Assembly Bill No. 116

Passed the Assembly June 27, 2025

_____

Chief Clerk of the Assembly

Passed the Senate June 27, 2025

_____

Secretary of the Senate

This bill was received by the Governor this _____ day of _____, 2025, at _____ o'clock ___M.

_____

Private Secretary of the Governor

CHAPTER _____

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

AB 116, Committee on Budget. Health omnibus trailer bill.

(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.

Appropriation: yes.

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

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

1265.9. (a) 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 the requirements of this section, Section 4144 of the Welfare and Institutions Code, and applicable regulations.

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

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

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

(1) Maintain a staff-to-patient ratio of one to five.

(2) Limit each room to one patient.

(3) Each patient room shall allow visual access by staff 24 hours per day.

(4) Each patient room shall have a toilet and sink in the room.

(5) Each patient room door shall have the capacity to be locked externally. The door may be locked when clinically indicated and determined to be the least restrictive treatment environment for the patient's care and treatment pursuant to Section 4144 of the Welfare and Institutions Code, but shall not be considered seclusion, as defined in subdivision (e) of Section 1180.1, for purposes of Division 1.5 (commencing with Section 1180).

(6) Provide emergency egress for ETP patients.

(7) In the event that seclusion or restraints, as defined in Section 1180.1, are used in an ETP, all state licensing and regulations shall be followed.

(8) A full-time independent patients' rights advocate who provides patients' rights advocacy services shall be assigned to each ETP.

(d) The ETPs shall adopt and implement policies and procedures necessary to encourage patient improvement, recovery, and a return

to a standard treatment environment, and to create identifiable facility requirements and benchmarks. The policies and procedures shall also provide all of the following:

(1) Criteria and process for admission into an ETP pursuant to Section 4144 of the Welfare and Institutions Code.

(2) Clinical assessment and review focused on behavior, history, high risk of most dangerous behavior, and clinical need for patients to receive treatment in an ETP as the least restrictive treatment environment.

(3) A process for identifying an ETP along a continuum of care that will best meet the patient's needs, including least restrictive treatment environment.

(4) A process for creating and implementing a treatment plan with regular clinical review and reevaluation of placement back into a standard treatment environment and discharge and reintegration planning as specified in subdivision (e) of Section 4144 of the Welfare and Institutions Code.

(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 (c).

(f) For purposes of paragraph (1) of subdivision (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) 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 unit, and transitional inpatient care unit. The regulation addressing the emergency department shall distinguish between regularly scheduled core staff licensed nurses and additional licensed nurses required to care for critical care patients in the emergency department.

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

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

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

(e) No registered nurse shall be assigned to a nursing unit or clinical area unless that nurse has first received orientation in that clinical area sufficient to provide competent care to patients in that

area, and has demonstrated current competence in providing care in that area.

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

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

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

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

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

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

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

(3) The adoption of emergency regulations pursuant to this subdivision and two readoptions of emergency regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Emergency regulations and readoptions authorized by this section shall be exempt from review by the Office of Administrative Law. The emergency regulations and the readoptions authorized by this

section shall be submitted to the Office of Administrative Law for filing with the Secretary of State. Notwithstanding any other provision of law, the adoption and readoptions of these emergency regulations shall be exempt from the requirements of subdivision (b) of Section 11346.1 of the Government Code and each shall remain in effect for no more than 180 days.

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

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

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

(C) Requirements that the State Department of Public Health deems necessary or relevant to staffing policies and procedures 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) 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.

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

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

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

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

(ii) Within 30 days of the State Department of Public Health's receipt of the facility's request for appeal, the State Department of Public Health shall submit, to both the facility and the State Department of Health Care Services, its responsive arguments and

all supporting documents that the State Department of Public Health will present at the hearing.

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

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

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

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

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

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

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

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

(e) In implementing this section, the State Department of Public Health may contract, as necessary, with California's Medicare Quality Improvement Organization, or other entities deemed qualified by the State Department of Public Health, not associated with a skilled nursing facility. The department may enter into

exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis for purposes of implementing this subdivision. Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, the State Administrative Manual, and the State Contracting Manual, and shall be exempt from the review or approval of any division of the State Department of General Services.

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

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

1280.15. (a) A clinic, health facility, home health agency, or hospice licensed pursuant to Section 1204, 1250, 1725, or 1745 shall prevent unlawful or unauthorized access to, and use or disclosure of, patients' medical information, as defined in Section 56.05 of the Civil Code and consistent with Section 1280.18. For purposes of this section, internal paper records, electronic mail, or facsimile transmissions inadvertently misdirected within the same facility or health care system within the course of coordinating care or delivering services shall not constitute unauthorized access to, or use or disclosure of, a patient's medical information. The department, after investigation, may assess an administrative penalty for a violation of this section of up to twenty-five thousand dollars ($25,000) per patient whose medical information was unlawfully or without authorization accessed, used, or disclosed, and up to seventeen thousand five hundred dollars ($17,500) per subsequent occurrence of unlawful or unauthorized access, use, or disclosure of that patient's medical information. For purposes of the investigation, the department shall consider the clinic's, health facility's, agency's, or hospice's history of compliance with this section and other related state and federal statutes and regulations, the extent to which the facility detected violations and took preventative action to immediately correct and prevent past violations from recurring, and factors outside its control that restricted the facility's ability to comply

with this section. The department shall have full discretion to consider all factors when determining whether to investigate and the amount of an administrative penalty, if any, pursuant to this section.

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

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

(c) (1) A clinic, health facility, home health agency, or hospice shall delay the reporting, as required pursuