 person's immigration status from the United States Citizenship  
2 and Immigration Services.

3 (3) The verification process shall protect the privacy of all  
4 participants. A person's immigration status shall be subject to  
5 verification by the United States Citizenship and Immigration  
6 Services, to the extent required for receipt of federal financial  
7 participation in the Medi-Cal program.

8 (i)

9 (j) If a person does not declare status as a lawful permanent  
10 resident or person permanently residing under color of law, or as  
11 a person legalized under Section 210, 210A, or 245A of the federal  
12 Immigration and Nationality Act (Public Law 82-414), Medi-Cal  
13 coverage under subdivision (d) of this section or in Section 14007.7  
14 14007.65, 14007.7, or 14007.8 shall be provided to the individual  
15 if they are otherwise eligible.

16 (j)

17 (k) If a person subject to this section is not fluent in English,  
18 the county department shall provide an understandable explanation  
19 of the requirements of this section in a language in which the  
20 person is fluent.

21 ~~(k) Persons who are not citizens or nationals of the United States~~  
22 ~~who were receiving long-term care or renal dialysis services (1)~~  
23 ~~on the day prior to the effective date of the amendment to paragraph~~  
24 ~~(1) of subdivision (f) of Section 1 of Chapter 1441 of the Statutes~~  
25 ~~of 1988 at the 1991-92 Regular Session of the Legislature and (2)~~  
26 ~~under the authority of paragraph (1) of subdivision (f) of Section~~  
27 ~~1 of Chapter 1441 of the Statutes of 1988 as it read on June 30,~~  
28 ~~1992, shall continue to receive these services. The authority for~~  
29 ~~continuation of long-term care or renal dialysis services in this~~  
30 ~~subdivision shall not apply to any person whose long-term care or~~  
31 ~~renal dialysis services end for any reason after the effective date~~  
32 ~~of the amendment described in this subdivision.~~

33 (l) *No sooner than July 1, 2026, all individuals described in*  
34 *subdivisions (c) and (d) who are 19 years of age or older shall not*  
35 *be eligible for dental services set forth in this chapter, except for*  
36 *the treatment of an emergency medical condition and medical care*  
37 *directly related to the emergency, as defined in federal law.*

38 (m) *Notwithstanding Chapter 3.5 (commencing with Section*  
39 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*  
40 *the State Department of Health Care Services may implement,*

interpret, or make specific this section, in whole or in part, by means of plan or county letter, information notices, plan or provider bulletins, or other similar instructions, without taking any further regulatory action.

(n) Subdivisions (e) and (l) shall be implemented only after the director determines, and communicates in writing to the Department of Finance, that systems have been programmed for implementation.

SEC. 74. Section 14007.65 of the Welfare and Institutions Code is amended to read:

14007.65. (a) Persons who are not citizens or nationals of the United States who were receiving long-term care services under the authority of subdivision (f) of Section 1 of Chapter 1441 of the Statutes of 1988 on the day prior to the effective date of this section shall continue to receive those long-term care services.

(b) On or after the effective date of this section, any applicant who is not lawfully present in the United States, who is otherwise eligible for Medi-Cal services, but who does not meet the requirements under subdivision (b) ~~or (e)~~ of Section 14007.5, would be eligible to receive federally reimbursable long-term care services pursuant to the Medicaid program provided for pursuant to Title 19 of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), shall be eligible to receive long-term care services to the extent that funding is made available for this purpose in the annual Budget Act. In no event shall expenditures for this program exceed the amount necessary to serve 110 percent of the 1999–2000 estimated eligible population without further authorization by the Legislature.

SEC. 75. Section 14007.8 of the Welfare and Institutions Code is amended to read:

14007.8. (a) (1) An individual who is 25 years of age or younger, and who does not have satisfactory immigration status or is unable to establish satisfactory immigration status as required by Section 14011.2, shall be eligible for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(2) (A) After the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of this subparagraph, but no sooner than May 1, 2022, an individual who is 50 years of

1 age or older, and who does not have satisfactory immigration status  
2 or is unable to establish satisfactory immigration status as required  
3 by Section 14011.2, shall be eligible for the full scope of Medi-Cal  
4 benefits, if they are otherwise eligible for benefits under this  
5 chapter.

6 (B) After the director determines, and communicates that  
7 determination in writing to the Department of Finance, that systems  
8 have been programmed for implementation of this subparagraph,  
9 but no later than January 1, 2024, an individual who is 26 to 49  
10 years of age, inclusive, and who does not have satisfactory  
11 immigration status as required by Section 14011.2, shall be eligible  
12 for the full scope of Medi-Cal benefits, if they are otherwise  
13 eligible for benefits under this chapter.

14 ~~(C) The effective date of enrollment into the Medi-Cal program~~  
15 ~~for an individual described in this paragraph, and enrolled in the~~  
16 ~~Medi-Cal program pursuant to subdivision (d) of Section 14007.5,~~  
17 ~~shall be on the same day on which the systems are operational to~~  
18 ~~begin processing new applications pursuant to the director's~~  
19 ~~determination described in either subparagraph (A) or (B), as~~  
20 ~~applicable.~~

21 ~~(3) (A) An individual enrolled in the Medi-Cal program~~  
22 ~~pursuant to this section and subdivision (d) of Section 14007.5~~  
23 ~~shall not be required to file a new application for the Medi-Cal~~  
24 ~~program.~~

25 ~~(B) The enrollment specified in subparagraph (A) shall be~~  
26 ~~conducted pursuant to an eligibility and enrollment plan, and shall~~  
27 ~~include outreach strategies developed by the department in~~  
28 ~~consultation with interested stakeholders, including, but not limited~~  
29 ~~to, counties, health care service plans, health care providers,~~  
30 ~~consumer advocates, and the Legislature.~~

31 ~~(C) (i) For individuals described in subparagraph (B) of~~  
32 ~~paragraph (2), the eligibility and enrollment plan shall enable, to~~  
33 ~~the maximum extent the department determines possible, an~~  
34 ~~individual to maintain their primary care provider or medical home~~  
35 ~~as their assigned primary care provider in the Medi-Cal managed~~  
36 ~~care health plan provider network without disruption, if the~~  
37 ~~provider is a contracted network provider with that Medi-Cal~~  
38 ~~managed care health plan. The department shall work with~~  
39 ~~counties, Medi-Cal managed care health plans, health care~~  
40 ~~providers, consumer advocates, and other interested stakeholders,~~

to identify and maintain that linkage, to the maximum extent the department determines possible.

(ii) ~~This subparagraph does not limit the ability of an individual enrolled in Medi-Cal pursuant to subparagraph (B) of paragraph (2) to select either, or both, a different primary care provider or, if there is more than one Medi-Cal managed care health plan available in the county where they reside, a different Medi-Cal managed care health plan, consistent with subdivision (g) of Section 14087.305 and paragraph (7) of subdivision (d) of Section 14089.~~

*(b) No sooner than January 1, 2026, an individual who is 19 years of age or older, who does not have satisfactory immigration status as required by Section 14011.2, who is otherwise eligible for Medi-Cal services pursuant to subdivision (d) of Section 14007.5, who applies for Medi-Cal on or after January 1, 2026, shall only be eligible for medically necessary pregnancy-related services, and care and services necessary for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law.*

*(c) (1) No sooner than January 1, 2026, if an individual described in subdivision (a) who is 19 years of age or older loses eligibility for full-scope Medi-Cal on or after January 1, 2026, the individual shall only be eligible for medically necessary pregnancy-related services, and care and services necessary for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law.*

*(2) No sooner than January 1, 2026, notwithstanding paragraph (1), if an individual described in subdivision (a) who is 19 years of age or older loses eligibility for full-scope Medi-Cal while pregnant, the individual shall remain eligible for full-scope Medi-Cal throughout the pregnancy and for 12 months after the pregnancy ends.*

*(3) Notwithstanding subdivision (b), an individual who is 19 years of age or older, who does not have satisfactory immigration status as required by Section 14011.2, who was enrolled in full-scope Medi-Cal and was not pregnant, but loses coverage for full-scope Medi-Cal, shall be eligible to reenroll in full-scope Medi-Cal within three months from the date of disenrollment for full-scope Medi-Cal, pregnancy-only Medi-Cal, or postpartum Medi-Cal. Repayment of outstanding premium balances prior to*

1 *the initiation of the three-month cure period shall be a condition*  
2 *of reenrollment under this subdivision for individuals disenrolled*  
3 *from Medi-Cal due to nonpayment of premiums.*

4 ~~(d)~~

5 (d) The department shall provide monthly updates to the  
6 appropriate policy and fiscal committees of the Legislature on the  
7 status of the implementation of this section.

8 ~~(b)~~

9 (e) To the extent permitted by state and federal law, an  
10 individual eligible ~~under this section for full-scope Medi-Cal~~  
11 *pursuant to subdivision (a)* shall be required to enroll in a Medi-Cal  
12 managed care health plan. Enrollment in a Medi-Cal managed care  
13 health plan shall not preclude a beneficiary from being enrolled  
14 in any other children's Medi-Cal specialty program that they would  
15 otherwise be eligible for.

16 ~~(e)~~

17 (f) (1) The department shall maximize federal financial  
18 participation in implementing this section to the extent allowable.  
19 For purposes of implementing this section, the department shall  
20 claim federal financial participation to the extent that the  
21 department determines it is available.

22 (2) To the extent that federal financial participation is  
23 unavailable, the department shall implement this section using  
24 state funds appropriated for this purpose.

25 ~~(d)~~

26 (g) This section shall be implemented only to the extent it is in  
27 compliance with Section 1621(d) of Title 8 of the United States  
28 Code.

29 ~~(e)~~

30 (h) (1) Notwithstanding Chapter 3.5 (commencing with Section  
31 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
32 the department, without taking any further regulatory action, shall  
33 implement, interpret, or make specific this section by means of  
34 all-county letters, plan letters, plan or provider bulletins, or similar  
35 instructions until the time any necessary regulations are adopted.  
36 Thereafter, the department shall adopt regulations in accordance  
37 with the requirements of Chapter 3.5 (commencing with Section  
38 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

39 (2) Notwithstanding Section 10231.5 of the Government Code,  
40 the department shall provide a status report to the Legislature on

1 a semiannual basis, in compliance with Section 9795 of the  
2 Government Code, until regulations have been adopted.

3 (f)

4 (i) In implementing this section, the department may contract,  
5 as necessary, on a bid or nonbid basis. This subdivision establishes  
6 an accelerated process for issuing contracts pursuant to this section.  
7 Those contracts, and any other contracts entered into pursuant to  
8 this subdivision, may be on a noncompetitive bid basis and shall  
9 be exempt from both of the following:

10 (1) Part 2 (commencing with Section 10100) of Division 2 of  
11 the Public Contract Code and any policies, procedures, or  
12 regulations authorized by that part.

13 (2) Review or approval of contracts by the Department of  
14 General Services.

15 (j) (1) *No sooner than July 1, 2026, except for individuals under*  
16 *19 years of age, individuals over 59 years of age, and pregnant*  
17 *women, all individuals described in subdivision (a) shall be*  
18 *required to pay a monthly premium as a condition of eligibility*  
19 *for Medi-Cal benefits, if they are otherwise eligible for benefits*  
20 *under this chapter.*

21 (2) *Monthly premiums imposed under this section shall be thirty*  
22 *dollars (\$30) per beneficiary.*

23 (3) *An individual described in paragraph (1), after no more*  
24 *than 90 days of nonpayment of the monthly premium, will only be*  
25 *eligible for medically necessary pregnancy-related services, and*  
26 *care and services necessary for the treatment of an emergency*  
27 *medical condition and medical care directly related to the*  
28 *emergency, as defined in federal law. All outstanding premium*  
29 *balances shall be paid in full as a condition of continued eligibility*  
30 *for full-scope Medi-Cal coverage.*

31 (k) *No sooner than July 1, 2026, and notwithstanding*  
32 *subdivision (a) and paragraph (2) of subdivision (c), an individual*  
33 *who is 19 years of age or older, who is eligible for Medi-Cal*  
34 *benefits pursuant to subdivision (a), shall not be eligible for dental*  
35 *services set forth in this chapter, except for the treatment of an*  
36 *emergency medical condition and medical care directly related to*  
37 *the emergency, as defined in federal law.*

38 (l) *Subdivisions (b), (c), (j), and (k) shall be implemented only*  
39 *after the director determines, and communicates in writing to the*

1 *Department of Finance, that systems have been programmed for*  
2 *implementation.*

3 *SEC. 76. Section 14007.9 of the Welfare and Institutions Code,*  
4 *as amended by Section 99 of Chapter 42 of the Statutes of 2023,*  
5 *is repealed.*

6 ~~14007.9.—(a) The department shall adopt the option made~~  
7 ~~available under Section 1902(a)(10)(A)(ii)(XIII) of the federal~~  
8 ~~Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIII)). In~~  
9 ~~order to be eligible for benefits under this section, an individual~~  
10 ~~shall be required to meet all of the following requirements:~~

11 ~~(1) The individual's net countable income is less than 250~~  
12 ~~percent of the federal poverty level for one person or, if the~~  
13 ~~deeming of spousal income applies to the individual, the~~  
14 ~~individual's net countable income is less than 250 percent of the~~  
15 ~~federal poverty level for two persons.~~

16 ~~(2) The individual is disabled under Title II of the Social~~  
17 ~~Security Act (Subch. 2 (commencing with Sec. 401), Ch. 7, Title~~  
18 ~~42 U.S.C.), Title XVI of the Social Security Act (Subch. 16~~  
19 ~~(commencing with Sec. 1381), Ch. 7, Title 42, U.S.C.), or Section~~  
20 ~~1902(v) of the Social Security Act (42 U.S.C. Sec. 1396a(v)). An~~  
21 ~~individual shall be determined to be eligible under this section~~  
22 ~~without regard to the individual's ability to engage in, or actual~~  
23 ~~engagement in, substantial gainful activity, as defined in Section~~  
24 ~~223(d)(4) of the Social Security Act (42 U.S.C. Sec. 423(d)(4)).~~

25 ~~(3) Except as otherwise provided in this section, the individual's~~  
26 ~~net nonexempt resources, which shall be determined in accordance~~  
27 ~~with the methodology used under Title XVI of the federal Social~~  
28 ~~Security Act (42 U.S.C. Sec. 1381 et seq.), are not in excess of the~~  
29 ~~limits provided for under those provisions.~~

30 ~~(b) (1) Countable income shall be determined under Section~~  
31 ~~1612 of the federal Social Security Act (42 U.S.C. Sec. 1382a),~~  
32 ~~except that the individual's disability income, including all federal~~  
33 ~~and state disability benefits and private disability insurance, shall~~  
34 ~~be exempted. Resources excluded under Section 1613 of the federal~~  
35 ~~Social Security Act (42 U.S.C. Sec. 1382b) shall be disregarded.~~

36 ~~(2) Resources in the form of employer or individual retirement~~  
37 ~~arrangements authorized under the Internal Revenue Code shall~~  
38 ~~be exempted as authorized by Section 1902(r) of the federal Social~~  
39 ~~Security Act (42 U.S.C. Sec. 1396a(r)).~~



1     ~~(3) (A) For the purposes of calculating countable income under~~  
2 ~~this section, an income exemption shall be applied as necessary~~  
3 ~~to adjust the income standard so that it is the same as the income~~  
4 ~~standard that was in place on May 1, 2009.~~

5     ~~(B) This additional income exemption shall cease to be~~  
6 ~~implemented when the SSI/SSP program payment levels increase~~  
7 ~~beyond those in effect on May 1, 2009.~~

8     ~~(C) Notwithstanding Chapter 3.5 (commencing with Section~~  
9 ~~11340) of Part 1 of Division 3 of Title 2 of the Government Code,~~  
10 ~~the department shall implement this paragraph by means of an~~  
11 ~~all-county letter or similar instruction without taking regulatory~~  
12 ~~action.~~

13     ~~(e) Medi-Cal benefits provided under this chapter pursuant to~~  
14 ~~this section shall be available in the same amount, duration, and~~  
15 ~~scope as those benefits are available for persons who are eligible~~  
16 ~~for Medi-Cal benefits as categorically needy persons and as~~  
17 ~~specified in Section 14007.5.~~

18     ~~(d) Individuals eligible for Medi-Cal benefits under this section~~  
19 ~~shall be subject to the payment of premiums determined under this~~  
20 ~~subdivision, except as provided in subdivision (j). The department~~  
21 ~~shall establish sliding-scale premiums that are based on countable~~  
22 ~~income, with a minimum premium of twenty dollars (\$20) per~~  
23 ~~month and a maximum premium of two hundred fifty dollars~~  
24 ~~(\$250) per month, and shall, by regulations, annually adjust the~~  
25 ~~premiums. Prior to adjustment of any premiums pursuant to this~~  
26 ~~subdivision, the department shall submit a report of proposed~~  
27 ~~premium adjustments to the appropriate committees of the~~  
28 ~~Legislature as part of the annual budget act process.~~

29     ~~(e) The department shall adopt regulations specifying the process~~  
30 ~~for discontinuance of eligibility under this section for nonpayment~~  
31 ~~of premiums for more than two months by a beneficiary.~~

32     ~~(f) In order to implement the collection of premiums under this~~  
33 ~~section, the department may develop and execute a contract with~~  
34 ~~a public or private entity to collect premiums, or may amend any~~  
35 ~~existing or future premium-collection contract that it has executed.~~  
36 ~~Notwithstanding any other law, any contract developed and~~  
37 ~~executed or amended pursuant to this subdivision is exempt from~~  
38 ~~the approval of the Director of General Services and from the~~  
39 ~~Public Contract Code.~~

~~(g) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement, without taking any regulatory action, this section by means of an all-county letter or similar instruction. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.~~

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

~~(i) Subject to subdivision (h), this section shall be implemented commencing April 1, 2000.~~

~~(j) (1) Effective July 1, 2022, to the extent allowable under federal law, and notwithstanding the provisions of this section to the contrary, the department may elect not to impose premiums on individuals eligible under this section for an applicable coverage period.~~

~~(2) If the department elects to not impose premiums for an applicable coverage period pursuant to paragraph (1) or elects to reinstate such premiums for a subsequent coverage period, the department shall specify that election in the published Medi-Cal Local Assistance Estimate for the impacted state fiscal year or years, subject to appropriation by the annual Budget Act.~~

~~(k) This section shall become inoperative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain inoperative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.~~

*SEC. 77. Section 14007.9 of the Welfare and Institutions Code, as added by Section 100 of Chapter 42 of the Statutes of 2023, is repealed.*

~~14007.9.— (a) The department shall adopt the option made available under Section 1902(a)(10)(A)(ii)(XIII) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIII)). In order to be eligible for benefits under this section, an individual shall be required to meet all of the following requirements:~~

~~(1) The individual's net countable income is less than 250 percent of the federal poverty level for one person or, if the deeming of spousal income applies to the individual, the individual's net countable income is less than 250 percent of the federal poverty level for two persons.~~

~~(2) The individual is disabled under Title II of the Social Security Act (Subch. 2 (commencing with Sec. 401), Ch. 7, Title 42 U.S.C.), Title XVI of the Social Security Act (Subch. 16 (commencing with Sec. 1381), Ch. 7, Title 42, U.S.C.), or Section 1902(v) of the Social Security Act (42 U.S.C. Sec. 1396a(v)). An individual shall be determined to be eligible under this section without regard to the individual's ability to engage in, or actual engagement in, substantial gainful activity, as defined in Section 223(d)(4) of the Social Security Act (42 U.S.C. Sec. 423(d)(4)).~~

~~(3) Resources that are not counted as income shall not be included in determinations of eligibility.~~

~~(b) (1) Countable income shall be determined under Section 1612 of the federal Social Security Act (42 U.S.C. Sec. 1382a), except that the individual's disability income, including all federal and state disability benefits and private disability insurance, shall be exempted.~~

~~(2) (A) For the purposes of calculating countable income under this section, an income exemption shall be applied as necessary to adjust the income standard so that it is the same as the income standard that was in place on May 1, 2009.~~

~~(B) This additional income exemption shall cease to be implemented when the SSI/SSP program payment levels increase beyond those in effect on May 1, 2009.~~

~~(C) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this paragraph by means of an all-county letter or similar instruction without taking regulatory action.~~

~~(e) Medi-Cal benefits provided under this chapter pursuant to this section shall be available in the same amount, duration, and~~

1 ~~scope as those benefits are available for persons who are eligible~~  
2 ~~for Medi-Cal benefits as categorically needy persons and as~~  
3 ~~specified in Section 14007.5.~~

4 ~~(d) Individuals eligible for Medi-Cal benefits under this section~~  
5 ~~shall be subject to the payment of premiums determined under this~~  
6 ~~subdivision, except as provided in subdivision (j). The department~~  
7 ~~shall establish sliding-scale premiums that are based on countable~~  
8 ~~income, with a minimum premium of twenty dollars (\$20) per~~  
9 ~~month and a maximum premium of two hundred fifty dollars~~  
10 ~~(\$250) per month, and shall, by regulations, annually adjust the~~  
11 ~~premiums. Prior to adjustment of any premiums pursuant to this~~  
12 ~~subdivision, the department shall submit a report of proposed~~  
13 ~~premium adjustments to the appropriate committees of the~~  
14 ~~Legislature as part of the annual budget act process.~~

15 ~~(e) The department shall adopt regulations specifying the process~~  
16 ~~for discontinuance of eligibility under this section for nonpayment~~  
17 ~~of premiums for more than two months by a beneficiary.~~

18 ~~(f) In order to implement the collection of premiums under this~~  
19 ~~section, the department may develop and execute a contract with~~  
20 ~~a public or private entity to collect premiums, or may amend any~~  
21 ~~existing or future premium-collection contract that it has executed.~~  
22 ~~Notwithstanding any other law, any contract developed and~~  
23 ~~executed or amended pursuant to this subdivision is exempt from~~  
24 ~~the approval of the Director of General Services and from the~~  
25 ~~Public Contract Code.~~

26 ~~(g) Notwithstanding the rulemaking provisions of Chapter 3.5~~  
27 ~~(commencing with Section 11340) of Part 1 of Division 3 of Title~~  
28 ~~2 of the Government Code, the department shall implement,~~  
29 ~~without taking any regulatory action, this section by means of an~~  
30 ~~all-county letter or similar instruction. Thereafter, the department~~  
31 ~~shall adopt regulations in accordance with the requirements of~~  
32 ~~Chapter 3.5 (commencing with Section 11340) of Part 1 of Division~~  
33 ~~3 of Title 2 of the Government Code.~~

34 ~~(h) Notwithstanding any other law, this section shall be~~  
35 ~~implemented only if, and to the extent that, the department~~  
36 ~~determines that federal financial participation is available pursuant~~  
37 ~~to Title XIX of the federal Social Security Act (42 U.S.C. Sec.~~  
38 ~~1396 et seq.).~~

39 ~~(i) Subject to subdivision (h), this section shall be implemented~~  
40 ~~commencing April 1, 2000.~~

~~(j) (1) Effective July 1, 2022, to the extent allowable under federal law, and notwithstanding the provisions of this section to the contrary, the department may elect not to impose premiums on individuals eligible under this section for an applicable coverage period.~~

~~(2) If the department elects to not impose premiums for an applicable coverage period pursuant to paragraph (1) or elects to reinstate such premiums for a subsequent coverage period, the department shall specify that election in the published Medi-Cal Local Assistance Estimate for the impacted state fiscal year or years, subject to appropriation by the annual Budget Act.~~

~~(k) This section shall become operative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain operative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.~~

*SEC. 78. Section 14007.9 of the Welfare and Institutions Code, as amended by Section 101 of Chapter 42 of the Statutes of 2023, is amended to read:*

14007.9. (a) (1) The department shall adopt the option made available under Section 1902(a)(10)(A)(ii)(XIII) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIII)). In order to be eligible for benefits under this section, an individual shall be required to meet all of the following requirements:

(A) The individual's net countable income is less than 250 percent of the federal poverty level for one person or, if the deeming of spousal income applies to the individual, the individual's net countable income is less than 250 percent of the federal poverty level for two persons.

(B) The individual is disabled under Title II of the federal Social Security Act (42 U.S.C. Sec. 401 et seq.), Title XVI of the federal Social Security Act (42 U.S.C. Sec. 1381 et seq.), or Section 1902(v) of the federal Social Security Act (42 U.S.C. Sec. 1396a(v)). An individual shall be determined to be eligible under this section without regard to their ability to engage in, or actual

1 engagement in, substantial gainful activity, as defined in Section  
2 223(d)(4) of the federal Social Security Act (42 U.S.C. Sec.  
3 423(d)(4)).

4 (C) ~~Except as otherwise provided in this section, the individual's~~  
5 ~~net nonexempt resources, which shall be determined in accordance~~  
6 ~~with the methodology used under Title XVI of the federal Social~~  
7 ~~Security Act (42 U.S.C. Sec. 1381 et seq.), are not in excess of the~~  
8 ~~limits provided for under those provisions. The individual's~~  
9 *countable resources shall not exceed the maximum levels*  
10 *established in subdivision (a) of Section 14005.62. The*  
11 *determination of countable resources shall follow the methodology*  
12 *used under Title XVI of the federal Social Security Act (42 U.S.C.*  
13 *Sec. 1381 et seq.), as applicable.*

14 (2) To the extent federal financial participation is available, an  
15 individual otherwise eligible under this section, but who is  
16 temporarily unemployed, may elect to remain on Medi-Cal under  
17 this section for up to 26 weeks, provided the individual continues  
18 to pay premiums during the temporary period of unemployment,  
19 for coverage periods in which premiums are imposed.

20 (b) (1) Countable income shall be determined under Section  
21 1612 of the federal Social Security Act (42 U.S.C. Sec. 1382a),  
22 except that the individual's disability income, including all federal  
23 and state disability benefits and private disability insurance, shall  
24 be exempted. Resources excluded under Section 1613 of the federal  
25 Social Security Act (42 U.S.C. Sec. 1382b) shall be disregarded.

26 (2) Resources in the form of employer or individual retirement  
27 arrangements authorized under the Internal Revenue Code shall  
28 be exempted as authorized by Section 1902(r) of the federal Social  
29 Security Act (42 U.S.C. Sec. 1396a(r)).

30 (3) (A) For the purposes of calculating countable income under  
31 this section, an income exemption shall be applied as necessary  
32 to adjust the income standard so that it is the same as the income  
33 standard that was in place on May 1, 2009.

34 (B) This additional income exemption shall cease to be  
35 implemented when the SSI/SSP program payment levels increase  
36 beyond those in effect on May 1, 2009.

37 (C) Notwithstanding Chapter 3.5 (commencing with Section  
38 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
39 the department shall implement this paragraph by means of an

1 all-county letter or similar instruction without taking regulatory  
2 action.

3 (4) Retained earned income of an eligible individual who is  
4 receiving health care benefits under this section shall be considered  
5 an exempt resource when held in a separately identifiable account  
6 and not commingled with other resources, as authorized by Section  
7 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec.  
8 1396a(r)(2)).

9 (5) Social security disability income that converts to social  
10 security retirement income upon the retirement of an individual,  
11 including any increases in the amount of that income, shall be  
12 exempt. The department shall submit a state plan amendment for  
13 this specific exemption, and the exemption shall be implemented  
14 only if, and to the extent that, the state plan amendment is  
15 approved.

16 (c) All resources exempted pursuant to paragraph (2) of  
17 subdivision (b) for an individual who is receiving health care  
18 benefits under this section shall continue to be exempt under any  
19 other Medi-Cal program that is subject to Section 1902(r)(2) of  
20 the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)) under  
21 which the beneficiary later becomes eligible for medical assistance  
22 where that eligibility is based on age, blindness, or disability. The  
23 department shall submit a state plan amendment for this specific  
24 exemption, and the exemption shall be implemented only if, and  
25 to the extent that, the state plan amendment is approved.

26 (d) After an individual is determined eligible for Medi-Cal  
27 benefits under this section, the individual's countable income, as  
28 determined under Section 1612 of the federal Social Security Act  
29 (42 U.S.C. Sec. 1382a), shall be used to determine the amount of  
30 the individual's required premium payment, as described in  
31 subdivision (f), when applicable. Disability income and converted  
32 retirement income made exempt under paragraphs (1) and (5),  
33 respectively, of subdivision (b) for eligibility purposes shall be  
34 considered countable income for purposes of determining the  
35 amount of the required premium payment.

36 (e) Medi-Cal benefits provided under this chapter pursuant to  
37 this section shall be available in the same amount, duration, and  
38 scope as those benefits are available for persons who are eligible  
39 for Medi-Cal benefits as categorically needy persons and as  
40 specified in Section 14007.5.

(f) ~~(1)~~—Individuals eligible for Medi-Cal benefits under this section shall be subject to the payment of premiums determined under this subdivision, except as provided in subdivision ~~(m)~~: (k). Each individual shall pay a monthly premium that is equal to 5 percent of their individual countable income, as described in subdivision (d), or if the deeming of spousal income of an ineligible spouse applies, a monthly premium that is equal to 5 percent of the total countable income of both spouses, except that the minimum premium payment per eligible individual shall be twenty dollars (\$20) per month, and the maximum premium payment per eligible individual shall be two hundred fifty dollars (\$250) per month.

~~(2) The amendments made to this subdivision by Chapter 282 of the Statutes of 2009 shall be implemented no later than 90 days after the operative date specified in paragraph (2) of subdivision (k).~~

(g) In order to implement the collection of premiums under this section, the department may develop and execute a contract with a public or private entity to collect premiums, or may amend any existing or future premium-collection contract that it has executed. Notwithstanding any other law, any contract developed and executed or amended pursuant to this subdivision is exempt from the approval of the Director of General Services and from the Public Contract Code.

(h) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement, without taking any regulatory action, this section by means of an all-county letter or similar instruction. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(i) Notwithstanding any other law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation is available pursuant to Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and only to the extent that the department seeks and obtains approval of all necessary Medicaid state plan amendments.

(j) If any provision of this section, or its application, is held invalid by a final judicial determination, it shall cease to be



1 implemented. A determination of invalidity shall not affect other  
2 provisions or applications of this section that can be given effect  
3 without the implementation of the invalid provision or application.

4 ~~(k) (1) Except as provided in paragraph (2), the amendments~~  
5 ~~made to this section by Chapter 282 of the Statutes of 2009 shall~~  
6 ~~not become operative until 30 days after the date that the increase~~  
7 ~~in the state's federal medical assistance percentage (FMAP)~~  
8 ~~pursuant to the federal American Recovery and Reinvestment Act~~  
9 ~~of 2009 (Public Law 111-5) is no longer available under that act~~  
10 ~~or any extension of that act.~~

11 ~~(2) The amendments made to this section by Chapter 282 of the~~  
12 ~~Statutes of 2009 contained in subdivisions (d) and (f) shall not~~  
13 ~~become operative until 30 days after the date that the director~~  
14 ~~executes a declaration stating that the implementation of~~  
15 ~~subdivisions (d) and (f) will not jeopardize the state's ability to~~  
16 ~~receive federal financial participation under the federal Patient~~  
17 ~~Protection and Affordable Care Act (Public Law 111-148) or any~~  
18 ~~amendment or extension of that act, any increase in the FMAP~~  
19 ~~available on or after October 1, 2008, or any additional federal~~  
20 ~~funds that the director, in consultation with the Department of~~  
21 ~~Finance, determines would be advantageous to the state.~~

22 ~~(3) If at any time the director determines that the statement in~~  
23 ~~the declaration executed pursuant to paragraph (2) may no longer~~  
24 ~~be accurate, the director shall give notice to the Joint Legislative~~  
25 ~~Budget Committee and to the Department of Finance. After giving~~  
26 ~~notice, the amendments made to this section by Chapter 282 of~~  
27 ~~the Statutes of 2009 contained in subdivisions (d) and (f) shall~~  
28 ~~become inoperative on the date that the director executes a~~  
29 ~~declaration stating that the department has determined, in~~  
30 ~~consultation with the Department of Finance, that it is necessary~~  
31 ~~to cease to implement subdivisions (d) and (f) in order to receive~~  
32 ~~federal financial participation, any increase in the FMAP available~~  
33 ~~on or after October 1, 2008, or any additional federal funds that~~  
34 ~~the director, in consultation with the Department of Finance, has~~  
35 ~~determined would be advantageous to the state, in which case,~~  
36 ~~subdivision (d) of this section, as stated by Section 32 of Chapter~~  
37 ~~5 of the Fourth Extraordinary Session of the Statutes of 2009, shall~~  
38 ~~be operative.~~

39 ~~(4) The director shall post a declaration made pursuant to~~  
40 ~~paragraph (2) or (3) on the department's internet website and the~~

1 director shall send the declaration to the Secretary of State, the  
2 Secretary of the Senate, the Chief Clerk of the Assembly, and the  
3 Legislative Counsel.

4 ~~(l) Notwithstanding Chapter 3.5 (commencing with Section~~  
5 ~~11340) of Part 1 of Division 3 of Title 2 of the Government Code,~~  
6 ~~the department may implement subdivision (k) by means of~~  
7 ~~all-county letters or similar instruction, without taking regulatory~~  
8 ~~action.~~

9 ~~(m)~~  
10 ~~(k) (1) Effective July 1, 2022, to the extent allowable under~~  
11 ~~federal law, and notwithstanding the provisions of this section to~~  
12 ~~the contrary, the department may elect not to impose premiums~~  
13 ~~on individuals eligible under this section for an applicable coverage~~  
14 ~~period.~~

15 ~~(2) If the department elects to not impose premiums for an~~  
16 ~~applicable coverage period pursuant to paragraph (1) or elects to~~  
17 ~~reinstate such premiums for a subsequent coverage period, the~~  
18 ~~department shall specify that election in the published Medi-Cal~~  
19 ~~Local Assistance Estimate for the impacted state fiscal year or~~  
20 ~~years, subject to appropriation by the annual Budget Act.~~

21 ~~(n) This section shall become inoperative on the later of either~~  
22 ~~January 1, 2024, or the date on which the determination of the~~  
23 ~~Director of Health Care Services is communicated in writing to~~  
24 ~~the Department of Finance pursuant to paragraph (2) of subdivision~~  
25 ~~(b) of Section 14005.62, and subject to implementation of Section~~  
26 ~~14005.62 pursuant to subdivision (d) of that section, and shall~~  
27 ~~remain inoperative for time periods in which the department has~~  
28 ~~obtained the necessary federal approvals to implement paragraph~~  
29 ~~(2) of subdivision (b) of Section 14005.62 for the applicable~~  
30 ~~population.~~

31 ~~(l) This section shall become operative on January 1, 2026.~~

32 *SEC. 79. Section 14007.9 of the Welfare and Institutions Code,*  
33 *as added by Section 102 of Chapter 42 of the Statutes of 2023, is*  
34 *amended to read:*

35 14007.9. (a) (1) The department shall adopt the option made  
36 available under Section 1902(a)(10)(A)(ii)(XIII) of the federal  
37 Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIII)). In  
38 order to be eligible for benefits under this section, an individual  
39 shall be required to meet all of the following requirements:

1 (A) The individual's net countable income is less than 250  
2 percent of the federal poverty level for one person or, if the  
3 deeming of spousal income applies to the individual, the  
4 individual's net countable income is less than 250 percent of the  
5 federal poverty level for two persons.

6 (B) The individual is disabled under Title II of the federal Social  
7 Security Act (42 U.S.C. Sec. 401 et seq.), Title XVI of the federal  
8 Social Security Act (42 U.S.C. Sec. 1381 et seq.), or Section  
9 1902(v) of the federal Social Security Act (42 U.S.C. Sec.  
10 1396a(v)). An individual shall be determined to be eligible under  
11 this section without regard to their ability to engage in, or actual  
12 engagement in, substantial gainful activity, as defined in Section  
13 223(d)(4) of the federal Social Security Act (42 U.S.C. Sec.  
14 423(d)(4)).

15 (C) Resources that are not counted as income shall not be  
16 included in determinations of eligibility.

17 (2) To the extent federal financial participation is available, an  
18 individual otherwise eligible under this section, but who is  
19 temporarily unemployed, may elect to remain on Medi-Cal under  
20 this section for up to 26 weeks, provided the individual continues  
21 to pay premiums during the temporary period of unemployment,  
22 for coverage periods in which premiums are imposed.

23 (b) Countable income shall be determined under Section 1612  
24 of the federal Social Security Act (42 U.S.C. Sec. 1382a), except  
25 that the individual's disability income, including all federal and  
26 state disability benefits and private disability insurance, shall be  
27 exempted.

28 (1) For the purposes of calculating countable income under this  
29 section, an income exemption shall be applied as necessary to  
30 adjust the income standard so that it is the same as the income  
31 standard that was in place on May 1, 2009.

32 (2) This additional income exemption shall cease to be  
33 implemented when the SSI/SSP program payment levels increase  
34 beyond those in effect on May 1, 2009.

35 (3) Notwithstanding Chapter 3.5 (commencing with Section  
36 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
37 the department shall implement this paragraph by means of an  
38 all-county letter or similar instruction without taking regulatory  
39 action.

1 (4) Social security disability income that converts to social  
2 security retirement income upon the retirement of an individual,  
3 including any increases in the amount of that income, shall be  
4 exempt. The department shall submit a state plan amendment for  
5 this specific exemption, and the exemption shall be implemented  
6 only if, and to the extent that, the state plan amendment is  
7 approved.

8 (c) After an individual is determined eligible for Medi-Cal  
9 benefits under this section, the individual's countable income, as  
10 determined under Section 1612 of the federal Social Security Act  
11 (42 U.S.C. Sec. 1382a), shall be used to determine the amount of  
12 the individual's required premium payment, as described in  
13 subdivision (f), when applicable. Disability income and converted  
14 retirement income made exempt under paragraphs (1) and (3),  
15 respectively, of subdivision (b) for eligibility purposes shall be  
16 considered countable income for purposes of determining the  
17 amount of the required premium payment.

18 (d) Medi-Cal benefits provided under this chapter pursuant to  
19 this section shall be available in the same amount, duration, and  
20 scope as those benefits are available for persons who are eligible  
21 for Medi-Cal benefits as categorically needy persons and as  
22 specified in Section 14007.5.

23 (e) (1) Individuals eligible for Medi-Cal benefits under this  
24 section shall be subject to the payment of premiums determined  
25 under this subdivision, except as provided in subdivision (m). Each  
26 individual shall pay a monthly premium that is equal to 5 percent  
27 of their individual countable income, as described in subdivision  
28 (c), or if the deeming of spousal income of an ineligible spouse  
29 applies, a monthly premium that is equal to 5 percent of the total  
30 countable income of both spouses, except that the minimum  
31 premium payment per eligible individual shall be twenty dollars  
32 (\$20) per month, and the maximum premium payment per eligible  
33 individual shall be two hundred fifty dollars (\$250) per month.

34 (2) The amendments made to this subdivision by Chapter 282  
35 of the Statutes of 2009 shall be implemented no later than 90 days  
36 after the operative date specified in paragraph (2) of subdivision  
37 (j).

38 (f) In order to implement the collection of premiums under this  
39 section, the department may develop and execute a contract with  
40 a public or private entity to collect premiums, or may amend any

1 existing or future premium-collection contract that it has executed.  
2 Notwithstanding any other law, any contract developed and  
3 executed or amended pursuant to this subdivision is exempt from  
4 the approval of the Director of General Services and from the  
5 Public Contract Code.

6 (g) Notwithstanding the rulemaking provisions of Chapter 3.5  
7 (commencing with Section 11340) of Part 1 of Division 3 of Title  
8 2 of the Government Code, the department shall implement,  
9 without taking any regulatory action, this section by means of an  
10 all-county letter or similar instruction. Thereafter, the department  
11 shall adopt regulations in accordance with the requirements of  
12 Chapter 3.5 (commencing with Section 11340) of Part 1 of Division  
13 3 of Title 2 of the Government Code.

14 (h) Notwithstanding any other law, this section shall be  
15 implemented only if, and to the extent that, the department  
16 determines that federal financial participation is available pursuant  
17 to Title XIX of the federal Social Security Act (42 U.S.C. Sec.  
18 1396 et seq.) and only to the extent that the department seeks and  
19 obtains approval of all necessary Medicaid state plan amendments.

20 (i) If any provision of this section, or its application, is held  
21 invalid by a final judicial determination, it shall cease to be  
22 implemented. A determination of invalidity shall not affect other  
23 provisions or applications of this section that can be given effect  
24 without the implementation of the invalid provision or application.

25 (j) (1) Except as provided in paragraph (2), the amendments  
26 made to this section by Chapter 282 of the Statutes of 2009 shall  
27 not become operative until 30 days after the date that the increase  
28 in the state's federal medical assistance percentage (FMAP)  
29 pursuant to the federal American Recovery and Reinvestment Act  
30 of 2009 (Public Law 111-5) is no longer available under that act  
31 or any extension of that act.

32 (2) The amendments made to this section by Chapter 282 of the  
33 Statutes of 2009 contained in subdivisions (c) and (e) shall not  
34 become operative until 30 days after the date that the director  
35 executes a declaration stating that the implementation of  
36 subdivisions (c) and (e) will not jeopardize the state's ability to  
37 receive federal financial participation under the federal Patient  
38 Protection and Affordable Care Act (Public Law 111-148) or any  
39 amendment or extension of that act, any increase in the FMAP  
40 available on or after October 1, 2008, or any additional federal

1 funds that the director, in consultation with the Department of  
2 Finance, determines would be advantageous to the state.

3 (3) If at any time the director determines that the statement in  
4 the declaration executed pursuant to paragraph (2) may no longer  
5 be accurate, the director shall give notice to the Joint Legislative  
6 Budget Committee and to the Department of Finance. After giving  
7 notice, the amendments made to this section by Chapter 282 of  
8 the Statutes of 2009 contained in subdivisions (c) and (e) shall  
9 become inoperative on the date that the director executes a  
10 declaration stating that the department has determined, in  
11 consultation with the Department of Finance, that it is necessary  
12 to cease to implement subdivisions (c) and (e) in order to receive  
13 federal financial participation, any increase in the FMAP available  
14 on or after October 1, 2008, or any additional federal funds that  
15 the director, in consultation with the Department of Finance, has  
16 determined would be advantageous to the state, in which case,  
17 subdivision (c) of this section, as stated by Section 32 of Chapter  
18 5 of the Fourth Extraordinary Session of the Statutes of 2009, shall  
19 be operative.

20 (4) The director shall post a declaration made pursuant to  
21 paragraph (2) or (3) on the department's internet website and the  
22 director shall send the declaration to the Secretary of State, the  
23 Secretary of the Senate, the Chief Clerk of the Assembly, and the  
24 Legislative Counsel.

25 (k) Notwithstanding Chapter 3.5 (commencing with Section  
26 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
27 the department may implement subdivision (j) by means of  
28 all-county letters or similar instruction, without taking regulatory  
29 action.

30 (l) (1) Effective July 1, 2022, to the extent allowable under  
31 federal law, and notwithstanding the provisions of this section to  
32 the contrary, the department may elect not to impose premiums  
33 on individuals eligible under this section for an applicable coverage  
34 period.

35 (2) If the department elects to not impose premiums for an  
36 applicable coverage period pursuant to paragraph (1) or elects to  
37 reinstate such premiums for a subsequent coverage period, the  
38 department shall specify that election in the published Medi-Cal  
39 Local Assistance Estimate for the impacted state fiscal year or  
40 years, subject to appropriation by the annual Budget Act.

~~(m) This section shall become operative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain operative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.~~

*(m) This section shall become inoperative on January 1, 2026, and, as of January 1, 2027, is repealed.*

*SEC. 80. Section 14009.6 of the Welfare and Institutions Code, as amended by Section 104 of Chapter 42 of the Statutes of 2023, is amended to read:*

14009.6. (a) As a result of providing medical assistance for home and facility care to an individual, the state shall, by operation of law, become a remainder beneficiary, to the extent required by Section 1917(e) of the federal Social Security Act (42 U.S.C. Sec. 1396p(e)), of annuities purchased in whole or in part by the individual or the individual's spouse in which the individual or the individual's spouse is an annuitant, except as provided in Section 14009.7, unless the individual or the individual's spouse notifies the department in writing that they prohibit the state from acquiring a remainder interest in their annuity, in which case subdivision (d) shall apply.

(b) This section shall only apply to the following annuities:

(1) Those purchased on or after February 8, 2006.

(2) Those purchased before February 8, 2006, and subjected to a transaction that occurred on or after February 8, 2006.

(A) For the purposes of this paragraph, "transaction" includes, but is not limited to, any action taken by the individual or the individual's spouse that changes the course of payments to be made by the annuity or the treatment of the income or principal of the annuity.

(B) For the purpose of this paragraph, "transaction" shall not include any of the following:

(i) Routine changes and automatic events that do not require any action or decision on or after February 8, 2006.

(ii) Changes that occur based on the terms of the annuity that existed prior to February 8, 2006, and that do not require a decision, election, or action to take effect.

(iii) Changes that are beyond the control of the individual or the individual's spouse.

(c) Any provision in any annuity subject to this section that has the effect of restricting the right of the state to become a remainder beneficiary is void.

(d) If an individual or the individual's spouse notifies the department in writing that they prohibit the state from acquiring a remainder interest in their annuity, the purchase of the annuity shall be treated as the transfer of an asset for less than fair market value that is subject to Section 14015.

(e) (1) When the state becomes aware of an annuity in which it has acquired a remainder interest, the department shall notify the issuer of the annuity of the state's acquisition of its remainder beneficiary interest.

(2) The issuer of the annuity shall, upon notification by the department, immediately inform the department of the amount of income and principal being withdrawn from the annuity as of the date of the individual's disclosure of the annuity.

(3) The issuer of the annuity shall, upon request by the department or any agent of the department, immediately disclose to the department the amount of income and principal being withdrawn from the annuity.

(4) The issuer of the annuity shall immediately notify the department if there is any change in either of the following:

(A) The amount of income or principal being withdrawn from that annuity.

(B) The named beneficiaries of the annuity.

(f) Any moneys received by the state pursuant to this section shall be deposited into the General Fund.

(g) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act, and only to the extent that federal financial participation is available.

(h) To the extent that regulations are necessary to implement this section, the department shall promulgate regulations using the nonemergency regulatory process described in Article 5



(commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of the Government Code.

(i) It is the intent of the Legislature that the provisions of this section shall apply prospectively to any individual to whom the act applies commencing from the date regulations adopted pursuant to this act are filed with the Secretary of State.

~~(j) This section shall become inoperative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain inoperative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.~~

*(j) This section shall become operative on January 1, 2026.*

*SEC. 81. Section 14009.6 of the Welfare and Institutions Code, as added by Section 105 of Chapter 42 of the Statutes of 2023, is amended to read:*

14009.6. (a) As a result of providing medical assistance for home and facility care to an individual, the state shall, by operation of law, become a remainder beneficiary, to the extent required by Section 1917(e) of the federal Social Security Act (42 U.S.C. Sec. 1396p(e)), of annuities purchased in whole or in part by the individual or the individual's spouse in which the individual or the individual's spouse is an annuitant, except as provided in Section 14009.7, unless the individual or the individual's spouse notifies the department in writing that they prohibit the state from acquiring a remainder interest in their annuity.

(b) This section shall only apply to the following annuities:

(1) Those purchased on or after February 8, 2006.

(2) Those purchased before February 8, 2006, and subjected to a transaction that occurred on or after February 8, 2006.

(A) For the purposes of this paragraph, "transaction" includes, but is not limited to, any action taken by the individual or the individual's spouse that changes the course of payments to be made by the annuity or the treatment of the income or principal of the annuity.

1 (B) For the purpose of this paragraph, “transaction” shall not  
2 include any of the following:

3 (i) Routine changes and automatic events that do not require  
4 any action or decision on or after February 8, 2006.

5 (ii) Changes that occur based on the terms of the annuity that  
6 existed prior to February 8, 2006, and that do not require a decision,  
7 election, or action to take effect.

8 (iii) Changes that are beyond the control of the individual or  
9 the individual’s spouse.

10 (c) Any provision in any annuity subject to this section that has  
11 the effect of restricting the right of the state to become a remainder  
12 beneficiary is void.

13 (d) (1) When the state becomes aware of an annuity in which  
14 it has acquired a remainder interest, the department shall notify  
15 the issuer of the annuity of the state’s acquisition of its remainder  
16 beneficiary interest.

17 (2) The issuer of the annuity shall, upon notification by the  
18 department, immediately inform the department of the amount of  
19 income and principal being withdrawn from the annuity as of the  
20 date of the individual’s disclosure of the annuity.

21 (3) The issuer of the annuity shall, upon request by the  
22 department or any agent of the department, immediately disclose  
23 to the department the amount of income and principal being  
24 withdrawn from the annuity.

25 (4) The issuer of the annuity shall immediately notify the  
26 department if there is any change in either of the following:

27 (A) The amount of income or principal being withdrawn from  
28 that annuity.

29 (B) The named beneficiaries of the annuity.

30 (e) Any moneys received by the state pursuant to this section  
31 shall be deposited into the General Fund.

32 (f) This section shall be implemented pursuant to the  
33 requirements of Title XIX of the federal Social Security Act (42  
34 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to  
35 that act, and only to the extent that federal financial participation  
36 is available.

37 (g) To the extent that regulations are necessary to implement  
38 this section, the department shall promulgate regulations using the  
39 nonemergency regulatory process described in Article 5

(commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of the Government Code.

(h) It is the intent of the Legislature that the provisions of this section shall apply prospectively to any individual to whom the act applies commencing from the date regulations adopted pursuant to this act are filed with the Secretary of State.

~~(i) This section shall become operative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain operative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.~~

*(j) This section shall become inoperative on January 1, 2026, and, as of January 1, 2027, is repealed.*

*SEC. 82. Section 14009.7 of the Welfare and Institutions Code, as amended by Section 106 of Chapter 42 of the Statutes of 2023, is amended to read:*

14009.7. (a) If an annuity is considered part or all of the community spouse resource allowance allowed under subdivision (c) of Section 14006, the state shall only become a remainder beneficiary of that portion of the annuity that is not a part of that community spouse resource allowance.

(b) The state shall not become a remainder beneficiary of an annuity that is any of the following:

(1) Purchased by a community spouse with resources of the community spouse during the continuous period in which the individual is receiving medical assistance for home and facility care and after the month in which the individual is determined eligible for these benefits.

(2) Contained in a retirement plan qualified under Title 26 of the United States Code, established by an employer or an individual, including, but not limited to, an Individual Retirement Annuity or Account (IRA), Roth IRA, or Keogh fund.

(3) An annuity that is all of the following:

(A) The annuity is irrevocable and nonassignable.

(B) The annuity is actuarially sound.

1 (C) The annuity provides for payments in equal amounts during  
2 the term of the annuity, with no deferral and no balloon payments  
3 made from the annuity.

4 (c) The individual or the community spouse, or both, shall bear  
5 the burden of demonstrating that the requirements of this section  
6 that limit the state's right to become a remainder beneficiary, as  
7 described in Section 14009.6, are met.

8 (d) This section shall be implemented pursuant to the  
9 requirements of Title XIX of the federal Social Security Act (42  
10 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to  
11 that act, and only to the extent that federal financial participation  
12 is available.

13 (e) To the extent that regulations are necessary to implement  
14 this section, the department shall promulgate regulations using the  
15 nonemergency regulatory process described in Article 5  
16 (commencing with Section 11346) of Chapter 3.5 of Part 1 of  
17 Division 3 of the Government Code.

18 (f) It is the intent of the Legislature that the provisions of this  
19 section shall apply prospectively to any individual to whom the  
20 act applies commencing from the date regulations adopted pursuant  
21 to this act are filed with the Secretary of State.

22 ~~(g) This section shall become inoperative on the later of either~~  
23 ~~January 1, 2024, or the date on which the determination of the~~  
24 ~~Director of Health Care Services is communicated in writing to~~  
25 ~~the Department of Finance pursuant to paragraph (2) of subdivision~~  
26 ~~(b) of Section 14005.62, and subject to implementation of Section~~  
27 ~~14005.62 pursuant to subdivision (d) of that section, and shall~~  
28 ~~remain inoperative for time periods in which the department has~~  
29 ~~obtained the necessary federal approvals to implement paragraph~~  
30 ~~(2) of subdivision (b) of Section 14005.62 for the applicable~~  
31 ~~population.~~

32 (g) *This section shall become operative on January 1, 2026.*

33 *SEC. 83. Section 14009.7 of the Welfare and Institutions Code,*  
34 *as added by Section 107 of Chapter 42 of the Statutes of 2023, is*  
35 *amended to read:*

36 14009.7. (a) The state shall not become a remainder beneficiary  
37 of an annuity that is any of the following:

38 (1) Purchased by a community spouse with resources of the  
39 community spouse before or during the continuous period in which  
40 the individual is receiving medical assistance for home and facility

1 care and after the month in which the individual is determined  
2 eligible for these benefits.

3 (2) Contained in a retirement plan qualified under Title 26 of  
4 the United States Code, established by an employer or an  
5 individual, including, but not limited to, an Individual Retirement  
6 Annuity or Account (IRA), Roth IRA, or Keogh fund.

7 (3) An annuity that is all of the following:

8 (A) The annuity is irrevocable and nonassignable.

9 (B) The annuity is actuarially sound.

10 (C) The annuity provides for payments in equal amounts during  
11 the term of the annuity, with no deferral and no balloon payments  
12 made from the annuity.

13 (b) The individual or the community spouse, or both, shall bear  
14 the burden of demonstrating that the requirements of this section  
15 that limit the state's right to become a remainder beneficiary, as  
16 described in Section 14009.6, are met.

17 (c) This section shall be implemented pursuant to the  
18 requirements of Title XIX of the federal Social Security Act (42  
19 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to  
20 that act, and only to the extent that federal financial participation  
21 is available.

22 (d) To the extent that regulations are necessary to implement  
23 this section, the department shall promulgate regulations using the  
24 nonemergency regulatory process described in Article 5  
25 (commencing with Section 11346) of Chapter 3.5 of Part 1 of  
26 Division 3 of the Government Code.

27 (e) It is the intent of the Legislature that the provisions of this  
28 section shall apply prospectively to any individual to whom the  
29 act applies commencing from the date regulations adopted pursuant  
30 to this act are filed with the Secretary of State.

31 ~~(f) This section shall become operative on the later of either~~  
32 ~~January 1, 2024, or the date on which the determination of the~~  
33 ~~Director of Health Care Services is communicated in writing to~~  
34 ~~the Department of Finance pursuant to paragraph (2) of subdivision~~  
35 ~~(b) of Section 14005.62, and subject to implementation of Section~~  
36 ~~14005.62 pursuant to subdivision (d) of that section, and shall~~  
37 ~~remain operative for time periods in which the department has~~  
38 ~~obtained the necessary federal approvals to implement paragraph~~  
39 ~~(2) of subdivision (b) of Section 14005.62 for the applicable~~  
40 ~~population.~~

1 (f) *This section shall become inoperative on January 1, 2026,*  
2 *and, as of January 1, 2027, is repealed.*

3 *SEC. 84. Section 14011 of the Welfare and Institutions Code,*  
4 *as amended by Section 108 of Chapter 42 of the Statutes of 2023,*  
5 *is amended to read:*

6 14011. (a) ~~Each~~An applicant who is not a recipient of aid  
7 under ~~the provisions of~~ Chapter 2 (commencing with Section  
8 11200) or Chapter 3 (commencing with Section 12000) shall be  
9 required to file an affirmation setting forth facts about their annual  
10 income and other resources and qualifications for eligibility as  
11 may be required by the department. Those statements shall be on  
12 forms prescribed by the department.

13 (b) To the extent permitted by federal law, eligibility for medical  
14 assistance for applicants shall not be granted until the applicant or  
15 designated representative provides independent documentation  
16 verifying statements of ~~gross~~ the following:

17 (1) *Gross* income by type and ~~source~~; ~~income~~ source.

18 (2) *Income* amounts withheld for ~~taxes~~, ~~health~~ taxes.

19 (3) *Health* care benefits available through employment,  
20 retirement, military service, work related injuries or settlements  
21 from prior ~~injuries~~, ~~employee injuries~~.

22 (4) *Employee* retirement contributions, and other employee  
23 benefit contributions, deductible expenses for maintenance or  
24 improvement of income-producing property and status and value  
25 of property owned, other than property exempt under Section  
26 14006. The director may prescribe those items of exempt property  
27 that the director deems should be verified as to status and value in  
28 order to reasonably assure a correct designation of those items as  
29 exempt.

30 (c) The verification requirements of subdivision (b) apply to  
31 income, income deductions and property both of applicants for  
32 medical ~~assistance (other than assistance, excluding applicants for~~  
33 ~~public assistance)~~ *assistance*, and to persons whose income, income  
34 deductions, expenses or property holdings must be considered in  
35 determining the applicant's eligibility and spend down of excess  
36 income.

37 (d) A determination of eligibility and spend down of excess  
38 income may be extended beyond otherwise prescribed timeframes  
39 if, in the county department's judgment, and subject to standards  
40 of the director, the applicant or designated representative has good

1 cause for failure to provide the required verification and continues  
2 to make a good faith effort to provide ~~such~~ verification.

3 (e) To the extent permitted by federal law, in addition to the  
4 other verification requirements of this section, a county department  
5 may require verification of any other applicant statements, or  
6 conduct a full and complete investigation of the statements,  
7 whenever a verification or investigation is warranted in the  
8 judgment of the county department.

9 (f) If documentation is unavailable, as defined in regulations  
10 promulgated by the department, the applicant's signed statement  
11 as to the value or amount shall be deemed to constitute verification.

12 ~~(g) This section shall become inoperative on the later of either~~  
13 ~~January 1, 2024, or the date on which the determination of the~~  
14 ~~Director of Health Care Services is communicated in writing to~~  
15 ~~the Department of Finance pursuant to paragraph (2) of subdivision~~  
16 ~~(b) of Section 14005.62, and subject to implementation of Section~~  
17 ~~14005.62 pursuant to subdivision (d) of that section, and shall~~  
18 ~~remain inoperative for time periods in which the department has~~  
19 ~~obtained the necessary federal approvals to implement paragraph~~  
20 ~~(2) of subdivision (b) of Section 14005.62 for the applicable~~  
21 ~~population.~~

22 (g) *This section shall become operative on January 1, 2026.*

23 SEC. 85. *Section 14011 of the Welfare and Institutions Code,*  
24 *as added by Section 109 of Chapter 42 of the Statutes of 2023, is*  
25 *amended to read:*

26 14011. (a) An applicant who is not a recipient of aid under  
27 Chapter 2 (commencing with Section 11200) or Chapter 3  
28 (commencing with Section 12000) shall be required to file an  
29 affirmation setting forth facts about their annual income and  
30 qualifications for eligibility as may be required by the department.  
31 Those statements shall be on forms prescribed by the department.

32 (b) To the extent permitted by federal law, eligibility for medical  
33 assistance for applicants shall not be granted until the applicant or  
34 designated representative provides independent documentation  
35 verifying statements of all of the following:

36 (1) Gross income by type and source.

37 (2) Income amounts withheld for taxes.

38 (3) Health care benefits available through employment,  
39 retirement, military service, work-related injuries or settlements  
40 from prior injuries.

1 (c) The verification requirements of subdivision (b) apply to  
2 income and income deductions of applicants for medical assistance,  
3 excluding applicants for public assistance, and to persons whose  
4 income, income deductions, or expenses must be considered in  
5 determining the applicant's eligibility and spend down of excess  
6 income.

7 (d) A determination of eligibility and spend down of excess  
8 income may be extended beyond otherwise prescribed timeframes  
9 if, in the county department's judgment, and subject to standards  
10 of the director, the applicant or designated representative has good  
11 cause for failure to provide the required verification and continues  
12 to make a good faith effort to provide verification.

13 (e) To the extent permitted by federal law, in addition to the  
14 other verification requirements of this section, a county department  
15 may require verification of any other applicant statements, or  
16 conduct a full and complete investigation of the statements,  
17 whenever a verification or investigation is warranted in the  
18 judgment of the county department.

19 (f) If documentation is unavailable, as defined in regulations  
20 promulgated by the department, the applicant's signed statement  
21 as to the value or amount shall be deemed to constitute verification.

22 ~~(g) This section shall become operative on the later of either~~  
23 ~~January 1, 2024, or the date on which the determination of the~~  
24 ~~Director of Health Care Services is communicated in writing to~~  
25 ~~the Department of Finance pursuant to paragraph (2) of subdivision~~  
26 ~~(b) of Section 14005.62, and subject to implementation of Section~~  
27 ~~14005.62 pursuant to subdivision (d) of that section, and shall~~  
28 ~~remain operative for time periods in which the department has~~  
29 ~~obtained the necessary federal approvals to implement paragraph~~  
30 ~~(2) of subdivision (b) of Section 14005.62 for the applicable~~  
31 ~~population.~~

32 *(g) This section shall become inoperative on January 1, 2026,*  
33 *and, as of January 1, 2027, is repealed.*

34 *SEC. 86. Section 14013.3 of the Welfare and Institutions Code,*  
35 *as amended by Section 113 of Chapter 42 of the Statutes of 2023,*  
36 *is amended to read:*

37 14013.3. (a) When determining whether an individual is  
38 eligible for Medi-Cal benefits, the department shall verify the  
39 accuracy of the information identified in this section that is



provided as a part of the application or redetermination process in conformity with this section.

(b) ~~Prior to~~ *Before* requesting additional verification from an applicant or beneficiary for information they provide as part of the application or redetermination process, the department shall obtain information about an individual that is available electronically from other state and federal agencies and programs in determining an individual's eligibility for Medi-Cal benefits or for potential eligibility for an insurance affordability program offered through the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code. Needed information shall be obtained from the following sources, including any other source the department determines is useful:

(1) Information related to wages, net earnings from self-employment, unearned income, and resources from any of the following:

- (A) The State Wage Information Collection Agency.
- (B) The federal Internal Revenue Service.
- (C) The federal Social Security Administration.
- (D) The Employment Development Department.
- (E) The state administered supplementary payment program under Section 1382e of Title 42 of the United States Code.
- (F) Any state program administered under a plan approved under Titles I, X, XIV, or XVI of the federal Social Security Act.

(2) Information related to eligibility or enrollment from any of the following:

- (A) The CalFresh program pursuant to Chapter 10 (commencing with Section 18900) of Part 6.
- (B) The CalWORKs program.
- (C) The state's children's health insurance program under Title XXI of the federal Social Security Act (42 U.S.C. 1397aa et seq.).
- (D) The California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code.

(E) The electronic service established in accordance with Section 435.949 of Title 42 of the Code of Federal Regulations.

(c) (1) If the income information obtained by the department pursuant to subdivision (b) is reasonably compatible with the information provided by or on behalf of the individual, the

1 department shall accept the information provided by or on behalf  
2 of the individual as being accurate.

3 (2) If the income information obtained by the department is not  
4 reasonably compatible with the information provided by or on  
5 behalf of the individual, the department shall require that the  
6 individual provide additional information that reasonably explains  
7 the discrepancy.

8 (3) For the purposes of this subdivision, income information  
9 obtained by the department is reasonably compatible with  
10 information provided by or on behalf of an individual if any of the  
11 following conditions are met:

12 (A) Both state that the individual's income is above the  
13 applicable income standard or other relevant income threshold for  
14 eligibility.

15 (B) Both state that the individual's income is at or below the  
16 applicable income standard or other relevant income threshold for  
17 eligibility.

18 (C) The information provided by or on behalf of the individual  
19 states that the individual's income is above, and the information  
20 obtained by the department states that the individual's income is  
21 at or below, the applicable income standard or other relevant  
22 income threshold for eligibility.

23 (4) If subparagraph (C) of paragraph (3) applies, the individual  
24 shall be informed that the income information provided by them  
25 was higher than the information that was electronically verified  
26 and that they may request a reconciliation of the difference. This  
27 paragraph shall be implemented no later than January 1, 2015.

28 (d) (1) The department shall accept the attestation of the  
29 individual regarding whether they are pregnant unless the  
30 department has information that is not reasonably compatible with  
31 the attestation.

32 (2) If the information obtained by the department is not  
33 reasonably compatible with the information provided by or on  
34 behalf of the individual under paragraph (1), the department shall  
35 require that the individual provide additional information that  
36 reasonably explains the discrepancy.

37 (e) If any information not described in subdivision (c) or (d)  
38 that is needed for an eligibility determination or redetermination  
39 and is obtained by the department is not reasonably compatible  
40 with the information provided by or on behalf of the individual,

1 the department shall require that the individual provide additional  
2 information that reasonably explains the discrepancy.

3 (f) The department shall develop, and update as it is modified,  
4 a verification plan describing the verification policies and  
5 procedures adopted by the department to verify eligibility  
6 information. If the department determines that any state or federal  
7 agencies or programs not previously identified in the verification  
8 plan are useful in determining an individual's eligibility for  
9 Medi-Cal benefits or for potential eligibility, for an insurance  
10 affordability program offered through the California Health Benefit  
11 Exchange, the department shall update the verification plan to  
12 identify those additional agencies or programs. The development  
13 and modification of the verification plan shall be undertaken in  
14 consultation with representatives from county human services  
15 departments, legal aid advocates, and the Legislature. This  
16 verification plan shall conform to all federal requirements and  
17 shall be posted on the department's internet website.

18 (g) Notwithstanding Chapter 3.5 (commencing with Section  
19 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
20 the department, without taking any further regulatory action, shall  
21 implement, interpret, or make specific this section by means of  
22 all-county letters, plan letters, plan or provider bulletins, or similar  
23 instructions until the time regulations are adopted. Thereafter, the  
24 department shall adopt regulations in accordance with the  
25 requirements of Chapter 3.5 (commencing with Section 11340) of  
26 Part 1 of Division 3 of Title 2 of the Government Code. ~~Beginning~~  
27 ~~six months after the effective date of this section, and~~  
28 ~~notwithstanding Section 10231.5 of the Government Code, the~~  
29 ~~department shall provide a status report to the Legislature on a~~  
30 ~~semiannual basis until regulations have been adopted.~~

31 (h) This section shall be implemented only if, and to the extent  
32 that, federal financial participation is available and any necessary  
33 federal approvals have been obtained.

34 ~~(i) This section shall become operative on January 1, 2014.~~

35 ~~(j) This section shall become inoperative on the later of either~~  
36 ~~January 1, 2024, or the date on which the determination of the~~  
37 ~~Director of Health Care Services is communicated in writing to~~  
38 ~~the Department of Finance pursuant to paragraph (2) of subdivision~~  
39 ~~(b) of Section 14005.62, and subject to implementation of Section~~  
40 ~~14005.62 pursuant to subdivision (d) of that section, and shall~~

1 ~~remain inoperative for time periods in which the department has~~  
2 ~~obtained the necessary federal approvals to implement paragraph~~  
3 ~~(2) of subdivision (b) of Section 14005.62 for the applicable~~  
4 ~~population.~~

5 *(i) This section shall become operative on January 1, 2026.*

6 SEC. 87. *Section 14013.3 of the Welfare and Institutions Code,*  
7 *as added by Section 114 of Chapter 42 of the Statutes of 2023, is*  
8 *amended to read:*

9 14013.3. (a) When determining whether an individual is  
10 eligible for Medi-Cal benefits, the department shall verify the  
11 accuracy of the information identified in this section that is  
12 provided as a part of the application or redetermination process in  
13 conformity with this section.

14 (b) Before requesting additional verification from an applicant  
15 or beneficiary for information they provide as part of the  
16 application or redetermination process, the department shall obtain  
17 information about an individual that is available electronically  
18 from other state and federal agencies and programs in determining  
19 an individual's eligibility for Medi-Cal benefits or for potential  
20 eligibility for an insurance affordability program offered through  
21 the California Health Benefit Exchange established pursuant to  
22 Title 22 (commencing with Section 100500) of the Government  
23 Code. Needed information shall be obtained from the following  
24 sources, including any other source the department determines is  
25 useful:

26 (1) Information related to wages, net earnings from  
27 self-employment, and unearned income from any of the following:

28 (A) The State Wage Information Collection Agency.

29 (B) The federal Internal Revenue Service.

30 (C) The federal Social Security Administration.

31 (D) The Employment Development Department.

32 (E) The state administered supplementary payment program  
33 under Section 1382e of Title 42 of the United States Code.

34 (F) Any state program administered under a plan approved under  
35 Titles I, X, XIV, or XVI of the federal Social Security Act.

36 (2) Information related to eligibility or enrollment from any of  
37 the following:

38 (A) The CalFresh program pursuant to Chapter 10 (commencing  
39 with Section 18900) of Part 6.

40 (B) The CalWORKs program.

1 (C) The state's children's health insurance program under Title  
2 XXI of the federal Social Security Act (42 U.S.C. 1397aa et seq.).

3 (D) The California Health Benefit Exchange established  
4 pursuant to Title 22 (commencing with Section 100500) of the  
5 Government Code.

6 (E) The electronic service established in accordance with Section  
7 435.949 of Title 42 of the Code of Federal Regulations.

8 (c) (1) If the income information obtained by the department  
9 pursuant to subdivision (b) is reasonably compatible with the  
10 information provided by or on behalf of the individual, the  
11 department shall accept the information provided by or on behalf  
12 of the individual as being accurate.

13 (2) If the income information obtained by the department is not  
14 reasonably compatible with the information provided by or on  
15 behalf of the individual, the department shall require that the  
16 individual provide additional information that reasonably explains  
17 the discrepancy.

18 (3) For the purposes of this subdivision, income information  
19 obtained by the department is reasonably compatible with  
20 information provided by or on behalf of an individual if any of the  
21 following conditions are met:

22 (A) Both state that the individual's income is above the  
23 applicable income standard or other relevant income threshold for  
24 eligibility.

25 (B) Both state that the individual's income is at or below the  
26 applicable income standard or other relevant income threshold for  
27 eligibility.

28 (C) The information provided by or on behalf of the individual  
29 states that the individual's income is above, and the information  
30 obtained by the department states that the individual's income is  
31 at or below, the applicable income standard or other relevant  
32 income threshold for eligibility.

33 (4) If subparagraph (C) of paragraph (3) applies, the individual  
34 shall be informed that the income information provided by them  
35 was higher than the information that was electronically verified  
36 and that they may request a reconciliation of the difference. This  
37 paragraph shall be implemented no later than January 1, 2015.

38 (d) (1) The department shall accept the attestation of the  
39 individual regarding whether they are pregnant unless the

1 department has information that is not reasonably compatible with  
2 the attestation.

3 (2) If the information obtained by the department is not  
4 reasonably compatible with the information provided by or on  
5 behalf of the individual under paragraph (1), the department shall  
6 require that the individual provide additional information that  
7 reasonably explains the discrepancy.

8 (e) If any information not described in subdivision (c) or (d)  
9 that is needed for an eligibility determination or redetermination  
10 and is obtained by the department is not reasonably compatible  
11 with the information provided by or on behalf of the individual,  
12 the department shall require that the individual provide additional  
13 information that reasonably explains the discrepancy.

14 (f) The department shall develop, and update as it is modified,  
15 a verification plan describing the verification policies and  
16 procedures adopted by the department to verify eligibility  
17 information. If the department determines that any state or federal  
18 agencies or programs not previously identified in the verification  
19 plan are useful in determining an individual's eligibility for  
20 Medi-Cal benefits or for potential eligibility, for an insurance  
21 affordability program offered through the California Health Benefit  
22 Exchange, the department shall update the verification plan to  
23 identify those additional agencies or programs. The development  
24 and modification of the verification plan shall be undertaken in  
25 consultation with representatives from county human services  
26 departments, legal aid advocates, and the Legislature. This  
27 verification plan shall conform to all federal requirements and  
28 shall be posted on the department's internet website.

29 (g) Notwithstanding Chapter 3.5 (commencing with Section  
30 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
31 the department, without taking any further regulatory action, shall  
32 implement, interpret, or make specific this section by means of  
33 all-county letters, plan letters, plan or provider bulletins, or similar  
34 instructions until the time regulations are adopted. Thereafter, the  
35 department shall adopt regulations in accordance with the  
36 requirements of Chapter 3.5 (commencing with Section 11340) of  
37 Part 1 of Division 3 of Title 2 of the Government Code. Beginning  
38 six months after the effective date of this section, and  
39 notwithstanding Section 10231.5 of the Government Code, the

department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(h) This section shall be implemented only if, and to the extent that, federal financial participation is available and any necessary federal approvals have been obtained.

~~(i) This section shall become operative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain operative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.~~

*(i) This section shall become inoperative on January 1, 2026, and, as of January 1, 2027, is repealed.*

SEC. 88. Section 14015 of the Welfare and Institutions Code is amended to read:

14015. (a) (1) The providing of health care under this chapter shall not impose any limitation or restriction upon the person's right to sell, exchange or change the form of property holdings nor shall the care provided constitute any encumbrance on the holdings. However, the transfer or gift of assets, including income and resources, for less than fair market value shall, pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act, result in a period of ineligibility for medical assistance for home and facility care, which may include partial months of ineligibility, applied in accordance with federal law.

(2) Any items, including notes, loans, life estates, or annuities that are held and distributed in a manner that is not in conformity with the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and regulations adopted pursuant to that act, shall be treated as a transferred asset and may result in a period of ineligibility as described in paragraph (1), as required by Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act.

(b) Pursuant to Section 1917 (c)(2)(C)(ii) of the federal Social Security Act (42 U.S.C. Sec. 1396p(c)(2)(C)(ii)), a satisfactory

1 showing that assets transferred exclusively for a purpose other  
2 than to qualify for medical assistance shall not result in ineligibility  
3 for Medi-Cal and shall include, but not be limited to, the following:

4 (1) Assets that would have been considered exempt for purposes  
5 of establishing eligibility pursuant to federal or state laws at the  
6 time of transfer.

7 (2) Property with a net market value that, when the property is  
8 transferred, if included in the property reserve, would not result  
9 in ineligibility.

10 (3) Assets for which adequate consideration is received.

11 (4) Property upon which foreclosure or repossession was  
12 imminent at the time of transfer, provided there is no evidence of  
13 collusion.

14 (5) Assets transferred in return for an enforceable contract for  
15 life care that does not include complete medical care.

16 (6) Assets transferred without adequate consideration, provided  
17 that the applicant or beneficiary provides convincing evidence to  
18 overcome the presumption that the transfer was for the purpose of  
19 establishing eligibility or reducing the spend down of excess  
20 income.

21 (c) In administering this section, it shall be presumed that assets  
22 transferred by the applicant or beneficiary prior to the look-back  
23 period established by the department preceding the date of initial  
24 application were not transferred to establish eligibility or reduce  
25 the spend down of excess income. These assets shall not be  
26 considered in determining eligibility.

27 (d) Any item of durable medical equipment that is purchased  
28 for a recipient pursuant to this chapter exclusively with Medi-Cal  
29 program funds shall be returned to the department when the  
30 department determines that the item is no longer medically  
31 necessary for the recipient. Items of durable medical equipment  
32 shall include, but are not limited to, wheelchairs and special  
33 hospital beds.

34 (e) This section shall be implemented pursuant to the  
35 requirements of Title XIX of the federal Social Security Act (42  
36 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to  
37 that act, and only to the extent that federal financial participation  
38 is available.

39 ~~(f) To the extent that regulations are necessary to implement~~  
40 ~~this section, the department shall promulgate regulations using the~~



1 nonemergency regulatory process described in Article 5  
2 (commencing with Section 11346) of Chapter 3.5 of Part 1 of  
3 Division 3 of the Government Code.

4 (g) It is the intent of the Legislature that the provisions of this  
5 section shall apply prospectively to any individual to whom the  
6 act applies commencing from the date regulations adopted pursuant  
7 to this act are filed with the Secretary of State.

8 (h) This section shall become inoperative on the later of either  
9 January 1, 2024, or the date on which the determination of the  
10 Director of Health Care Services is communicated in writing to  
11 the Department of Finance pursuant to paragraph (2) of subdivision  
12 (b) of Section 14005.62, and subject to implementation of Section  
13 14005.62 pursuant to subdivision (d) of that section, and shall  
14 remain inoperative for time periods in which the department has  
15 obtained the necessary federal approvals to implement paragraph  
16 (2) of subdivision (b) of Section 14005.62 for the applicable  
17 population.

18 (f) (1) Notwithstanding Chapter 3.5 (commencing with Section  
19 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
20 the department, without taking any further regulatory action, shall  
21 implement, interpret, or make specific this section by means of  
22 all-county letters, plan letters, plan or provider bulletins, or similar  
23 instructions until regulations are adopted.

24 (2) The department shall adopt regulations by January 1, 2030,  
25 in accordance with the requirements of Chapter 3.5 (commencing  
26 with Section 11340) of Part 1 of Division 3 of Title 2 of the  
27 Government Code. The department shall provide a status report  
28 to the Legislature on a semiannual basis, in compliance with  
29 Section 9795 of the Government Code, until regulations are  
30 adopted.

31 (g) It is the intent of the Legislature that the provisions of this  
32 section shall apply prospectively to any individual to whom the  
33 act applies commencing from the date regulations adopted  
34 pursuant to this section are filed with the Secretary of State.  
35 Transfers or gifts of assets prior to the implementation of this  
36 section are exempt, to the extent allowed under federal law and  
37 regulations.

38 (h) This section shall become operative on January 1, 2026.

1     *SEC. 89. Section 14051 of the Welfare and Institutions Code,*  
2     *as amended by Section 120 of Chapter 42 of the Statutes of 2023,*  
3     *is amended to read:*

4     14051. (a) “Medically needy person” means any of the  
5     following:

6     (1) An aged, blind, or disabled person who meets the definition  
7     of aged, blind, or disabled under the Supplemental Security Income  
8     program and whose income and resources are insufficient to  
9     provide for the costs of health care or coverage.

10    (2) A child in foster care for whom public agencies are assuming  
11    financial responsibility, in whole or in part, or a person receiving  
12    aid under Chapter 2.1 (commencing with Section 16115) of Part  
13    4.

14    (3) A child who is eligible to receive Medi-Cal benefits pursuant  
15    to interstate agreements for adoption assistance and related services  
16    and benefits entered into under Chapter 2.6 (commencing with  
17    Section 16170) of Part 4, to the extent federal financial  
18    participation is available.

19    (b) “Medically needy family person” means a parent or caretaker  
20    relative of a child or a child under 21 years of age or a pregnant  
21    woman of any age with a confirmed pregnancy, exclusive of those  
22    persons specified in subdivision (a), whose income and resources  
23    are insufficient to provide for the costs of health care or coverage.

24    ~~(c) This section shall become inoperative on the later of either~~  
25    ~~January 1, 2024, or the date on which the determination of the~~  
26    ~~Director of Health Care Services is communicated to the~~  
27    ~~Department of Finance pursuant to paragraph (2) of subdivision~~  
28    ~~(b) of Section 14005.62, and subject to implementation of Section~~  
29    ~~14005.62 pursuant to subdivision (d) of that section, and shall~~  
30    ~~remain inoperative for time periods in which the department has~~  
31    ~~obtained the necessary federal approvals to implement paragraph~~  
32    ~~(2) of subdivision (b) of Section 14005.62 for the applicable~~  
33    ~~population.~~

34    (c) *This section shall become operative on January 1, 2026.*

35    *SEC. 90. Section 14051 of the Welfare and Institutions Code,*  
36    *as added by Section 121 of Chapter 42 of the Statutes of 2023, is*  
37    *amended to read:*

38    14051. (a) “Medically needy person” means any of the  
39    following:

1 (1) An aged, blind, or disabled person who meets the definition  
2 of aged, blind, or disabled under the Supplemental Security Income  
3 program and whose income is insufficient to provide for the costs  
4 of health care or coverage.

5 (2) A child in foster care for whom public agencies are assuming  
6 financial responsibility, in whole or in part, or a person receiving  
7 aid under Chapter 2.1 (commencing with Section 16115) of Part  
8 4.

9 (3) A child who is eligible to receive Medi-Cal benefits pursuant  
10 to interstate agreements for adoption assistance and related services  
11 and benefits entered into under Chapter 2.6 (commencing with  
12 Section 16170) of Part 4, to the extent federal financial  
13 participation is available.

14 (b) “Medically needy family person” means a parent or caretaker  
15 relative of a child or a child under 21 years of age or a pregnant  
16 woman of any age with a confirmed pregnancy, exclusive of those  
17 persons specified in subdivision (a), whose income is insufficient  
18 to provide for the costs of health care or coverage.

19 ~~(e) This section shall become operative on the later of either~~  
20 ~~January 1, 2024, or the date on which the determination of the~~  
21 ~~Director of Health Care Services is communicated to the~~  
22 ~~Department of Finance pursuant to paragraph (2) of subdivision~~  
23 ~~(b) of Section 14005.62, and subject to implementation of Section~~  
24 ~~14005.62 pursuant to subdivision (d) of that section, and shall~~  
25 ~~remain operative for time periods in which the department has~~  
26 ~~obtained the necessary federal approvals to implement paragraph~~  
27 ~~(2) of subdivision (b) of Section 14005.62 for the applicable~~  
28 ~~population.~~

29 *(c) This section shall become inoperative on January 1, 2026,*  
30 *and, as of January 1, 2027, is repealed.*

31 *SEC. 91. Section 14051.5 of the Welfare and Institutions Code,*  
32 *as amended by Section 122 of Chapter 42 of the Statutes of 2023,*  
33 *is amended to read:*

34 14051.5. (a) “Medically needy person” also means any person  
35 who receives in-home supportive services pursuant to Section  
36 12305.5 and whose income and resources are insufficient to provide  
37 for the costs of health care or coverage.

38 ~~(b) This section shall become inoperative on the later of either~~  
39 ~~January 1, 2024, or the date on which the determination of the~~  
40 ~~Director of Health Care Services is communicated to the~~

~~Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain inoperative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.~~

*(b) This section shall become operative on January 1, 2026.*

*SEC. 92. Section 14051.5 of the Welfare and Institutions Code, as added by Section 123 of Chapter 42 of the Statutes of 2023, is amended to read:*

14051.5. (a) “Medically needy person” also means any person who receives in-home supportive services pursuant to Section 12305.5 and whose income is insufficient to provide for the costs of health care or coverage.

~~(b) This section shall become operative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care Services is communicated to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain operative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.~~

*(b) This section shall become inoperative on January 1, 2026, and, as of January 1, 2027, is repealed.*

*SEC. 93. Section 14105.33 of the Welfare and Institutions Code is amended to read:*

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

(b) (1) Contracts executed pursuant to this section shall be for the manufacturer’s best price, as defined in Section 14105.31, which shall be specified in the contract, and subject to agreed-upon price escalators, as defined in that section. The contracts shall provide for a state rebate, as defined in Section 14105.31, to be remitted to the department quarterly. The department shall submit

1 an invoice to each manufacturer for the state rebate, including  
 2 supporting utilization data from the department's prescription drug  
 3 paid claims tapes within 30 days of receipt of the federal Centers  
 4 for Medicare and Medicaid Services' file of manufacturer rebate  
 5 information. In lieu of paying the entire invoiced amount, a  
 6 manufacturer may contest the invoiced amount pursuant to  
 7 procedures established by the federal Centers for Medicare and  
 8 Medicaid Services' Medicaid Drug Rebate Program Releases or  
 9 regulations by mailing a notice, that shall set forth its grounds for  
 10 contesting the invoiced amount, to the department within 38 days  
 11 of the department's mailing of the state invoice and supporting  
 12 utilization data. For purposes of state accounting practices only,  
 13 the contested balance shall not be considered an accounts receivable  
 14 amount until final resolution of the dispute pursuant to procedures  
 15 established by the federal Centers for Medicare and Medicaid  
 16 Services' Medicaid Drug Rebate Program Releases or regulations  
 17 that results in a finding of an underpayment by the manufacturer.  
 18 Manufacturers may request, and the department shall timely  
 19 provide, at cost, Medi-Cal provider level drug utilization data, and  
 20 other Medi-Cal utilization data necessary to resolve a contested  
 21 department-invoiced rebate amount.

22 (2) The department shall provide for an annual audit of  
 23 utilization data used to calculate the state rebate to verify the  
 24 accuracy of that data. The findings of the audit shall be documented  
 25 in a written audit report to be made available to manufacturers  
 26 within 90 days of receipt of the report from the auditor. Any  
 27 manufacturer may receive a copy of the audit report upon written  
 28 request. Contracts between the department and manufacturers shall  
 29 provide for any equalization payment adjustments determined  
 30 necessary pursuant to an audit.

31 (3) (A) Utilization data used to determine the state rebate shall  
 32 exclude data from both of the following:

33 (i) Health maintenance organizations, as defined in Section  
 34 300e(a) of Title 42 of the United States Code, including those  
 35 organizations that contract under Section 1396b(m) of Title 42 of  
 36 the United States Code.

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

40 (B) This paragraph shall become inoperative on July 1, 2014.

(4) Commencing July 1, 2014, utilization data used to determine the state rebate shall include data from all programs, including, but not limited to, fee-for-service Medi-Cal, and utilization data, as limited in paragraph (5), from health plans contracting with the department to provide services to beneficiaries pursuant to this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591), that qualify for federal drug rebates pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8) or that otherwise qualify for federal funds under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) pursuant to the Medicaid state plan or waivers.

(5) Health plan utilization data shall be limited to those drugs for which a health plan is authorizing a prescription drug described in subparagraph (A), and pursuant to the coverage policies established in subparagraph (B):

(A) A prescription drug for which the department reimburses the health plan through a separate capitated payment or other supplemental payment. Payment shall not be withheld for decisions determined pursuant to Section 1374.34 of the Health and Safety Code.

(B) The department shall develop coverage policies, consistent with the criteria set forth in paragraph (1) of subdivision (c) of Section 14105.39 and in consultation with clinical experts, Medi-Cal managed care plans, and other stakeholders, for prescription drugs described in subparagraph (A). These coverage policies shall apply to the entire Medi-Cal program, including fee-for-service and Medi-Cal managed care, through the Medi-Cal List of Contract Drugs or through provider bulletins, all plan letters, or similar instructions. Coverage policies developed pursuant to this section shall be revised on a semiannual basis or upon approval by the Food and Drug Administration of a new drug subject to subparagraph (A). For the purposes of this section, “coverage policies” include, but are not limited to, clinical guidelines and treatment and utilization policies.

(6) For prescription drugs not subject to the requirements of paragraph (5), utilization data used to determine the state rebate shall include all data from health plans, except for health maintenance organizations, as defined in Section 300e(a) of Title 42 of the United States Code, including those organizations that

1 contract pursuant to Section 1396b(m) of Title 42 of the United  
2 States Code.

3 (7) Notwithstanding Chapter 3.5 (commencing with Section  
4 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
5 the department, without taking any further regulatory action, shall  
6 implement, interpret, or make specific paragraph (5) by means of  
7 all-county letters, plan letters, plan or provider bulletins, or similar  
8 instructions, until the time regulations are adopted. The department  
9 shall adopt regulations by October 1, 2017, in accordance with the  
10 requirements of Chapter 3.5 (commencing with Section 11340) of  
11 Part 1 of Division 3 of Title 2 of the Government Code.  
12 Notwithstanding Section 10231.5 of the Government Code,  
13 beginning six months after the effective date of this section, the  
14 department shall provide a status report to the Legislature on a  
15 semiannual basis, in compliance with Section 9795 of the  
16 Government Code, until regulations have been adopted.

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

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

31 (e) (1) In order to fully implement subdivision (d), the  
32 department shall, to the extent necessary, negotiate or renegotiate  
33 contracts to ensure there are as many single-source drugs within  
34 each therapeutic category or subcategory as the department  
35 determines necessary to meet the health needs of the Medi-Cal  
36 population. The department may determine in selected therapeutic  
37 categories or subcategories that no single-source drugs are  
38 necessary because there are currently sufficient multiple-source  
39 drugs in the therapeutic category or subcategory on the list of  
40 contract drugs to meet the health needs of the Medi-Cal population.

1 However, in no event shall a beneficiary be denied continued use  
2 of a drug that is part of a prescribed therapy in effect as of  
3 September 2, 1992, until the prescribed therapy is no longer  
4 prescribed.

5 (2) In the development of decisions by the department on the  
6 required number of single-source drugs in a therapeutic category  
7 or subcategory, and the relative therapeutic merits of each drug in  
8 a therapeutic category or subcategory, the department shall consult  
9 with the Medi-Cal Contract Drug Advisory Committee. The  
10 committee members shall communicate their comments and  
11 recommendations to the department within 30 business days of a  
12 request for consultation, and shall disclose any associations with  
13 pharmaceutical manufacturers or any remuneration from  
14 pharmaceutical manufacturers.

15 (f) In order to achieve maximum cost savings, the Legislature  
16 declares that an expedited process for contracts under this section  
17 is necessary. Therefore, contracts entered into on a nonbid basis  
18 shall be exempt from Chapter 2 (commencing with Section 10290)  
19 of Part 2 of Division 2 of the Public Contract Code.

20 (g) In no event shall a beneficiary be denied continued use of  
21 a drug that is part of a prescribed therapy in effect as of September  
22 2, 1992, until the prescribed therapy is no longer prescribed.

23 (h) Contracts executed pursuant to this section shall be  
24 confidential and shall be exempt from disclosure under the  
25 California Public Records Act (Division 10 (commencing with  
26 Section 7920.000) of Title 1 of the Government Code).

27 (i) The department shall provide individual notice to Medi-Cal  
28 beneficiaries at least 60 calendar days prior to the effective date  
29 of the deletion or suspension of any drug from the list of contract  
30 drugs. The notice shall include a description of the beneficiary's  
31 right to a fair hearing and shall encourage the beneficiary to consult  
32 a physician to determine if an appropriate substitute medication  
33 is available from Medi-Cal.

34 (j) In carrying out the provisions of this section, the department  
35 may contract either directly, or through the fiscal intermediary,  
36 for pharmacy consultant staff necessary to initially accomplish the  
37 treatment authorization request reviews.

38 (k) (1) Manufacturers shall calculate and pay interest on late  
39 or unpaid rebates. The interest shall not apply to any prior period



1 adjustments of unit rebate amounts or department utilization  
2 adjustments.

3 (2) For state rebate payments, manufacturers shall calculate and  
4 pay interest on late or unpaid rebates for quarters that begin on or  
5 after the effective date of the act that added this subdivision.

6 (3) Following final resolution of any dispute pursuant to  
7 procedures established by the federal Centers for Medicare and  
8 Medicaid Services' Medicaid Drug Rebate Program Releases or  
9 regulations regarding the amount of a rebate, any underpayment  
10 by a manufacturer shall be paid with interest calculated pursuant  
11 to subdivisions (m) and (n), and any overpayment, together with  
12 interest at the rate calculated pursuant to subdivisions (m) and (n),  
13 shall be credited by the department against future rebates due.

14 (l) Interest pursuant to subdivision (k) shall begin accruing 38  
15 calendar days from the date of mailing of the invoice, including  
16 supporting utilization data sent to the manufacturer. Interest shall  
17 continue to accrue until the date of mailing of the manufacturer's  
18 payment.

19 (m) Except as specified in subdivision (n), interest rates and  
20 calculations pursuant to subdivision (k) for Medicaid rebates and  
21 state rebates shall be identical and shall be determined by the  
22 federal Centers for Medicare and Medicaid Services' Medicaid  
23 Drug Rebate Program Releases or regulations.

24 (n) If the date of mailing of a state rebate payment is 69 days  
25 or more from the date of mailing of the invoice, including  
26 supporting utilization data sent to the manufacturer, the interest  
27 rate and calculations pursuant to subdivision (k) shall be as  
28 specified in subdivision (m), however the interest rate shall be  
29 increased by 10 percentage points. This subdivision shall apply to  
30 payments for amounts invoiced for any quarters that begin on or  
31 after the effective date of the act that added this subdivision.

32 (o) If the rebate payment is not received, the department shall  
33 send overdue notices to the manufacturer at 38, 68, and 98 days  
34 after the date of mailing of the invoice, and supporting utilization  
35 data. If the department has not received a rebate payment, including  
36 interest, within 180 days of the date of mailing of the invoice,  
37 including supporting utilization data, the manufacturer's contract  
38 with the department shall be deemed to be in default and the  
39 contract may be terminated in accordance with the terms of the  
40 contract. For all other manufacturers, if the department has not

1 received a rebate payment, including interest, within 180 days of  
2 the date of mailing of the invoice, including supporting utilization  
3 data, all of the drug products of those manufacturers shall be made  
4 available only through prior authorization effective 270 days after  
5 the date of mailing of the invoice, including utilization data sent  
6 to manufacturers.

7 (p) If the manufacturer provides payment or evidence of  
8 payment to the department at least 40 days prior to the proposed  
9 date the drug is to be made available only through prior  
10 authorization pursuant to subdivision (o), the department shall  
11 terminate its actions to place the manufacturers' drug products on  
12 prior authorization.

13 (q) The department shall direct the state's fiscal intermediary  
14 to remove prior authorization requirements imposed pursuant to  
15 subdivision (o) and notify providers within 60 days after payment  
16 by the manufacturer of the rebate, including interest. If a contract  
17 was in place at the time the manufacturers' drugs were placed on  
18 prior authorization, removal of prior authorization requirements  
19 shall be contingent upon good faith negotiations and a signed  
20 contract with the department.

21 ~~(r) A beneficiary may obtain drugs Beginning January 1, 2026,~~  
22 ~~a beneficiary may obtain covered drugs placed on prior~~  
23 ~~authorization pursuant to subdivision (o) if the beneficiary qualifies~~  
24 ~~for continuing care status. To be eligible for continuing care status,~~  
25 ~~a beneficiary must be taking the drug when its manufacturer is~~  
26 ~~placed on prior authorization status. Additionally, the department~~  
27 ~~shall have received a claim for the drug with a date of service that~~  
28 ~~is within 100 days prior to the date the manufacturer was placed~~  
29 ~~on prior authorization. only if their pharmacy provider or~~  
30 ~~prescriber initiates a prior authorization request that is~~  
31 ~~subsequently approved by the department.~~

32 ~~(s) A beneficiary may remain eligible for continuing care status,~~  
33 ~~provided that a claim is submitted for the drug in question at least~~  
34 ~~every 100 days and the date of service of the claim is within 100~~  
35 ~~days of the date of service of the last claim submitted for the same~~  
36 ~~drug.~~

37 *(s) Beginning January 1, 2026, a beneficiary may continue to*  
38 *receive drugs previously prescribed but subject to prior*  
39 *authorization if their pharmacy provider or prescriber initiates a*

1 *prior authorization request that is subsequently approved by the*  
2 *department.*

3 (t) Drugs covered pursuant to Sections 14105.43 and 14133.2  
4 shall not be subject to prior authorization pursuant to subdivision  
5 (o), and any other drug may be exempted from prior authorization  
6 by the department if the director determines that an essential need  
7 exists for that drug, and there are no other drugs currently available  
8 without prior authorization that meet that need.

9 (u) It is the intent of the Legislature in enacting subdivisions  
10 (k) to (t), inclusive, that the department and manufacturers shall  
11 cooperate and make every effort to resolve rebate payment disputes  
12 within 90 days of notification by the manufacturer to the  
13 department of a dispute in the calculation of rebate payments.

14 *SEC. 94. Section 14105.38 of the Welfare and Institutions Code*  
15 *is repealed.*

16 ~~14105.38. (a) (1) In the event the department determines a~~  
17 ~~drug should be deleted from the list of contract drugs, the~~  
18 ~~department shall conduct a public hearing, as provided in this~~  
19 ~~section, to receive comment on the impact of removing the drug.~~

20 ~~(2) (A) The department shall provide written notice 30 days~~  
21 ~~prior to the hearing.~~

22 ~~(B) The department shall send the notice required by this~~  
23 ~~subdivision to the manufacturer of the drug proposed to be deleted~~  
24 ~~and to organizations representing Medi-Cal beneficiaries.~~

25 ~~(b) (1) The hearing panel shall consist of the Chief, Medi-Cal~~  
26 ~~Drug Discount Program, who shall serve as chair, and the Medi-Cal~~  
27 ~~Contract Drug Advisory Committee.~~

28 ~~(2) The hearing shall be recorded and transcribed, and the~~  
29 ~~transcript available for public review.~~

30 ~~(3) Subsequent to hearing all public comment, and within 30~~  
31 ~~days of the hearing, each panel member shall submit a~~  
32 ~~recommendation regarding deletion of the drug and the reason for~~  
33 ~~the recommendation to the director.~~

34 ~~(e) The director shall consider public comments provided at the~~  
35 ~~hearing and the recommendations of each panel member in~~  
36 ~~determining whether to delete the drug.~~

37 *SEC. 95. Section 14105.38 is added to the Welfare and*  
38 *Institutions Code, to read:*

39 *14105.38. When the department determines that a drug should*  
40 *be removed from the list of contract drugs, the department shall*

1 *provide individual notice to impacted beneficiaries, at least 60*  
2 *calendar days prior to the drug being removed from the list of*  
3 *contract drugs, that the drug is only obtainable through the prior*  
4 *authorization process. The notice shall include a description of*  
5 *the beneficiary's right to a fair hearing and shall encourage the*  
6 *beneficiary to consult a physician to determine if an appropriate*  
7 *substitute medication is available from Medi-Cal. The department*  
8 *shall also provide provider notice about the removal at least 60*  
9 *calendar days prior to the drug being removed from the list of*  
10 *contract drugs on the department's internet website.*

11 *SEC. 96. Section 14105.436 of the Welfare and Institutions*  
12 *Code is amended to read:*

13 14105.436. (a) Effective July 1, 2002, all pharmaceutical  
14 manufacturers shall provide to the department a state rebate, in  
15 addition to rebates pursuant to other provisions of state or federal  
16 law, for any drug products that have been added to the Medi-Cal  
17 list of contract drugs pursuant to Section 14105.43 or 14133.2 and  
18 reimbursed through the Medi-Cal outpatient fee-for-service drug  
19 program. The state rebate shall be negotiated as necessary between  
20 the department and the pharmaceutical manufacturer. The  
21 negotiations shall take into account offers such as rebates,  
22 discounts, disease management programs, and other cost savings  
23 offerings and shall be retroactive to July 1, 2002.

24 (b) The department may use existing administrative mechanisms  
25 for any drug for which the department does not obtain a rebate  
26 pursuant to subdivision (a). The department may only use those  
27 mechanisms in the event that, by February 1, 2003, the  
28 manufacturer refuses to provide the additional rebate. This  
29 subdivision shall become inoperative on January 1, 2010.

30 (c) For purposes of this section, "Medi-Cal utilization data"  
31 means the data used by the department to reimburse providers  
32 under all programs that qualify for federal drug rebates pursuant  
33 to Section 1927 of the federal Social Security Act (42 U.S.C. Sec.  
34 1396r-8) or that otherwise qualify for federal funds under Title  
35 XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et  
36 seq.) pursuant to the Medicaid state plan or waivers. Medi-Cal  
37 utilization data excludes data from covered entities identified in  
38 Section 256b(a)(4) of Title 42 of the United States Code in  
39 accordance with Sections 256b(a)(5)(A) and 1396r-8(a)(5)(C) of  
40 Title 42 of the United States Code, and those capitated plans that

1 include a prescription drug benefit in the capitated rate and that  
2 have negotiated contracts for rebates or discounts with  
3 manufacturers.

4 (d) Upon implementation of paragraphs (4) and (5) of  
5 subdivision (b) of Section 14105.33 for drugs pursuant to this  
6 section, subdivisions (a) and (c) shall become inoperative and  
7 “utilization data” shall be described pursuant to subdivision (b) of  
8 Section 14105.33. The department shall post on its ~~Internet Web~~  
9 ~~site~~ *internet website* a notice that it has implemented paragraphs  
10 (4) and (5) of subdivision (b) of Section 14105.33 for drugs  
11 pursuant to this section.

12 (e) Effective July 1, 2009, all pharmaceutical manufacturers  
13 shall provide to the department a state rebate, in addition to rebates  
14 pursuant to other provisions of state or federal law, equal to an  
15 amount not less than 10 percent of the average manufacturer price  
16 based on Medi-Cal utilization data for any drug products that have  
17 been added to the Medi-Cal list of contract drugs pursuant to  
18 Section 14105.43 or 14133.2.

19 (f) Pharmaceutical manufacturers shall, by January 1, 2010,  
20 enter into a supplemental rebate agreement for the rebate required  
21 in subdivision (e) for drug products added to the Medi-Cal list of  
22 contract drugs on or before December 31, 2009.

23 (g) Effective January 1, 2010, all pharmaceutical manufacturers  
24 who have not entered into a supplemental rebate agreement  
25 pursuant to subdivisions (e) and (f) shall provide to the department  
26 a state rebate, in addition to rebates pursuant to other provisions  
27 of state or federal law, equal to an amount not less than 20 percent  
28 of the average manufacturer price based on Medi-Cal utilization  
29 data for any drug products that have been added to the Medi-Cal  
30 list of contract drugs pursuant to Section 14105.43 or 14133.2  
31 prior to January 1, 2010. If the pharmaceutical manufacturer does  
32 not enter into a supplemental rebate agreement by March 1, 2010,  
33 the manufacturer’s drug product shall be made available only  
34 through an approved treatment authorization request pursuant to  
35 subdivision (i).

36 (h) For a drug product added to the Medi-Cal list of contract  
37 drugs pursuant to Section 14105.43 or 14133.2 on or after January  
38 1, 2010, a pharmaceutical manufacturer shall provide to the  
39 department a state rebate pursuant to subdivision (e). If the  
40 pharmaceutical manufacturer does not enter into a supplemental

1 rebate agreement within 60 days after the addition of the drug to  
2 the Medi-Cal list of contract drugs, the manufacturer shall provide  
3 to the department a state rebate equal to not less than 20 percent  
4 of the average—~~manufacturers~~ *manufacturer* price based on  
5 Medi-Cal utilization data for any drug products that have been  
6 added to the Medi-Cal list of contract drugs pursuant to Section  
7 14105.43 or 14133.2. If the pharmaceutical manufacturer does not  
8 enter into a supplemental rebate agreement within 120 days after  
9 the addition of the drug to the Medi-Cal list of contract drugs, the  
10 pharmaceutical manufacturer's drug product shall be made  
11 available only through an approved treatment authorization request  
12 pursuant to subdivision (i). For supplemental rebate agreements  
13 executed more than 120 days after the addition of the drug product  
14 to the Medi-Cal list of contract drugs, the state rebate shall equal  
15 an amount not less than 20 percent of the average—~~manufacturers~~  
16 *manufacturer* price based on Medi-Cal utilization data for any  
17 drug products that have been added to the Medi-Cal list of contract  
18 drugs pursuant to Section 14105.43 or 14133.2.

19 (i) Notwithstanding any other law, drug products added to the  
20 Medi-Cal list of contract drugs pursuant to Section 14105.43 or  
21 14133.2 of manufacturers who do not execute an agreement to pay  
22 additional rebates pursuant to this section shall be available only  
23 through an approved treatment authorization request.

24 ~~(j) For drug products added on or before December 31, 2009,~~  
25 ~~a beneficiary may obtain a drug product that requires a treatment~~  
26 ~~authorization request pursuant to subdivision (i) if the beneficiary~~  
27 ~~qualifies for continuing care status. To be eligible for continuing~~  
28 ~~care status, a beneficiary must be taking the drug product and the~~  
29 ~~department must have record of a reimbursed claim for the drug~~  
30 ~~product with a date of service that is within 100 days prior to the~~  
31 ~~date the drug product was placed on treatment authorization request~~  
32 ~~status. A beneficiary may remain eligible for continuing care status;~~  
33 ~~provided that a claim is submitted for the drug product in question~~  
34 ~~at least every 100 days and the date of service of the claim is within~~  
35 ~~100 days of the date of service of the last claim submitted for the~~  
36 ~~same drug product.~~

37 ~~(k)~~

38 (j) Changes made to the Medi-Cal list of contract drugs under  
39 this section shall be exempt from the requirements of the  
40 Administrative Procedure Act (Chapter 3.5 (commencing with

Section 11340), Chapter 4 (commencing with Section 11370), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and shall not be subject to the review and approval of the Office of Administrative Law.

*(k) This section shall remain in effect only until January 1, 2026, and as of that date is repealed.*

SEC. 97. Section 14105.436 is added to the Welfare and Institutions Code, to read:

14105.436. (a) Effective July 1, 2002, all pharmaceutical manufacturers shall provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal law, for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 and reimbursed through the Medi-Cal outpatient fee-for-service drug program. The state rebate shall be negotiated as necessary between the department and the pharmaceutical manufacturer. The negotiations shall take into account offers such as rebates, discounts, disease management programs, and other cost savings offerings and shall be retroactive to July 1, 2002.

(b) The department may use existing administrative mechanisms for any drug for which the department does not obtain a rebate pursuant to subdivision (a). The department may only use those mechanisms in the event that, by February 1, 2003, the manufacturer refuses to provide the additional rebate. This subdivision shall become inoperative on January 1, 2010.

(c) For purposes of this section, "Medi-Cal utilization data" means the data used by the department to reimburse providers under all programs that qualify for federal drug rebates pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8) or that otherwise qualify for federal funds under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) pursuant to the Medicaid state plan or waivers. Medi-Cal utilization data excludes data from covered entities identified in Section 256b(a)(4) of Title 42 of the United States Code in accordance with Sections 256b(a)(5)(A) and 1396r-8(a)(5)(C) of Title 42 of the United States Code, and those capitated plans that include a prescription drug benefit in the capitated rate and that have negotiated contracts for rebates or discounts with manufacturers.

1 (d) Upon implementation of paragraphs (4) and (5) of  
2 subdivision (b) of Section 14105.33 for drugs pursuant to this  
3 section, subdivisions (a) and (c) shall become inoperative and  
4 “utilization data” shall be described pursuant to subdivision (b)  
5 of Section 14105.33. The department shall post on its internet  
6 website a notice that it has implemented paragraphs (4) and (5)  
7 of subdivision (b) of Section 14105.33 for drugs pursuant to this  
8 section.

9 (e) Effective January 1, 2026, all pharmaceutical manufacturers  
10 renewing or entering new state rebate agreements shall provide  
11 to the department a state rebate, in addition to rebates pursuant  
12 to other provisions of state or federal law, in the following amounts  
13 based on Medi-Cal utilization data for any drug products that  
14 have been added to the Medi-Cal list of contract drugs pursuant  
15 to Section 14105.43 or 14133.2:

16 (1) An amount not less than 20 percent of the average  
17 manufacturer price if the federal rebate is less than 50 percent of  
18 the average manufacturer price.

19 (2) An amount not less than 15 percent of the average  
20 manufacturer price if the federal rebate is 50 percent or greater  
21 of the average manufacturer price.

22 (f) Pharmaceutical manufacturers shall, by January 1, 2010,  
23 enter into a supplemental rebate agreement for the rebate required  
24 in subdivision (e) for drug products added to the Medi-Cal list of  
25 contract drugs on or before December 31, 2009.

26 (g) Effective January 1, 2010, all pharmaceutical manufacturers  
27 who have not entered into a supplemental rebate agreement  
28 pursuant to subdivisions (e) and (f) shall provide to the department  
29 a state rebate, in addition to rebates pursuant to other provisions  
30 of state or federal law, equal to an amount not less than 20 percent  
31 of the average manufacturer price based on Medi-Cal utilization  
32 data for any drug products that have been added to the Medi-Cal  
33 list of contract drugs pursuant to Section 14105.43 or 14133.2  
34 prior to January 1, 2010. If the pharmaceutical manufacturer does  
35 not enter into a supplemental rebate agreement by March 1, 2010,  
36 the manufacturer’s drug product shall be made available only  
37 through an approved treatment authorization request pursuant to  
38 subdivision (i).

39 (h) For a drug product added to the Medi-Cal list of contract  
40 drugs pursuant to Section 14105.43 or 14133.2 on or after January



1 *1, 2026, a pharmaceutical manufacturer shall provide to the*  
2 *department a state rebate pursuant to subdivision (e). If the*  
3 *pharmaceutical manufacturer does not enter into a supplemental*  
4 *rebate agreement within 60 days after the addition of the drug to*  
5 *the Medi-Cal list of contract drugs, the manufacturer shall provide*  
6 *to the department a state rebate equal to not less than 25 percent*  
7 *of the average manufacturer price based on Medi-Cal utilization*  
8 *data for any drug products that have been added to the Medi-Cal*  
9 *list of contract drugs pursuant to Section 14105.43 or 14133.2. If*  
10 *the pharmaceutical manufacturer does not enter into a*  
11 *supplemental rebate agreement within 120 days after the addition*  
12 *of the drug to the Medi-Cal list of contract drugs, the*  
13 *pharmaceutical manufacturer's drug product shall be made*  
14 *available only through an approved treatment authorization*  
15 *request pursuant to subdivision (i). For supplemental rebate*  
16 *agreements executed more than 120 days after the addition of the*  
17 *drug product to the Medi-Cal list of contract drugs, the state rebate*  
18 *shall equal an amount not less than 25 percent of the average*  
19 *manufacturer price based on Medi-Cal utilization data for any*  
20 *drug products that have been added to the Medi-Cal list of contract*  
21 *drugs pursuant to Section 14105.43 or 14133.2.*

22 *(i) Notwithstanding any other law, drug products added to the*  
23 *Medi-Cal list of contract drugs pursuant to Section 14105.43 or*  
24 *14133.2 of manufacturers who do not execute an agreement to*  
25 *pay additional rebates pursuant to this section shall be available*  
26 *only through an approved treatment authorization request.*

27 *(j) Changes made to the Medi-Cal list of contract drugs under*  
28 *this section shall be exempt from the requirements of the*  
29 *Administrative Procedure Act (Chapter 3.5 (commencing with*  
30 *Section 11340), Chapter 4 (commencing with Section 11370), and*  
31 *Chapter 5 (commencing with Section 11500) of Part 1 of Division*  
32 *3 of Title 2 of the Government Code), and shall not be subject to*  
33 *the review and approval of the Office of Administrative Law.*

34 *(k) This section shall become operative on January 1, 2026.*

35 *SEC. 98. Section 14107.115 is added to the Welfare and*  
36 *Institutions Code, immediately following Section 14107.11, to*  
37 *read:*

38 *14107.115. (a) The Medi-Cal Anti-Fraud Special Deposit*  
39 *Fund is hereby created in the State Treasury.*

1 (b) All outstanding Medi-Cal payments intercepted by the State  
2 Controller's Office at the direction of the department, as a result  
3 of a payment suspension imposed on a Medi-Cal provider pursuant  
4 to Section 14107.11, shall be deposited into the Medi-Cal  
5 Anti-Fraud Special Deposit Fund.

6 (c) All moneys deposited into the Medi-Cal Anti-Fraud Special  
7 Deposit Fund shall be continuously appropriated and allocated  
8 in accordance with subdivision (d), but shall remain in the fund  
9 until the department lifts the suspension pursuant to subdivision  
10 (c) of Section 14107.11.

11 (d) Upon the lifting of a suspension, the department may return  
12 the intercepted Medi-Cal payments to the Medi-Cal provider or  
13 may offset the payments against any liabilities or restitution owed  
14 by the Medi-Cal provider to the department, including, but not  
15 limited to, any liabilities described in paragraph (1) of subdivision  
16 (a) of Section 14107.11.

17 SEC. 99. Section 14126.024 of the Welfare and Institutions  
18 Code is amended to read:

19 14126.024. (a) For managed care rating periods that begin  
20 between January 1, 2023, and December 31, ~~2026~~, 2025, inclusive,  
21 the department, in consultation with representatives from the  
22 long-term care industry, organized labor, consumer advocates, and  
23 Medi-Cal managed care plans, shall establish and implement the  
24 Workforce and Quality Incentive Program under which a network  
25 provider furnishing skilled nursing facility services to a Medi-Cal  
26 managed care enrollee may earn performance-based directed  
27 payments from the Medi-Cal managed care plan they contract with  
28 in accordance with this section.

29 (b) Subject to appropriation by the Legislature in the annual  
30 Budget Act, the department shall do all of the following:

31 (1) Set the amount of performance-based directed payments to  
32 target an aggregate amount of two hundred eighty million dollars  
33 (\$280,000,000) for the 2023 calendar year.

34 (2) For the 2024 through ~~2026~~ 2025 calendar years, the  
35 department shall set the amount of the performance-based directed  
36 payments to target the previous calendar year's target plus the  
37 annual increase specified by clause (ii) of subparagraph (A) of  
38 paragraphs (18), (19), and (20) of subdivision (c) of Section  
39 14126.033.

1 (3) No sooner than December 31, 2023, the department shall  
2 make a one-time increase to the performance-based directed  
3 payment target amount by the amounts described in subdivision  
4 (f) of Section 14126.032. This one-time increase shall not be  
5 factored into the amount calculated for a subsequent calendar year  
6 pursuant to paragraph (2).

7 (c) The department, in consultation with stakeholders listed in  
8 subdivision (a), shall establish the methodology or methodologies,  
9 parameters, and eligibility criteria for the directed payments  
10 pursuant to this section. This shall include, but is not limited to,  
11 the milestones and metrics that network providers of skilled nursing  
12 facility services must meet in order to receive a directed payment  
13 from a Medi-Cal managed care plan pursuant to this section, with  
14 at least two of these milestones and metrics tied to workforce  
15 measures. Subject to subdivision (j), the department may implement  
16 the directed payment described in this section using one or more  
17 of the models authorized at Section 438.6(c)(1)(i)-(iii), inclusive,  
18 of Title 42 of the Code of Federal Regulations.

19 (d) A freestanding pediatric subacute care facility, as defined  
20 in Section 51215.8 of Title 22 of the California Code of  
21 Regulations, shall be exempt from the directed payments described  
22 in this section.

23 (e) Notwithstanding any other law, special program services  
24 for the mentally disordered that are entitled to receive the  
25 supplemental payment under Section 51511.1 of Title 22 of the  
26 California Code of Regulations shall be exempt from the directed  
27 payments described in this section.

28 (f) Directed payments made pursuant to this section shall be in  
29 addition to any other payments made by the a Medi-Cal managed  
30 care plan to applicable network providers of skilled nursing facility  
31 services and shall not supplant amounts that would otherwise be  
32 payable by a Medi-Cal managed care plan to a provider of skilled  
33 nursing facility services, including those payments made in  
34 accordance with paragraph (2) of subdivision (b) of Section  
35 14184.201.

36 (g) For managed care rating periods during which this section  
37 is implemented, capitation rates paid by the department to a  
38 Medi-Cal managed care plan shall be actuarially sound and shall  
39 account for the directed payments described in this section.

1 (h) The department may require Medi-Cal managed care plans  
2 and network providers of skilled nursing facility services to submit  
3 information the department deems necessary to implement this  
4 section, at the times and in the form and manner specified by the  
5 department.

6 (i) Payments pursuant to this section shall be made in accordance  
7 with the requirements for directed payment arrangements described  
8 in Section 438.6(c) of Title 42 of the Code of Federal Regulations  
9 and any associated federal guidance.

10 (j) In implementing this section, the department may contract,  
11 as necessary, with California's Medicare Quality Improvement  
12 Organization, or other entities deemed qualified by the department,  
13 not associated with a skilled nursing facility, to assist with  
14 development, collection, analysis, and reporting of the performance  
15 data pursuant to this section. The department may enter into  
16 exclusive or nonexclusive contracts, or amend existing contracts,  
17 on a bid or negotiated basis for purposes of implementing this  
18 subdivision. Contracts entered into or amended pursuant to this  
19 subdivision shall be exempt from Chapter 6 (commencing with  
20 Section 14825) of Part 5.5 of Division 3 of Title 2 of the  
21 Government Code, Part 2 (commencing with Section 10100) of  
22 Division 2 of the Public Contract Code, and State Administrative  
23 Manual, and the State Contracting Manual, and shall be exempt  
24 from the review or approval of any division of the State Department  
25 of General Services.

26 (k) This section shall be implemented only to the extent that  
27 any necessary federal approvals are obtained and federal financial  
28 participation is available and is not otherwise jeopardized.

29 (l) For purposes of this section, the following definitions apply:

30 (1) "Medi-Cal managed care plan" has the same meaning as set  
31 forth in subdivision (j) of Section 14184.101.

32 (2) "Network provider" has the same meaning as set forth in  
33 Section 438.2 of Title 42 of the Code of Federal Regulations.

34 (3) "Skilled nursing facility" has the same meaning as set forth  
35 in subdivision (c) of Section 1250 of the Health and Safety Code,  
36 excluding a nursing facility that is a distinct part of a facility that  
37 is licensed as a general acute care hospital as described in  
38 subdivision (a) of Section 1250 of the Health and Safety Code.

39 (m) (1) *This section shall become inoperative on January 1,*  
40 *2026. The department may conduct all necessary closeout activities*

1 *applicable to any managed care rating period before January 1,*  
2 *2026.*

3 *(2) This section shall be repealed on January 1, 2027, or on the*  
4 *date that the director certifies to the Secretary of State that all*  
5 *necessary closeout activities have been completed pursuant to*  
6 *paragraph (1), whichever is later.*

7 *SEC. 100. Section 14126.033 of the Welfare and Institutions*  
8 *Code is amended to read:*

9 14126.033. (a) The Legislature finds and declares all of the  
10 following:

11 (1) Costs within the Medi-Cal program continue to grow due  
12 to the rising cost of providing health care throughout the state and  
13 also due to increases in enrollment, which are more pronounced  
14 during difficult economic times.

15 (2) In order to minimize the need for drastically cutting  
16 enrollment standards or benefits during times of economic crisis,  
17 it is crucial to find areas within the program where reimbursement  
18 levels are higher than required under the standard provided in  
19 Section 1902(a)(30)(A) of the federal Social Security Act and can  
20 be reduced in accordance with federal law.

21 (3) The Medi-Cal program delivers its services and benefits to  
22 Medi-Cal beneficiaries through a wide variety of health care  
23 providers, under multiple delivery systems, including managed  
24 care, other contract models, or fee-for-service arrangements.

25 (4) The setting of rates within the Medi-Cal program is complex  
26 and is subject to close supervision by the United States Department  
27 of Health and Human Services.

28 (5) As the single state agency for the Medicaid program in  
29 California, the State Department of Health Care Services has  
30 unique expertise that can inform decisions that set or adjust  
31 reimbursement methodologies and levels consistent with the  
32 requirements of federal law.

33 (b) Therefore, it is the intent of the Legislature for the  
34 department to analyze and identify where reimbursement levels  
35 can be reduced consistent with the standard provided in Section  
36 1902(a)(30)(A) of the federal Social Security Act and federal and  
37 state law and policies, including any exemptions contained in the  
38 act that added this section, provided that the reductions in  
39 reimbursement shall not exceed 10 percent on an aggregate basis  
40 for all providers, services, and products.

(c) Subject to an appropriation by the Legislature in the annual Budget Act, this article shall be funded as follows:

(1) General Fund moneys appropriated for purposes of this article pursuant to Section 6 of the act adding this section shall be used for increasing rates, except as provided in Section 14126.031, for freestanding skilled nursing facilities, and shall be consistent with the approved methodology required to be submitted to the federal Centers for Medicare and Medicaid Services pursuant to Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code.

(2) (A) Notwithstanding Section 14126.023, for the 2005–06 rate year, the maximum annual increase in the weighted average Medi-Cal rate required for purposes of this article shall not exceed 8 percent of the weighted average Medi-Cal reimbursement rate for the 2004–05 rate year as adjusted for the change in the cost to the facility to comply with the nursing facility quality assurance fee for the 2005–06 rate year, as required under subdivision (b) of Section 1324.21 of the Health and Safety Code, plus the total projected Medi-Cal cost to the facility of complying with new state or federal mandates.

(B) Beginning with the 2006–07 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not exceed 5 percent of the weighted average Medi-Cal reimbursement rate for the prior fiscal year, as adjusted for the projected cost of complying with new state or federal mandates.

(C) Beginning with the 2007–08 rate year and continuing through the 2008–09 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not exceed 5.5 percent of the weighted average Medi-Cal reimbursement rate for the prior fiscal year, as adjusted for the projected cost of complying with new state or federal mandates.

(D) For the 2009–10 rate year, the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not be increased with respect to the weighted average Medi-Cal reimbursement rate for the 2008–09 rate year, as adjusted for the projected cost of complying with new state or federal mandates.

(3) (A) For the 2010–11 rate year, if the increase in the federal medical assistance percentage (FMAP) pursuant to the federal

American Recovery and Reinvestment Act of 2009 (ARRA) (Public Law 111-5) is extended for the entire 2010–11 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate for the purposes of this article shall not exceed 3.93 percent, or 3.14 percent, if the increase in the FMAP pursuant to ARRA is not extended for that period of time, plus the projected cost of complying with new state or federal mandates. If the increase in the FMAP pursuant to ARRA is extended at a different rate, or for a different time period, the rate adjustment for facilities shall be adjusted accordingly.

(B) The weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) shall be adjusted by the department for the following reasons:

(i) If the federal Centers for Medicare and Medicaid Services does not approve exemption changes to the facilities subject to the quality assurance fee.

(ii) If the federal Centers for Medicare and Medicaid Services does not approve any proposed modification to the methodology for calculation of the quality assurance fee.

(iii) To ensure that the state does not incur any additional General Fund expenses to pay for the 2010–11 weighted average Medi-Cal reimbursement rate increase.

(C) If the maximum annual increase in the weighted average Medi-Cal rate is reduced pursuant to subparagraph (B), the department shall recalculate and publish the final maximum annual increase in the weighted average Medi-Cal reimbursement rate.

(4) (A) Subject to the following provisions, for the 2011–12 rate year, the increase in the Medi-Cal reimbursement rate for the purpose of this article, for each skilled nursing facility as defined in subdivision (c) of Section 1250 of the Health and Safety Code, shall not exceed 2.4 percent of the rate on file that was applicable on May 31, 2011, plus the projected cost of complying with new state or federal mandates. The percentage increase shall be applied equally to each rate on file as of May 31, 2011.

(B) The weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) shall be adjusted by the department for the following reasons:

(i) If the federal Centers for Medicare and Medicaid Services does not approve exemption changes to the facilities subject to the quality assurance fee.

1 (ii) If the federal Centers for Medicare and Medicaid Services  
2 does not approve any proposed modification to the methodology  
3 for calculation of the quality assurance fee.

4 (iii) To ensure that the state does not incur any additional  
5 General Fund expenses to pay for the 2011–12 weighted average  
6 Medi-Cal reimbursement rate increase.

7 (C) The department may recalculate and publish the weighted  
8 average Medi-Cal reimbursement rate increase for the 2011–12  
9 rate year if the difference in the projected quality assurance fee  
10 collections from the 2011–12 rate year, compared to the projected  
11 quality assurance fee collections for the 2010–11 rate year, would  
12 result in any additional General Fund expense to pay for the  
13 2011–12 rate year weighted average reimbursement rate increase.

14 (5) To the extent that rates are projected to exceed the adjusted  
15 limits calculated pursuant to subparagraphs (A) to (D), inclusive,  
16 of paragraph (2) and, as applicable, paragraphs (3) and (4), the  
17 department shall adjust each skilled nursing facility's projected  
18 rate for the applicable rate year by an equal percentage.

19 (6) (A) (i) Notwithstanding any other law, and except as  
20 provided in subparagraph (B), payments resulting from the  
21 application of paragraphs (3) and (4), the provisions of paragraph  
22 (5), and all other applicable adjustments and limits as required by  
23 this section, shall be reduced by 10 percent for dates of service on  
24 and after June 1, 2011, through July 31, 2012. This one-time  
25 reduction shall be evenly distributed across all facilities to ensure  
26 long-term stability of nursing homes serving the Medi-Cal  
27 population.

28 (ii) Notwithstanding any other law, the director may adjust the  
29 percentage reductions specified in clause (i), as long as the resulting  
30 reductions, in the aggregate, total no more than 10 percent.

31 (iii) The adjustments authorized under this subparagraph shall  
32 be implemented only if the director determines that the payments  
33 resulting from the adjustments comply with paragraph (7).

34 (B) Payments to facilities owned or operated by the state shall  
35 be exempt from the payment reduction required by this paragraph.

36 (7) (A) Notwithstanding this section, the payment reductions  
37 and adjustments required by paragraph (6) shall be implemented  
38 only if the director determines that the payments that result from  
39 the application of paragraph (6) shall comply with applicable



1 federal Medicaid requirements and that federal financial  
2 participation will be available.

3 (B) In determining whether federal financial participation is  
4 available, the director shall determine whether the payments  
5 comply with applicable federal Medicaid requirements, including  
6 those set forth in Section 1396a(a)(30)(A) of Title 42 of the United  
7 States Code.

8 (C) To the extent that the director determines that the payments  
9 do not comply with applicable federal Medicaid requirements or  
10 that federal financial participation is unavailable with respect to  
11 any payment that is reduced pursuant to this section, the director  
12 retains the discretion to not implement the particular payment  
13 reduction or adjustment and may adjust the payment as necessary  
14 to comply with federal Medicaid requirements.

15 (8) For managed care health plans that contract with the  
16 department pursuant to this chapter and Chapter 8 (commencing  
17 with Section 14200), except for contracts with the Senior Care  
18 Action Network and AIDS Healthcare Foundation, and to the  
19 extent that these services are provided through any of those  
20 contracts, payments shall be reduced by the actuarial equivalent  
21 amount of the reduced provider reimbursements specified in  
22 paragraph (6) pursuant to contract amendments or change orders  
23 effective on July 1, 2011, or thereafter.

24 (9) (A) For the 2012–13 rate year, all of the following shall  
25 apply:

26 (i) The department shall determine the amounts of reduced  
27 payments for each skilled nursing facility, as defined in subdivision  
28 (c) of Section 1250 of the Health and Safety Code, resulting from  
29 the 10-percent reduction imposed pursuant to clause (i) of  
30 subparagraph (A) of paragraph (6) for the period beginning on  
31 June 1, 2011, through July 31, 2012.

32 (ii) For claims adjudicated through October 1, 2012, each skilled  
33 nursing facility as defined in subdivision (c) of Section 1250 of  
34 the Health and Safety Code that is reimbursed under the Medi-Cal  
35 fee-for-service program, shall receive the total payments calculated  
36 by the department in clause (i), not later than December 31, 2012.

37 (iii) For managed care plans that contract with the department  
38 pursuant to this chapter or Chapter 8 (commencing with Section  
39 14200), except contracts with Senior Care Action Network and  
40 AIDS Healthcare Foundation, and to the extent that skilled nursing

1 services are provided through any of those contracts, payments  
2 shall be adjusted by the actuarial equivalent amount of the  
3 reimbursements calculated in clause (i) pursuant to contract  
4 amendments or change orders effective on July 1, 2012, or  
5 thereafter.

6 (B) Notwithstanding subparagraph (A), beginning on August  
7 1, 2012, through July 31, 2013, the department shall pay the facility  
8 specific Medi-Cal reimbursement rate that was on file and  
9 applicable to the specific skilled nursing facility on August 1, 2011,  
10 prior to and excluding any rate reduction implemented pursuant  
11 to clause (i) of subparagraph (A) of paragraph (6) for the period  
12 beginning on June 1, 2011, to July 31, 2012, inclusive, and adjusted  
13 for the projected costs of complying with new state or federal  
14 mandates. These rates are deemed to be sufficient to meet operating  
15 expenses.

16 (C) The weighted average Medi-Cal reimbursement rate increase  
17 specified in subparagraph (B) shall be adjusted by the department  
18 if the federal Centers for Medicare and Medicaid Services does  
19 not approve any proposed modification to the methodology for  
20 calculation of the skilled nursing quality assurance fee pursuant  
21 to Article 7.6 (commencing with Section 1324.20) of Chapter 2  
22 of Division 2 of the Health and Safety Code.

23 (D) Notwithstanding any other law, beginning on January 1,  
24 2013, Article 7.6 (commencing with Section 1324.20) of Chapter  
25 2 of Division 2 of the Health and Safety Code, which imposes a  
26 skilled nursing facility quality assurance fee, shall be unenforceable  
27 against any skilled nursing facility unless each skilled nursing  
28 facility is paid the rate provided for in subparagraphs (A) and (B).  
29 Any amount collected during the 2012–13 rate year by the  
30 department pursuant to Article 7.6 (commencing with Section  
31 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code  
32 shall be refunded to each facility not later than February 1, 2013.

33 (E) The provisions of this paragraph shall also be included as  
34 part of a state plan amendment implementing the 2011–12 and  
35 2012–13 Medi-Cal reimbursement rates authorized under this  
36 article.

37 (10) (A) Subject to the following provisions, for the 2013–14  
38 and 2014–15 rate years, the annual increase in the weighted average  
39 Medi-Cal reimbursement rate for the purpose of this article, for  
40 each skilled nursing facility as defined in subdivision (c) of Section

1 1250 of the Health and Safety Code, shall be 3 percent for each  
2 rate year, respectively, plus the projected cost of complying with  
3 new state or federal mandates.

4 (B) (i) For the 2013–14 rate year, if there is a rate increase in  
5 the weighted average Medi-Cal reimbursement rate, the department  
6 shall set aside 1 percent of the increase in the weighted average  
7 Medi-Cal reimbursement rate, from which the department shall  
8 transfer the nonfederal portion into the Skilled Nursing Facility  
9 Quality and Accountability Special Fund, to be used for the  
10 supplemental rate pool.

11 (ii) For the 2014–15 rate year, if there is a rate increase in the  
12 weighted average Medi-Cal reimbursement rate, the department  
13 shall set aside at least one-third of the weighted average Medi-Cal  
14 reimbursement rate increase, up to a maximum of 1 percent, from  
15 which the department shall transfer the nonfederal portion of this  
16 amount into the Skilled Nursing Facility Quality and Accountability  
17 Special Fund.

18 (C) The weighted average Medi-Cal reimbursement rate increase  
19 specified in subparagraph (A) shall be adjusted by the department  
20 for the following reasons:

21 (i) If the federal Centers for Medicare and Medicaid Services  
22 does not approve exemption changes to the facilities subject to the  
23 quality assurance fee.

24 (ii) If the federal Centers for Medicare and Medicaid Services  
25 does not approve any proposed modification to the methodology  
26 for calculation of the quality assurance fee.

27 (11) The director shall seek any necessary federal approvals for  
28 the implementation of this section. This section shall not be  
29 implemented until federal approval is obtained. When federal  
30 approval is obtained, the payments resulting from the application  
31 of paragraph (6) shall be implemented retroactively to June 1,  
32 2011, or on any other date or dates as may be applicable.

33 (12) (A) (i) Beginning with the 2015–16 rate year, and through  
34 the conclusion of the rate period from August 1, 2020, to December  
35 31, 2020, inclusive, the annual increase in the weighted average  
36 Medi-Cal reimbursement rate, required for the purposes of this  
37 article, shall be 3.62 percent, plus the projected cost of complying  
38 with new state or federal mandates.

39 (ii) The reimbursement rates established for the rate period of  
40 August 1, 2020, to December 31, 2020, inclusive, shall be no less

1 than the amounts that would have been established under the  
2 reimbursement methodology pursuant to this section for the  
3 2019–20 rate year, subject to subparagraph (B).

4 (B) The weighted average Medi-Cal reimbursement rate increase  
5 specified in subparagraph (A) may be adjusted by the department  
6 as it deems necessary to obtain any applicable federal approval  
7 and shall not exceed the applicable federal upper payment limit.

8 (C) (i) Only to the extent any necessary federal approvals are  
9 obtained for this subparagraph, the department may condition a  
10 facility's receipt of the annual increase in the weighted average  
11 Medi-Cal reimbursement rate pursuant to this paragraph for the  
12 rate period of August 1, 2020, to December 31, 2020, inclusive,  
13 upon that facility's good faith efforts to comply with any  
14 requirements related to the COVID-19 Public Health Emergency  
15 described in All Facility Letters issued by the State Department  
16 of Public Health. The department shall consult with the State  
17 Department of Public Health in determining a facility's compliance  
18 for purposes of this subparagraph.

19 (ii) For purposes of this subparagraph, "COVID-19 Public  
20 Health Emergency" means the federal Public Health Emergency  
21 declaration made pursuant to Section 247d of Title 42 of the United  
22 States Code on January 30, 2020, entitled "Determination that a  
23 Public Health Emergency Exists Nationwide as the Result of the  
24 2019 Novel Coronavirus," and any renewal of that declaration.

25 (13) (A) For the 2021 calendar year, the annual aggregate  
26 increase in the weighted average Medi-Cal reimbursement rate  
27 that is required for the purposes of this article shall be 3.5 percent  
28 plus the projected cost of complying with new state or federal  
29 mandates.

30 (B) The aggregate, weighted average Medi-Cal reimbursement  
31 rate increase specified in subparagraph (A) may be adjusted by  
32 the department as it deems necessary to obtain any applicable  
33 federal approval, and shall not exceed the applicable federal upper  
34 payment limit.

35 (C) (i) Only to the extent any necessary federal approvals are  
36 obtained for this subparagraph, the department may condition a  
37 facility's receipt of the annual increase in the weighted average  
38 Medi-Cal reimbursement rate pursuant to this paragraph for the  
39 2021 calendar year upon that facility's good faith efforts to comply  
40 with any requirements related to the COVID-19 Public Health

1 Emergency described in All Facility Letters issued by the State  
2 Department of Public Health. The department shall consult with  
3 the State Department of Public Health in determining a facility's  
4 compliance for purposes of this subparagraph.

5 (ii) For purposes of this subparagraph, "COVID-19 Public  
6 Health Emergency" shall mean the federal Public Health  
7 Emergency declaration made pursuant to Section 247d of Title 42  
8 of the United States Code on January 30, 2020, entitled  
9 "Determination that a Public Health Emergency Exists Nationwide  
10 as the Result of the 2019 Novel Coronavirus," and any renewal of  
11 that declaration.

12 (14) (A) For the 2022 calendar year, the annual aggregate  
13 increase in the weighted average Medi-Cal reimbursement rate  
14 that is required for the purposes of this article shall be 2.4 percent  
15 plus the projected cost of complying with new state or federal  
16 mandates.

17 (B) The aggregate, weighted average Medi-Cal reimbursement  
18 rate increase specified in subparagraph (A) may be adjusted by  
19 the department as it deems necessary to obtain any applicable  
20 federal approval, and shall not exceed the applicable federal upper  
21 payment limit.

22 (C) (i) Only to the extent any necessary federal approvals are  
23 obtained for this subparagraph, the department may condition a  
24 facility's receipt of the annual increase in the weighted average  
25 Medi-Cal reimbursement rate pursuant to this paragraph for the  
26 2022 calendar year upon that facility's good faith efforts to comply  
27 with any requirements related to the COVID-19 Public Health  
28 Emergency described in All Facility Letters issued by the State  
29 Department of Public Health. The department shall consult with  
30 the State Department of Public Health in determining a facility's  
31 compliance for purposes of this subparagraph.

32 (ii) For purposes of this subparagraph, "COVID-19 Public  
33 Health Emergency" shall mean the federal Public Health  
34 Emergency declaration made pursuant to Section 247d of Title 42  
35 of the United States Code on January 30, 2020, entitled  
36 "Determination that a Public Health Emergency Exists Nationwide  
37 as the Result of the 2019 Novel Coronavirus," and any renewal of  
38 such declaration.

39 (15) (A) For the 2022 and 2023 calendar years, inclusive, the  
40 reimbursement rate established for a skilled nursing facility

1 pursuant to this section shall continue to be increased by the  
2 temporary Medicaid payments associated with the COVID-19  
3 Public Health Emergency in effect for that facility on July 31,  
4 2020, or an amount equivalent to those temporary increased  
5 Medicaid payments should the COVID-19 Public Health  
6 Emergency expire prior to December 31, 2023.

7 (B) For the 2023 calendar year, 85 percent of the amount of  
8 temporary Medicaid payments associated with the COVID-19  
9 Public Health Emergency, or amounts equivalent to those  
10 temporary increased Medicaid payments should the COVID-19  
11 Public Health Emergency expire prior to December 31, 2023,  
12 received by a facility shall be spent on additional labor costs,  
13 including, but not limited to, increased wages or benefits, shift  
14 incentive payments, staff retention bonuses, pay differential for  
15 workers employed by more than one facility, and overtime  
16 payments to nonmanagerial workers. Such increased wages or  
17 benefits, shift incentive payments, staff retention bonuses, pay  
18 differential for workers employed by more than one facility,  
19 overtime payments to nonmanagerial workers or other additional  
20 labor costs shall qualify for this purpose if they were either of the  
21 following:

22 (i) Implemented prior to January 1, 2023, and continued during  
23 the 2023 calendar year.

24 (ii) Implemented on or after January 1, 2023.

25 (C) If the COVID-19 Public Health Emergency is renewed past  
26 December 31, 2023, the temporary Medicaid payments for skilled  
27 nursing facilities associated with the COVID-19 Public Health  
28 Emergency, as authorized in the Medi-Cal State Plan, shall cease  
29 on December 31, 2023, subject to subdivision (h).

30 (D) For purposes of this subparagraph, “COVID-19 Public  
31 Health Emergency” shall mean the federal Public Health  
32 Emergency declaration made pursuant to Section 247d of Title 42  
33 of the United States Code on January 30, 2020, entitled  
34 “Determination that a Public Health Emergency Exists Nationwide  
35 as the Result of the 2019 Novel Coronavirus,” and any renewal of  
36 such declaration.

37 (16) (A) For the 2023 calendar year, the maximum annual  
38 aggregate increase in the weighted average Medi-Cal  
39 reimbursement rate required for the purposes of this article shall

1 be the following, plus the projected cost of complying with new  
2 state or federal mandates:

3 (i) For the labor cost category as specified in paragraph (1) of  
4 subdivision (a) of Section 14126.023, the annual aggregate increase  
5 shall be 5 percent.

6 (ii) For each of the indirect care nonlabor cost, administrative  
7 cost, capital cost, and direct passthrough categories as specified  
8 in paragraphs (2) to (5), inclusive, of subdivision (a) of Section  
9 14126.023, the annual aggregate increase shall be 2 percent.

10 (B) The aggregate, weighted average Medi-Cal reimbursement  
11 rate increases specified in subparagraph (A) may be adjusted by  
12 the department as it deems necessary to obtain any applicable  
13 federal approval, and shall not exceed the applicable federal upper  
14 payment limit.

15 (17) (A) Beginning in the 2024 calendar year, the department  
16 shall establish a workforce adjustment, as further described in  
17 paragraphs (18), (19) and (20), for a skilled nursing facility that  
18 meets workforce standards, as determined by the department in  
19 consultation with representatives from the long-term care industry,  
20 organized labor, and consumer advocates.

21 (B) The workforce standards may include, but need not be  
22 limited to, criteria such as maintaining a collective bargaining  
23 agreement or comparable, legally binding, written commitment  
24 with its direct and indirect care staff, payment of a prevailing wage  
25 for its direct and indirect care staff, payment of an average salary  
26 above minimum wage, participation in a statewide, multiemployer  
27 joint labor-management committee of skilled nursing facility  
28 employers and workers, or other factors, as determined by the  
29 department in consultation with the stakeholders listed above. The  
30 criteria may vary for facilities based on facility demographics or  
31 other factors such as facility size, location or other factor, as  
32 determined by the department in consultation with the stakeholders  
33 listed above.

34 (18) (A) For the 2024 calendar year, the maximum annual  
35 increase in the Medi-Cal reimbursement rate required for the  
36 purposes of this article shall be the following, plus the projected  
37 cost of complying with new state or federal mandates:

38 (i) For the labor cost category specified in paragraph (1) of  
39 subdivision (a) of Section 14126.023, the annual increase shall be  
40 determined as follows:

1 (I) If the department determines the facility meets the criteria  
2 described in paragraph (17), the annual increase for the facility  
3 shall not have a percentage growth limit applied to the facility's  
4 audited costs within the labor cost category trended to the 2024  
5 calendar year.

6 (II) If the facility does not meet the criteria described in  
7 paragraph (17), an annual increase of up to 5 percent shall be  
8 applied to the labor cost category rate included in the facility's  
9 2023 calendar year rate based on audited cost reports trended to  
10 the calendar 2024 year.

11 (ii) For the 2024 calendar year, for each of the indirect care  
12 nonlabor cost, administrative cost, capital cost, and direct  
13 passthrough categories as specified in paragraphs (2) through (5),  
14 inclusive, of subdivision (a) of Section 14126.023, the annual  
15 aggregate increase in the weighted average Medi-Cal  
16 reimbursement rate for those categories shall be 1 percent.  
17 Additionally, for the 2024 calendar year, an amount equivalent to  
18 the annual aggregate increase of 1 percent calculated pursuant to  
19 this clause, as determined by the department, shall be used to  
20 supplement the funds available for payments made pursuant to  
21 subdivision (a) of Section 14126.024.

22 (B) The Medi-Cal reimbursement rate specified in subparagraph  
23 (A) may be adjusted by the department as it deems necessary to  
24 obtain any applicable federal approval, and shall not exceed the  
25 applicable federal upper payment limit.

26 (19) (A) For the 2025 calendar year, the Medi-Cal  
27 reimbursement rate required for the purposes of this article shall  
28 be the following, plus the projected cost of complying with new  
29 state or federal mandates:

30 (i) The rate for the labor cost category as specified in paragraph  
31 (1) of subdivision (a) of Section 14126.023 shall be determined  
32 as follows:

33 (I) If the department determines the facility meets the criteria  
34 described in paragraph (17), the facility's rate for the labor cost  
35 category shall equal the facility's audited costs for the labor cost  
36 category that would have been used for calculating the facility's  
37 2024 calendar year rate had the facility met the criteria described  
38 in paragraph (17) in the 2024 calendar year increased by up to 5  
39 percent for the 2025 calendar year based on audited cost reports  
40 trended to the 2025 calendar year.



1 (II) If the facility does not meet the criteria described in  
2 paragraph (17), the facility's rate for the labor cost category shall  
3 equal the labor cost category rate included in the facility's 2023  
4 calendar year rate increased by up to 5 percent for each of the 2024  
5 and 2025 calendar years based on audited cost reports trended to  
6 the applicable calendar year.

7 (ii) For the 2025 calendar year, for each of the indirect care  
8 nonlabor cost, administrative cost, capital cost, and direct  
9 passthrough categories as specified in paragraphs (2) through (5),  
10 inclusive, of subdivision (a) of Section 14126.023, the facility's  
11 rate for those categories shall equal the reimbursement included  
12 in the facility's 2024 calendar year rate for those categories  
13 increased by an aggregate of 1 percent in the weighted average  
14 Medi-Cal reimbursement rate for those categories. Additionally,  
15 for the 2025 calendar year, an amount equivalent to the annual  
16 aggregate increase of 1 percent calculated pursuant to this clause,  
17 as determined by the department, shall be used to supplement the  
18 funds available for payments made pursuant to subdivision (a) of  
19 Section 14126.024.

20 (B) The Medi-Cal reimbursement rate specified in subparagraph  
21 (A) may be adjusted by the department as it deems necessary to  
22 obtain any applicable federal approval, and shall not exceed the  
23 applicable federal upper payment limit.

24 (20) (A) For the 2026 calendar year, the Medi-Cal  
25 reimbursement rate required for the purposes of this article shall  
26 be the following, plus the projected cost of complying with new  
27 state or federal mandates:

28 (i) The rate for labor cost category as specified in paragraph (1)  
29 of subdivision (a) of Section 14126.023 shall be determined as  
30 follows:

31 (I) If the department determines the facility meets the criteria  
32 described in paragraph (17), the facility's rate for the labor cost  
33 category shall equal the facility's audited costs within the labor  
34 cost category that would have been used for calculating the  
35 facility's 2024 calendar year rate had the facility met the criteria  
36 in the 2024 calendar year increased by up to 5 percent for each of  
37 the 2025 and 2026 calendar years based on audited cost reports  
38 trended to the applicable calendar year.

39 (II) If the facility does not meet the criteria described in  
40 paragraph (17), the facility's rate for the labor cost category shall

1 equal the labor cost category rate included in the facility's 2023  
2 calendar year rate increased by up to 5 percent for each of the  
3 2024, 2025, and 2026 calendar years based on audited cost reports  
4 trended to the applicable calendar year.

5 (ii) For the 2026 calendar year, for each of the indirect care  
6 nonlabor cost, administrative cost, capital cost, and direct  
7 passthrough categories as specified in paragraphs (2) through (5),  
8 inclusive, of subdivision (a) of Section 14126.023, the facility's  
9 rate for those categories shall equal the reimbursement included  
10 in the facility's 2025 calendar year rate for those categories  
11 increased by an aggregate of 1 percent in the weighted average  
12 Medi-Cal reimbursement rate for those categories. ~~Additionally,~~  
13 ~~for the 2026 calendar year, an amount equivalent to the annual~~  
14 ~~aggregate increase of 1 percent calculated pursuant to this clause,~~  
15 ~~as determined by the department, shall be used to supplement the~~  
16 ~~funds available for payments made pursuant to subdivision (a) of~~  
17 ~~Section 14126.024.~~

18 (B) The Medi-Cal reimbursement rate specified in subparagraph  
19 (A) may be adjusted by the department as it deems necessary to  
20 obtain any applicable federal approval, and shall not exceed the  
21 applicable federal upper payment limit.

22 (d) (1) The department may modify any methodology or other  
23 provision specified in this article to the extent it deems necessary  
24 to meet the requirements of federal law or regulations, to obtain  
25 or maintain federal approval, or to ensure federal financial  
26 participation is available or is not otherwise jeopardized, provided  
27 the modification does not violate the spirit, purposes, and intent  
28 of this article.

29 (2) If the department determines that a modification is necessary  
30 pursuant to paragraph (1), the department shall consult with  
31 affected providers and stakeholders to the extent practicable.

32 (3) In the event of a modification made pursuant to this  
33 subdivision, the department shall notify affected providers, the  
34 Joint Legislative Budget Committee, and the relevant policy and  
35 fiscal committees of the Legislature within 10 business days of  
36 the modification.

37 (e) The rate methodology shall cease to be implemented after  
38 December 31, 2026.

39 (f) (1) It is the intent of the Legislature that the implementation  
40 of this article result in individual access to appropriate long-term

1 care services, quality resident care, decent wages and benefits for  
2 nursing home workers, a stable workforce, provider compliance  
3 with all applicable state and federal requirements, and  
4 administrative efficiency.

5 (2) Not later than December 1, 2006, the California State  
6 Auditor's Office shall conduct an accountability evaluation of the  
7 department's progress toward implementing a facility-specific  
8 reimbursement system, including a review of data to ensure that  
9 the new system is appropriately reimbursing facilities within  
10 specified cost categories and a review of the fiscal impact of the  
11 new system on the General Fund.

12 (3) Not later than January 1, 2007, to the extent information is  
13 available for the three years immediately preceding the  
14 implementation of this article, the department shall provide baseline  
15 information in a report to the Legislature on all of the following:

16 (A) The number and percent of freestanding skilled nursing  
17 facilities that complied with minimum staffing requirements.

18 (B) The staffing levels before the implementation of this article.

19 (C) The staffing retention rates before the implementation of  
20 this article.

21 (D) The numbers and percentage of freestanding skilled nursing  
22 facilities with findings of immediate jeopardy, substandard quality  
23 of care, or actual harm, as determined by the certification survey  
24 of each freestanding skilled nursing facility conducted before the  
25 implementation of this article.

26 (E) The number of freestanding skilled nursing facilities that  
27 received state citations and the number and class of citations issued  
28 during calendar year 2004.

29 (F) The average wage and benefits for employees before the  
30 implementation of this article.

31 (4) Not later than January 1, 2009, the department shall provide  
32 a report to the Legislature that does both of the following:

33 (A) Compares the information required in paragraph (2) to that  
34 same information two years after the implementation of this article.

35 (B) Reports on the extent to which residents who had expressed  
36 a preference to return to the community, as provided in Section  
37 1418.81 of the Health and Safety Code, were able to return to the  
38 community.

39 (5) The department may contract for the reports required under  
40 this subdivision.

(g) (1) Beginning with the 2021 calendar year, and continuing each calendar year thereafter, a skilled nursing facility shall demonstrate its compliance with the following Medi-Cal funded requirements upon request by, and in the form and manner specified by, the department:

(A) Direct care service hours per patient day requirements pursuant to Section 1276.65 of the Health and Safety Code and as enforced pursuant to Section 14126.022.

(B) Applicable minimum wage laws.

(C) Wage passthrough requirements pursuant to Section 14110.6 of this code and Section 1338 of the Health and Safety Code.

(2) If the department determines that a skilled nursing facility has not demonstrated satisfactory compliance pursuant to subparagraphs (B) and (C) of paragraph (1), in consultation with State Department of Public Health or other applicable state agencies and departments if necessary, the department shall assess a monthly penalty up to fifty thousand dollars (\$50,000) for that skilled nursing facility, except as provided in paragraph (3), until the facility demonstrates its compliance to the department. The penalty amounts assessed pursuant to this subdivision in any one calendar year shall be limited to 4 percent of the total Medi-Cal revenue received by the skilled nursing facility in the previous calendar year. If the department determines a facility is out of compliance for multiple calendar years, additional penalty amounts may be assessed for each respective calendar year.

(3) The department may waive a portion or all of the penalties assessed pursuant to this subdivision with respect to a petitioning skilled nursing facility in the event the department determines, in its sole discretion, that the facility has demonstrated that imposing the full penalty has a high likelihood of creating an undue financial hardship for the facility or creates a significant financial difficulty in providing services to Medi-Cal beneficiaries.

(h) In implementing this article, the department shall seek any federal approvals it deems necessary. This article 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. 101. Section 14132 of the Welfare and Institutions Code is amended to read:*

1 14132. The following is the schedule of benefits under this  
2 chapter:

3 (a) Outpatient services are covered as follows:

4 Physician, hospital or clinic outpatient, surgical center,  
5 respiratory care, optometric, chiropractic, psychology, podiatric,  
6 occupational therapy, physical therapy, speech therapy, audiology,  
7 acupuncture to the extent federal matching funds are provided for  
8 acupuncture, and services of persons rendering treatment by prayer  
9 or healing by spiritual means in the practice of any church or  
10 religious denomination insofar as these can be encompassed by  
11 federal participation under an approved plan, subject to utilization  
12 controls.

13 (b) (1) Inpatient hospital services, including, but not limited  
14 to, physician and podiatric services, physical therapy, and  
15 occupational therapy, are covered subject to utilization controls.

16 (2) For a Medi-Cal fee-for-service beneficiary, emergency  
17 services and care that are necessary for the treatment of an  
18 emergency medical condition and medical care directly related to  
19 the emergency medical condition. This paragraph does not change  
20 the obligation of Medi-Cal managed care plans to provide  
21 emergency services and care. For the purposes of this paragraph,  
22 “emergency services and care” and “emergency medical condition”  
23 have the same meanings as those terms are defined in Section  
24 1317.1 of the Health and Safety Code.

25 (c) Nursing facility services, subacute care services, and services  
26 provided by any category of intermediate care facility for the  
27 developmentally disabled, including podiatry, physician, nurse  
28 practitioner services, and prescribed drugs, as described in  
29 subdivision (d), are covered subject to utilization controls.  
30 Respiratory care, physical therapy, occupational therapy, speech  
31 therapy, and audiology services for patients in nursing facilities  
32 and any category of intermediate care facility for persons with  
33 developmental disabilities are covered subject to utilization  
34 controls.

35 (d) (1) Purchase of prescribed drugs is covered subject to the  
36 Medi-Cal List of Contract Drugs and utilization controls.

37 (2) Purchase of drugs used to treat erectile dysfunction or any  
38 off-label uses of those drugs are covered only to the extent that  
39 federal financial participation is available.

(3) (A) To the extent required by federal law, the purchase of outpatient prescribed drugs, for which the prescription is executed by a prescriber in written, nonelectronic form on or after April 1, 2008, is covered only when executed on a tamper resistant prescription form. The implementation of this paragraph shall conform to the guidance issued by the federal Centers for Medicare and Medicaid Services, but shall not conflict with state statutes on the characteristics of tamper resistant prescriptions for controlled substances, including Section 11162.1 of the Health and Safety Code. The department shall provide providers and beneficiaries with as much flexibility in implementing these rules as allowed by the federal government. The department shall notify and consult with appropriate stakeholders in implementing, interpreting, or making specific this paragraph.

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instructions without taking regulatory action.

(4) (A) (i) For the purposes of this paragraph, nonlegend has the same meaning as defined in subdivision (a) of Section 14105.45.

(ii) Nonlegend acetaminophen-containing products, including children's acetaminophen-containing products, selected by the department are covered benefits.

(iii) Nonlegend cough and cold products selected by the department are covered benefits.

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instruction without taking regulatory action.

(e) Outpatient dialysis services and home hemodialysis services, including physician services, medical supplies, drugs, and equipment required for dialysis, are covered, subject to utilization controls.

(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetist services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and x-ray

1 services are covered, subject to utilization controls. This  
2 subdivision does not require prior authorization for anesthesiologist  
3 services provided as part of an outpatient medical procedure or  
4 for portable x-ray services in a nursing facility or any category of  
5 intermediate care facility for the developmentally disabled.

6 (g) Blood and blood derivatives are covered.

7 (h) (1) Emergency and essential diagnostic and restorative  
8 dental services, except for orthodontic, fixed bridgework, and  
9 partial dentures that are not necessary for balance of a complete  
10 artificial denture, are covered, subject to utilization controls. The  
11 utilization controls shall allow emergency and essential diagnostic  
12 and restorative dental services and prostheses that are necessary  
13 to prevent a significant disability or to replace previously furnished  
14 prostheses that are lost or destroyed due to circumstances beyond  
15 the beneficiary's control. Notwithstanding the foregoing, the  
16 director may by regulation provide for certain fixed artificial  
17 dentures necessary for obtaining employment or for medical  
18 conditions that preclude the use of removable dental prostheses,  
19 and for orthodontic services in cleft palate deformities administered  
20 by the department's California Children's Services program.

21 (2) For persons 21 years of age or older, the services specified  
22 in paragraph (1) shall be provided subject to the following  
23 conditions:

24 (A) Periodontal treatment is not a benefit.

25 (B) Endodontic therapy is not a benefit except for vital  
26 pulpotomy.

27 (C) Laboratory processed crowns are not a benefit.

28 (D) Removable prosthetics shall be a benefit only for patients  
29 as a requirement for employment.

30 (E) The director may, by regulation, provide for the provision  
31 of fixed artificial dentures that are necessary for medical conditions  
32 that preclude the use of removable dental prostheses.

33 (F) Notwithstanding the conditions specified in subparagraphs  
34 (A) to (E), inclusive, the department may approve services for  
35 persons with special medical disorders subject to utilization review.

36 (3) Paragraph (2) shall become inoperative on July 1, 1995.

37 (i) Medical transportation is covered, subject to utilization  
38 controls.

39 (j) Home health care services are covered, subject to utilization  
40 controls.

1 (k) (1) Prosthetic and orthotic devices and eyeglasses are  
2 covered, subject to utilization controls. Utilization controls shall  
3 allow replacement of prosthetic and orthotic devices and eyeglasses  
4 necessary because of loss or destruction due to circumstances  
5 beyond the beneficiary's control. Frame styles for eyeglasses  
6 replaced pursuant to this subdivision shall not change more than  
7 once every two years, unless the department so directs.

8 (2) Orthopedic and conventional shoes are covered when  
9 provided by a prosthetic and orthotic supplier on the prescription  
10 of a physician and when at least one of the shoes will be attached  
11 to a prosthesis or brace, subject to utilization controls. Modification  
12 of stock conventional or orthopedic shoes when medically indicated  
13 is covered, subject to utilization controls. If there is a clearly  
14 established medical need that cannot be satisfied by the  
15 modification of stock conventional or orthopedic shoes,  
16 custom-made orthopedic shoes are covered, subject to utilization  
17 controls.

18 (3) Therapeutic shoes and inserts are covered when provided  
19 to a beneficiary with a diagnosis of diabetes, subject to utilization  
20 controls, to the extent that federal financial participation is  
21 available.

22 (l) Hearing aids are covered, subject to utilization controls.  
23 Utilization controls shall allow replacement of hearing aids  
24 necessary because of loss or destruction due to circumstances  
25 beyond the beneficiary's control.

26 (m) Durable medical equipment and medical supplies are  
27 covered, subject to utilization controls. The utilization controls  
28 shall allow the replacement of durable medical equipment and  
29 medical supplies when necessary because of loss or destruction  
30 due to circumstances beyond the beneficiary's control. The  
31 utilization controls shall allow authorization of durable medical  
32 equipment needed to assist a disabled beneficiary in caring for a  
33 child for whom the disabled beneficiary is a parent, stepparent,  
34 foster parent, or legal guardian, subject to the availability of federal  
35 financial participation. The department shall adopt emergency  
36 regulations to define and establish criteria for assistive durable  
37 medical equipment in accordance with the rulemaking provisions  
38 of the Administrative Procedure Act (Chapter 3.5 (commencing  
39 with Section 11340) of Part 1 of Division 3 of Title 2 of the  
40 Government Code).



1 (n) Family planning services are covered, subject to utilization  
2 controls. However, for Medi-Cal managed care plans, utilization  
3 controls shall be subject to Section 1367.25 of the Health and  
4 Safety Code.

5 (o) Inpatient intensive rehabilitation hospital services, including  
6 respiratory rehabilitation services, in a general acute care hospital  
7 are covered, subject to utilization controls, when either of the  
8 following criteria are met:

9 (1) A patient with a permanent disability or severe impairment  
10 requires an inpatient intensive rehabilitation hospital program as  
11 described in Section 14064 to develop function beyond the limited  
12 amount that would occur in the normal course of recovery.

13 (2) A patient with a chronic or progressive disease requires an  
14 inpatient intensive rehabilitation hospital program as described in  
15 Section 14064 to maintain the patient's present functional level as  
16 long as possible.

17 (p) (1) Adult day health care is covered in accordance with  
18 Chapter 8.7 (commencing with Section 14520).

19 (2) Commencing 30 days after the effective date of the act that  
20 added this paragraph, and notwithstanding the number of days  
21 previously approved through a treatment authorization request,  
22 adult day health care is covered for a maximum of three days per  
23 week.

24 (3) As provided in accordance with paragraph (4), adult day  
25 health care is covered for a maximum of five days per week.

26 (4) As of the date that the director makes the declaration  
27 described in subdivision (g) of Section 14525.1, paragraph (2)  
28 shall become inoperative and paragraph (3) shall become operative.

29 (q) (1) Application of fluoride, or other appropriate fluoride  
30 treatment as defined by the department, and other prophylaxis  
31 treatment for children 17 years of age and under are covered.

32 (2) All dental hygiene services provided by a registered dental  
33 hygienist, registered dental hygienist in extended functions, and  
34 registered dental hygienist in alternative practice licensed pursuant  
35 to Sections 1753, 1917, 1918, and 1922 of the Business and  
36 Professions Code may be covered as long as they are within the  
37 scope of Denti-Cal benefits and they are necessary services  
38 provided by a registered dental hygienist, registered dental  
39 hygienist in extended functions, or registered dental hygienist in  
40 alternative practice.

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under former Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of former Section 1482 of the article.

(2) A provider enrolled under this subdivision shall satisfy all applicable statutory and regulatory requirements for becoming a Medi-Cal provider.

(3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.

(s) (1) In-home medical care services are covered when medically appropriate and subject to utilization controls, for a beneficiary who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be provided to a patient placed in a shared or congregate living arrangement, if a home setting is not medically appropriate or available to the beneficiary.

(2) As used in this subdivision, “in-home medical care service” includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

(3) As used in this subdivision, in-home medical care services include, but are not limited to:

(A) Level-of-care and cost-of-care evaluations.

(B) Expenses, directly attributable to home care activities, for materials.

(C) Physician fees for home visits.

(D) Expenses directly attributable to home care activities for shelter and modification to shelter.

(E) Expenses directly attributable to additional costs of special diets, including tube feeding.

(F) Medically related personal services.

(G) Home nursing education.

(H) Emergency maintenance repair.

1 (I) Home health agency personnel benefits that permit coverage  
2 of care during periods when regular personnel are on vacation or  
3 using sick leave.

4 (J) All services needed to maintain antiseptic conditions at stoma  
5 or shunt sites on the body.

6 (K) Emergency and nonemergency medical transportation.

7 (L) Medical supplies.

8 (M) Medical equipment, including, but not limited to, scales,  
9 gurneys, and equipment racks suitable for paralyzed patients.

10 (N) Utility use directly attributable to the requirements of home  
11 care activities that are in addition to normal utility use.

12 (O) Special drugs and medications.

13 (P) Home health agency supervision of visiting staff that is  
14 medically necessary, but not included in the home health agency  
15 rate.

16 (Q) Therapy services.

17 (R) Household appliances and household utensil costs directly  
18 attributable to home care activities.

19 (S) Modification of medical equipment for home use.

20 (T) Training and orientation for use of life-support systems,  
21 including, but not limited to, support of respiratory functions.

22 (U) Respiratory care practitioner services as defined in Sections  
23 3702 and 3703 of the Business and Professions Code, subject to  
24 prescription by a physician and surgeon.

25 (4) A beneficiary receiving in-home medical care services is  
26 entitled to the full range of services within the Medi-Cal scope of  
27 benefits as defined by this section, subject to medical necessity  
28 and applicable utilization control. Services provided pursuant to  
29 this subdivision, which are not otherwise included in the Medi-Cal  
30 schedule of benefits, shall be available only to the extent that  
31 federal financial participation for these services is available in  
32 accordance with a home- and community-based services waiver.

33 (t) Home- and community-based services approved by the  
34 United States Department of Health and Human Services are  
35 covered to the extent that federal financial participation is available  
36 for those services under the state plan or waivers granted in  
37 accordance with Section 1315 or 1396n of Title 42 of the United  
38 States Code. The director may seek waivers for any or all home-  
39 and community-based services approvable under Section 1315 or  
40 1396n of Title 42 of the United States Code. Coverage for those

1 services shall be limited by the terms, conditions, and duration of  
2 the federal waivers.

3 (u) Comprehensive perinatal services, as provided through an  
4 agreement with a health care provider designated in Section  
5 14134.5 and meeting the standards developed by the department  
6 pursuant to Section 14134.5, subject to utilization controls.

7 The department shall seek any federal waivers necessary to  
8 implement the provisions of this subdivision. The provisions for  
9 which appropriate federal waivers cannot be obtained shall not be  
10 implemented. Provisions for which waivers are obtained or for  
11 which waivers are not required shall be implemented  
12 notwithstanding any inability to obtain federal waivers for the  
13 other provisions. No provision of this subdivision shall be  
14 implemented unless matching funds from Subchapter XIX  
15 (commencing with Section 1396) of Chapter 7 of Title 42 of the  
16 United States Code are available.

17 (v) Early and periodic screening, diagnosis, and treatment for  
18 any individual under 21 years of age is covered, consistent with  
19 the requirements of Subchapter XIX (commencing with Section  
20 1396) of Chapter 7 of Title 42 of the United States Code.

21 ~~(w) Hospice service that is Medicare-certified hospice service~~  
22 ~~is covered.~~ (1) *Hospice services are covered, in accordance with*  
23 *Medicare requirements, and are subject to utilization controls.*  
24 Coverage shall be available only to the extent that no additional  
25 net program costs are incurred.

26 (2) *This subdivision shall be implemented only to the extent that*  
27 *federal financial participation is available and not otherwise*  
28 *jeopardized, and any necessary federal approvals have been*  
29 *obtained.*

30 (3) *Notwithstanding any other law, the department, without*  
31 *taking any further regulatory action, may implement, interpret, or*  
32 *make specific this subdivision by means of all-county letters, plan*  
33 *letters, plan or provider bulletins, or similar instructions.*

34 (x) When a claim for treatment provided to a beneficiary  
35 includes both services that are authorized and reimbursable under  
36 this chapter and services that are not reimbursable under this  
37 chapter, that portion of the claim for the treatment and services  
38 authorized and reimbursable under this chapter shall be payable.

39 (y) Home- and community-based services approved by the  
40 United States Department of Health and Human Services for a

beneficiary with a diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex, who requires intermediate care or a higher level of care.

Services provided pursuant to a waiver obtained from the Secretary of the United States Department of Health and Human Services pursuant to this subdivision, and that are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with the waiver, and subject to the terms, conditions, and duration of the waiver. These services shall be provided to a beneficiary in accordance with the client's needs as identified in the plan of care, and subject to medical necessity and applicable utilization control.

The director may, under this section, contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to an eligible beneficiary. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract Code.

(z) Respiratory care when provided in organized health care systems as defined in Section 3701 of the Business and Professions Code, and as an in-home medical service as outlined in subdivision (s).

(aa) (1) There is hereby established in the department a program to provide comprehensive clinical family planning services to any person who has a family income at or below 200 percent of the federal poverty level, as revised annually, and who is eligible to receive these services pursuant to the waiver identified in paragraph (2). This program shall be known as the Family Planning, Access, Care, and Treatment (Family PACT) Program.

(2) The department shall seek a waiver in accordance with Section 1315 of Title 42 of the United States Code, or a state plan amendment adopted in accordance with Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code, which was added to Section 1396a of Title 42 of the United States Code by Section 2303(a)(2) of the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), for a program to provide comprehensive clinical family planning services as described in paragraph (8). Under the waiver, the program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the

1 terms, conditions, and duration of the waiver. Under the state plan  
2 amendment, which shall replace the waiver and shall be known as  
3 the Family PACT successor state plan amendment, the program  
4 shall be operated only in accordance with this subdivision and the  
5 statutes and regulations in paragraph (4). The state shall use the  
6 standards and processes imposed by the state on January 1, 2007,  
7 including the application of an eligibility discount factor to the  
8 extent required by the federal Centers for Medicare and Medicaid  
9 Services, for purposes of determining eligibility as permitted under  
10 Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States  
11 Code. To the extent that federal financial participation is available,  
12 the program shall continue to conduct education, outreach,  
13 enrollment, service delivery, and evaluation services as specified  
14 under the waiver. The services shall be provided under the program  
15 only if the waiver and, when applicable, the successor state plan  
16 amendment are approved by the federal Centers for Medicare and  
17 Medicaid Services and only to the extent that federal financial  
18 participation is available for the services. This section does not  
19 prohibit the department from seeking the Family PACT successor  
20 state plan amendment during the operation of the waiver.

21 (3) Solely for the purposes of the waiver or Family PACT  
22 successor state plan amendment and notwithstanding any other  
23 law, the collection and use of an individual's social security number  
24 shall be necessary only to the extent required by federal law.

25 (4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005,  
26 and 24013, and any regulations adopted under these statutes shall  
27 apply to the program provided for under this subdivision. No other  
28 law under the Medi-Cal program or the State-Only Family Planning  
29 Program shall apply to the program provided for under this  
30 subdivision.

31 (5) Notwithstanding Chapter 3.5 (commencing with Section  
32 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
33 the department may implement, without taking regulatory action,  
34 the provisions of the waiver after its approval by the federal Centers  
35 for Medicare and Medicaid Services and the provisions of this  
36 section by means of an all-county letter or similar instruction to  
37 providers. Thereafter, the department shall adopt regulations to  
38 implement this section and the approved waiver in accordance  
39 with the requirements of Chapter 3.5 (commencing with Section  
40 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

1 Beginning six months after the effective date of the act adding this  
2 subdivision, the department shall provide a status report to the  
3 Legislature on a semiannual basis until regulations have been  
4 adopted.

5 (6) If the Department of Finance determines that the program  
6 operated under the authority of the waiver described in paragraph  
7 (2) or the Family PACT successor state plan amendment is no  
8 longer cost effective, this subdivision shall become inoperative on  
9 the first day of the first month following the issuance of a 30-day  
10 notification of that determination in writing by the Department of  
11 Finance to the chairperson in each house that considers  
12 appropriations, the chairpersons of the committees, and the  
13 appropriate subcommittees in each house that considers the State  
14 Budget, and the Chairperson of the Joint Legislative Budget  
15 Committee.

16 (7) If this subdivision ceases to be operative, all persons who  
17 have received or are eligible to receive comprehensive clinical  
18 family planning services pursuant to the waiver described in  
19 paragraph (2) shall receive family planning services under the  
20 Medi-Cal program pursuant to subdivision (n) if they are otherwise  
21 eligible for Medi-Cal with no spend down of excess income, or  
22 shall receive comprehensive clinical family planning services under  
23 the program established in Division 24 (commencing with Section  
24 24000) either if they are eligible for Medi-Cal with a spend down  
25 of excess income or if they are otherwise eligible under Section  
26 24003.

27 (8) For purposes of this subdivision, “comprehensive clinical  
28 family planning services” means the process of establishing  
29 objectives for the number and spacing of children, and selecting  
30 the means by which those objectives may be achieved. These  
31 means include a broad range of acceptable and effective methods  
32 and services to limit or enhance fertility, including contraceptive  
33 methods, federal Food and Drug Administration-approved  
34 contraceptive drugs, devices, and supplies, natural family planning,  
35 abstinence methods, and basic, limited fertility management.  
36 Comprehensive clinical family planning services include, but are  
37 not limited to, preconception counseling, maternal and fetal health  
38 counseling, general reproductive health care, including diagnosis  
39 and treatment of infections and conditions, including cancer, that  
40 threaten reproductive capability, medical family planning treatment

1 and procedures, including supplies and followup, and  
2 informational, counseling, and educational services.  
3 Comprehensive clinical family planning services shall not include  
4 abortion, pregnancy testing solely for the purposes of referral for  
5 abortion or services ancillary to abortions, or pregnancy care that  
6 is not incident to the diagnosis of pregnancy. Comprehensive  
7 clinical family planning services shall be subject to utilization  
8 control and include all of the following:

9 (A) Family planning related services and male and female  
10 sterilization. Family planning services for men and women shall  
11 include emergency services and services for complications directly  
12 related to the contraceptive method, federal Food and Drug  
13 Administration-approved contraceptive drugs, devices, and  
14 supplies, and followup, consultation, and referral services, as  
15 indicated, which may require treatment authorization requests.

16 (B) All United States Department of Agriculture, federal Food  
17 and Drug Administration-approved contraceptive drugs, devices,  
18 and supplies that are in keeping with current standards of practice  
19 and from which the individual may choose.

20 (C) Culturally and linguistically appropriate health education  
21 and counseling services, including informed consent, that include  
22 all of the following:

- 23 (i) Psychosocial and medical aspects of contraception.
- 24 (ii) Sexuality.
- 25 (iii) Fertility.
- 26 (iv) Pregnancy.
- 27 (v) Parenthood.
- 28 (vi) Infertility.
- 29 (vii) Reproductive health care.
- 30 (viii) Preconception and nutrition counseling.
- 31 (ix) Prevention and treatment of sexually transmitted infection.
- 32 (x) Use of contraceptive methods, federal Food and Drug  
33 Administration-approved contraceptive drugs, devices, and  
34 supplies.
- 35 (xi) Possible contraceptive consequences and followup.
- 36 (xii) Interpersonal communication and negotiation of  
37 relationships to assist individuals and couples in effective  
38 contraceptive method use and planning families.

39 (D) A comprehensive health history, updated at the next periodic  
40 visit (between 11 and 24 months after initial examination) that



1 includes a complete obstetrical history, gynecological history,  
2 contraceptive history, personal medical history, health risk factors,  
3 and family health history, including genetic or hereditary  
4 conditions.

5 (E) A complete physical examination on initial and subsequent  
6 periodic visits.

7 (F) Services, drugs, devices, and supplies deemed by the federal  
8 Centers for Medicare and Medicaid Services to be appropriate for  
9 inclusion in the program.

10 (G) (i) Home test kits for sexually transmitted diseases,  
11 including any laboratory costs of processing the kit, that are  
12 deemed medically necessary or appropriate and ordered directly  
13 by an enrolled Medi-Cal or Family PACT clinician or furnished  
14 through a standing order for patient use based on clinical guidelines  
15 and individual patient health needs.

16 (ii) For purposes of this subparagraph, “home test kit” means a  
17 product used for a test recommended by the federal Centers for  
18 Disease Control and Prevention guidelines or the United States  
19 Preventive Services Task Force that has been CLIA-waived,  
20 FDA-cleared or -approved, or developed by a laboratory in  
21 accordance with established regulations and quality standards, to  
22 allow individuals to self-collect specimens for STDs, including  
23 HIV, remotely at a location outside of a clinical setting.

24 (iii) Reimbursement under this subparagraph shall be contingent  
25 upon the addition of codes specific to home test kits in the Current  
26 Procedural Terminology or Healthcare Common Procedure Coding  
27 System to comply with Health Insurance Portability and  
28 Accountability Act requirements. The home test kit shall be sent  
29 by the enrolled Family PACT provider to a Medi-Cal-enrolled  
30 laboratory with fee based on Medicare Clinical Diagnostic  
31 Laboratory Tests Payment System Final Rule.

32 (9) In order to maximize the availability of federal financial  
33 participation under this subdivision, the director shall have the  
34 discretion to implement the Family PACT successor state plan  
35 amendment retroactively to July 1, 2010.

36 (ab) (1) Purchase of prescribed enteral nutrition products is  
37 covered, subject to the Medi-Cal list of enteral nutrition products  
38 and utilization controls.

39 (2) Purchase of enteral nutrition products is limited to those  
40 products to be administered through a feeding tube, including, but

1 not limited to, a gastric, nasogastric, or jejunostomy tube. A  
2 beneficiary under the Early and Periodic Screening, Diagnostic,  
3 and Treatment Program shall be exempt from this paragraph.

4 (3) Notwithstanding paragraph (2), the department may deem  
5 an enteral nutrition product, not administered through a feeding  
6 tube, including, but not limited to, a gastric, nasogastric, or  
7 jejunostomy tube, a benefit for patients with diagnoses, including,  
8 but not limited to, malabsorption and inborn errors of metabolism,  
9 if the product has been shown to be neither investigational nor  
10 experimental when used as part of a therapeutic regimen to prevent  
11 serious disability or death.

12 (4) Notwithstanding Chapter 3.5 (commencing with Section  
13 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
14 the department may implement the amendments to this subdivision  
15 made by the act that added this paragraph by means of all-county  
16 letters, provider bulletins, or similar instructions, without taking  
17 regulatory action.

18 (5) The amendments made to this subdivision by the act that  
19 added this paragraph shall be implemented June 1, 2011, or on the  
20 first day of the first calendar month following 60 days after the  
21 date the department secures all necessary federal approvals to  
22 implement this section, whichever is later.

23 (ac) Diabetic testing supplies are covered when provided by a  
24 pharmacy, subject to utilization controls.

25 (ad) (1) Nonmedical transportation is covered, subject to  
26 utilization controls and permissible time and distance standards,  
27 for a beneficiary to obtain covered Medi-Cal services.

28 (2) (A) (i) Nonmedical transportation includes, at a minimum,  
29 round trip transportation for a beneficiary to obtain covered  
30 Medi-Cal services by passenger car, taxicab, or any other form of  
31 public or private conveyance, and mileage reimbursement when  
32 conveyance is in a private vehicle arranged by the beneficiary and  
33 not through a transportation broker, bus passes, taxi vouchers, or  
34 train tickets.

35 (ii) Nonmedical transportation does not include the  
36 transportation of a sick, injured, invalid, convalescent, infirm, or  
37 otherwise incapacitated beneficiary by ambulance, litter van, or  
38 wheelchair van licensed, operated, and equipped in accordance  
39 with state and local statutes, ordinances, or regulations.

1 (B) Nonmedical transportation shall be provided for a  
2 beneficiary who can attest in a manner to be specified by the  
3 department that other currently available resources have been  
4 reasonably exhausted. For a beneficiary enrolled in a managed  
5 care plan, nonmedical transportation shall be provided by the  
6 beneficiary's managed care plan. For a Medi-Cal fee-for-service  
7 beneficiary, the department shall provide nonmedical transportation  
8 when those services are not available to the beneficiary under  
9 Sections 14132.44 and 14132.47.

10 (3) Nonmedical transportation shall be provided in a form and  
11 manner that is accessible, in terms of physical and geographic  
12 accessibility, for the beneficiary and consistent with applicable  
13 state and federal disability rights laws.

14 (4) It is the intent of the Legislature in enacting this subdivision  
15 to affirm the requirement under Section 431.53 of Title 42 of the  
16 Code of Federal Regulations, in which the department is required  
17 to provide necessary transportation, including nonmedical  
18 transportation, for recipients to and from covered services. This  
19 subdivision shall not be interpreted to add a new benefit to the  
20 Medi-Cal program.

21 (5) The department shall seek any federal approvals that may  
22 be required to implement this subdivision, including, but not  
23 limited to, approval of revisions to the existing state plan that the  
24 department determines are necessary to implement this subdivision.

25 (6) This subdivision shall be implemented only to the extent  
26 that federal financial participation is available and not otherwise  
27 jeopardized and any necessary federal approvals have been  
28 obtained.

29 (7) Prior to the effective date of any necessary federal approvals,  
30 nonmedical transportation was not a Medi-Cal managed care  
31 benefit with the exception of when provided as an Early and  
32 Periodic Screening, Diagnostic, and Treatment service.

33 (8) Notwithstanding Chapter 3.5 (commencing with Section  
34 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
35 the department, without taking any further regulatory action, shall  
36 implement, interpret, or make specific this subdivision by means  
37 of all-county letters, plan letters, plan or provider bulletins, or  
38 similar instructions until the time regulations are adopted. By July  
39 1, 2018, the department shall adopt regulations in accordance with  
40 the requirements of Chapter 3.5 (commencing with Section 11340)

1 of Part 1 of Division 3 of Title 2 of the Government Code.  
2 Commencing January 1, 2018, and notwithstanding Section  
3 10231.5 of the Government Code, the department shall provide a  
4 status report to the Legislature on a semiannual basis, in  
5 compliance with Section 9795 of the Government Code, until  
6 regulations have been adopted.

7 (9) This subdivision shall not be implemented until July 1, 2017.

8 (ae) (1) No sooner than January 1, 2022, Rapid Whole Genome  
9 Sequencing, including individual sequencing, trio sequencing for  
10 a parent or parents and their baby, and ultra-rapid sequencing, is  
11 a covered benefit for any Medi-Cal beneficiary who is one year  
12 of age or younger and is receiving inpatient hospital services in  
13 an intensive care unit.

14 (2) Notwithstanding Chapter 3.5 (commencing with Section  
15 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
16 the department, without taking any further regulatory action, shall  
17 implement, interpret, or make specific this subdivision by means  
18 of all-county letters, plan letters, plan or provider bulletins, or  
19 similar instructions until the time regulations are adopted.

20 (3) This subdivision shall be implemented only to the extent  
21 that any necessary federal approvals are obtained, and federal  
22 financial participation is available and not otherwise jeopardized.

23 (af) (1) Home test kits for sexually transmitted diseases that  
24 are deemed medically necessary or appropriate and ordered directly  
25 by an enrolled Medi-Cal clinician or furnished through a standing  
26 order for patient use based on clinical guidelines and individual  
27 patient health needs.

28 (2) For purposes of this subdivision, “home test kit” means a  
29 product used for a test recommended by the federal Centers for  
30 Disease Control and Prevention guidelines or the United States  
31 Preventive Services Task Force that has been CLIA-waived,  
32 FDA-cleared or -approved, or developed by a laboratory in  
33 accordance with established regulations and quality standards, to  
34 allow individuals to self-collect specimens for STDs, including  
35 HIV, remotely at a location outside of a clinical setting.

36 (3) Reimbursement under this subparagraph shall be contingent  
37 upon the addition of codes specific to home test kits in the Current  
38 Procedural Terminology or Healthcare Common Procedure Coding  
39 System to comply with Health Insurance Portability and  
40 Accountability Act requirements. The home test kit shall be sent

1 by the enrolled Medi-Cal provider to a Medi-Cal-enrolled  
2 laboratory with fee based on Medicare Clinical Diagnostic  
3 Laboratory Tests Payment System Final Rule.

4 (4) This subdivision shall be implemented only to the extent  
5 that federal financial participation is available and not otherwise  
6 jeopardized, and any necessary federal approvals have been  
7 obtained.

8 (5) Notwithstanding Chapter 3.5 (commencing with Section  
9 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
10 the State Department of Health Care Services may implement this  
11 subdivision by means of all-county letters, plan letters, plan or  
12 provider bulletins, or similar instructions, without taking any  
13 further regulatory action.

14 (ag) (1) Violence prevention services are covered, subject to  
15 medical necessity and utilization controls.

16 (2) Notwithstanding Chapter 3.5 (commencing with Section  
17 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
18 the department, without taking any further regulatory action, may  
19 implement, interpret, or make specific this subdivision by means  
20 of all-county letters, plan letters, plan or provider bulletins, or  
21 similar instructions until the time regulations are adopted.

22 (3) This subdivision shall be implemented only to the extent  
23 that any necessary federal approvals are obtained, and federal  
24 financial participation is available and not otherwise jeopardized.

25 (4) The department shall post on its internet website the date  
26 upon which violence prevention services may be provided and  
27 billed pursuant to this subdivision.

28 (5) “Violence prevention services” means evidence-based,  
29 trauma-informed, and culturally responsive preventive services  
30 provided to reduce the incidence of violent injury or reinjury,  
31 trauma, and related harms and promote trauma recovery,  
32 stabilization, and improved health outcomes.

33 *SEC. 102. Section 14132.36 of the Welfare and Institutions*  
34 *Code is amended to read:*

35 14132.36. (a) Community health worker services are a covered  
36 Medi-Cal benefit.

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

38 (1) “Community health worker” ~~has the same meaning as~~  
39 ~~defined in subdivision (b) of Section 18998.~~ *means a liaison, link,*  
40 *or intermediary between health and social services and the*

1 *community to facilitate access to services and to improve the access*  
2 *and cultural competence of service delivery. A community health*  
3 *worker is a frontline health worker either trusted by, or who has*  
4 *a close understanding of, the community served. Community health*  
5 *workers include Promotores, Promotores de Salud, Community*  
6 *Health Representatives, navigators, and other nonlicensed health*  
7 *workers, including violence prevention professionals. A community*  
8 *health worker's lived experience shall align with and provide a*  
9 *connection to the community being served.*

10 (2) "Supervising provider" is an enrolled Medi-Cal provider  
11 that is authorized to supervise a community health worker pursuant  
12 to the federally approved Medicaid state plan amendment and that  
13 ensures that a community health worker meets the qualifications  
14 as required by the department. The supervising provider directly  
15 or indirectly oversees community health workers and the services  
16 that they deliver to Medi-Cal members.

17 (c) A Medi-Cal managed care plan shall engage in outreach and  
18 education efforts to enrollees in a form and manner as directed by  
19 the department. At a minimum, the department shall require a  
20 Medi-Cal managed care plan to provide the following information  
21 to an enrollee:

22 (1) A description of the community health worker services  
23 benefit, including eligibility and coverage criteria.

24 (2) A list of providers that are authorized to refer an enrollee to  
25 community health worker services, and an explanation of how to  
26 request a referral.

27 (3) A list of contracted community health worker entities,  
28 including community-based organizations, community clinics,  
29 local health jurisdictions, licensed providers, clinics, or hospitals  
30 available to provide community health worker services, updated  
31 at least annually.

32 (4) An email address, internet website, and telephone number  
33 for an enrollee to access to request additional information regarding  
34 community health worker services.

35 (d) The outreach and education efforts conducted by a Medi-Cal  
36 managed care plan pursuant to subdivision (c) shall meet cultural  
37 and linguistic appropriateness standards, as determined by the  
38 department.

(e) The Medi-Cal managed care plan shall notify providers about the community health worker services benefit, as set forth by the department.

(f) (1) No later than July 1, 2025, a Medi-Cal managed care plan shall adopt policies and procedures to effectuate a billing pathway for supervising providers, including contracted hospitals, to claim for the provision of community health worker services to enrollees during an emergency department visit and an outpatient followup to an emergency department visit, that are consistent with guidance developed by the department pursuant to paragraph (2).

(2) No later than July 1, 2025, the department shall, consistent with subdivision (g), develop guidance on policies and procedures to effectuate a billing pathway for supervising providers, including contracted hospitals, to claim for the provision of community health worker services to Medi-Cal members under the fee-for-service delivery system during an emergency department visit and as an outpatient followup to an emergency department visit.

(g) The department shall, through existing and regular stakeholder processes, inform stakeholders about, and accept input from stakeholders on, implementation of the community health worker services benefit.

(h) This section shall be implemented only to the extent that federal financial participation is available and not otherwise jeopardized, and any necessary federal approvals have been obtained.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of policy letters, provider bulletins, or other similar instructions, without taking any further regulatory action.

*SEC. 103. Section 14132.100 of the Welfare and Institutions Code is amended to read:*

14132.100. (a) The federally qualified health center services described in Section 1396d(a)(2)(C) of Title 42 of the United States Code are covered benefits.

(b) The rural health clinic services described in Section 1396d(a)(2)(B) of Title 42 of the United States Code are covered benefits.

1 (c) Federally qualified health center services and rural health  
2 clinic services shall be reimbursed on a per-visit basis in  
3 accordance with the definition of “visit” set forth in subdivision  
4 (g).

5 (d) Effective October 1, 2004, and on each October 1 thereafter,  
6 until no longer required by federal law, federally qualified health  
7 center (FQHC) and rural health clinic (RHC) per-visit rates shall  
8 be increased by the Medicare Economic Index applicable to  
9 primary care services in the manner provided for in Section  
10 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to  
11 January 1, 2004, FQHC and RHC per-visit rates shall be adjusted  
12 by the Medicare Economic Index in accordance with the  
13 methodology set forth in the state plan in effect on October 1,  
14 2001.

15 (e) (1) An FQHC or RHC may apply for an adjustment to its  
16 per-visit rate based on a change in the scope of services provided  
17 by the FQHC or RHC. Rate changes based on a change in the  
18 scope of services provided by an FQHC or RHC shall be evaluated  
19 in accordance with Medicare reasonable cost principles, as set  
20 forth in Part 413 (commencing with Section 413.1) of Title 42 of  
21 the Code of Federal Regulations, or its successor.

22 (2) Subject to the conditions set forth in subparagraphs (A) to  
23 (D), inclusive, of paragraph (3), a change in scope of service means  
24 any of the following:

25 (A) The addition of a new FQHC or RHC service that is not  
26 incorporated in the baseline prospective payment system (PPS)  
27 rate, or a deletion of an FQHC or RHC service that is incorporated  
28 in the baseline PPS rate.

29 (B) A change in service due to amended regulatory requirements  
30 or rules.

31 (C) A change in service resulting from relocating or remodeling  
32 an FQHC or RHC.

33 (D) A change in types of services due to a change in applicable  
34 technology and medical practice utilized by the center or clinic.

35 (E) An increase in service intensity attributable to changes in  
36 the types of patients served, including, but not limited to,  
37 populations with HIV or AIDS, or other chronic diseases, or  
38 homeless, elderly, migrant, or other special populations.



1 (F) Any changes in any of the services described in subdivision  
2 (a) or (b), or in the provider mix of an FQHC or RHC or one of  
3 its sites.

4 (G) Changes in operating costs attributable to capital  
5 expenditures associated with a modification of the scope of any  
6 of the services described in subdivision (a) or (b), including new  
7 or expanded service facilities, regulatory compliance, or changes  
8 in technology or medical practices at the center or clinic.

9 (H) Indirect medical education adjustments and a direct graduate  
10 medical education payment that reflects the costs of providing  
11 teaching services to interns and residents.

12 (I) Any changes in the scope of a project approved by the federal  
13 Health Resources and Services Administration (HRSA).

14 (3) A change in costs is not, in and of itself, a scope-of-service  
15 change, unless all of the following apply:

16 (A) The increase or decrease in cost is attributable to an increase  
17 or decrease in the scope of services defined in subdivisions (a) and  
18 (b), as applicable.

19 (B) The cost is allowable under Medicare reasonable cost  
20 principles set forth in Part 413 (commencing with Section 413.1)  
21 of Title 42 of the Code of Federal Regulations, or its successor.

22 (C) The change in the scope of services is a change in the type,  
23 intensity, duration, or amount of services, or any combination  
24 thereof.

25 (D) The net change in the FQHC's or RHC's rate equals or  
26 exceeds 1.75 percent for the affected FQHC or RHC site. For  
27 FQHCs and RHCs that filed consolidated cost reports for multiple  
28 sites to establish the initial prospective payment reimbursement  
29 rate, the 1.75-percent threshold shall be applied to the average  
30 per-visit rate of all sites for the purposes of calculating the cost  
31 associated with a scope-of-service change. "Net change" means  
32 the per-visit rate change attributable to the cumulative effect of all  
33 increases and decreases for a particular fiscal year.

34 (4) An FQHC or RHC may submit requests for scope-of-service  
35 changes once per fiscal year, only within 90 days following the  
36 beginning of the FQHC's or RHC's fiscal year. Any approved  
37 increase or decrease in the provider's rate shall be retroactive to  
38 the beginning of the FQHC's or RHC's fiscal year in which the  
39 request is submitted.

(5) An FQHC or RHC shall submit a scope-of-service rate change request within 90 days of the beginning of any FQHC or RHC fiscal year occurring after the effective date of this section, if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope of services provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If an FQHC or RHC discontinues providing onsite pharmacy or dental services, it shall submit a scope-of-service rate change request within 90 days of the beginning of the following fiscal year. The rate change shall be effective as provided for in paragraph (4). As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent.

(6) Notwithstanding paragraph (4), if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of-service change, the adjusted reimbursement rate for that scope-of-service change shall be made retroactive to the date the scope-of-service change was initially implemented. Scope-of-service changes under this paragraph shall be required to be submitted within the later of 150 days after the adoption and issuance of the written instructions by the department, or 150 days after the end of the FQHC's or RHC's fiscal year ending in 2003.

(7) All references in this subdivision to "fiscal year" shall be construed to be references to the fiscal year of the individual FQHC or RHC, as the case may be.

(f) (1) An FQHC or RHC may request a supplemental payment if extraordinary circumstances beyond the control of the FQHC or RHC occur after December 31, 2001, and PPS payments are insufficient due to these extraordinary circumstances. Supplemental payments arising from extraordinary circumstances under this subdivision shall be solely and exclusively within the discretion of the department and shall not be subject to subdivision (l). These supplemental payments shall be determined separately from the scope-of-service adjustments described in subdivision (e). Extraordinary circumstances include, but are not limited to, acts of nature, changes in applicable requirements in the Health and Safety Code, changes in applicable licensure requirements, and

changes in applicable rules or regulations. Mere inflation of costs alone, absent extraordinary circumstances, shall not be grounds for supplemental payment. If an FQHC's or RHC's PPS rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, then a supplemental payment is not warranted.

(2) The department shall accept requests for supplemental payment at any time throughout the prospective payment rate year.

(3) Requests for supplemental payments shall be submitted in writing to the department and shall set forth the reasons for the request. Each request shall be accompanied by sufficient documentation to enable the department to act upon the request. Documentation shall include the data necessary to demonstrate that the circumstances for which supplemental payment is requested meet the requirements set forth in this section. Documentation shall include both of the following:

(A) A presentation of data to demonstrate reasons for the FQHC's or RHC's request for a supplemental payment.

(B) Documentation showing the cost implications. The cost impact shall be material and significant, two hundred thousand dollars (\$200,000) or 1 percent of a facility's total costs, whichever is less.

(4) A request shall be submitted for each affected year.

(5) Amounts granted for supplemental payment requests shall be paid as lump-sum amounts for those years and not as revised PPS rates, and shall be repaid by the FQHC or RHC to the extent that it is not expended for the specified purposes.

(6) The department shall notify the provider of the department's discretionary decision in writing.

(g) (1) An FQHC or RHC "visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, licensed professional clinical counselor, or a visiting nurse. A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a comprehensive perinatal practitioner, as defined in Section 51179.7 of Title 22 of the California Code of Regulations, providing comprehensive perinatal services, a four-hour day of attendance at an adult day health care center, and any other provider identified in the state plan's definition of an FQHC or RHC visit.

1 (2) (A) A visit shall also include a face-to-face encounter  
2 between an FQHC or RHC patient and a dental hygienist, a dental  
3 hygienist in alternative practice, or a marriage and family therapist.

4 (B) Notwithstanding subdivision (e), if an FQHC or RHC that  
5 currently includes the cost of the services of a dental hygienist in  
6 alternative practice, or a marriage and family therapist for the  
7 purposes of establishing its FQHC or RHC rate chooses to bill  
8 these services as a separate visit, the FQHC or RHC shall apply  
9 for an adjustment to its per-visit rate, and, after the rate adjustment  
10 has been approved by the department, shall bill these services as  
11 a separate visit. However, multiple encounters with dental  
12 professionals or marriage and family therapists that take place on  
13 the same day shall constitute a single visit. The department shall  
14 develop the appropriate forms to determine which FQHC's or  
15 RHC's rates shall be adjusted and to facilitate the calculation of  
16 the adjusted rates. An FQHC's or RHC's application for, or the  
17 department's approval of, a rate adjustment pursuant to this  
18 subparagraph shall not constitute a change in scope of service  
19 within the meaning of subdivision (e). An FQHC or RHC that  
20 applies for an adjustment to its rate pursuant to this subparagraph  
21 may continue to bill for all other FQHC or RHC visits at its existing  
22 per-visit rate, subject to reconciliation, until the rate adjustment  
23 for visits between an FQHC or RHC patient and a dental hygienist,  
24 a dental hygienist in alternative practice, or a marriage and family  
25 therapist has been approved. Any approved increase or decrease  
26 in the provider's rate shall be made within six months after the  
27 date of receipt of the department's rate adjustment forms pursuant  
28 to this subparagraph and shall be retroactive to the beginning of  
29 the fiscal year in which the FQHC or RHC submits the request,  
30 but in no case shall the effective date be earlier than January 1,  
31 2008.

32 (C) An FQHC or RHC that does not provide dental hygienist  
33 or dental hygienist in alternative practice services, and later elects  
34 to add these services and bill these services as a separate visit,  
35 shall process the addition of these services as a change in scope  
36 of service pursuant to subdivision (e).

37 (3) Notwithstanding any other provision of this section, no later  
38 than July 1, 2018, a visit shall include a marriage and family  
39 therapist.

1 (4) (A) (i) Subject to subparagraphs (C) and (D), a visit shall  
2 also include an encounter between an FQHC or RHC patient and  
3 a physician, physician assistant, nurse practitioner, certified  
4 nurse-midwife, clinical psychologist, licensed clinical social  
5 worker, licensed professional clinical counselor, visiting nurse,  
6 comprehensive perinatal services program practitioner, dental  
7 hygienist, dental hygienist in alternative practice, or marriage and  
8 family therapist using video synchronous interaction, when services  
9 delivered through that interaction meet the applicable standard of  
10 care. A visit described in this clause shall be reimbursed at the  
11 applicable FQHC's or RHC's per-visit PPS rate to the extent the  
12 department determines that the FQHC or RHC has met all billing  
13 requirements that would have applied if the applicable services  
14 were delivered via a face-to-face encounter. An FQHC or RHC is  
15 not precluded from establishing a new patient relationship through  
16 video synchronous interaction. An FQHC patient who receives  
17 telehealth services shall otherwise be eligible to receive in-person  
18 services from that FQHC pursuant to HRSA requirements.

19 (ii) Subject to subparagraphs (C) and (D), a visit shall also  
20 include an encounter between an FQHC or RHC patient and a  
21 physician, physician assistant, nurse practitioner, certified  
22 nurse-midwife, clinical psychologist, licensed clinical social  
23 worker, licensed professional clinical counselor, visiting nurse,  
24 comprehensive perinatal services program practitioner, dental  
25 hygienist, dental hygienist in alternative practice, or marriage and  
26 family therapist using audio-only synchronous interaction, when  
27 services delivered through that modality meet the applicable  
28 standard of care. A visit described in this clause shall be reimbursed  
29 at the applicable FQHC's or RHC's per-visit PPS rate to the extent  
30 the department determines that the FQHC or RHC has met all  
31 billing requirements that would have applied if the applicable  
32 services were delivered via a face-to-face encounter.

33 (iii) Subject to subparagraphs (C) and (D), a visit shall also  
34 include an encounter between an FQHC or RHC patient and a  
35 physician, physician assistant, nurse practitioner, certified  
36 nurse-midwife, clinical psychologist, licensed clinical social  
37 worker, licensed professional clinical counselor, visiting nurse,  
38 comprehensive perinatal services program practitioner, dental  
39 hygienist, dental hygienist in alternative practice, or marriage and  
40 family therapist using an asynchronous store and forward modality,

1 when services delivered through that modality meet the applicable  
2 standard of care. A visit described in this clause shall be reimbursed  
3 at the applicable FQHC's or RHC's per-visit PPS rate to the extent  
4 the department determines that the FQHC or RHC has met all  
5 billing requirements that would have applied if the applicable  
6 services were delivered via a face-to-face encounter.

7 (iv) (I) An FQHC or RHC may not establish a new patient  
8 relationship using an audio-only synchronous interaction.

9 (II) Notwithstanding subclause (I), the department may provide  
10 for exceptions to the prohibition established by subclause (I),  
11 including, but not limited to, the exceptions described in  
12 sub-subclauses (ia) and (ib), which shall be developed in  
13 consultation with affected stakeholders and published in  
14 departmental guidance.

15 (ia) Notwithstanding the prohibition in subclause (I) and subject  
16 to subparagraphs (C) and (D), an FQHC or RHC may establish a  
17 new patient relationship using an audio-only synchronous  
18 interaction when the visit is related to sensitive services, as defined  
19 in subdivision (n) of Section 56.05 of the Civil Code, and when  
20 established in accordance with department-specific requirements  
21 and consistent with federal and state laws, regulations, and  
22 guidance.

23 (ib) Notwithstanding the prohibition in subclause (I) and subject  
24 to subparagraphs (C) and (D), an FQHC or RHC may establish a  
25 new patient relationship using an audio-only synchronous  
26 interaction when the patient requests an audio-only modality or  
27 attests they do not have access to video, and when established in  
28 accordance with department-specific requirements and consistent  
29 with federal and state laws, regulations, and guidance.

30 (v) An FQHC or RHC is not precluded from establishing a new  
31 patient relationship through an asynchronous store and forward  
32 modality, as defined in subdivision (a) of Section 2290.5 of the  
33 Business and Professions Code, if the visit meets all of the  
34 following conditions:

35 (I) The patient is physically present at the FQHC or RHC, or at  
36 an intermittent site of the FQHC or RHC, at the time the service  
37 is performed.

38 (II) The individual who creates the patient records at the  
39 originating site is an employee or contractor of the FQHC or RHC,

1 or other person lawfully authorized by the FQHC or RHC to create  
2 a patient record.

3 (III) The FQHC or RHC determines that the billing provider is  
4 able to meet the applicable standard of care.

5 (IV) An FQHC patient who receives telehealth services shall  
6 otherwise be eligible to receive in-person services from that FQHC  
7 pursuant to HRSA requirements.

8 (B) (i) Pursuant to an effective date designated by the  
9 department that is no sooner than January 1, 2024, an FQHC or  
10 RHC furnishing applicable health care services via audio-only  
11 synchronous interaction shall also offer those same health care  
12 services via video synchronous interaction to preserve beneficiary  
13 choice.

14 (ii) The department may provide specific exceptions to the  
15 requirement specified in clause (i), based on an FQHC's or RHC's  
16 access to requisite technologies, which shall be developed in  
17 consultation with affected stakeholders and published in  
18 departmental guidance.

19 (iii) Effective on the date designated by the department pursuant  
20 to clause (i), an FQHC or RHC furnishing services through video  
21 synchronous interaction or audio-only synchronous interaction  
22 shall also do one of the following:

23 (I) Offer those services via in-person, face-to-face contact.

24 (II) Arrange for a referral to, and a facilitation of, in-person care  
25 that does not require a patient to independently contact a different  
26 provider to arrange for that care.

27 (iv) In addition to any existing law requiring beneficiary consent  
28 to telehealth, including, but not limited to, subdivision (b) of  
29 Section 2290.5 of the Business and Professions Code, all of the  
30 following shall be communicated by an FQHC or RHC to a  
31 Medi-Cal beneficiary, in writing or verbally, on at least one  
32 occasion prior to, or concurrent with, initiating the delivery of one  
33 or more health care services via telehealth to a Medi-Cal  
34 beneficiary: an explanation that beneficiaries have the right to  
35 access covered services that may be delivered via telehealth through  
36 an in-person, face-to-face visit; an explanation that use of telehealth  
37 is voluntary and that consent for the use of telehealth can be  
38 withdrawn at any time by the Medi-Cal beneficiary without  
39 affecting their ability to access covered Medi-Cal services in the  
40 future; an explanation of the availability of Medi-Cal coverage for

1 nonmedical transportation services to in-person visits when other  
2 available resources have been reasonably exhausted; and the  
3 potential limitations or risks related to receiving services through  
4 telehealth as compared to an in-person visit, to the extent any  
5 limitations or risks are identified by the FQHC or RHC.

6 (I) The FQHC or RHC shall document in the patient record the  
7 provision of this information and the patient's verbal or written  
8 acknowledgment that the information was received.

9 (II) The department shall develop, in consultation with affected  
10 stakeholders, model language for purposes of the communication  
11 described in this subparagraph.

12 (C) The department shall seek any federal approvals it deems  
13 necessary to implement this paragraph. This paragraph shall be  
14 implemented only to the extent that any necessary federal approvals  
15 are obtained and federal financial participation is available and  
16 not otherwise jeopardized.

17 (D) This paragraph shall be operative on January 1, 2023, or on  
18 the operative date or dates reflected in the applicable federal  
19 approvals obtained by the department pursuant to subparagraph  
20 (C), whichever is later. This paragraph shall not be construed to  
21 limit coverage of, and reimbursement for, covered telehealth  
22 services provided before the operative date of this paragraph.

23 (E) Notwithstanding Chapter 3.5 (commencing with Section  
24 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
25 the department may implement, interpret, and make specific this  
26 paragraph by means of all-county letters, plan letters, provider  
27 manuals, information notices, provider bulletins, and similar  
28 instructions, without taking any further regulatory action.

29 (F) Telehealth modalities authorized pursuant to this paragraph  
30 shall be subject to the billing, reimbursement, and utilization  
31 management policies imposed by the department.

32 (G) Services delivered via telehealth modalities described in  
33 this paragraph shall comply with the privacy and security  
34 requirements contained in the federal Health Insurance Portability  
35 and Accountability Act of 1996 found in Parts 160 and 164 of Title  
36 45 of the Code of Federal Regulations, the Medicaid state plan,  
37 and any other applicable state and federal statutes and regulations.

38 (5) For purposes of this section, "physician" shall be interpreted  
39 in a manner consistent with the federal Centers for Medicare and  
40 Medicaid Services' Medicare Rural Health Clinic and Federally



1 Qualified Health Center Manual (Publication 27), or its successor,  
2 only to the extent that it defines the professionals whose services  
3 are reimbursable on a per-visit basis and not as to the types of  
4 services that these professionals may render during these visits  
5 and shall include a physician and surgeon, osteopath, podiatrist,  
6 dentist, optometrist, and chiropractor.

7 (h) If FQHC or RHC services are partially reimbursed by a  
8 third-party payer, such as a managed care entity, as defined in  
9 Section 1396u-2(a)(1)(B) of Title 42 of the United States Code,  
10 the Medicare Program, or the Child Health and Disability  
11 Prevention (CHDP) Program, the department shall reimburse an  
12 FQHC or RHC for the difference between its per-visit PPS rate  
13 and receipts from other plans or programs on a contract-by-contract  
14 basis and not in the aggregate, and may not include managed care  
15 financial incentive payments that are required by federal law to  
16 be excluded from the calculation.

17 (i) (1) Provided that the following entities are not operating as  
18 intermittent clinics, as defined in subdivision (h) of Section 1206  
19 of the Health and Safety Code, each entity shall have its  
20 reimbursement rate established in accordance with one of the  
21 methods outlined in paragraph (2) or (3), as selected by the FQHC  
22 or RHC:

23 (A) An entity that first qualifies as an FQHC or RHC in 2001  
24 or later.

25 (B) A newly licensed facility at a new location added to an  
26 existing FQHC or RHC.

27 (C) An entity that is an existing FQHC or RHC that is relocated  
28 to a new site.

29 (2) (A) An FQHC or RHC that adds a new licensed location to  
30 its existing primary care license under paragraph (1) of subdivision  
31 (b) of Section 1212 of the Health and Safety Code may elect to  
32 have the reimbursement rate for the new location established in  
33 accordance with paragraph (3), or notwithstanding subdivision  
34 (e), an FQHC or RHC may choose to have one PPS rate for all  
35 locations that appear on its primary care license determined by  
36 submitting a change in scope of service request if both of the  
37 following requirements are met:

38 (i) The change in scope of service request includes the costs  
39 and visits for those locations for the first full fiscal year

1 immediately following the date the new location is added to the  
2 FQHC's or RHC's existing licensee.

3 (ii) The FQHC or RHC submits the change in scope of service  
4 request within 90 days after the FQHC's or RHC's first full fiscal  
5 year.

6 (B) The FQHC's or RHC's single PPS rate for those locations  
7 shall be calculated based on the total costs and total visits of those  
8 locations and shall be determined based on the following:

9 (i) An audit in accordance with Section 14170.

10 (ii) Rate changes based on a change in scope of service request  
11 shall be evaluated in accordance with Medicare reasonable cost  
12 principles, as set forth in Part 413 (commencing with Section  
13 413.1) of Title 42 of the Code of Federal Regulations, or its  
14 successors.

15 (iii) Any approved increase or decrease in the provider's rate  
16 shall be retroactive to the beginning of the FQHC's or RHC's fiscal  
17 year in which the request is submitted.

18 (C) Except as specified in subdivision (j), this paragraph does  
19 not apply to a location that was added to an existing primary care  
20 clinic license by the State Department of Public Health, whether  
21 by a regional district office or the centralized application unit, prior  
22 to January 1, 2017.

23 (3) If an FQHC or RHC does not elect to have the PPS rate  
24 determined by a change in scope of service request, the FQHC or  
25 RHC shall have the reimbursement rate established for any of the  
26 entities identified in paragraph (1) or (2) in accordance with one  
27 of the following methods at the election of the FQHC or RHC:

28 (A) The rate may be calculated on a per-visit basis in an amount  
29 that is equal to the average of the per-visit rates of three comparable  
30 FQHCs or RHCs located in the same or adjacent area with a similar  
31 caseload.

32 (B) In the absence of three comparable FQHCs or RHCs with  
33 a similar caseload, the rate may be calculated on a per-visit basis  
34 in an amount that is equal to the average of the per-visit rates of  
35 three comparable FQHCs or RHCs located in the same or an  
36 adjacent service area, or in a reasonably similar geographic area  
37 with respect to relevant social, health care, and economic  
38 characteristics.

39 (C) At a new entity's one-time election, the department shall  
40 establish a reimbursement rate, calculated on a per-visit basis, that

1 is equal to 100 percent of the projected allowable costs to the  
2 FQHC or RHC of furnishing FQHC or RHC services during the  
3 first 12 months of operation as an FQHC or RHC. After the first  
4 12-month period, the projected per-visit rate shall be increased by  
5 the Medicare Economic Index then in effect. The projected  
6 allowable costs for the first 12 months shall be cost settled and the  
7 prospective payment reimbursement rate shall be adjusted based  
8 on actual and allowable cost per visit.

9 (D) The department may adopt any further and additional  
10 methods of setting reimbursement rates for newly qualified FQHCs  
11 or RHCs as are consistent with Section 1396a(bb)(4) of Title 42  
12 of the United States Code.

13 (4) In order for an FQHC or RHC to establish the comparability  
14 of its caseload for purposes of subparagraph (A) or (B) of paragraph  
15 (1), the department shall require that the FQHC or RHC submit  
16 its most recent annual utilization report as submitted to the Office  
17 of Statewide Health Planning and Development, unless the FQHC  
18 or RHC was not required to file an annual utilization report. FQHCs  
19 or RHCs that have experienced changes in their services or  
20 caseload subsequent to the filing of the annual utilization report  
21 may submit to the department a completed report in the format  
22 applicable to the prior calendar year. FQHCs or RHCs that have  
23 not previously submitted an annual utilization report shall submit  
24 to the department a completed report in the format applicable to  
25 the prior calendar year. The FQHC or RHC shall not be required  
26 to submit the annual utilization report for the comparable FQHCs  
27 or RHCs to the department, but shall be required to identify the  
28 comparable FQHCs or RHCs.

29 (5) The rate for any newly qualified entity set forth under this  
30 subdivision shall be effective retroactively to the later of the date  
31 that the entity was first qualified by the applicable federal agency  
32 as an FQHC or RHC, the date a new facility at a new location was  
33 added to an existing FQHC or RHC, or the date on which an  
34 existing FQHC or RHC was relocated to a new site. The FQHC  
35 or RHC shall be permitted to continue billing for Medi-Cal covered  
36 benefits on a fee-for-service basis under its existing provider  
37 number until it is informed of its FQHC or RHC enrollment  
38 approval, and the department shall reconcile the difference between  
39 the fee-for-service payments and the FQHC's or RHC's prospective  
40 payment rate at that time.

(j) (1) Visits occurring at an intermittent clinic site, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, of an existing FQHC or RHC, in a mobile unit as defined in subdivision (b) of Section 1765.105 of the Health and Safety Code, or at the election of the FQHC or RHC and subject to paragraph (2), a location added to an existing primary care clinic license by the State Department of Public Health prior to January 1, 2017, shall be billed by and reimbursed at the same rate as the FQHC or RHC that either established the intermittent clinic site or mobile unit, or that held the clinic license to which the location was added prior to January 1, 2017.

(2) If an FQHC or RHC with at least one additional location on its primary care clinic license that was added by the State Department of Public Health prior to January 1, 2017, applies for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC as described in subdivision (e), all locations on the FQHC's or RHC's primary care clinic license shall be subject to a scope-of-service adjustment in accordance with either paragraph (2) or (3) of subdivision (i), as selected by the FQHC or RHC.

(3) This subdivision does not preclude or otherwise limit the right of the FQHC or RHC to request a scope-of-service adjustment to the rate.

(k) An FQHC or RHC may elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. These costs shall be adjusted out of the FQHC's or RHC's clinic base rate as scope-of-service changes. An FQHC or RHC that reverses its election under this subdivision shall revert to its prior rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with applicable scope-of-service adjustments as provided in subdivision (e).

(l) Reimbursement for Drug Medi-Cal services shall be provided pursuant to this subdivision.

(1) An FQHC or RHC may elect to have Drug Medi-Cal services reimbursed directly from a county or the department under contract with the FQHC or RHC pursuant to paragraph (4).

(2) (A) For an FQHC or RHC to receive reimbursement for Drug Medi-Cal services directly from the county or the department

1 under contract with the FQHC or RHC pursuant to paragraph (4),  
2 costs associated with providing Drug Medi-Cal services shall not  
3 be included in the FQHC's or RHC's per-visit PPS rate. For  
4 purposes of this subdivision, the costs associated with providing  
5 Drug Medi-Cal services shall not be considered to be within the  
6 FQHC's or RHC's clinic base PPS rate if in delivering Drug  
7 Medi-Cal services the clinic uses different clinical staff at a  
8 different location.

9 (B) If the FQHC or RHC does not use different clinical staff at  
10 a different location to deliver Drug Medi-Cal services, the FQHC  
11 or RHC shall submit documentation, in a manner determined by  
12 the department, that the current per-visit PPS rate does not include  
13 any costs related to rendering Drug Medi-Cal services, including  
14 costs related to utilizing space in part of the FQHC's or RHC's  
15 building, that are or were previously calculated as part of the  
16 clinic's base PPS rate.

17 (3) If the costs associated with providing Drug Medi-Cal  
18 services are within the FQHC's or RHC's clinic base PPS rate, as  
19 determined by the department, the Drug Medi-Cal services costs  
20 shall be adjusted out of the FQHC's or RHC's per-visit PPS rate  
21 as a change in scope of service.

22 (A) An FQHC or RHC shall submit to the department a  
23 scope-of-service change request to adjust the FQHC's or RHC's  
24 clinic base PPS rate after the first full fiscal year of rendering Drug  
25 Medi-Cal services outside of the PPS rate. Notwithstanding  
26 subdivision (e), the scope-of-service change request shall include  
27 a full fiscal year of activity that does not include Drug Medi-Cal  
28 services costs.

29 (B) An FQHC or RHC may submit requests for scope-of-service  
30 change under this subdivision only within 90 days following the  
31 beginning of the FQHC's or RHC's fiscal year. Any  
32 scope-of-service change request under this subdivision approved  
33 by the department shall be retroactive to the first day that Drug  
34 Medi-Cal services were rendered and reimbursement for Drug  
35 Medi-Cal services was received outside of the PPS rate, but in no  
36 case shall the effective date be earlier than January 1, 2018.

37 (C) The FQHC or RHC may bill for Drug Medi-Cal services  
38 outside of the PPS rate when the FQHC or RHC obtains approval  
39 as a Drug Medi-Cal provider and enters into a contract with a

1 county or the department to provide these services pursuant to  
2 paragraph (4).

3 (D) Within 90 days of receipt of the request for a  
4 scope-of-service change under this subdivision, the department  
5 shall issue the FQHC or RHC an interim rate equal to 90 percent  
6 of the FQHC's or RHC's projected allowable cost, as determined  
7 by the department. An audit to determine the final rate shall be  
8 performed in accordance with Section 14170.

9 (E) Rate changes based on a request for scope-of-service change  
10 under this subdivision shall be evaluated in accordance with  
11 Medicare reasonable cost principles, as set forth in Part 413  
12 (commencing with Section 413.1) of Title 42 of the Code of  
13 Federal Regulations, or its successor.

14 (F) For purposes of recalculating the PPS rate, the FQHC or  
15 RHC shall provide upon request to the department verifiable  
16 documentation as to which employees spent time, and the actual  
17 time spent, providing federally qualified health center services or  
18 rural health center services and Drug Medi-Cal services.

19 (G) After the department approves the adjustment to the FQHC's  
20 or RHC's clinic base PPS rate and the FQHC or RHC is approved  
21 as a Drug Medi-Cal provider, an FQHC or RHC shall not bill the  
22 PPS rate for any Drug Medi-Cal services provided pursuant to a  
23 contract entered into with a county or the department pursuant to  
24 paragraph (4).

25 (H) An FQHC or RHC that reverses its election under this  
26 subdivision shall revert to its prior PPS rate, subject to an increase  
27 to account for all Medicare Economic Index increases occurring  
28 during the intervening time period, and subject to any increase or  
29 decrease associated with the applicable scope-of-service  
30 adjustments as provided for in subdivision (e).

31 (4) Reimbursement for Drug Medi-Cal services shall be  
32 determined according to subparagraph (A) or (B), depending on  
33 whether the services are provided in a county that participates in  
34 the Drug Medi-Cal organized delivery system (DMC-ODS).

35 (A) In a county that participates in the DMC-ODS, the FQHC  
36 or RHC shall receive reimbursement pursuant to a mutually agreed  
37 upon contract entered into between the county or county designee  
38 and the FQHC or RHC. If the county or county designee refuses  
39 to contract with the FQHC or RHC, the FQHC or RHC may follow

1 the contract denial process set forth in the Special Terms and  
2 Conditions.

3 (B) In a county that does not participate in the DMC-ODS, the  
4 FQHC or RHC shall receive reimbursement pursuant to a mutually  
5 agreed upon contract entered into between the county and the  
6 FQHC or RHC. If the county refuses to contract with the FQHC  
7 or RHC, the FQHC or RHC may request to contract directly with  
8 the department and shall be reimbursed for those services at the  
9 Drug Medi-Cal fee-for-service rate.

10 (5) The department shall not reimburse an FQHC or RHC  
11 pursuant to subdivision (h) for the difference between its per-visit  
12 PPS rate and any payments for Drug Medi-Cal services made  
13 pursuant to this subdivision.

14 (6) For purposes of this subdivision, the following definitions  
15 apply:

16 (A) “Drug Medi-Cal organized delivery system” or  
17 “DMC-ODS” means the Drug Medi-Cal organized delivery system  
18 authorized under the California Medi-Cal 2020 Demonstration,  
19 Number 11-W-00193/9, as approved by the federal Centers for  
20 Medicare and Medicaid Services and described in the Special  
21 Terms and Conditions.

22 (B) “Special Terms and Conditions” has the same meaning as  
23 set forth in subdivision (o) of Section 14184.10.

24 (m) Reimbursement for specialty mental health services shall  
25 be provided pursuant to this subdivision.

26 (1) An FQHC or RHC and one or more mental health plans that  
27 contract with the department pursuant to Section 14712 may  
28 mutually elect to enter into a contract to have the FQHC or RHC  
29 provide specialty mental health services to Medi-Cal beneficiaries  
30 as part of the mental health plan’s network.

31 (2) (A) For an FQHC or RHC to receive reimbursement for  
32 specialty mental health services pursuant to a contract entered into  
33 with the mental health plan under paragraph (1), the costs  
34 associated with providing specialty mental health services shall  
35 not be included in the FQHC’s or RHC’s per-visit PPS rate. For  
36 purposes of this subdivision, the costs associated with providing  
37 specialty mental health services shall not be considered to be within  
38 the FQHC’s or RHC’s clinic base PPS rate if in delivering specialty  
39 mental health services the clinic uses different clinical staff at a  
40 different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver specialty mental health services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering specialty mental health services, including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing specialty mental health services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the specialty mental health services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a scope-of-service change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering specialty mental health services outside of the PPS rate. Notwithstanding subdivision (e), the scope-of-service change request shall include a full fiscal year of activity that does not include specialty mental health costs.

(B) An FQHC or RHC may submit requests for a scope-of-service change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any scope-of-service change request under this subdivision approved by the department is retroactive to the first day that specialty mental health services were rendered and reimbursement for specialty mental health services was received outside of the PPS rate, but the effective date shall not be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for specialty mental health services outside of the PPS rate when the FQHC or RHC contracts with a mental health plan to provide these services pursuant to paragraph (1).

(D) Within 90 days of receipt of the request for a scope-of-service change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.



1 (E) Rate changes based on a request for scope-of-service change  
2 under this subdivision shall be evaluated in accordance with  
3 Medicare reasonable cost principles, as set forth in Part 413  
4 (commencing with Section 413.1) of Title 42 of the Code of  
5 Federal Regulations, or its successor.

6 (F) For the purpose of recalculating the PPS rate, the FQHC or  
7 RHC shall provide upon request to the department verifiable  
8 documentation as to which employees spent time, and the actual  
9 time spent, providing federally qualified health center services or  
10 rural health center services and specialty mental health services.

11 (G) After the department approves the adjustment to the FQHC's  
12 or RHC's clinic base PPS rate, an FQHC or RHC shall not bill the  
13 PPS rate for any specialty mental health services that are provided  
14 pursuant to a contract entered into with a mental health plan  
15 pursuant to paragraph (1).

16 (H) An FQHC or RHC that reverses its election under this  
17 subdivision shall revert to its prior PPS rate, subject to an increase  
18 to account for all Medicare Economic Index increases occurring  
19 during the intervening time period, and subject to any increase or  
20 decrease associated with the applicable scope-of-service  
21 adjustments as provided for in subdivision (e).

22 (4) The department shall not reimburse an FQHC or RHC  
23 pursuant to subdivision (h) for the difference between its per-visit  
24 PPS rate and any payments made for specialty mental health  
25 services under this subdivision.

26 (n) The department shall seek any necessary federal approvals  
27 and issue appropriate guidance to allow an FQHC or RHC to bill,  
28 under a supervising licensed behavioral health practitioner, for an  
29 encounter between an FQHC or RHC patient and a psychological  
30 associate, associate professional clinical counselor, associate  
31 clinical social worker, or associate marriage and family therapist  
32 when all of the following conditions are met:

33 (1) The psychological associate, associate professional clinical  
34 counselor, associate clinical social worker, or associate marriage  
35 and family therapist is supervised by the designated licensed  
36 behavioral health practitioner, as required by their applicable  
37 clinical licensing board.

38 (2) The behavioral health visit is billed under the supervising  
39 licensed practitioner of the FQHC or RHC, pursuant to paragraph  
40 (1).

1 (3) The FQHC or RHC is otherwise authorized to bill for  
2 services provided by the supervising licensed behavioral health  
3 practitioner as a separate visit.

4 (o) FQHCs and RHCs may appeal a grievance or complaint  
5 concerning ratesetting, scope-of-service changes, and settlement  
6 of cost report audits, in the manner prescribed by Section 14171.  
7 The rights and remedies provided under this subdivision are  
8 cumulative to the rights and remedies available under all other  
9 provisions of law of this state.

10 (p) The department shall promptly seek all necessary federal  
11 approvals in order to implement this section, including any  
12 amendments to the state plan. To the extent that any element or  
13 requirement of this section is not approved, the department shall  
14 submit a request to the federal Centers for Medicare and Medicaid  
15 Services for any waivers that would be necessary to implement  
16 this section.

17 (q) The department shall implement this section only to the  
18 extent that federal financial participation is available.

19 (r) Notwithstanding any other law, the director may, without  
20 taking regulatory action pursuant to Chapter 3.5 (commencing  
21 with Section 11340) of Part 1 of Division 3 of Title 2 of the  
22 Government Code, implement, interpret, or make specific this  
23 section by means of a provider bulletin or similar instruction. The  
24 department shall notify and consult with interested parties and  
25 appropriate stakeholders in implementing, interpreting, or making  
26 specific the provisions of this section, including all of the  
27 following:

28 (1) Notifying provider representatives in writing of the proposed  
29 action or change. The notice shall occur, and the applicable draft  
30 provider bulletin or similar instruction, shall be made available at  
31 least 10 business days prior to the meeting described in paragraph  
32 (2).

33 (2) Scheduling at least one meeting with interested parties and  
34 appropriate stakeholders to discuss the proposed action or change.

35 (3) Allowing for written input regarding the proposed action or  
36 change, to which the department shall provide summary written  
37 responses in conjunction with the issuance of the applicable final  
38 written provider bulletin or similar instruction.

39 (4) Providing at least 60 days advance notice of the effective  
40 date of the proposed action or change.

(s) This section shall become inoperative on July 1, 2026, and, as of January 1, 2027, is repealed.

SEC. 104. Section 14132.100 is added to the Welfare and Institutions Code, to read:

14132.100. (a) The federally qualified health center services described in Section 1396d(a)(2)(C) of Title 42 of the United States Code are covered benefits.

(b) The rural health clinic services described in Section 1396d(a)(2)(B) of Title 42 of the United States Code are covered benefits.

(c) Federally qualified health center services and rural health clinic services that are eligible for federal financial participation shall be reimbursed on a per-visit basis in accordance with the definition of “visit” set forth in subdivision (g).

(d) Effective October 1, 2004, and on each October 1 thereafter, until no longer required by federal law, federally qualified health center (FQHC) and rural health clinic (RHC) per-visit rates shall be increased by the Medicare Economic Index applicable to primary care services in the manner provided for in Section 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to January 1, 2004, FQHC and RHC per-visit rates shall be adjusted by the Medicare Economic Index in accordance with the methodology set forth in the state plan in effect on October 1, 2001.

(e) (1) An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC. Rate changes based on a change in the scope of services provided by an FQHC or RHC shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(2) Subject to the conditions set forth in subparagraphs (A) to (D), inclusive, of paragraph (3), a change in scope of service means any of the following:

(A) The addition of a new FQHC or RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate.

(B) A change in service due to amended regulatory requirements or rules.

1 (C) A change in service resulting from relocating or remodeling  
2 an FQHC or RHC.

3 (D) A change in types of services due to a change in applicable  
4 technology and medical practice utilized by the center or clinic.

5 (E) An increase in service intensity attributable to changes in  
6 the types of patients served, including, but not limited to,  
7 populations with HIV or AIDS, or other chronic diseases, or  
8 homeless, elderly, migrant, or other special populations.

9 (F) Any changes in any of the services described in subdivision  
10 (a) or (b), or in the provider mix of an FQHC or RHC or one of  
11 its sites.

12 (G) Changes in operating costs attributable to capital  
13 expenditures associated with a modification of the scope of any of  
14 the services described in subdivision (a) or (b), including new or  
15 expanded service facilities, regulatory compliance, or changes in  
16 technology or medical practices at the center or clinic.

17 (H) Indirect medical education adjustments and a direct  
18 graduate medical education payment that reflects the costs of  
19 providing teaching services to interns and residents.

20 (I) Any changes in the scope of a project approved by the federal  
21 Health Resources and Services Administration (HRSA).

22 (3) A change in costs is not, in and of itself, a scope-of-service  
23 change, unless all of the following apply:

24 (A) The increase or decrease in cost is attributable to an  
25 increase or decrease in the scope of services defined in subdivisions  
26 (a) and (b), as applicable.

27 (B) The cost is allowable under Medicare reasonable cost  
28 principles set forth in Part 413 (commencing with Section 413.1)  
29 of Title 42 of the Code of Federal Regulations, or its successor.

30 (C) The change in the scope of services is a change in the type,  
31 intensity, duration, or amount of services, or any combination  
32 thereof.

33 (D) The net change in the FQHC's or RHC's rate equals or  
34 exceeds 1.75 percent for the affected FQHC or RHC site. For  
35 FQHCs and RHCs that filed consolidated cost reports for multiple  
36 sites to establish the initial prospective payment reimbursement  
37 rate, the 1.75-percent threshold shall be applied to the average  
38 per-visit rate of all sites for the purposes of calculating the cost  
39 associated with a scope-of-service change. "Net change" means

1 *the per-visit rate change attributable to the cumulative effect of*  
2 *all increases and decreases for a particular fiscal year.*

3 *(4) An FQHC or RHC may submit requests for scope-of-service*  
4 *changes once per fiscal year, only within 90 days following the*  
5 *beginning of the FQHC's or RHC's fiscal year. Any approved*  
6 *increase or decrease in the provider's rate shall be retroactive to*  
7 *the beginning of the FQHC's or RHC's fiscal year in which the*  
8 *request is submitted.*

9 *(5) An FQHC or RHC shall submit a scope-of-service rate*  
10 *change request within 90 days of the beginning of any FQHC or*  
11 *RHC fiscal year occurring after the effective date of this section,*  
12 *if, during the FQHC's or RHC's prior fiscal year, the FQHC or*  
13 *RHC experienced a decrease in the scope of services provided that*  
14 *the FQHC or RHC either knew or should have known would have*  
15 *resulted in a significantly lower per-visit rate. If an FQHC or RHC*  
16 *discontinues providing onsite pharmacy or dental services, it shall*  
17 *submit a scope-of-service rate change request within 90 days of*  
18 *the beginning of the following fiscal year. The rate change shall*  
19 *be effective as provided for in paragraph (4). As used in this*  
20 *paragraph, "significantly lower" means an average per-visit rate*  
21 *decrease in excess of 2.5 percent.*

22 *(6) Notwithstanding paragraph (4), if the approved*  
23 *scope-of-service change or changes were initially implemented*  
24 *on or after the first day of an FQHC's or RHC's fiscal year ending*  
25 *in calendar year 2001, but before the adoption and issuance of*  
26 *written instructions for applying for a scope-of-service change,*  
27 *the adjusted reimbursement rate for that scope-of-service change*  
28 *shall be made retroactive to the date the scope-of-service change*  
29 *was initially implemented. Scope-of-service changes under this*  
30 *paragraph shall be required to be submitted within the later of*  
31 *150 days after the adoption and issuance of the written instructions*  
32 *by the department, or 150 days after the end of the FQHC's or*  
33 *RHC's fiscal year ending in 2003.*

34 *(7) All references in this subdivision to "fiscal year" shall be*  
35 *construed to be references to the fiscal year of the individual*  
36 *FQHC or RHC, as the case may be.*

37 *(f) (1) An FQHC or RHC may request a supplemental payment*  
38 *if extraordinary circumstances beyond the control of the FQHC*  
39 *or RHC occur after December 31, 2001, and PPS payments are*  
40 *insufficient due to these extraordinary circumstances. Supplemental*

1 *payments arising from extraordinary circumstances under this*  
2 *subdivision shall be solely and exclusively within the discretion*  
3 *of the department and shall not be subject to subdivision (l). These*  
4 *supplemental payments shall be determined separately from the*  
5 *scope-of-service adjustments described in subdivision (e).*  
6 *Extraordinary circumstances include, but are not limited to, acts*  
7 *of nature, changes in applicable requirements in the Health and*  
8 *Safety Code, changes in applicable licensure requirements, and*  
9 *changes in applicable rules or regulations. Mere inflation of costs*  
10 *alone, absent extraordinary circumstances, shall not be grounds*  
11 *for supplemental payment. If an FQHC's or RHC's PPS rate is*  
12 *sufficient to cover its overall costs, including those associated with*  
13 *the extraordinary circumstances, then a supplemental payment is*  
14 *not warranted.*

15 *(2) The department shall accept requests for supplemental*  
16 *payment at any time throughout the prospective payment rate year.*

17 *(3) Requests for supplemental payments shall be submitted in*  
18 *writing to the department and shall set forth the reasons for the*  
19 *request. Each request shall be accompanied by sufficient*  
20 *documentation to enable the department to act upon the request.*  
21 *Documentation shall include the data necessary to demonstrate*  
22 *that the circumstances for which supplemental payment is*  
23 *requested meet the requirements set forth in this section.*  
24 *Documentation shall include both of the following:*

25 *(A) A presentation of data to demonstrate reasons for the*  
26 *FQHC's or RHC's request for a supplemental payment.*

27 *(B) Documentation showing the cost implications. The cost*  
28 *impact shall be material and significant, two hundred thousand*  
29 *dollars (\$200,000) or 1 percent of a facility's total costs, whichever*  
30 *is less.*

31 *(4) A request shall be submitted for each affected year.*

32 *(5) Amounts granted for supplemental payment requests shall*  
33 *be paid as lump-sum amounts for those years and not as revised*  
34 *PPS rates, and shall be repaid by the FQHC or RHC to the extent*  
35 *that it is not expended for the specified purposes.*

36 *(6) The department shall notify the provider of the department's*  
37 *discretionary decision in writing.*

38 *(g) (1) An FQHC or RHC "visit" means a face-to-face*  
39 *encounter between an FQHC or RHC patient and a physician,*  
40 *physician assistant, nurse practitioner, certified nurse-midwife,*

1 clinical psychologist, licensed clinical social worker, licensed  
2 professional clinical counselor, or a visiting nurse that is eligible  
3 for federal financial participation. A visit shall also include a  
4 face-to-face encounter between an FQHC or RHC patient and a  
5 comprehensive perinatal practitioner, as defined in Section 51179.7  
6 of Title 22 of the California Code of Regulations, providing  
7 comprehensive perinatal services, a four-hour day of attendance  
8 at an adult day health care center, and any other provider  
9 identified in the state plan's definition of an FQHC or RHC visit  
10 that is eligible for federal financial participation.

11 (2) (A) A visit shall also include a face-to-face encounter  
12 between an FQHC or RHC patient and a dental hygienist, a dental  
13 hygienist in alternative practice, or a marriage and family therapist  
14 that is eligible for federal financial participation.

15 (B) Notwithstanding subdivision (e), if an FQHC or RHC that  
16 currently includes the cost of the services of a dental hygienist in  
17 alternative practice, or a marriage and family therapist for the  
18 purposes of establishing its FQHC or RHC rate chooses to bill  
19 these services as a separate visit, the FQHC or RHC shall apply  
20 for an adjustment to its per-visit rate, and, after the rate adjustment  
21 has been approved by the department, shall bill these services as  
22 a separate visit. However, multiple encounters with dental  
23 professionals or marriage and family therapists that take place  
24 on the same day shall constitute a single visit. The department  
25 shall develop the appropriate forms to determine which FQHC's  
26 or RHC's rates shall be adjusted and to facilitate the calculation  
27 of the adjusted rates. An FQHC's or RHC's application for, or  
28 the department's approval of, a rate adjustment pursuant to this  
29 subparagraph shall not constitute a change in scope of service  
30 within the meaning of subdivision (e). An FQHC or RHC that  
31 applies for an adjustment to its rate pursuant to this subparagraph  
32 may continue to bill for all other FQHC or RHC visits at its  
33 existing per-visit rate, subject to reconciliation, until the rate  
34 adjustment for visits between an FQHC or RHC patient and a  
35 dental hygienist, a dental hygienist in alternative practice, or a  
36 marriage and family therapist has been approved. Any approved  
37 increase or decrease in the provider's rate shall be made within  
38 six months after the date of receipt of the department's rate  
39 adjustment forms pursuant to this subparagraph and shall be  
40 retroactive to the beginning of the fiscal year in which the FQHC

1 or RHC submits the request, but in no case shall the effective date  
2 be earlier than January 1, 2008.

3 (C) An FQHC or RHC that does not provide dental hygienist  
4 or dental hygienist in alternative practice services, and later elects  
5 to add these services and bill these services as a separate visit,  
6 shall process the addition of these services as a change in scope  
7 of service pursuant to subdivision (e).

8 (3) Notwithstanding any other provision of this section, no later  
9 than July 1, 2018, a visit shall include a marriage and family  
10 therapist that is eligible for federal financial participation.

11 (4) (A) (i) Subject to subparagraphs (C) and (D), a visit shall  
12 also include an encounter between an FQHC or RHC patient and  
13 a physician, physician assistant, nurse practitioner, certified  
14 nurse-midwife, clinical psychologist, licensed clinical social  
15 worker, licensed professional clinical counselor, visiting nurse,  
16 comprehensive perinatal services program practitioner, dental  
17 hygienist, dental hygienist in alternative practice, or marriage and  
18 family therapist using video synchronous interaction, when services  
19 delivered through that interaction meet the applicable standard  
20 of care and are eligible for federal financial participation. A visit  
21 described in this clause shall be reimbursed at the applicable  
22 FQHC's or RHC's per-visit PPS rate to the extent the department  
23 determines that the FQHC or RHC has met all billing requirements  
24 that would have applied if the applicable services were delivered  
25 via a face-to-face encounter. An FQHC or RHC is not precluded  
26 from establishing a new patient relationship through video  
27 synchronous interaction. An FQHC patient who receives telehealth  
28 services shall otherwise be eligible to receive in-person services  
29 from that FQHC pursuant to HRSA requirements.

30 (ii) Subject to subparagraphs (C) and (D), a visit shall also  
31 include an encounter between an FQHC or RHC patient and a  
32 physician, physician assistant, nurse practitioner, certified  
33 nurse-midwife, clinical psychologist, licensed clinical social  
34 worker, licensed professional clinical counselor, visiting nurse,  
35 comprehensive perinatal services program practitioner, dental  
36 hygienist, dental hygienist in alternative practice, or marriage and  
37 family therapist using audio-only synchronous interaction, when  
38 services delivered through that modality meet the applicable  
39 standard of care and are eligible for federal financial participation.

40 A visit described in this clause shall be reimbursed at the



1 applicable FQHC's or RHC's per-visit PPS rate to the extent the  
2 department determines that the FQHC or RHC has met all billing  
3 requirements that would have applied if the applicable services  
4 were delivered via a face-to-face encounter.

5 (iii) Subject to subparagraphs (C) and (D), a visit shall also  
6 include an encounter between an FQHC or RHC patient and a  
7 physician, physician assistant, nurse practitioner, certified  
8 nurse-midwife, clinical psychologist, licensed clinical social  
9 worker, licensed professional clinical counselor, visiting nurse,  
10 comprehensive perinatal services program practitioner, dental  
11 hygienist, dental hygienist in alternative practice, or marriage and  
12 family therapist using an asynchronous store and forward modality,  
13 when services delivered through that modality meet the applicable  
14 standard of care and are eligible for federal financial participation.  
15 A visit described in this clause shall be reimbursed at the  
16 applicable FQHC's or RHC's per-visit PPS rate to the extent the  
17 department determines that the FQHC or RHC has met all billing  
18 requirements that would have applied if the applicable services  
19 were delivered via a face-to-face encounter.

20 (iv) (I) An FQHC or RHC may not establish a new patient  
21 relationship using an audio-only synchronous interaction.

22 (II) Notwithstanding subclause (I), the department may provide  
23 for exceptions to the prohibition established by subclause (I),  
24 including, but not limited to, the exceptions described in  
25 sub-subclauses (ia) and (ib), which shall be developed in  
26 consultation with affected stakeholders and published in  
27 departmental guidance.

28 (ia) Notwithstanding the prohibition in subclause (I) and subject  
29 to subparagraphs (C) and (D), an FQHC or RHC may establish  
30 a new patient relationship using an audio-only synchronous  
31 interaction when the visit is related to sensitive services, as defined  
32 in subdivision (n) of Section 56.05 of the Civil Code, and when  
33 established in accordance with department-specific requirements  
34 and consistent with federal and state laws, regulations, and  
35 guidance.

36 (ib) Notwithstanding the prohibition in subclause (I) and subject  
37 to subparagraphs (C) and (D), an FQHC or RHC may establish  
38 a new patient relationship using an audio-only synchronous  
39 interaction when the patient requests an audio-only modality or  
40 attests they do not have access to video, and when established in

1 *accordance with department-specific requirements and consistent*  
2 *with federal and state laws, regulations, and guidance.*

3 *(v) An FQHC or RHC is not precluded from establishing a new*  
4 *patient relationship through an asynchronous store and forward*  
5 *modality, as defined in subdivision (a) of Section 2290.5 of the*  
6 *Business and Professions Code, if the visit meets all of the*  
7 *following conditions:*

8 *(I) The patient is physically present at the FQHC or RHC, or*  
9 *at an intermittent site of the FQHC or RHC, at the time the service*  
10 *is performed.*

11 *(II) The individual who creates the patient records at the*  
12 *originating site is an employee or contractor of the FQHC or RHC,*  
13 *or other person lawfully authorized by the FQHC or RHC to create*  
14 *a patient record.*

15 *(III) The FQHC or RHC determines that the billing provider is*  
16 *able to meet the applicable standard of care.*

17 *(IV) An FQHC patient who receives telehealth services shall*  
18 *otherwise be eligible to receive in-person services from that FQHC*  
19 *pursuant to HRSA requirements.*

20 *(B) (i) Pursuant to an effective date designated by the*  
21 *department that is no sooner than January 1, 2024, an FQHC or*  
22 *RHC furnishing applicable health care services via audio-only*  
23 *synchronous interaction shall also offer those same health care*  
24 *services via video synchronous interaction to preserve beneficiary*  
25 *choice.*

26 *(ii) The department may provide specific exceptions to the*  
27 *requirement specified in clause (i), based on an FQHC's or RHC's*  
28 *access to requisite technologies, which shall be developed in*  
29 *consultation with affected stakeholders and published in*  
30 *departmental guidance.*

31 *(iii) Effective on the date designated by the department pursuant*  
32 *to clause (i), an FQHC or RHC furnishing services through video*  
33 *synchronous interaction or audio-only synchronous interaction*  
34 *shall also do one of the following:*

35 *(I) Offer those services via in-person, face-to-face contact.*

36 *(II) Arrange for a referral to, and a facilitation of, in-person*  
37 *care that does not require a patient to independently contact a*  
38 *different provider to arrange for that care.*

39 *(iv) In addition to any existing law requiring beneficiary consent*  
40 *to telehealth, including, but not limited to, subdivision (b) of*

1 *Section 2290.5 of the Business and Professions Code, all of the*  
2 *following shall be communicated by an FQHC or RHC to a*  
3 *Medi-Cal beneficiary, in writing or verbally, on at least one*  
4 *occasion prior to, or concurrent with, initiating the delivery of*  
5 *one or more health care services via telehealth to a Medi-Cal*  
6 *beneficiary: an explanation that beneficiaries have the right to*  
7 *access covered services that may be delivered via telehealth*  
8 *through an in-person, face-to-face visit; an explanation that use*  
9 *of telehealth is voluntary and that consent for the use of telehealth*  
10 *can be withdrawn at any time by the Medi-Cal beneficiary without*  
11 *affecting their ability to access covered Medi-Cal services in the*  
12 *future; an explanation of the availability of Medi-Cal coverage*  
13 *for nonmedical transportation services to in-person visits when*  
14 *other available resources have been reasonably exhausted; and*  
15 *the potential limitations or risks related to receiving services*  
16 *through telehealth as compared to an in-person visit, to the extent*  
17 *any limitations or risks are identified by the FQHC or RHC.*

18 *(I) The FQHC or RHC shall document in the patient record the*  
19 *provision of this information and the patient's verbal or written*  
20 *acknowledgment that the information was received.*

21 *(II) The department shall develop, in consultation with affected*  
22 *stakeholders, model language for purposes of the communication*  
23 *described in this subparagraph.*

24 *(C) The department shall seek any federal approvals it deems*  
25 *necessary to implement this paragraph. This paragraph shall be*  
26 *implemented only to the extent that any necessary federal approvals*  
27 *are obtained and federal financial participation is available and*  
28 *not otherwise jeopardized.*

29 *(D) This paragraph shall be operative on January 1, 2023, or*  
30 *on the operative date or dates reflected in the applicable federal*  
31 *approvals obtained by the department pursuant to subparagraph*  
32 *(C), whichever is later. This paragraph shall not be construed to*  
33 *limit coverage of, and reimbursement for, covered telehealth*  
34 *services provided before the operative date of this paragraph.*

35 *(E) Notwithstanding Chapter 3.5 (commencing with Section*  
36 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*  
37 *the department may implement, interpret, and make specific this*  
38 *paragraph by means of all-county letters, plan letters, provider*  
39 *manuals, information notices, provider bulletins, and similar*  
40 *instructions, without taking any further regulatory action.*

1 (F) Telehealth modalities authorized pursuant to this paragraph  
2 shall be subject to the billing, reimbursement, and utilization  
3 management policies imposed by the department.

4 (G) Services delivered via telehealth modalities described in  
5 this paragraph shall comply with the privacy and security  
6 requirements contained in the federal Health Insurance Portability  
7 and Accountability Act of 1996 found in Parts 160 and 164 of Title  
8 45 of the Code of Federal Regulations, the Medicaid state plan,  
9 and any other applicable state and federal statutes and regulations.

10 (5) For purposes of this section, “physician” shall be interpreted  
11 in a manner consistent with the federal Centers for Medicare and  
12 Medicaid Services’ Medicare Rural Health Clinic and Federally  
13 Qualified Health Center Manual (Publication 27), or its successor;  
14 only to the extent that it defines the professionals whose services  
15 are reimbursable on a per-visit basis and not as to the types of  
16 services that these professionals may render during these visits  
17 and shall include a physician and surgeon, osteopath, podiatrist,  
18 dentist, optometrist, and chiropractor.

19 (h) If FQHC or RHC services are partially reimbursed by a  
20 third-party payer, such as a managed care entity, as defined in  
21 Section 1396u-2(a)(1)(B) of Title 42 of the United States Code,  
22 the Medicare Program, or the Child Health and Disability  
23 Prevention (CHDP) Program, the department shall reimburse an  
24 FQHC or RHC for the difference between its per-visit PPS rate  
25 and receipts from other plans or programs on a  
26 contract-by-contract basis and not in the aggregate, and may not  
27 include managed care financial incentive payments that are  
28 required by federal law to be excluded from the calculation.

29 (i) (1) Provided that the following entities are not operating as  
30 intermittent clinics, as defined in subdivision (h) of Section 1206  
31 of the Health and Safety Code, each entity shall have its  
32 reimbursement rate established in accordance with one of the  
33 methods outlined in paragraph (2) or (3), as selected by the FQHC  
34 or RHC:

35 (A) An entity that first qualifies as an FQHC or RHC in 2001  
36 or later.

37 (B) A newly licensed facility at a new location added to an  
38 existing FQHC or RHC.

39 (C) An entity that is an existing FQHC or RHC that is relocated  
40 to a new site.

1 (2) (A) An FQHC or RHC that adds a new licensed location to  
2 its existing primary care license under paragraph (1) of subdivision  
3 (b) of Section 1212 of the Health and Safety Code may elect to  
4 have the reimbursement rate for the new location established in  
5 accordance with paragraph (3), or notwithstanding subdivision  
6 (e), an FQHC or RHC may choose to have one PPS rate for all  
7 locations that appear on its primary care license determined by  
8 submitting a change in scope of service request if both of the  
9 following requirements are met:

10 (i) The change in scope of service request includes the costs  
11 and visits for those locations for the first full fiscal year  
12 immediately following the date the new location is added to the  
13 FQHC's or RHC's existing licensee.

14 (ii) The FQHC or RHC submits the change in scope of service  
15 request within 90 days after the FQHC's or RHC's first full fiscal  
16 year.

17 (B) The FQHC's or RHC's single PPS rate for those locations  
18 shall be calculated based on the total costs and total visits of those  
19 locations and shall be determined based on the following:

20 (i) An audit in accordance with Section 14170.

21 (ii) Rate changes based on a change in scope of service request  
22 shall be evaluated in accordance with Medicare reasonable cost  
23 principles, as set forth in Part 413 (commencing with Section  
24 413.1) of Title 42 of the Code of Federal Regulations, or its  
25 successors.

26 (iii) Any approved increase or decrease in the provider's rate  
27 shall be retroactive to the beginning of the FQHC's or RHC's  
28 fiscal year in which the request is submitted.

29 (C) Except as specified in subdivision (j), this paragraph does  
30 not apply to a location that was added to an existing primary care  
31 clinic license by the State Department of Public Health, whether  
32 by a regional district office or the centralized application unit,  
33 prior to January 1, 2017.

34 (3) If an FQHC or RHC does not elect to have the PPS rate  
35 determined by a change in scope of service request, the FQHC or  
36 RHC shall have the reimbursement rate established for any of the  
37 entities identified in paragraph (1) or (2) in accordance with one  
38 of the following methods at the election of the FQHC or RHC:

39 (A) The rate may be calculated on a per-visit basis in an amount  
40 that is equal to the average of the per-visit rates of three

1 comparable FQHCs or RHCs located in the same or adjacent area  
2 with a similar caseload.

3 (B) In the absence of three comparable FQHCs or RHCs with  
4 a similar caseload, the rate may be calculated on a per-visit basis  
5 in an amount that is equal to the average of the per-visit rates of  
6 three comparable FQHCs or RHCs located in the same or an  
7 adjacent service area, or in a reasonably similar geographic area  
8 with respect to relevant social, health care, and economic  
9 characteristics.

10 (C) At a new entity's one-time election, the department shall  
11 establish a reimbursement rate, calculated on a per-visit basis,  
12 that is equal to 100 percent of the projected allowable costs to the  
13 FQHC or RHC of furnishing FQHC or RHC services during the  
14 first 12 months of operation as an FQHC or RHC. After the first  
15 12-month period, the projected per-visit rate shall be increased  
16 by the Medicare Economic Index then in effect. The projected  
17 allowable costs for the first 12 months shall be cost settled and  
18 the prospective payment reimbursement rate shall be adjusted  
19 based on actual and allowable cost per visit.

20 (D) The department may adopt any further and additional  
21 methods of setting reimbursement rates for newly qualified FQHCs  
22 or RHCs as are consistent with Section 1396a(bb)(4) of Title 42  
23 of the United States Code.

24 (4) In order for an FQHC or RHC to establish the comparability  
25 of its caseload for purposes of subparagraph (A) or (B) of  
26 paragraph (1), the department shall require that the FQHC or  
27 RHC submit its most recent annual utilization report as submitted  
28 to the Office of Statewide Health Planning and Development,  
29 unless the FQHC or RHC was not required to file an annual  
30 utilization report. FQHCs or RHCs that have experienced changes  
31 in their services or caseload subsequent to the filing of the annual  
32 utilization report may submit to the department a completed report  
33 in the format applicable to the prior calendar year. FQHCs or  
34 RHCs that have not previously submitted an annual utilization  
35 report shall submit to the department a completed report in the  
36 format applicable to the prior calendar year. The FQHC or RHC  
37 shall not be required to submit the annual utilization report for  
38 the comparable FQHCs or RHCs to the department, but shall be  
39 required to identify the comparable FQHCs or RHCs.

(5) The rate for any newly qualified entity set forth under this subdivision shall be effective retroactively to the later of the date that the entity was first qualified by the applicable federal agency as an FQHC or RHC, the date a new facility at a new location was added to an existing FQHC or RHC, or the date on which an existing FQHC or RHC was relocated to a new site. The FQHC or RHC shall be permitted to continue billing for Medi-Cal covered benefits on a fee-for-service basis under its existing provider number until it is informed of its FQHC or RHC enrollment approval, and the department shall reconcile the difference between the fee-for-service payments and the FQHC's or RHC's prospective payment rate at that time.

(j) (1) Visits occurring at an intermittent clinic site, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, of an existing FQHC or RHC, in a mobile unit as defined in subdivision (b) of Section 1765.105 of the Health and Safety Code, or at the election of the FQHC or RHC and subject to paragraph (2), a location added to an existing primary care clinic license by the State Department of Public Health prior to January 1, 2017, shall be billed by and reimbursed at the same rate as the FQHC or RHC that either established the intermittent clinic site or mobile unit, or that held the clinic license to which the location was added prior to January 1, 2017.

(2) If an FQHC or RHC with at least one additional location on its primary care clinic license that was added by the State Department of Public Health prior to January 1, 2017, applies for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC as described in subdivision (e), all locations on the FQHC's or RHC's primary care clinic license shall be subject to a scope-of-service adjustment in accordance with either paragraph (2) or (3) of subdivision (i), as selected by the FQHC or RHC.

(3) This subdivision does not preclude or otherwise limit the right of the FQHC or RHC to request a scope-of-service adjustment to the rate.

(k) An FQHC or RHC may elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. These costs shall be adjusted out of the FQHC's or RHC's clinic base rate as scope-of-service changes. An FQHC or RHC that reverses its

1 election under this subdivision shall revert to its prior rate, subject  
2 to an increase to account for all Medicare Economic Index  
3 increases occurring during the intervening time period, and subject  
4 to any increase or decrease associated with applicable  
5 scope-of-service adjustments as provided in subdivision (e).

6 (l) Reimbursement for Drug Medi-Cal services shall be provided  
7 pursuant to this subdivision.

8 (1) An FQHC or RHC may elect to have Drug Medi-Cal services  
9 reimbursed directly from a county or the department under contract  
10 with the FQHC or RHC pursuant to paragraph (4).

11 (2) (A) For an FQHC or RHC to receive reimbursement for  
12 Drug Medi-Cal services directly from the county or the department  
13 under contract with the FQHC or RHC pursuant to paragraph  
14 (4), costs associated with providing Drug Medi-Cal services shall  
15 not be included in the FQHC's or RHC's per-visit PPS rate. For  
16 purposes of this subdivision, the costs associated with providing  
17 Drug Medi-Cal services shall not be considered to be within the  
18 FQHC's or RHC's clinic base PPS rate if in delivering Drug  
19 Medi-Cal services the clinic uses different clinical staff at a  
20 different location.

21 (B) If the FQHC or RHC does not use different clinical staff at  
22 a different location to deliver Drug Medi-Cal services, the FQHC  
23 or RHC shall submit documentation, in a manner determined by  
24 the department, that the current per-visit PPS rate does not include  
25 any costs related to rendering Drug Medi-Cal services, including  
26 costs related to utilizing space in part of the FQHC's or RHC's  
27 building, that are or were previously calculated as part of the  
28 clinic's base PPS rate.

29 (3) If the costs associated with providing Drug Medi-Cal  
30 services are within the FQHC's or RHC's clinic base PPS rate,  
31 as determined by the department, the Drug Medi-Cal services costs  
32 shall be adjusted out of the FQHC's or RHC's per-visit PPS rate  
33 as a change in scope of service.

34 (A) An FQHC or RHC shall submit to the department a  
35 scope-of-service change request to adjust the FQHC's or RHC's  
36 clinic base PPS rate after the first full fiscal year of rendering  
37 Drug Medi-Cal services outside of the PPS rate. Notwithstanding  
38 subdivision (e), the scope-of-service change request shall include  
39 a full fiscal year of activity that does not include Drug Medi-Cal  
40 services costs.



1 (B) An FQHC or RHC may submit requests for scope-of-service  
2 change under this subdivision only within 90 days following the  
3 beginning of the FQHC's or RHC's fiscal year. Any  
4 scope-of-service change request under this subdivision approved  
5 by the department shall be retroactive to the first day that Drug  
6 Medi-Cal services were rendered and reimbursement for Drug  
7 Medi-Cal services was received outside of the PPS rate, but in no  
8 case shall the effective date be earlier than January 1, 2018.

9 (C) The FQHC or RHC may bill for Drug Medi-Cal services  
10 outside of the PPS rate when the FQHC or RHC obtains approval  
11 as a Drug Medi-Cal provider and enters into a contract with a  
12 county or the department to provide these services pursuant to  
13 paragraph (4).

14 (D) Within 90 days of receipt of the request for a  
15 scope-of-service change under this subdivision, the department  
16 shall issue the FQHC or RHC an interim rate equal to 90 percent  
17 of the FQHC's or RHC's projected allowable cost, as determined  
18 by the department. An audit to determine the final rate shall be  
19 performed in accordance with Section 14170.

20 (E) Rate changes based on a request for scope-of-service change  
21 under this subdivision shall be evaluated in accordance with  
22 Medicare reasonable cost principles, as set forth in Part 413  
23 (commencing with Section 413.1) of Title 42 of the Code of Federal  
24 Regulations, or its successor.

25 (F) For purposes of recalculating the PPS rate, the FQHC or  
26 RHC shall provide upon request to the department verifiable  
27 documentation as to which employees spent time, and the actual  
28 time spent, providing federally qualified health center services or  
29 rural health center services and Drug Medi-Cal services.

30 (G) After the department approves the adjustment to the FQHC's  
31 or RHC's clinic base PPS rate and the FQHC or RHC is approved  
32 as a Drug Medi-Cal provider, an FQHC or RHC shall not bill the  
33 PPS rate for any Drug Medi-Cal services provided pursuant to a  
34 contract entered into with a county or the department pursuant to  
35 paragraph (4).

36 (H) An FQHC or RHC that reverses its election under this  
37 subdivision shall revert to its prior PPS rate, subject to an increase  
38 to account for all Medicare Economic Index increases occurring  
39 during the intervening time period, and subject to any increase or

1 decrease associated with the applicable scope-of-service  
2 adjustments as provided for in subdivision (e).

3 (4) Reimbursement for Drug Medi-Cal services shall be  
4 determined according to subparagraph (A) or (B), depending on  
5 whether the services are provided in a county that participates in  
6 the Drug Medi-Cal organized delivery system (DMC-ODS).

7 (A) In a county that participates in the DMC-ODS, the FQHC  
8 or RHC shall receive reimbursement pursuant to a mutually agreed  
9 upon contract entered into between the county or county designee  
10 and the FQHC or RHC. If the county or county designee refuses  
11 to contract with the FQHC or RHC, the FQHC or RHC may follow  
12 the contract denial process set forth in the Special Terms and  
13 Conditions.

14 (B) In a county that does not participate in the DMC-ODS, the  
15 FQHC or RHC shall receive reimbursement pursuant to a mutually  
16 agreed upon contract entered into between the county and the  
17 FQHC or RHC. If the county refuses to contract with the FQHC  
18 or RHC, the FQHC or RHC may request to contract directly with  
19 the department and shall be reimbursed for those services at the  
20 Drug Medi-Cal fee-for-service rate.

21 (5) The department shall not reimburse an FQHC or RHC  
22 pursuant to subdivision (h) for the difference between its per-visit  
23 PPS rate and any payments for Drug Medi-Cal services made  
24 pursuant to this subdivision.

25 (6) For purposes of this subdivision, the following definitions  
26 apply:

27 (A) “Drug Medi-Cal organized delivery system” or  
28 “DMC-ODS” means the Drug Medi-Cal organized delivery system  
29 authorized under the California Medi-Cal 2020 Demonstration,  
30 Number 11-W-00193/9, as approved by the federal Centers for  
31 Medicare and Medicaid Services and described in the Special  
32 Terms and Conditions.

33 (B) “Special Terms and Conditions” has the same meaning as  
34 set forth in subdivision (o) of Section 14184.10.

35 (m) Reimbursement for specialty mental health services shall  
36 be provided pursuant to this subdivision.

37 (1) An FQHC or RHC and one or more mental health plans  
38 that contract with the department pursuant to Section 14712 may  
39 mutually elect to enter into a contract to have the FQHC or RHC

1 *provide specialty mental health services to Medi-Cal beneficiaries*  
2 *as part of the mental health plan's network.*

3 *(2) (A) For an FQHC or RHC to receive reimbursement for*  
4 *specialty mental health services pursuant to a contract entered*  
5 *into with the mental health plan under paragraph (1), the costs*  
6 *associated with providing specialty mental health services shall*  
7 *not be included in the FQHC's or RHC's per-visit PPS rate. For*  
8 *purposes of this subdivision, the costs associated with providing*  
9 *specialty mental health services shall not be considered to be*  
10 *within the FQHC's or RHC's clinic base PPS rate if in delivering*  
11 *specialty mental health services the clinic uses different clinical*  
12 *staff at a different location.*

13 *(B) If the FQHC or RHC does not use different clinical staff at*  
14 *a different location to deliver specialty mental health services, the*  
15 *FQHC or RHC shall submit documentation, in a manner*  
16 *determined by the department, that the current per-visit PPS rate*  
17 *does not include any costs related to rendering specialty mental*  
18 *health services, including costs related to utilizing space in part*  
19 *of the FQHC's or RHC's building, that are or were previously*  
20 *calculated as part of the clinic's base PPS rate.*

21 *(3) If the costs associated with providing specialty mental health*  
22 *services are within the FQHC's or RHC's clinic base PPS rate,*  
23 *as determined by the department, the specialty mental health*  
24 *services costs shall be adjusted out of the FQHC's or RHC's*  
25 *per-visit PPS rate as a change in scope of service.*

26 *(A) An FQHC or RHC shall submit to the department a*  
27 *scope-of-service change request to adjust the FQHC's or RHC's*  
28 *clinic base PPS rate after the first full fiscal year of rendering*  
29 *specialty mental health services outside of the PPS rate.*  
30 *Notwithstanding subdivision (e), the scope-of-service change*  
31 *request shall include a full fiscal year of activity that does not*  
32 *include specialty mental health costs.*

33 *(B) An FQHC or RHC may submit requests for a*  
34 *scope-of-service change under this subdivision only within 90 days*  
35 *following the beginning of the FQHC's or RHC's fiscal year. Any*  
36 *scope-of-service change request under this subdivision approved*  
37 *by the department is retroactive to the first day that specialty*  
38 *mental health services were rendered and reimbursement for*  
39 *specialty mental health services was received outside of the PPS*

1 rate, but the effective date shall not be earlier than January 1,  
2 2018.

3 (C) The FQHC or RHC may bill for specialty mental health  
4 services outside of the PPS rate when the FQHC or RHC contracts  
5 with a mental health plan to provide these services pursuant to  
6 paragraph (1).

7 (D) Within 90 days of receipt of the request for a  
8 scope-of-service change under this subdivision, the department  
9 shall issue the FQHC or RHC an interim rate equal to 90 percent  
10 of the FQHC's or RHC's projected allowable cost, as determined  
11 by the department. An audit to determine the final rate shall be  
12 performed in accordance with Section 14170.

13 (E) Rate changes based on a request for scope-of-service change  
14 under this subdivision shall be evaluated in accordance with  
15 Medicare reasonable cost principles, as set forth in Part 413  
16 (commencing with Section 413.1) of Title 42 of the Code of Federal  
17 Regulations, or its successor.

18 (F) For the purpose of recalculating the PPS rate, the FQHC  
19 or RHC shall provide upon request to the department verifiable  
20 documentation as to which employees spent time, and the actual  
21 time spent, providing federally qualified health center services or  
22 rural health center services and specialty mental health services.

23 (G) After the department approves the adjustment to the FQHC's  
24 or RHC's clinic base PPS rate, an FQHC or RHC shall not bill  
25 the PPS rate for any specialty mental health services that are  
26 provided pursuant to a contract entered into with a mental health  
27 plan pursuant to paragraph (1).

28 (H) An FQHC or RHC that reverses its election under this  
29 subdivision shall revert to its prior PPS rate, subject to an increase  
30 to account for all Medicare Economic Index increases occurring  
31 during the intervening time period, and subject to any increase or  
32 decrease associated with the applicable scope-of-service  
33 adjustments as provided for in subdivision (e).

34 (4) The department shall not reimburse an FQHC or RHC  
35 pursuant to subdivision (h) for the difference between its per-visit  
36 PPS rate and any payments made for specialty mental health  
37 services under this subdivision.

38 (n) The department shall seek any necessary federal approvals  
39 and issue appropriate guidance to allow an FQHC or RHC to bill,  
40 under a supervising licensed behavioral health practitioner, for

1 *an encounter between an FQHC or RHC patient and a*  
2 *psychological associate, associate professional clinical counselor,*  
3 *associate clinical social worker, or associate marriage and family*  
4 *therapist when all of the following conditions are met:*

5 *(1) The psychological associate, associate professional clinical*  
6 *counselor, associate clinical social worker, or associate marriage*  
7 *and family therapist is supervised by the designated licensed*  
8 *behavioral health practitioner, as required by their applicable*  
9 *clinical licensing board.*

10 *(2) The behavioral health visit is billed under the supervising*  
11 *licensed practitioner of the FQHC or RHC, pursuant to paragraph*  
12 *(1).*

13 *(3) The FQHC or RHC is otherwise authorized to bill for*  
14 *services provided by the supervising licensed behavioral health*  
15 *practitioner as a separate visit.*

16 *(o) FQHCs and RHCs may appeal a grievance or complaint*  
17 *concerning ratesetting, scope-of-service changes, and settlement*  
18 *of cost report audits, in the manner prescribed by Section 14171.*  
19 *The rights and remedies provided under this subdivision are*  
20 *cumulative to the rights and remedies available under all other*  
21 *provisions of law of this state.*

22 *(p) The department shall promptly seek all necessary federal*  
23 *approvals in order to implement this section, including any*  
24 *amendments to the state plan. To the extent that any element or*  
25 *requirement of this section is not approved, the department shall*  
26 *submit a request to the federal Centers for Medicare and Medicaid*  
27 *Services for any waivers that would be necessary to implement*  
28 *this section.*

29 *(q) The department shall implement this section only to the*  
30 *extent that federal financial participation is available.*

31 *(r) Notwithstanding any other law, the director may, without*  
32 *taking regulatory action pursuant to Chapter 3.5 (commencing*  
33 *with Section 11340) of Part 1 of Division 3 of Title 2 of the*  
34 *Government Code, implement, interpret, or make specific this*  
35 *section by means of a provider bulletin or similar instruction. The*  
36 *department shall notify and consult with interested parties and*  
37 *appropriate stakeholders in implementing, interpreting, or making*  
38 *specific the provisions of this section, including all of the following:*

39 *(1) Notifying provider representatives in writing of the proposed*  
40 *action or change. The notice shall occur, and the applicable draft*

1 provider bulletin or similar instruction, shall be made available  
2 at least 10 business days prior to the meeting described in  
3 paragraph (2).

4 (2) Scheduling at least one meeting with interested parties and  
5 appropriate stakeholders to discuss the proposed action or change.

6 (3) Allowing for written input regarding the proposed action  
7 or change, to which the department shall provide summary written  
8 responses in conjunction with the issuance of the applicable final  
9 written provider bulletin or similar instruction.

10 (4) Providing at least 60 days advance notice of the effective  
11 date of the proposed action or change.

12 (s) This section shall become operative on July 1, 2026.

13 SEC. 105. Section 14132.171 of the Welfare and Institutions  
14 Code is amended to read:

15 14132.171. (a) (1) An annual cognitive health assessment for  
16 Medi-Cal beneficiaries who are 65 years of age or older is a  
17 covered benefit if they are otherwise ineligible for a similar  
18 assessment as part of an annual wellness visit under the Medicare  
19 Program. Subject to paragraph (3), the department shall provide  
20 reimbursement to a Medi-Cal provider who renders this service.

21 (2) The payment for the cognitive health assessment developed  
22 pursuant to paragraph (1) shall only be available upon appropriation  
23 by the Legislature for these purposes.

24 (3) (A) A Medi-Cal provider shall only be eligible to receive  
25 the payment for the benefit specified in paragraph (1) if the  
26 provider ~~complies with both of the following requirements:~~  
27 *conducts the cognitive health assessment using validated tools, as*  
28 *recommended by the department.*

29 ~~(i) Completes cognitive health assessment training, as specified~~  
30 ~~and approved by the department.~~

31 ~~(ii) Conducts the cognitive health assessment using validated~~  
32 ~~tools, as recommended by the department.~~

33 (B) (i) The department shall determine the cognitive health  
34 assessment ~~training and~~ validated tools, as described in  
35 subparagraph (A), in consultation with the State Department of  
36 Public Health's Alzheimer's Disease Program (Article 4  
37 (commencing with Section 125275) of Chapter 2 of Part 5 of  
38 Division 106 of the Health and Safety Code), that program's 10  
39 California Alzheimer's Disease Centers, representatives of primary  
40 care physician specialties, including, but not limited to, family

1 medicine, and the Alzheimer's Disease and Related Disorders  
2 Advisory Committee of the California Health and Human Services  
3 Agency (Chapter 3.1 (commencing with Section 1568.15) of  
4 Division 2 of the Health and Safety Code).

5 (ii) With respect to the validated tools, the department shall  
6 select multiple tools. To improve overall accessibility of these  
7 tools and minimize access barriers, at least one of those tools shall  
8 not carry any restrictions on copyright or trademark.

9 (b) An annual cognitive health assessment shall identify signs  
10 of Alzheimer's disease or dementia, consistent with the standards  
11 for detecting cognitive impairment under the federal Centers for  
12 Medicare and Medicaid Services and the recommendations by the  
13 American Academy of Neurology.

14 (c) By January 1, 2024, ~~and every two years thereafter~~, the  
15 department shall do both of the following:

16 (1) Consolidate and analyze the data on the administration of  
17 the cognitive health assessment in the Medi-Cal managed care and  
18 fee-for-service delivery systems.

19 (2) Post information on the utilization of, and payment for, this  
20 benefit on its internet website.

21 (d) Notwithstanding Chapter 3.5 (commencing with Section  
22 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
23 the department may implement this section, in whole or in part,  
24 by means of all-plan letters, provider bulletins, or similar  
25 instructions, without taking any further regulatory action.

26 (e) This section shall be implemented only to the extent any  
27 necessary federal approvals are obtained and federal financial  
28 participation is available.

29 *SEC. 106. Section 14132.994 is added to the Welfare and*  
30 *Institutions Code, to read:*

31 *14132.994. A Medi-Cal managed care plan, as defined in*  
32 *subdivision (j) of Section 14184.101, shall cover COVID-19*  
33 *screening, testing, immunizations, and therapeutics in accordance*  
34 *with applicable statutes, regulations, all plan letters, the Medi-Cal*  
35 *provider manual, Medi-Cal managed care plan contracts with the*  
36 *department pursuant to this chapter or Chapter 8 (commencing*  
37 *with Section 14200), and other guidance.*

38 *SEC. 107. Section 14133.85 of the Welfare and Institutions*  
39 *Code is amended to read:*

1 14133.85. (a) (1) Except as otherwise provided in this  
2 subdivision, prior authorization shall not be required for hospice  
3 services.

4 (2) Paragraph (1) shall not apply to any admission ~~which~~ *that*  
5 violates federal law.

6 (b) Prior authorization shall be required for inpatient hospice  
7 services.

8 (c) *This section shall become inoperative on July 1, 2026, and,*  
9 *as of January 1, 2027, is repealed.*

10 SEC. 108. *Section 14148.5 of the Welfare and Institutions*  
11 *Code, as amended by Section 152 of Chapter 42 of the Statutes of*  
12 *2023, is amended to read:*

13 14148.5. (a) State-funded perinatal services shall be provided  
14 under the Medi-Cal program to pregnant persons and state-funded  
15 medical services to infants up to one year of age in families with  
16 incomes above 185 percent, but not more than 208 percent, of the  
17 federal poverty level, in the same manner that these services are  
18 being provided to the Medi-Cal population, including eligibility  
19 requirements and integration of eligibility determinations and  
20 payment of claims. When determining eligibility under this section,  
21 an applicant's or beneficiary's income and resources shall be  
22 determined, counted, and valued in accordance with the  
23 methodology set forth in Section 14005.64.

24 (b) Services provided under this section shall not be subject to  
25 any spend down of excess income requirements.

26 (c) (1) The department, in implementing the Medi-Cal program  
27 and public health programs, ~~in coordination with the Managed~~  
28 ~~Risk Medical Insurance Board's Access for Infants and Mothers~~  
29 ~~component~~, may provide for outreach activities in order to enhance  
30 participation and access to perinatal services. Funding received  
31 pursuant to the federal provisions shall be used to expand perinatal  
32 outreach activities. These outreach activities shall be implemented  
33 if funding is provided for this purpose by an appropriation in the  
34 annual Budget Act or other statute.

35 (2) Those outreach activities authorized by paragraph (1) shall  
36 be targeted toward both Medi-Cal and non-Medi-Cal eligible high  
37 risk or uninsured pregnant persons and infants. Outreach activities  
38 may include, but not be limited to, all of the following:



1 (A) Education of the targeted persons on the availability and  
2 importance of early prenatal care and referral to Medi-Cal and  
3 other programs.

4 (B) Information provided through toll-free telephone numbers.

5 (C) Recruitment and retention of perinatal providers.

6 (d) Notwithstanding any other law, contracts required to  
7 implement the provisions of this section shall be exempt from the  
8 approval of the Director of General Services and from the  
9 provisions of the Public Contract Code.

10 ~~(e) This section shall become inoperative on the later of either~~  
11 ~~January 1, 2024, or the date on which the determination of the~~  
12 ~~Director of Health Care Services is communicated to the~~  
13 ~~Department of Finance pursuant to paragraph (2) of subdivision~~  
14 ~~(b) of Section 14005.62, and subject to implementation of Section~~  
15 ~~14005.62 pursuant to subdivision (d) of that section, and shall~~  
16 ~~remain inoperative for time periods in which the department has~~  
17 ~~obtained the necessary federal approvals to implement paragraph~~  
18 ~~(2) of subdivision (b) of Section 14005.62 for the applicable~~  
19 ~~population.~~

20 *(e) This section shall become operative on January 1, 2026.*

21 *SEC. 109. Section 14148.5 of the Welfare and Institutions*  
22 *Code, as added by Section 153 of Chapter 42 of the Statutes of*  
23 *2023, is amended to read:*

24 14148.5. (a) State-funded perinatal services shall be provided  
25 under the Medi-Cal program to pregnant persons and state-funded  
26 medical services to infants up to one year of age in families with  
27 incomes above 185 percent, but not more than 208 percent, of the  
28 federal poverty level, in the same manner that these services are  
29 being provided to the Medi-Cal population, including eligibility  
30 requirements and integration of eligibility determinations and  
31 payment of claims. When determining eligibility under this section,  
32 an applicant's or beneficiary's income shall be determined,  
33 counted, and valued in accordance with the methodology set forth  
34 in Section 14005.64.

35 (b) Services provided under this section shall not be subject to  
36 any spend down of excess income requirements.

37 (c) (1) The department, in implementing the Medi-Cal program  
38 and public health programs, may provide for outreach activities  
39 in order to enhance participation and access to perinatal services.  
40 Funding received pursuant to the federal provisions shall be used

1 to expand perinatal outreach activities. These outreach activities  
2 shall be implemented if funding is provided for this purpose by an  
3 appropriation in the annual Budget Act or other statute.

4 (2) Those outreach activities authorized by paragraph (1) shall  
5 be targeted toward both Medi-Cal and non-Medi-Cal eligible high  
6 risk or uninsured pregnant persons and infants. Outreach activities  
7 may include, but not be limited to, all of the following:

8 (A) Education of the targeted persons on the availability and  
9 importance of early prenatal care and referral to Medi-Cal and  
10 other programs.

11 (B) Information provided through toll-free telephone numbers.

12 (C) Recruitment and retention of perinatal providers.

13 (d) Notwithstanding any other law, contracts required to  
14 implement this section shall be exempt from the approval of the  
15 Director of General Services and from the Public Contract Code.

16 ~~(e) This section shall become operative on the later of either~~  
17 ~~January 1, 2024, or the date on which the determination of the~~  
18 ~~Director of Health Care Services is communicated to the~~  
19 ~~Department of Finance pursuant to paragraph (2) of subdivision~~  
20 ~~(b) of Section 14005.62, and subject to implementation of Section~~  
21 ~~14005.62 pursuant to subdivision (d) of that section, and shall~~  
22 ~~remain operative for time periods in which the department has~~  
23 ~~obtained the necessary federal approvals to implement paragraph~~  
24 ~~(2) of subdivision (b) of Section 14005.62 for the applicable~~  
25 ~~population.~~

26 *(e) This section shall become inoperative on January 1, 2026,*  
27 *and, as of January 1, 2027, is repealed.*

28 *SEC. 110. Section 14165.57 of the Welfare and Institutions*  
29 *Code is amended to read:*

30 14165.57. (a) The IGT allocation formula shall use data from  
31 each nondesignated public hospital's latest Hospital Annual  
32 Financial Disclosure Report on file with OSHPD as of March 1  
33 of each prior fiscal year and shall be as follows:

34 (1) The Nondesignated Public Hospital IGT Pool shall be  
35 allocated into two allocations: the Contract Hospitals allocation  
36 and the Non-Contract Hospitals allocation. This allocation shall  
37 be made to each group, respectively, based upon the ratio of  
38 Medi-Cal fee-for-service acute patient days listed in the latest  
39 OSHPD Annual Financial Disclosure Report for Contract Hospitals  
40 and Non-Contract Hospitals to the total Medi-Cal fee-for-service

1 acute patient days provided by all Contract Hospitals and  
2 Non-Contract Hospitals. Medi-Cal fee-for-service acute patient  
3 days for converted hospitals and new hospitals will not be included  
4 in this allocation.

5 (2) The department shall determine if a nondesignated public  
6 hospital provides services in either a federally recognized Health  
7 Professional Shortage Area or to a federally recognized Medically  
8 Underserved Area or Population. The department shall also  
9 determine if the nondesignated public hospital is federally  
10 recognized as either a Critical Access Hospital or a Sole  
11 Community Provider. If any of these conditions apply, the hospital  
12 shall score one point. Otherwise, the hospital shall score zero  
13 points.

14 (3) The department shall calculate for each nondesignated public  
15 hospital the charity care charges as a percentage of the hospital's  
16 total gross revenue. If the charity care charges are greater than or  
17 equal to 3 percent of the total gross revenue, the hospital shall  
18 score three points. If the charity care charges are less than 3  
19 percent, but more than or equal to 1 percent, of the total gross  
20 revenue, the hospital shall score two points. If the charity care  
21 charges are less than 1 percent, but greater than 0 percent, of the  
22 total gross revenue, the hospital shall score one point. If charity  
23 care charges are less than or equal to 0 percent, of the total gross  
24 revenue, the hospital shall score zero points.

25 (4) The department shall calculate for each nondesignated public  
26 hospital the bad debt charges as a percentage of the hospital's other  
27 payer's gross revenue, as disclosed in the Hospital Annual  
28 Financial Disclosure Report. If the bad debt charges are greater  
29 than or equal to 40 percent of the other gross revenue, the hospital  
30 shall score two points. If the bad debt charges are less than 40  
31 percent, but greater than 0 percent, of the other gross revenue, the  
32 hospital shall score one point. If the bad debt charges are less than  
33 or equal to 0 percent, of the other gross revenue, the hospital shall  
34 score zero points.

35 (5) The department shall calculate for each nondesignated public  
36 hospital the Medi-Cal charges as a percentage of the hospital's  
37 total gross revenue. If the Medi-Cal charges are greater than or  
38 equal to 25 percent of the total gross revenue, the hospital shall  
39 score three points. If the Medi-Cal charges are less than 25 percent,  
40 but more than or equal to 12 percent, of the total gross revenue,

1 the hospital shall score two points. If the Medi-Cal charges are  
2 less than 12 percent, but greater than 0 percent, of the total gross  
3 revenue, the hospital shall score one point. If the Medi-Cal charges  
4 are less than or equal to 0 percent of total gross revenue, the  
5 hospital shall score zero points.

6 (6) The sum of each nondesignated public hospital's points  
7 accumulated pursuant to paragraphs (2) to (5), inclusive, shall  
8 constitute the hospital's IGT Formula Score. The IGT Formula  
9 Score for a new hospital or a converted hospital shall be equal to  
10 zero.

11 (7) The Contract Hospital allocation shall be allocated among  
12 Contract Hospitals and the Non-Contract Hospital allocation shall  
13 be allocated among Non-Contract Hospitals to determine  
14 preliminary allocations in accordance with the following:

15 (A) Each Contract Hospital that has an IGT Formula Score of  
16 between seven and nine, inclusive, shall be allocated three times  
17 the amount of the Contract Hospital allocation that is allocated to  
18 each Contract Hospital that has a score of one to three, inclusive.

19 (B) Each Contract Hospital that has an IGT Formula Score of  
20 between four and six, inclusive, shall be allocated two times the  
21 amount of the Contract Hospital allocation that is allocated to each  
22 Contract Hospital that has an IGT Formula Score of one to three,  
23 inclusive.

24 (C) Each Non-Contract Hospital that has an IGT Formula Score  
25 of between seven and nine, inclusive, shall be allocated three times  
26 the amount of the Non-Contract Hospital allocation that is allocated  
27 to each Non-Contract Hospital that has an IGT Formula Score of  
28 one to three, inclusive.

29 (D) Each Non-Contract Hospital that has an IGT Formula Score  
30 of between four and six, inclusive, shall be allocated two times  
31 the amount of the Non-Contract Hospital allocation that is allocated  
32 to each Non-Contract Hospital that has an IGT Formula Score of  
33 one to three, inclusive.

34 (E) No amount shall be allocated to a nondesignated public  
35 hospital with an IGT Formula Score of zero points.

36 (8) The sum of the preliminary allocation determined under  
37 paragraph (7) for all hospitals within each IGT Formula Group  
38 shall be reallocated among the hospitals within each IGT Formula  
39 Group based on the ratio of each hospital's staffed acute beds listed

1 in the latest OSHPD Annual Financial Disclosure Report, to the  
2 total staffed acute beds of all hospitals in the IGT Formula Group.

3 (b) By no later than September 1 of the 2011–12 fiscal year or  
4 as soon thereafter as federal approvals are obtained, and by no  
5 later than September 1 of each fiscal year thereafter, the department  
6 shall provide each nondesignated public hospital with an estimated  
7 IGT allocation notice that includes the calculations and data sources  
8 used to calculate the estimated IGT allocation, as described in this  
9 section.

10 (c) Each nondesignated public hospital shall have 30 days from  
11 receipt of the estimated IGT allocation notice from the department  
12 to review the department’s hospital-specific estimated IGT  
13 allocation and to notify the department of any data or calculation  
14 errors. If the hospital does not respond within 30 days, the  
15 information will be deemed accurate. No later than November 30  
16 of each fiscal year, the department shall incorporate all appropriate  
17 corrections or data updates for all of the nondesignated public  
18 hospitals and then recalculate the IGT allocations using the IGT  
19 allocation formula to obtain a final IGT allocation for each  
20 nondesignated public hospital.

21 (d) Beginning with the 2011–12 fiscal year, on or before  
22 December 1 or as soon thereafter as federal approvals are obtained,  
23 and by no later than December 1 of each fiscal year thereafter, the  
24 department shall send each nondesignated public hospital a notice  
25 of eligibility indicating the final IGT allocation for the  
26 nondesignated public hospital. The nondesignated public hospital  
27 shall have 20 business days after receipt of the notice to either  
28 accept or decline the offer. If a nondesignated public hospital  
29 accepts the offer, the nondesignated public hospital may enter into  
30 an IGT agreement with the department. If the department receives  
31 no response, the offer will be considered declined.

32 (e) Before the later of December 31 of the 2011–12 fiscal year,  
33 the date upon which all federal approvals are obtained, and by no  
34 later than January 15 of each state fiscal year thereafter, the  
35 department shall document all nondesignated public hospital IGT  
36 allocation offers that are either accepted or declined. After the  
37 department has recorded all IGT allocations as being either  
38 accepted or declined, any remaining unsubscribed IGT allocations  
39 will be allocated to all the other participating nondesignated public  
40 hospitals on a pro rata basis based on the final IGT allocations

1 calculated pursuant to subdivision (b) during January of each fiscal  
2 year. The department shall inform each nondesignated public  
3 hospital participating in the program of the revised final IGT  
4 allocation assigned to that hospital by January 30. At that time,  
5 the department shall give each nondesignated public hospital  
6 participant five days to accept or decline participation in the  
7 program.

8 (f) The state may accept all public funds in the amount of the  
9 final IGT allocation from a transferring entity pursuant to this  
10 section, provided that any funds from a transferring entity must  
11 be permitted by law to be used for these purposes. The transferring  
12 entity shall certify to the department that the funds it proposes to  
13 transfer satisfy the requirements of this subdivision, and are in  
14 compliance with all federal rules and regulations.

15 (g) The state shall deposit the funds received from the  
16 transferring entities pursuant to this article into the Medi-Cal  
17 Inpatient Payment Adjustment Fund established in accordance  
18 with Section 14163.

19 (h) Nondesignated public hospitals participating in the program  
20 shall inform the public entity funding the IGT to transfer the  
21 appropriate IGT allocation, by February 5 of each fiscal year, to  
22 the state according to the time schedule specified in the written  
23 agreement specified in subdivision (d). By March 31 of each fiscal  
24 year, the department shall make the supplemental payment to the  
25 nondesignated public hospital including the associated federal  
26 financial participation. The deadlines set forth in this subdivision  
27 shall be implemented beginning with the 2011–12 fiscal year or  
28 as soon thereafter as federal approvals are obtained.

29 (i) The department shall establish written policies and procedures  
30 for transferring entity intergovernmental transfers and payments  
31 made to nondesignated public hospitals pursuant to this section.  
32 The department shall effectively communicate these policies and  
33 procedures to nondesignated public hospitals and the public entities  
34 that will be funding the IGTs in order to facilitate a smooth process  
35 using local public entity moneys for purposes of drawing down  
36 federal financial participation for supplemental payments to  
37 nondesignated public hospitals.

38 (j) (1) *A nondesignated public hospital participating in the*  
39 *program, as a condition of receiving supplemental payment*

*pursuant to this section, shall reimburse the department for the costs of administering this section.*

~~(j) The~~

*(2) For each fiscal year up to and including the 2025–26 fiscal year, the state shall retain 9 percent of each IGT amount to reimburse the department, or transfer to the General Fund, for the administrative costs of operating the Nondesignated Public Hospital Intergovernmental Transfer Program and for the benefit of Medi-Cal children’s health care programs.*

*(3) (A) Beginning with the 2026–27 fiscal year and every fiscal year thereafter, the state shall retain a percentage of each IGT amount associated with interim supplemental payments such that the total amount retained is equal to the projected administrative cost to the department associated with implementing this section. The department shall project the administrative cost associated with implementing this section each fiscal year in order to determine the percentage of each IGT associated with interim supplemental payments to be retained. That calculation shall account for any excess funds remaining from a prior fiscal year.*

*(B) It is the intent of the Legislature in enacting the changes to this section made by the act that added this paragraph to provide the supplement payment described in this section without any expenditure from the General Fund, beginning with the 2026–27 fiscal year and every fiscal year thereafter.*

*(k) Participation in the intergovernmental transfers under this article is voluntary on the part of the transferring entities for the purpose of all applicable federal laws.*

*(l) (1) The department shall report annually to the Legislature on the Nondesignated Public Hospital Intergovernmental Transfer Program. This report shall include, but not be limited to, the amount of funds available within the UPL, the total amount of IGT allocation funds transferred by public entities, the total amount of federal financial participation received by nondesignated public hospitals, and information on the effectiveness of the IGT allocation formula to distribute available federal matching funds among participating nondesignated public hospitals.*

*(2) The requirement for submitting a report to the Legislature on the Nondesignated Public Hospital Intergovernmental Transfer Program imposed under paragraph (1) is inoperative four years after the date the first report is due.*

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

(m) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this article by means of policy letters or similar instructions, without taking further regulatory action.

*SEC. 111. Section 14166.17 of the Welfare and Institutions Code is amended to read:*

14166.17. (a) The California Medical Assistance Commission shall negotiate payment amounts in accordance with the selective provider contracting program established pursuant to Article 2.6 (commencing with Section 14081) from the Nondesignated Public Hospital Supplemental Fund established pursuant to subdivision (b) for distribution to nondesignated public hospitals that satisfy the criteria of subdivision (c). Pursuant to Section 14165, on and after July 1, 2012, the Director of Health Care Services shall exercise the discretion granted to the California Medical Assistance Commission.

(b) (1) The Nondesignated Public Hospital Supplemental Fund is hereby established in the State Treasury. For purposes of this section, “fund” means the Nondesignated Public Hospital Supplemental Fund.

(2) *Effective December 31, 2028, the Nondesignated Public Hospital Supplemental Fund in the State Treasury, created pursuant to this section, is hereby abolished. All moneys remaining in the fund or moneys designated to be deposited to the fund shall be transferred to the General Fund.*

(c) Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to the department for the purposes specified in this section.

(d) Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) One million nine hundred thousand dollars (\$1,900,000), which shall be transferred annually from General Fund amounts appropriated in the annual Budget Act for the fund.

(2) Any additional moneys appropriated to the fund.

(3) All stabilization funding transferred to the fund.



1 (4) All private moneys donated by private individuals or entities  
2 to the department for deposit in the fund as permitted under  
3 applicable federal Medicaid laws.

4 (5) Any interest that accrues on amounts in the fund.

5 (e) The department may accept or not accept moneys offered  
6 to the department for deposit in the fund. If the department accepts  
7 moneys pursuant to this section, the department shall obtain federal  
8 financial participation to the full extent permitted by law. With  
9 respect to funds transferred or donated from private individuals or  
10 entities, the department shall accept only those funds that are  
11 certified by the transferring or donating entity as qualifying for  
12 federal financial participation under the terms of the Medicaid  
13 Voluntary Contribution and Provider-Specific Tax Amendments  
14 of 1991 (Public Law 102-234) or Section 433.51 of Title 42 of the  
15 Code of Federal Regulations, as applicable. The department may  
16 return any funds transferred or donated in error.

17 (f) Moneys in the funds shall be used as the source for the  
18 nonfederal share of payments to hospitals under this section.

19 (g) Any funds remaining in the fund at the end of a fiscal year  
20 shall be carried forward for use in the following fiscal year.

21 (h) Moneys shall be allocated from the fund by the department  
22 and shall be applied to obtain federal financial participation in  
23 accordance with customary Medi-Cal accounting procedures for  
24 purposes of payments under this section. Distributions from the  
25 fund shall be supplemental to any other Medi-Cal reimbursement  
26 received by the hospitals, including amounts that hospitals receive  
27 under the selective provider contracts negotiated under Article 2.6  
28 (commencing with Section 14081), and shall not affect provider  
29 rates paid under the selective provider contracting program.

30 (i) Each nondesignated public hospital that was a nondesignated  
31 public hospital during the 2002–03 fiscal year, received payments  
32 for the 2002–03 fiscal year from any of the prior supplemental  
33 funds, and, during the project year satisfies the criteria in  
34 subdivision (o) to be eligible to negotiate for distributions under  
35 any of those sections shall receive no less from the Nondesignated  
36 Public Hospital Supplemental Fund for the project year than 100  
37 percent of the amount the hospital received from the prior  
38 supplemental funds for the 2002–03 fiscal year, minus the total  
39 amount of intergovernmental transfers made by or on behalf of  
40 the hospital pursuant to subdivision (o) for the same fiscal year.

1 Each hospital described in this subdivision shall be eligible for  
2 additional payments from the fund pursuant to subdivision (j).

3 (j) ~~All~~(1) *For each fiscal year up to and including the 2024–25*  
4 *fiscal year, all amounts that are in the fund for a project year in*  
5 *excess of the amount necessary to make the payments under*  
6 *subdivision (i) shall be available for negotiation by the California*  
7 *Medical Assistance Commission, along with corresponding federal*  
8 *financial participation, for supplemental payments to nondesignated*  
9 *public hospitals that for the project year satisfy the criteria under*  
10 *subdivision (o) to be eligible to negotiate for distributions under*  
11 *any of those sections, and paid for services rendered during the*  
12 *project year pursuant to the selective provider contracting program*  
13 *under Article 2.6 (commencing with Section 14081).*

14 (2) *For the 2025–26 fiscal year, all amounts that are in the fund*  
15 *for a project year in excess of the amount necessary to make the*  
16 *payments under subdivision (i) shall be available for supplemental*  
17 *payments to nondesignated public hospitals, as follows:*

18 (A) *Additional supplemental payments shall be made to*  
19 *nondesignated public hospitals that meet the criteria for*  
20 *supplemental payments pursuant to paragraph (1) such that the*  
21 *payments under this subparagraph together with the payments*  
22 *under subdivision (i) to those hospitals are equal to the amounts*  
23 *transferred to the fund pursuant to paragraph (1) of subdivision*  
24 *(d) plus the applicable amount of federal financial participation*  
25 *that is available for the nonfederal share of payments described*  
26 *in paragraph (1) of subdivision (d).*

27 (B) *All remaining amounts in the fund, including any funds that*  
28 *have been carried forward pursuant to subdivision (g), shall be*  
29 *used for supplemental payments to nondesignated public hospitals*  
30 *pursuant to a methodology developed by the department that is*  
31 *based on all Medi-Cal inpatient days, as described in Section*  
32 *1396r-4(b)(2) of Title 42 of the United States Code, in the*  
33 *numerator of the Medi-Cal inpatient utilization rate for each*  
34 *hospital, as determined in the most recent final calculation of the*  
35 *Medi-Cal inpatient utilization rate pursuant to paragraph (4) of*  
36 *subdivision (f) of Section 14105.98 as of July 1, 2025.*

37 (k) The amount of any stabilization funding transferred to the  
38 fund with respect to a project year may in the discretion of the  
39 California Medical Assistance Commission, until its dissolution  
40 on June 30, 2012, to be paid for services furnished in the same

project year regardless of when the stabilization funds become available, provided the payment is consistent with other applicable federal or state legal requirements and does not result in a hospital exceeding any applicable reimbursement limitations. On and after July 1, 2012, the Director of Health Care Services shall exercise the discretion granted to the California Medical Assistance Commission by this subdivision.

(l) The department shall pay amounts due to a nondesignated hospital from the fund for a project year, with the exception of stabilization funding, in up to four installment payments, unless otherwise provided in the hospital's contract negotiated with the California Medical Assistance Commission, except that hospitals that are not described in subdivision (i) shall not receive the first installment payment. The first payment shall be made as soon as practicable after the issuance of the tentative disproportionate share hospital list for the project year, and in no event later than January 1 of the project year. The second and subsequent payments shall be made after the issuance of the final disproportionate hospital list for the project year, and shall be made only to hospitals that are on the final disproportionate share hospital list for the project year. The second payment shall be made by February 1 of the project year or as soon as practicable after the issuance of the final disproportionate share hospital list for the project year. The third payment, if scheduled, shall be made by April 1 of the project year. The fourth payment, if scheduled, shall be made by June 30 of the project year. This subdivision does not apply to hospitals that are scheduled to receive payments from the fund because they meet the criteria under paragraph (2) of subdivision (o) but do not meet the criteria under paragraph (1), (3), or (4) of subdivision (o).

(m) The department shall pay stabilization funding transferred to the fund in amounts negotiated by the California Medical Assistance Commission and paid in accordance with the applicable contract or contract amendment.

(n) A nondesignated public hospital that receives payment pursuant to this section for a particular project year shall not submit a notice for the termination of its participation in the selective provider contracting program established pursuant to Article 2.6 (commencing with Section 14081) until the later of the following dates:

- (1) On or after December 31 of the next project year.

1 (2) The date specified in the hospital's contract, if applicable.

2 (o) In order for a hospital to receive distributions pursuant to  
3 Article 2.6 (commencing with Section 14081), the hospital shall  
4 satisfy the eligibility criteria in paragraph (1), (2), (3), or (4) of  
5 this subdivision.

6 (1) The hospital meets all of the following criteria:

7 (A) The hospital is contracting under Article 2.6 (commencing  
8 with Section 14081).

9 (B) The hospital meets the criteria contained in the Medicaid  
10 State Plan for disproportionate share hospital status.

11 (C) The hospital is one of the following:

12 (i) A licensed provider of basic emergency services as described  
13 in Section 70411 of Title 22 of the California Code of Regulations.

14 (ii) A licensed provider of comprehensive emergency medical  
15 services as defined in Section 70451 of Title 22 of the California  
16 Code of Regulations.

17 (iii) A children's hospital, as defined in Section 14087.21, that  
18 satisfies clause (i) or (ii), or that jointly provides basic or  
19 comprehensive emergency services in conjunction with another  
20 licensed hospital.

21 (iv) A hospital owned and operated by a public agency that  
22 operates two or more hospitals that qualify under subparagraph  
23 (A) or (B) with respect to the particular state fiscal year.

24 (v) A hospital designated by the National Cancer Institute as a  
25 comprehensive or clinical cancer research center that primarily  
26 treats acutely ill cancer patients and that is exempt from the federal  
27 Medicare prospective payment system pursuant to Section  
28 1886(d)(1)(B)(v) of the federal Social Security Act (42 U.S.C.  
29 Sec. 1395ww(d)(1)(B)(v)).

30 (D) (1) The hospital is able to demonstrate a purpose for  
31 additional funding under the selective provider contracting program  
32 including proposals relating to emergency services and other health  
33 care services, including infrequent yet high-cost services, such as  
34 anti-AB human antitoxin treatment for infant botulism (human  
35 botulinum immune globulin (HBIG), commonly referred to as  
36 "Baby-BIG"), that are made available, or will be made available,  
37 to Medi-Cal beneficiaries.

38 (2) The hospital is contracting under Article 2.6 (commencing  
39 with Section 14081) and meets the definition of a university  
40 teaching hospital or major, nonuniversity, teaching hospital as set

1 forth on page 51 and as listed on page 57 of the department's report  
2 dated May 1991, entitled "Hospital Peer Grouping." Payments  
3 from the fund shall be used solely for the purposes identified in  
4 the contract between the hospital and the state.

5 (3) The hospital is contracting under Article 2.6 (commencing  
6 with Section 14081) and meets the definition of any of the  
7 following:

8 (A) A large teaching emphasis hospital, as set forth on page 51  
9 and listed on page 57 of the department's report dated May 1991,  
10 entitled "Hospital Peer Grouping," and also meets the definition  
11 of eligible hospital as defined in paragraph (3) of subdivision (a)  
12 of Section 14105.98.

13 (B) A children's hospital pursuant to Section 10727, and also  
14 meets the definition of eligible hospital as defined in paragraph  
15 (3) of subdivision (a) of Section 14105.98.

16 (C) Notwithstanding the requirement in subparagraph (A) of  
17 paragraph (3) that a hospital must be listed on page 57 of the  
18 department's report dated May 1991, entitled "Hospital Peer  
19 Grouping," any hospital whose license pursuant to Chapter 2  
20 (commencing with Section 1250) of Division 2 of the Health and  
21 Safety Code was consolidated during the 1999 calendar year with  
22 a large teaching emphasis hospital that is listed on page 57 of the  
23 above-described report shall be eligible. All other requirements of  
24 paragraph (3) shall continue to apply.

25 (4) The hospital meets all of the following criteria:

26 (A) The hospital is contracting under Article 2.6 (commencing  
27 with Section 14081).

28 (B) The hospital satisfies the Medicaid State Plan criteria for  
29 disproportionate share hospital status.

30 (C) The hospital is a small and rural hospital as defined in  
31 Section 124840 of the Health and Safety Code.

32 (D) The hospital is a licensed provider of standby emergency  
33 services as described in Section 70649 of Title 22 of the California  
34 Code of Regulations.

35 (E) The hospital is able to demonstrate a purpose for additional  
36 funding under the selective provider contracting program with  
37 proposals relating to health care services that are made available,  
38 or will be made available, to Medi-Cal beneficiaries.

39 (F) The hospital is determined by the California Medical  
40 Assistance Commission to be a hospital that provides an important

1 community service that otherwise would not be provided in the  
2 community.

3 *(p) This section shall become inoperative on June 30, 2026,*  
4 *and, as of July 1, 2030, is repealed. The department may conduct*  
5 *any necessary and remaining duties related to this section even*  
6 *after the section becomes inoperative.*

7 *SEC. 112. Section 14184.200 of the Welfare and Institutions*  
8 *Code is amended to read:*

9 14184.200. (a) Notwithstanding any other law, the department  
10 may standardize those populations that are subject to mandatory  
11 enrollment in a Medi-Cal managed care plan across all aid code  
12 groups and Medi-Cal managed care models statewide, subject to  
13 a Medi-Cal managed care plan readiness, continuity of care  
14 transition plan, and disenrollment process developed in consultation  
15 with stakeholders, in accordance with the CalAIM Terms and  
16 Conditions and as described in this section.

17 (1) (A) The department shall ensure the Medi-Cal managed  
18 care plan's readiness for network adequacy includes a geographic  
19 access review of rural ZIP Codes to ensure time or distance  
20 standards are met, or alternative access standard requests are  
21 approved, as applicable, and the plan's ability to meet existing  
22 federal and state mandatory provider type requirements, where  
23 available.

24 (B) The department shall not require a population to enroll in  
25 managed care if Medi-Cal managed care plans fail to meet the  
26 Medi-Cal managed care plan readiness requirements detailed in  
27 this paragraph for that population.

28 (2) The Medi-Cal managed care plan shall comply with the  
29 continuity of care requirements in Section 1373.96 of the Health  
30 and Safety Code and shall be consistent with and no more  
31 restrictive than existing or future policy and guidance issued by  
32 the department, including All Plan Letter 22-032, any superseding  
33 all plan letter, and related guidance.

34 (3) The disenrollment process for an enrollee in any county  
35 shall be consistent with and no more restrictive than existing federal  
36 and state statutes and regulations, including Section 53889 and  
37 subdivision (c) of Section 53891 of Title 22 of the California Code  
38 of Regulations. The beneficiary may request a medical exemption  
39 from mandatory enrollment in a Medi-Cal managed care plan in  
40 accordance with Section 53887 of Title 22 of the California Code

of Regulations and may disenroll or be exempted from mandatory enrollment under the limited circumstances set forth in subdivision (c) of Section 53891 of Title 22 of the California Code of Regulations. That disenrollment or exemption from mandatory enrollment in a Medi-Cal managed care plan shall be consistent with subsection (c) of Section 438.56 of Title 42 of the Code of Federal Regulations and applicable state law.

(b) (1) Notwithstanding any other law, if the department standardizes those populations subject to mandatory enrollment in a Medi-Cal managed care plan pursuant to subdivision (a), commencing January 1, 2022, and subject to subdivision (f) of Section 14184.102, a non-dual-eligible beneficiary, except a beneficiary identified in paragraph (2), shall be required to enroll, or shall continue to be required to enroll, in a Medi-Cal managed care plan for purposes of their receipt of covered Medi-Cal benefits.

(2) Notwithstanding any other law, if the department standardizes those populations subject to mandatory enrollment in a Medi-Cal managed care plan pursuant to subdivision (a), commencing January 1, 2022, subject to subdivision (f) of Section 14184.102, the following dual and non-dual beneficiary groups, as identified by the department, shall be exempt from mandatory enrollment in a Medi-Cal managed care plan:

(A) A beneficiary eligible for only restricted-scope Medi-Cal benefits, as described in subdivision (d) of Section ~~14007.5~~ *14007.5 and Sections 14005.65 and 14007.7*.

(B) A beneficiary made eligible on the basis of a share of cost, including, but not limited to, a non-dual-eligible beneficiary residing in a county that is authorized to operate a county organized health system (COHS), as described in Article 2.8 (commencing with Section 14087.5), except for a non-dual-eligible beneficiary that is eligible on the basis of their need for long-term care services with a share of cost, as identified by the department.

(C) A beneficiary made eligible on the basis of a federally approved Medi-Cal Presumptive Eligibility program, as determined by the department, but only during the relevant period of presumptive eligibility.

(D) An eligible beneficiary who is an inmate of a public institution, or who is released pursuant to Section 26605.6 or 26605.7 of the Government Code.

1 (E) A beneficiary with satisfactory immigration status, including  
2 a noncitizen that is lawfully present, who is eligible for only  
3 pregnancy-related Medi-Cal coverage and who received services  
4 through the Medi-Cal fee-for-service delivery system prior to  
5 January 1, 2022, as identified by the department, but only through  
6 the end of the postpartum period.

7 (F) A beneficiary without satisfactory immigration status or  
8 who is unable to establish satisfactory immigration status as  
9 required by Section 14011.2, who is eligible for only  
10 pregnancy-related Medi-Cal coverage, excluding a beneficiary  
11 enrolled in the Medi-Cal Access Program described in Chapter 2  
12 (commencing Section 15810) of Part 3.3.

13 (G) A non-dual-eligible beneficiary who is an Indian, as defined  
14 in subdivision (a) of Section 438.14 of Title 42 of the Code of  
15 Federal Regulations, and who elects to forego voluntary enrollment  
16 in a Medi-Cal managed care plan.

17 (H) A non-dual-eligible beneficiary eligible on the basis of their  
18 receipt of services through a state foster care program, or eligible  
19 pursuant to Section 14005.28, who elects to forego voluntary  
20 enrollment in a Medi-Cal managed care plan, except for a non-dual  
21 beneficiary described in this subparagraph who resides in a county  
22 that is authorized to operate COHS, as described in Article 2.8  
23 (commencing with Section 14087.5), or, effective January 1, 2025,  
24 in a county operating a Single Plan model of managed care  
25 established under Article 2.7 (commencing with Section 14087.3)  
26 and Article 2.8 (commencing with Section 14087.5). For the  
27 purpose of this subdivision, the following requirements shall apply  
28 to non-dual-eligible beneficiaries eligible on the basis of their  
29 receipt of services through a state foster care program, or eligible  
30 pursuant to Section 14005.28, who are transitioning to mandatory  
31 enrollment in a Medi-Cal managed care plan in a county operating  
32 a Single Plan model of managed care:

33 (i) Medi-Cal managed care plans shall comply with the access  
34 requirements in Section 14197 and in accordance with All Plan  
35 Letter 23-001, any superseding all plan letter, and any related  
36 guidance.

37 (ii) The department shall use the Intercounty Transfer process  
38 as outlined in All County Welfare Directors Letter 18-02E to  
39 provide for immediate access to care and treatment services in the



1 month of enrollment when a beneficiary moves from one county  
2 to another.

3 (iii) The department shall issue guidance with input from  
4 stakeholders, including county child welfare departments.

5 (I) A non-dual-eligible beneficiary enrolled with an entity with  
6 a contract with the department pursuant to the Program of  
7 All-Inclusive Care for the Elderly (PACE), as described in Chapter  
8 8.75 (commencing with Section 14591).

9 (J) Any other non-dual-eligible beneficiary, as identified by the  
10 department, for whom federal law prohibits mandatory enrollment  
11 in a Medi-Cal managed care plan.

12 (K) A beneficiary residing in one of the Veterans' Homes of  
13 California, as described in Chapter 1 (commencing with Section  
14 1010) of Division 5 of the Military and Veterans Code.

15 (c) (1) Notwithstanding any other law, if the department  
16 standardizes those populations subject to mandatory enrollment  
17 in a Medi-Cal managed care plan pursuant to subdivision (a),  
18 commencing January 1, 2023, and subject to subdivision (f) of  
19 Section 14184.102, a dual eligible beneficiary, except as provided  
20 in paragraph (2) of subdivision (b) or paragraph (2) of this  
21 subdivision, shall be required to enroll, or shall continue to be  
22 required to enroll, in a Medi-Cal managed care plan for purposes  
23 of their receipt of covered Medi-Cal benefits.

24 (2) The following dual eligible beneficiary groups, as identified  
25 by the department, shall be exempt from mandatory enrollment in  
26 Medi-Cal managed care as described in paragraph (1):

27 (A) A dual eligible beneficiary made eligible on the basis of a  
28 share of cost, including, but not limited to, a dual eligible  
29 beneficiary residing in a county that is authorized to operate COHS,  
30 as described in Article 2.8 (commencing with Section 14087.5),  
31 except for a dual eligible beneficiary who is eligible on the basis  
32 of their need for long-term care services with a share of cost, as  
33 determined by the department.

34 (B) A dual eligible beneficiary enrolled with an entity with a  
35 contract with the department pursuant to PACE as described in  
36 Chapter 8.75 (commencing with Section 14591).

37 (C) A dual eligible beneficiary enrolled with an entity with a  
38 Senior Care Action Network (SCAN) contract with the department.

39 (D) A dual eligible beneficiary who is an Indian, as defined in  
40 subsection (a) of Section 438.14 of Title 42 of the Code of Federal

1 Regulations, and who elects to forego voluntary enrollment in a  
2 Medi-Cal managed care plan.

3 (E) A dual eligible beneficiary with HIV/AIDS who elects to  
4 forego voluntary enrollment in a Medi-Cal managed care plan.

5 (F) A dual eligible beneficiary eligible on the basis of their  
6 receipt of services through a state foster care program, or eligible  
7 pursuant to Section 14005.28, who elects to forego voluntary  
8 enrollment in a Medi-Cal managed care plan, except for a dual  
9 beneficiary described in this subparagraph who resides in a county  
10 that is authorized to operate COHS, as described in Article 2.8  
11 (commencing with Section 14087.5), or, effective January 1, 2025,  
12 in a county operating a Single Plan model of managed care  
13 established under Article 2.7 (commencing with Section 14087.3)  
14 and Article 2.8 (commencing with Section 14087.5). For the  
15 purpose of this subdivision, the following requirements shall apply  
16 to non-dual-eligible beneficiaries eligible on the basis of their  
17 receipt of services through a state foster care program, or eligible  
18 pursuant to Section 14005.28, who are transitioning to mandatory  
19 enrollment in a Medi-Cal managed care plan in a county operating  
20 a Single Plan model of managed care:

21 (i) Medi-Cal managed care plans shall comply with the access  
22 requirements in Section 14197 and in accordance with All Plan  
23 Letter 23-001, any superseding all plan letter, and any related  
24 guidance.

25 (ii) The department shall use the Intercounty Transfer process  
26 as outlined in All County Welfare Directors Letter 18-02E to  
27 provide for immediate access to care and treatment services in the  
28 month of enrollment when a beneficiary moves from one county  
29 to another.

30 (iii) The department shall issue guidance with input from  
31 stakeholders, including county child welfare departments.

32 (G) A dual eligible beneficiary residing in one of the Veterans'  
33 Homes of California, as described in Chapter 1 (commencing with  
34 Section 1010) of Division 5 of the Military and Veterans Code.

35 (H) Any other dual eligible beneficiary, as identified by the  
36 department, for whom federal law prohibits mandatory enrollment  
37 in a Medi-Cal managed care plan.

38 (d) (1) This section shall not prohibit a Medi-Cal beneficiary  
39 from receiving covered benefits on a temporary basis through the  
40 Medi-Cal fee-for-service delivery system pending enrollment into

1 an individual Medi-Cal managed care plan in accordance with this  
2 section and the CalAIM Terms and Conditions.

3 (2) This section shall not prohibit certain Medi-Cal beneficiaries  
4 eligible for full-scope benefits under the Medi-Cal State plan, as  
5 identified by the department, from voluntarily enrolling in a  
6 Medi-Cal managed care plan, in accordance with the CalAIM  
7 Terms and Conditions.

8 (e) (1) No later than January 1, 2023, in all non-County  
9 Organized Health System counties, in areas where a PACE plan  
10 is available, the PACE plan shall be presented as an enrollment  
11 option, included in enrollment materials, and made available to an  
12 applicable beneficiary whenever enrollment choices and options  
13 are presented. Outreach and enrollment materials shall enable a  
14 Medi-Cal beneficiary to understand what PACE provides, that, if  
15 eligible, they may be assessed for PACE eligibility and enroll in  
16 PACE, and how they can receive additional information and request  
17 to be assessed for PACE eligibility. A person meeting the age  
18 qualifications for PACE and who chooses PACE shall not be  
19 assigned to a Medi-Cal managed care plan for the lesser of 60 days  
20 or until they are assessed for eligibility for PACE and determined  
21 not to be eligible for PACE. A person enrolled in a PACE plan  
22 shall receive all Medicare and Medi-Cal services from the PACE  
23 plan pursuant to the three-way agreement between the PACE plan,  
24 the department, and the federal Centers for Medicare and Medicaid  
25 Services.

26 (2) In areas of the state where a presentation on Medi-Cal  
27 managed care plan enrollment options is unavailable, the  
28 department, or its contracted vendor, shall provide informational,  
29 outreach, and enrollment materials about the PACE program.

30 (f) For purposes of this section, the following definitions apply:

31 (1) “Dual eligible beneficiary” means an individual 21 years of  
32 age or older who is enrolled for benefits under Medicare Part A  
33 (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec.  
34 1395j et seq.), or both, and is eligible for medical assistance under  
35 the Medi-Cal State Plan. For purposes of this article, “dual eligible  
36 beneficiary” shall include both a “full-benefit dual eligible  
37 beneficiary” and a “partial-benefit dual eligible beneficiary,” as  
38 those terms are defined in this subdivision.

39 (2) “Full-benefit dual eligible beneficiary” means an individual  
40 21 years or older who is enrolled for benefits under Medicare Part

1 A (42 U.S.C. Sec. 1395c et seq.), Medicare Part B (42 U.S.C. Sec.  
2 1395j et seq.), and Medicare Part D (42 U.S.C. Sec. 1395w-101),  
3 and is eligible for medical assistance under the Medi-Cal State  
4 Plan.

5 (3) “Non-dual-eligible beneficiary” means an individual eligible  
6 for medical assistance under the Medi-Cal State plan, as determined  
7 by the department, that is not eligible for benefits under Medicare  
8 Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42  
9 U.S.C. Sec. 1395j et seq.).

10 (4) “Partial-benefit dual eligible beneficiary” means an  
11 individual 21 years of age or older who is enrolled for benefits  
12 under Medicare Part A (42 U.S.C. Sec. 1395c et seq.), but not  
13 Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or who is enrolled  
14 for Medicare Part B (42 U.S.C. Sec. 1395j et seq.), but not  
15 Medicare Part A (42 U.S.C. Sec. 1395c et seq.), and is eligible for  
16 medical assistance under the Medi-Cal State Plan.

17 *SEC. 113. Section 14197.7 of the Welfare and Institutions Code*  
18 *is amended to read:*

19 14197.7. (a) (1) Notwithstanding any other law, if the director  
20 finds that an entity that contracts with the department for the  
21 delivery of health care services (contractor), including a Medi-Cal  
22 managed care plan or a prepaid health plan, fails to comply with  
23 contract requirements, state or federal law or regulations, or the  
24 state plan or approved waivers, or for other good cause, the director  
25 may terminate the contract or impose sanctions as set forth in this  
26 section.

27 (2) Good cause includes, but is not limited to, a finding of  
28 deficiency that results in improper denial or delay in the delivery  
29 of health care services, potential endangerment to patient care,  
30 disruption in the contractor’s provider network, failure to approve  
31 continuity of care, that claims accrued or to accrue have not or  
32 will not be recompensed, or a delay in required contractor reporting  
33 to the department.

34 (b) The director may identify findings of noncompliance or  
35 good cause through any means, including, but not limited to,  
36 findings in audits, investigations, contract compliance reviews,  
37 quality improvement system monitoring, routine monitoring,  
38 facility site surveys, encounter and provider data submissions,  
39 grievances and appeals, network adequacy reviews, assessments  
40 of timely access requirements, reviews of utilization data, health

1 plan rating systems, fair hearing decisions, complaints from  
2 beneficiaries and other stakeholders, whistleblowers, and contractor  
3 self-disclosures.

4 (c) (1) Except when the director determines there is an  
5 immediate threat to the health of Medi-Cal beneficiaries receiving  
6 health care services from the contractor, at the request of the  
7 contractor, the department shall hold a public hearing to commence  
8 30 days after notice of intent to terminate the contract has been  
9 received by the contractor.

10 (2) The department shall present evidence at the hearing showing  
11 good cause for the termination.

12 (3) The department shall assign an administrative law judge  
13 who shall provide a written recommendation to the department on  
14 the termination of the contract within 30 days after conclusion of  
15 the hearing.

16 (4) (A) Reasonable notice of the hearing shall be given to the  
17 contractor, Medi-Cal beneficiaries receiving services through the  
18 contractor, and other interested parties, including any other person  
19 and organization the director may deem necessary.

20 (B) The notice shall state the effective date of, and the reason  
21 for, the termination.

22 (d) In lieu of contract termination, the director shall have the  
23 power and authority to require or impose a plan of correction and  
24 issue one or more of the following sanctions against a contractor  
25 for findings of noncompliance or good cause, including, but not  
26 limited to, those specified in subdivision (a):

27 (1) Temporarily or permanently suspend enrollment and  
28 marketing activities.

29 (2) Require the contractor to suspend or terminate contractor  
30 personnel or subcontractors.

31 (3) Issue one or more of the temporary suspension orders set  
32 forth in subdivision (j).

33 (4) Impose temporary management consistent with the  
34 requirements specified in Section 438.706 of Title 42 of the Code  
35 of Federal Regulations.

36 (5) Suspend default enrollment of enrollees who do not select  
37 a contractor for the delivery of health care services.

38 (6) Impose civil monetary sanctions consistent with the dollar  
39 amounts and violations specified in Section 438.704 of Title 42  
40 of the Code of Federal Regulations, as follows:

1 (A) A limit of twenty-five thousand dollars (\$25,000) for each  
2 determination of the following:

3 (i) The contractor fails to provide medically necessary services  
4 that the contractor is required to provide, under law or under its  
5 contract with the department, to an enrollee covered under the  
6 contract.

7 (ii) The contractor misrepresents or falsifies information to an  
8 enrollee, potential enrollee, or health care provider.

9 (iii) The contractor distributes directly, or indirectly through an  
10 agent or independent contractor, marketing materials that have not  
11 been approved by the state or that contain false or materially  
12 misleading information.

13 (B) A limit of one hundred thousand dollars (\$100,000) for each  
14 determination of the following:

15 (i) The contractor conducts an act of discrimination against an  
16 enrollee on the basis of their health status or need for health care  
17 services. This includes termination of enrollment or refusal to  
18 reenroll a beneficiary, except as permitted under the Medicaid  
19 program, or a practice that would reasonably be expected to  
20 discourage enrollment by beneficiaries whose medical condition  
21 or history indicates probable need for substantial future medical  
22 services.

23 (ii) The contractor misrepresents or falsifies information that it  
24 furnishes to the federal Centers for Medicare and Medicaid Services  
25 or to the department.

26 (C) A limit of fifteen thousand dollars (\$15,000) for each  
27 beneficiary the director determines was not enrolled because of a  
28 discriminatory practice under clause (i) of subparagraph (B). This  
29 sanction is subject to the overall limit of one hundred thousand  
30 dollars (\$100,000) under subparagraph (B).

31 (e) Notwithstanding the monetary sanctions imposed for the  
32 violations set forth in paragraph (6) of subdivision (d), the director  
33 may impose monetary sanctions in accordance with this section  
34 based on any of the following:

35 (1) The contractor violates a federal or state statute or regulation.

36 (2) The contractor violates a provision of its contract with the  
37 department.

38 (3) The contractor violates a provision of the state plan or  
39 approved waivers.

1 (4) The contractor fails to meet quality metrics or benchmarks  
2 established by the department. Any changes to the minimum quality  
3 metrics or benchmarks made by the department that are effective  
4 on or after January 1, 2020, shall be established in advance of the  
5 applicable reporting or performance measurement period, unless  
6 required by the federal government.

7 (5) The contractor fails to demonstrate that it has an adequate  
8 network to meet anticipated utilization in its service area.

9 (6) The contractor fails to comply with network adequacy  
10 standards, including, but not limited to, time and distance, timely  
11 access, and provider-to-beneficiary ratio requirements pursuant to  
12 standards and formulae that are set forth in federal or state law,  
13 regulation, state plan, or contract and that are posted in advance  
14 to the department's internet website.

15 (7) The contractor fails to comply with the requirements of a  
16 corrective action plan.

17 (8) The contractor fails to submit timely and accurate network  
18 provider data.

19 (9) The director identifies deficiencies in the contractor's  
20 delivery of health care services.

21 (10) The director identifies deficiencies in the contractor's  
22 operations, including the timely payment of claims.

23 (11) The contractor fails to comply with reporting requirements,  
24 including, but not limited to, those set forth in Section 53862 of  
25 Title 22 of the California Code of Regulations.

26 (12) The contractor fails to timely and accurately process  
27 grievances or appeals.

28 (f) (1) Monetary sanctions imposed pursuant to subdivision (e)  
29 may be separately and independently assessed and may also be  
30 assessed for each day the contractor fails to correct an identified  
31 deficiency. For a deficiency that impacts beneficiaries, each  
32 beneficiary impacted constitutes a separate violation. Monetary  
33 sanctions shall be assessed in the following amounts:

34 (A) Up to twenty-five thousand dollars (\$25,000) for a first  
35 violation.

36 (B) Up to fifty thousand dollars (\$50,000) for a second violation.

37 (C) Up to one hundred thousand dollars (\$100,000) for each  
38 subsequent violation.

39 (2) For monetary sanctions imposed on a contractor that is  
40 funded from one or more of the realigned accounts described in

1 paragraphs (2) to (4), inclusive, of subdivision (n), the department  
2 shall calculate a percentage of the funds attributable to the  
3 contractor to be offset per month pursuant to paragraphs (2) to (4),  
4 inclusive, of subdivision (n) until the amount offset equals the  
5 amount of the penalty imposed pursuant to paragraph (1).

6 (g) When assessing sanctions pursuant to this section, the  
7 director shall determine the appropriate amount of the penalty for  
8 each violation based upon one or more of the following  
9 nonexclusive factors:

10 (1) The nature, scope, and gravity of the violation, including  
11 the potential harm or impact on beneficiaries.

12 (2) The good or bad faith of the contractor.

13 (3) The contractor's history of violations.

14 (4) The willfulness of the violation.

15 (5) The nature and extent to which the contractor cooperated  
16 with the department's investigation.

17 (6) The nature and extent to which the contractor aggravated or  
18 mitigated any injury or damage caused by the violation.

19 (7) The nature and extent to which the contractor has taken  
20 corrective action to ensure the violation will not recur.

21 (8) The financial status of the contractor, including whether the  
22 sanction will affect the ability of the contractor to come into  
23 compliance.

24 (9) The financial cost of the health care service that was denied,  
25 delayed, or modified.

26 (10) Whether the violation is an isolated incident.

27 (11) The amount of the penalty necessary to deter similar  
28 violations in the future.

29 (12) Other mitigating factors presented by the contractor.

30 (h) (1) Except in exigent circumstances in which there is an  
31 immediate risk to the health of beneficiaries, as determined by the  
32 department, the director shall give reasonable written notice to the  
33 contractor of the intention to impose any of the sanctions authorized  
34 by this section and others who may be directly interested, including  
35 any other persons and organizations the director may deem  
36 necessary.

37 (2) The notice shall include the effective date for, the duration  
38 of, and the reason for each sanction proposed by the director.

39 (3) A contractor may request the department to meet and confer  
40 with the contractor to discuss information and evidence that may



1 impact the director's final decision to impose sanctions authorized  
2 by this section.

3 (4) The director shall grant a request to meet and confer prior  
4 to issuance of a final sanction if the contractor submits the request  
5 in writing to the department no later than two business days after  
6 the contractor's receipt of the director's notice of intention to  
7 impose sanctions.

8 (i) Notwithstanding subdivision (d), the director shall terminate  
9 a contract with a contractor that the United States Secretary of  
10 Health and Human Services has determined does not meet the  
11 requirements for participation in the Medicaid program contained  
12 in Subchapter XIX (commencing with Section 1396) of Chapter  
13 7 of Title 42 of the United States Code.

14 (j) (1) The department may make one or more of the following  
15 temporary suspension orders as an immediate sanction:

16 (A) Temporarily suspend enrollment activities.

17 (B) Temporarily suspend marketing activities.

18 (C) Require the contractor to temporarily suspend specified  
19 personnel of the contractor.

20 (D) Require the contractor to temporarily suspend participation  
21 by a specified subcontractor.

22 (2) The temporary suspension orders shall be effective no earlier  
23 than 20 days after the notice specified in subdivision (k).

24 (k) (1) Prior to issuing a temporary suspension order, or  
25 temporarily withholding funds pursuant to subdivision (o), the  
26 department shall provide the contractor with a written notice.

27 (2) The notice shall state the department's intent to impose a  
28 temporary suspension or temporary withhold and specify the nature  
29 and effective date of the temporary suspension or temporary  
30 withhold.

31 (3) The contractor shall have 30 calendar days from the date of  
32 receipt of the notice to file a written appeal with the department.

33 (4) Upon receipt of a written appeal filed by the contractor, the  
34 department shall, within 15 days, set the matter for hearing, which  
35 shall be held as soon as possible but not later than 30 days after  
36 receipt of the notice of hearing by the contractor.

37 (5) The hearing may be continued at the request of the contractor  
38 if a continuance is necessary to permit presentation of an adequate  
39 defense.

1 (6) The temporary suspension order shall remain in effect until  
2 the hearing is completed and the department has made a final  
3 determination on the merits. However, the temporary suspension  
4 order shall be deemed vacated if the director fails to make a final  
5 determination on the merits within 60 days of the close of the  
6 record for the matter.

7 (7) The department shall stay imposition of a temporary  
8 withhold, pursuant to subdivision (o), until the hearing is completed  
9 and the department has made a final determination on the merits  
10 within 60 days of the close of the record for the matter.

11 (l) (1) A contractor may request a hearing in connection with  
12 sanctions applied pursuant to subdivision (d) or (e) within 15  
13 working days after the notice of the effective date of the sanctions  
14 has been given by sending a letter so stating to the address specified  
15 in the notice.

16 (2) The department shall stay collection of monetary sanctions  
17 upon receipt of the request for a hearing.

18 (3) Collection of the sanction shall remain stayed until the  
19 effective date of the final decision of the department.

20 (m) Except as otherwise provided in this section, all hearings  
21 to review the imposition of sanctions, including temporary  
22 suspension orders, the withholding or offsetting of funds pursuant  
23 to subdivision (n), or the temporary withholding of funds pursuant  
24 to subdivision (o) shall be held pursuant to the procedures set forth  
25 in Section 100171 of the Health and Safety Code.

26 (n) (1) If the director imposes monetary sanctions pursuant to  
27 this section on a contractor, except for a contractor described in  
28 paragraphs (2) to (5), inclusive, the amount of the sanction may  
29 be collected by withholding the amount from capitation or other  
30 associated payments owed to the contractor.

31 (2) If the director imposes monetary sanctions on a contractor  
32 that is funded from the Mental Health Subaccount, the Mental  
33 Health Equity Subaccount, the Vehicle License Collection Account  
34 of the Local Revenue Fund, or the Mental Health Account, the  
35 director may offset the monetary sanctions from the respective  
36 account. The offset is subject to paragraph (2) of subdivision (q).

37 (3) If the director imposes monetary sanctions on a contractor  
38 that is funded from the Behavioral Health Subaccount of the Local  
39 Revenue Fund 2011, the director may offset the monetary sanctions  
40 from that account from the distribution attributable to the applicable

1 contractor. The offset is subject to paragraph (2) of subdivision  
2 (q).

3 (4) If the director imposes monetary sanctions on a contractor  
4 that is funded from another mental health or substance use disorder  
5 realignment fund from which the Controller is authorized to make  
6 distributions to the contractor, the director may offset the monetary  
7 sanctions from these funds if the funds described in paragraphs  
8 (2) and (3) are insufficient for the purposes described in this  
9 subdivision, as appropriate. The offset is subject to paragraph (2)  
10 of subdivision (q).

11 (5) (A) If the director imposes monetary sanctions pursuant to  
12 subdivision (e) of Section 5963.04, the director may offset the  
13 monetary sanctions from the Behavioral Health Services Fund  
14 from the distribution attributable to the applicable contractor.

15 (B) With respect to an individual contractor, the department  
16 shall not collect via offset more than 25 percent of the total amount  
17 of the funds distributed from the Behavioral Health Services Fund  
18 that are attributable to the contractor in a given month.

19 (C) If the department is not able to collect the full amount of  
20 monetary sanctions imposed on a contractor in a given month, the  
21 department shall continue to offset the amounts attributable to the  
22 contractor in subsequent months until the full amount of monetary  
23 sanctions has been collected. The offset is subject to paragraph (3)  
24 of subdivision (q).

25 (o) (1) (A) Whenever the department determines that a mental  
26 health plan or an entity that contracts with the department to  
27 provide Drug Medi-Cal services has violated state or federal law,  
28 a requirement of this chapter, Chapter 8 (commencing with Section  
29 14200), Chapter 8.8 (commencing with Section 14600), or Chapter  
30 8.9 (commencing with Section 14700), or any regulations, the state  
31 plan, a term or condition of an approved waiver, or a provision of  
32 its contract with the department, the department may temporarily  
33 withhold payments of federal financial participation and payments  
34 from the accounts listed in paragraphs (2) to (4), inclusive, of  
35 subdivision (n).

36 (B) The department shall temporarily withhold amounts it deems  
37 necessary to ensure the mental health plan or the entity that  
38 contracts with the department to provide Drug Medi-Cal services  
39 promptly corrects the violation.

1 (C) The department shall release the temporarily withheld funds  
2 when it determines the mental health plan or the entity that  
3 contracts with the department to provide Drug Medi-Cal services  
4 has come into compliance.

5 (2) (A) A mental health plan or an entity that contracts with  
6 the department to provide Drug Medi-Cal services may appeal the  
7 imposition of a temporary withhold pursuant to this subdivision  
8 in accordance with the procedures described in subdivisions (k)  
9 and (m).

10 (B) Imposition of a temporary withhold shall be stayed until  
11 the effective date of the final decision of the department.

12 (p) This section shall be read in conjunction with, and apply in  
13 addition to, any other applicable law that authorizes the department  
14 to impose sanctions or otherwise take remedial action upon  
15 contractors.

16 (q) (1) (A) Notwithstanding any other law, nonfederal moneys  
17 collected by the department pursuant to this section, except for  
18 moneys collected from a contractor funded from one or more of  
19 the realigned accounts described in paragraphs (2) to (4), inclusive,  
20 of subdivision (n), shall be deposited into the General Fund for  
21 use and, upon appropriation by the Legislature, to address  
22 workforce issues in the Medi-Cal program and improve access to  
23 care in the Medi-Cal program.

24 (B) Beginning July 1, 2024, and continuing until June 30, 2027,  
25 unless otherwise specified in law, nonfederal moneys collected by  
26 the department pursuant to this section, except for moneys collected  
27 from a contractor funded from one or more of the realigned  
28 accounts described in paragraphs (2) to (4), inclusive, of  
29 subdivision (n), shall be deposited into the General Fund for use  
30 and, upon appropriation by the Legislature, for the nonfederal  
31 share of Medi-Cal costs for health care services furnished to  
32 children, adults, seniors, and persons with disabilities, and persons  
33 dually eligible for the Medi-Cal program and the Medicare  
34 Program.

35 (2) (A) Monetary sanctions imposed via offset on a contractor  
36 that is funded from one or more of the realigned accounts described  
37 in paragraphs (2) to (4), inclusive, of subdivision (n) shall be  
38 redeposited into the account from which the monetary sanctions  
39 were offset pursuant to paragraphs (2) to (4), inclusive, of  
40 subdivision (n).

1 (B) The department shall notify the Department of Finance of  
2 the percentage reduction for the affected county.

3 (C) The Department of Finance shall subsequently notify the  
4 Controller, and the Controller shall redistribute the monetary  
5 sanction amount to nonsanctioned counties based on each county's  
6 prorated share of the monthly base allocations from the realigned  
7 account.

8 (D) With respect to an individual contractor, the department  
9 shall not collect via offset more than 25 percent of the total amount  
10 of the funds distributed from the applicable account or accounts  
11 that are attributable to the contractor in a given month.

12 (E) If the department is not able to collect the full amount of  
13 monetary sanctions imposed on a contractor funded from one or  
14 more of the realigned accounts described in paragraphs (2) to (4),  
15 inclusive, of subdivision (n) in a given month, the department shall  
16 continue to offset the amounts attributable to the contractor in  
17 subsequent months until the full amount of monetary sanctions  
18 has been collected.

19 (3) Monetary sanctions imposed via offset on a contractor  
20 pursuant to subdivision (e) of Section 5963.04 shall be redeposited  
21 into the account from which the monetary sanctions were offset  
22 pursuant to paragraph (5) of subdivision (n).

23 (r) Notwithstanding Chapter 3.5 (commencing with Section  
24 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
25 the department may implement, interpret, or make specific this  
26 section, in whole or in part, by means of plan or county letters,  
27 information notices, plan or provider bulletins, or other similar  
28 instructions without taking any further regulatory action.

29 (s) This section shall be implemented only to the extent that  
30 necessary federal approvals have been obtained and that federal  
31 financial participation is available.

32 (t) For purposes of this section, "contractor" means an  
33 individual, organization, or entity that enters into a contract with  
34 the department to provide services to enrolled Medi-Cal  
35 beneficiaries or other individuals receiving behavioral health  
36 services, as applicable, pursuant to any of the following:

37 (1) Article 2.7 (commencing with Section 14087.3), including  
38 dental managed care programs developed pursuant to Section  
39 14087.46.

40 (2) Article 2.8 (commencing with Section 14087.5).

1 (3) Article 2.81 (commencing with Section 14087.96).

2 (4) Article 2.82 (commencing with Section 14087.98).

3 (5) Article 2.9 (commencing with Section 14088).

4 (6) Article 2.91 (commencing with Section 14089).

5 (7) Chapter 8 (commencing with Section 14200), including  
6 dental managed care plans.

7 (8) Chapter 8.9 (commencing with Section 14700).

8 (9) A county Drug Medi-Cal organized delivery system  
9 authorized under the California Medi-Cal 2020 Demonstration  
10 pursuant to Article 5.5 (commencing with Section 14184) or a  
11 successor demonstration or waiver, as applicable.

12 (10) Chapter 2 (commencing with Section 5650) of Part 2 of  
13 Division 5, solely for purposes of imposition of corrective action  
14 plans, monetary sanctions, or temporary withholds pursuant to  
15 subdivision (e) of Section 5963.04.

16 (11) Section 12534 of the Government Code.

17 (12) *The Home- and Community-Based Alternatives (HCBA)*  
18 *Waiver pursuant to state law and Section 1915(c) of the federal*  
19 *Social Security Act (42 U.S.C. Sec. 1396n(c)).*

20 (13) *The Program of All-Inclusive Care for the Elderly (PACE)*  
21 *pursuant to Chapter 8.75 (commencing with Section 14591).*

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

25 *SEC. 114. Section 14199.128 of the Welfare and Institutions*  
26 *Code is amended to read:*

27 14199.128. Definitions

28 For purposes of this chapter, as used in both the singular and  
29 plural form, the following definitions shall apply:

30 (a) “Abortion” has the same meaning as set forth in subdivision  
31 (a) of Section 123464 of the Health and Safety Code.

32 (b) “Acute psychiatric hospital” has the same meaning as set  
33 forth in subdivision (b) of Section 1250 of the Health and Safety  
34 Code.

35 (c) “Advanced practice clinicians and allied health care  
36 professionals” shall be defined by the department, subject to the  
37 stakeholder input requirements of Section 14199.121, to include  
38 appropriate health profession careers.

1 (d) “Article 7.1” means Article 7.1 (commencing with Section  
2 14199.80) of Chapter 7, as added by Chapter 13 of the Statutes of  
3 2023.

4 (e) “Base data source” means the most recent available quarterly  
5 financial statement filings or annual enrollment data submitted by  
6 health plans to the Department of Managed Health Care for that  
7 updated base year, retrieved by the department, and supplemented  
8 by, as necessary, Medi-Cal enrollment data for the updated base  
9 year as maintained by the department, and as modified by the  
10 department to account for known or anticipated contracting changes  
11 that will affect Medi-Cal enrollment.

12 (f) “Base year” means a 12-month period running from January  
13 1 through December 31 of a calendar year selected by the  
14 department. The department may elect to update the base year to  
15 the extent it deems necessary to meet the requirements of federal  
16 statute or regulations, to obtain or maintain federal approval, or to  
17 ensure federal financial participation is available or is not otherwise  
18 jeopardized.

19 (g) “Bona fide labor-management cooperation committee” or  
20 “bona fide LMCC” means a joint labor-management committee  
21 that is established pursuant to the federal Labor Management  
22 Cooperation Act of 1978 (29 U.S.C. Sec. 175a) and meets the  
23 following criteria:

24 (1) The bona fide LMCC is not involved in the governance of  
25 a health care entity but exists to promote worker training,  
26 workforce expansion, and support for workers during training.

27 (2) The bona fide LMCC has the following composition:

28 (A) Fifty percent of the committee consists of representatives  
29 of organized labor unions that represent health workers in the state.

30 (B) Fifty percent of the committee consists of representatives  
31 of health care employers that primarily serve Medi-Cal patients  
32 located in the state.

33 (h) “CalHealthCares Program” means the Medi-Cal Physicians  
34 and Dentists Loan Repayment Program Act established pursuant  
35 to Section 14114.

36 (i) “California Affordable Drug Manufacturing Act of 2020”  
37 means the program established pursuant to Chapter 10  
38 (commencing with Section 127690) of Part 2 of Division 107 of  
39 the Health and Safety Code.

40 (j) “Clinic” means any of the following:

1 (1) Federally qualified health centers (FQHC), including FQHC  
2 look-alike clinics designated by the federal Health Resources and  
3 Services Administration as meeting FQHC program requirements  
4 as set forth in Sections 1395x(aa)(4)(B) and 1396d(1)(2)(B) of  
5 Title 42 of the United States Code.

6 (2) Rural health clinics (RHC) meeting the definition set forth  
7 in Section 1396d(l)(1) of Title 42 of the United States Code.

8 (3) Clinics licensed pursuant to subdivision (a) of Section 1204  
9 of the Health and Safety Code.

10 (4) Tribal clinics exempt from licensure pursuant to subdivision  
11 (c) of Section 1206 of the Health and Safety Code.

12 (5) Intermittent clinics exempt from licensure pursuant to  
13 subdivision (h) of Section 1206 of the Health and Safety Code.

14 (6) Clinics exempt from licensure pursuant to subdivision (b)  
15 of Section 1206 of the Health and Safety Code. If clinics exempt  
16 from licensure pursuant to subdivision (b) of Section 1206 of the  
17 Health and Safety Code choose to participate in a directed payment  
18 program described in Section 14199.120.5, the directed payment  
19 program will use the “classes of provider” functionality at a  
20 minimum to create a tier for those clinics and allow for payments  
21 to those clinics to be based on an amount allocated to their class’s  
22 pool.

23 (7) Indian health clinics that provide services in California  
24 pursuant to the Indian Health Program, as set forth in Chapter 4  
25 (commencing with Section 124575) of Part 4 of Division 106 of  
26 the Health and Safety Code.

27 (k) “Committee” or “stakeholder advisory committee” means  
28 the Protect Access to Health Care Act Stakeholder Advisory  
29 Committee established pursuant to Section 14199.129.

30 (l) “Community-based organization” means a nonprofit  
31 organization of demonstrated effectiveness that is representative  
32 of a community or significant segments of a community and  
33 promotes access to, or provides physical or mental health or related  
34 services to, individuals in the community.

35 (m) “Community health worker” shall have the same meaning  
36 as defined in *paragraph (1) of* subdivision (b) of Section ~~18998.~~  
37 ~~14132.36.~~

38 (n) “Community provider” means a holder of a certificate  
39 described in Section 2050 of the Business and Professions Code  
40 who serves Medi-Cal patients.



1 (o) “Comprehensive clinical family planning services” means  
2 the services set forth in subdivision (aa) of Section 14132.

3 (p) “Countable enrollee” means an individual enrolled in a health  
4 plan during a month of the base year according to the base data  
5 source. “Countable enrollee” does not include an individual  
6 enrolled in a Medicare plan, a plan-to-plan enrollee, or an  
7 individual enrolled in a health plan pursuant to the Federal  
8 Employees Health Benefits Act of 1959 (Public Law 86-382) to  
9 the extent the imposition of the tax under Article 6 (commencing  
10 with Section 14199.123) of this chapter or Article 7.1 (commencing  
11 with Section 14199.80) of Chapter 7 is preempted pursuant to  
12 Section 8909(f) of Title 5 of the United States Code.

13 (q) “County mental health plan” means an entity or local agency  
14 that contracts with the department to provide covered specialty  
15 mental health services pursuant to Section 14184.400 and Chapter  
16 8.9 (commencing with Section 14700).

17 (r) “Department” means the State Department of Health Care  
18 Services.

19 (s) “Designated public hospital system” means a designated  
20 public hospital as defined in paragraph (1) of subdivision (f) of  
21 Section 14184.10 and its affiliated governmental providers and  
22 contracted governmental and nongovernmental entities that  
23 constitute a hospital and health care system. A single designated  
24 public hospital system may include multiple designated public  
25 hospitals under common government ownership.

26 (t) (1) “Directed payment” means a payment arrangement  
27 whereby the department directs certain expenditures made by a  
28 Medi-Cal managed care plan that is approved by the federal Centers  
29 for Medicare and Medicaid Services as described in Section 438(c)  
30 of Title 42 of the Code of Federal Regulations, established pursuant  
31 to Section 438(c) of Title 42 of the Code of Federal Regulations,  
32 or otherwise required by the Medi-Cal managed care plan contract,  
33 and documented in a rate certification approved by the federal  
34 Centers for Medicare and Medicaid Services as applicable.

35 (2) References in this subdivision to Section 438(c) of Title 42  
36 of the Code of Federal Regulations shall include any subsequent  
37 amendments thereto.

38 (u) “Director” means the director of the State Department of  
39 Health Care Services.

1 (v) “Emergency air ambulance transport” means emergency  
2 medical transportation by air, as described in paragraph (1) of  
3 subdivision (c) of Section 51323 of Title 22 of the California Code  
4 of Regulations, by air ambulance, as defined in Section 100280  
5 of Title 22 of the California Code of Regulations.

6 (w) “Family PACT” means the Family Planning, Access, Care,  
7 and Treatment Program established pursuant to subdivision (aa)  
8 of Section 14132.

9 (x) “Family planning services and family planning-related  
10 services in the Medi-Cal program” means the services covered by  
11 the Medi-Cal program pursuant to subdivision (n) of Section 14132.

12 (y) “Family planning services in the State-Only Family Planning  
13 Program” means the services covered by that program pursuant  
14 to Division 24 (commencing with Section 24000).

15 (z) “Fund” means the Protect Access to Health Care Fund  
16 established in the State Treasury pursuant to Section 14199.103.

17 (aa) “General acute care hospital” has the same meaning as in  
18 subdivision (a) of Section 1250 of the Health and Safety Code.

19 (ab) “Ground emergency medical transports” means emergency  
20 medical transports, as defined in Section 14129, that originate from  
21 a 911 call center or equivalent public safety answering point.

22 (ac) “Health care service plan” or “health plan” means a health  
23 care service plan, other than a plan that provides only specialized  
24 or discount services, that is licensed by the Department of Managed  
25 Health Care under the Knox-Keene Health Care Service Plan Act  
26 of 1975 (Chapter 2.2 (commencing with Section 1340) of Division  
27 2 of the Health and Safety Code) or a Medi-Cal managed care plan  
28 contracted with the department to provide full-scope Medi-Cal  
29 services.

30 (ad) “Medi-Cal patient” means a Medi-Cal beneficiary as  
31 defined in Section 14252.

32 (ae) “Medi-Cal enrollee” means an individual enrolled in a  
33 health plan, as defined in subdivision (ac), who is a Medi-Cal  
34 patient for whom the department directly pays the health plan a  
35 capitated payment.

36 (af) “Medi-Cal managed care plan” means any individual,  
37 organization, or entity that enters into a comprehensive risk contract  
38 with the department to provide covered full-scope health care  
39 services to enrolled Medi-Cal patients pursuant to this chapter or  
40 Chapter 8 (commencing with Section 14200).

1 (ag) “Medi-Cal per enrollee tax amount” means the amount of  
2 tax assessed per countable Medi-Cal enrollee within a Medi-Cal  
3 taxing tier.

4 (ah) “Medi-Cal taxing tier” means a range of cumulative  
5 enrollment of countable Medi-Cal enrollees for the base year.

6 (ai) “Net reimbursement” or “net reimbursement levels” means  
7 the total payments to Medi-Cal providers for the applicable services  
8 and procedures received as of January 1, 2024, less any amounts  
9 financed by Medi-Cal providers as the nonfederal share of those  
10 payments via provider taxes or fees, certified public expenditures,  
11 or intergovernmental transfers.

12 (aj) “Network provider” has the same meaning as set forth in  
13 Section 438.2 of Title 42 of the Code of Federal Regulations.

14 (ak) “Other enrollee” means an individual enrolled in a health  
15 plan who is not a Medi-Cal enrollee.

16 (al) “Other per enrollee tax amount” means the amount of tax  
17 assessed per countable other enrollee within an other taxing tier.

18 (am) “Other taxing tier” means a range of cumulative enrollment  
19 of countable other enrollees for the base year.

20 (an) “Plan-to-plan enrollee” means an individual who receives  
21 their health care services through a health plan pursuant to a  
22 subcontract from another health plan.

23 (ao) “Primary care” has the same meaning as in Section 51170.5  
24 of Title 22 of the California Code of Regulations.

25 (ap) “Private ground emergency medical transport provider”  
26 means a provider of ground emergency medical transports that  
27 does not meet the definition of paragraph (1) of subdivision (a) of  
28 Section 14105.945.

29 (aq) “Qualified family planning provider” means a Medi-Cal  
30 provider that meets all of the following conditions:

31 (1) Is a community clinic licensed pursuant to subdivision (a)  
32 of Section 1204 of the Health and Safety Code.

33 (2) Is enrolled in the Family PACT program, as described in  
34 subdivision (aa) of Section 14132.

35 (3) Provides both abortion and contraception services.

36 (ar) “Specialist” means a physician or surgeon or other licensee  
37 pursuant to the Medical Practice Act (Chapter 5 (commencing  
38 with Section 2000) of Division 2 of the Business and Professions  
39 Code) or the Osteopathic Act (Chapter 8 (commencing with Section  
40 3600) of Division 2 of the Business and Professions Code) who

1 delivers to Medi-Cal patients health care services, treatment, or  
2 procedures at least some of which do not qualify as primary care.

3 (as) “Specialty care” means health care services provided by a  
4 specialist.

5 (at) “State-Only Family Planning Program” means the program  
6 established pursuant to Division 24 (commencing with Section  
7 24000).

8 (au) “Tax period” means a period of not more than 12 months  
9 for which the tax imposed pursuant to Article 6 (commencing with  
10 Section 14199.123) is assessed.

11 *SEC. 115. Chapter 16.5 (commencing with Section 18998) of*  
12 *Part 6 of Division 9 of the Welfare and Institutions Code is*  
13 *repealed.*

14 *SEC. 116. Section 83 of Chapter 40 of the Statutes of 2024 is*  
15 *amended to read:*

16 SEC. 83. (a) To the extent that these activities are an allowable  
17 use of the AIDS Drug Assistance Program Rebate Fund, this  
18 section authorizes the State Department of Public Health to spend  
19 up to twenty-three million dollars (\$23,000,000) from the AIDS  
20 Drug Assistance Program Rebate Fund to implement the following  
21 programs, consistent with Sections 120955, 120956, 120960,  
22 120972, 120972.1, and 120972.2 of the Health and Safety Code:

23 (1) Beginning January 1, 2025, or as soon as technically feasible  
24 thereafter, increase AIDS Drug Assistance Program (ADAP) and  
25 PrEP-Assistance Program financial eligibility standards from a  
26 modified adjusted gross income that does not exceed 500 percent  
27 of the federal poverty level per year based on family size and  
28 household income to 600 percent of the federal poverty level per  
29 year based on family size and household income.

30 (2) Beginning January 1, 2025, or as soon as technically feasible  
31 thereafter, increase the cap on premium payments from one  
32 thousand nine hundred thirty-eight dollars (\$1,938) per month to  
33 two thousand nine hundred ninety-six dollars (\$2,996) per month  
34 for the Office of AIDS Health Insurance Premium Payment  
35 program, the Employer-Based HIPP program, and the Medicare  
36 Premium Payment Program.

37 (3) Beginning January 1, 2025, or as soon as is technically  
38 feasible thereafter, modify the ADAP formulary to an open  
39 formulary.

(4) Allocate five million dollars (\$5,000,000) annually for three years, beginning July 1, ~~2024~~, 2025, to the Transgender, Gender Nonconforming, and Intersex Wellness and Equity Fund to fund services related to *HIV prevention and* care and treatment for eligible individuals living with HIV and AIDS.

(5) Allocate ten million dollars (\$10,000,000) annually for three years, beginning July 1, 2024, to fund the Harm Reduction Supply Clearinghouse to fund HIV prevention supplies to California syringe access programs.

(6) Allocate two hundred thousand dollars (\$200,000) in the 2024–25 fiscal year, available until June 30, 2027, for the Office of AIDS to create, develop, or contract out for a needs assessment and analysis to identify needs for client navigation and retention services for clients enrolled in a Ryan White HIV/AIDS Program through the Office of AIDS.

(7) Allocate two hundred thousand dollars (\$200,000) in the 2024–25 fiscal year, available until June 30, 2027, for the Office of AIDS to create, develop, or contract out for a needs assessment and analysis aimed at understanding the potential needs for the Pre-Exposure Prophylaxis (PrEP) Navigation Services Program.

(8) Allocate five million dollars (\$5,000,000) in the 2024–25 fiscal year, available until June 30, ~~2027~~, 2028, to distribute funding to a community-based organization to make internal and external condoms ~~available pursuant to Section 35292.7 of the Education Code, if Senate Bill 954 of the 2023–24 Regular Session becomes effective~~, available, aimed at preventing the transmission of HIV and sexually transmitted infections.

(b) The State Department of Public Health shall submit to the Legislature, as part of the 2025–26 Governor’s Budget, a plan for modernization and expansion of ADAP and related programs with a focus on addressing the epidemic of HIV/AIDS in California, including, but not limited to, the programs described in paragraphs (1), (2), and (3) of subdivision (a). The plan shall be developed in consultation with stakeholders and the Legislature and should consider whether the proposed activity is an eligible use of the AIDS Drug Assistance Program Rebate Fund, availability of funding, and whether it advances access to services.

*SEC. 117. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school*

1 *district because, in that regard, this act creates a new crime or*  
2 *infraction, eliminates a crime or infraction, or changes the penalty*  
3 *for a crime or infraction, within the meaning of Section 17556 of*  
4 *the Government Code, or changes the definition of a crime within*  
5 *the meaning of Section 6 of Article XIII B of the California*  
6 *Constitution.*

7 *However, if the Commission on State Mandates determines that*  
8 *this act contains other costs mandated by the state, reimbursement*  
9 *to local agencies and school districts for those costs shall be made*  
10 *pursuant to Part 7 (commencing with Section 17500) of Division*  
11 *4 of Title 2 of the Government Code.*

12 *SEC. 118. (a) The State Department of Public Health may*  
13 *spend up to seventy-five million dollars (\$75,000,000) from the*  
14 *AIDS Drug Assistance Program Rebate Fund to support current*  
15 *or eligible services and programs, consistent with Sections 120955,*  
16 *120956, 120960, 120972, 120972.1, and 120972.2 of the Health*  
17 *and Safety Code and with the following:*

18 *(1) Beginning July 1, 2025, up to sixty-five million dollars*  
19 *(\$65,000,000) is available to supplement or fund services,*  
20 *programs, or initiatives funded by the AIDS Drug Assistance*  
21 *Program Rebate Fund for which federal funding has been reduced*  
22 *or eliminated as a result of federal policy actions to cancel, delay,*  
23 *or reduce funding for HIV and AIDS prevention and treatment*  
24 *programs.*

25 *(A) Upon notification to the department of federal action, or*  
26 *the nonreceipt of Notices of Award, that result in reductions to or*  
27 *elimination of federal funding for those services, programs, or*  
28 *initiatives, the department shall notify the Department of Finance.*  
29 *The Department of Finance shall authorize funding allocations*  
30 *that are equivalent to the amount, to the extent these amounts are*  
31 *within the amount of funds appropriated for this purpose, and*  
32 *correspond to services that would have otherwise been funded by*  
33 *the reduced or eliminated federal funds as soon as practicable,*  
34 *but no later than 30 days following notification from the*  
35 *department.*

36 *(B) (i) If the federal funding that was reduced or eliminated is*  
37 *restored by the federal government, funding made available under*  
38 *this paragraph shall be repaid to the AIDS Drug Assistance*  
39 *Program Rebate Fund within 180 days. A repayment process shall*

1 *be established by the department, in consultation with the*  
2 *Department of Finance.*

3 *(ii) A local public health agency or community-based*  
4 *organization that has received funding made available under this*  
5 *paragraph shall not be required to repay the funding until it has*  
6 *received the restored federal funding.*

7 *(2) Beginning July 1, 2025, nine million dollars (\$9,000,000)*  
8 *is available to fund state and local disease intervention specialists.*

9 *(3) Beginning July 1, 2025, one million dollars (\$1,000,000) is*  
10 *available for the department to purchase rapid Hepatitis C Virus*  
11 *(HCV) testing equipment for distribution to local health*  
12 *departments and community-based organizations. The department*  
13 *shall establish a process for local health departments and*  
14 *community-based organizations to receive HCV testing equipment*  
15 *based on need in the specific geographic area.*

16 *(b) The department may enter into exclusive or nonexclusive*  
17 *contracts, or amend existing contracts, on a bid or negotiated*  
18 *basis. Contracts and grants entered into or amended pursuant to*  
19 *this section shall be exempt from Chapter 6 (commencing with*  
20 *Section 14825) of Part 5.5 of Division 3 of Title 2 of the*  
21 *Government Code, Section 19130 of the Government Code, Part*  
22 *2 (commencing with Section 10100) of Division 2 of the Public*  
23 *Contract Code, the State Administrative Manual, and the State*  
24 *Contracting Manual, and shall be exempt from the review or*  
25 *approval of any division of the Department of General Services.*

26 *(c) The department may, in consultation with the Department*  
27 *of Finance, use an alternative local fiscal agent that is not*  
28 *identified in this section, if necessary, to achieve the intended*  
29 *legislative purpose.*

30 *SEC. 119. This act is a bill providing for appropriations related*  
31 *to the Budget Bill within the meaning of subdivision (e) of Section*  
32 *12 of Article IV of the California Constitution, has been identified*  
33 *as related to the budget in the Budget Bill, and shall take effect*  
34 *immediately.*

35 ~~SECTION 1. It is the intent of the Legislature to enact statutory~~  
36 ~~changes relating to the Budget Act of 2025.~~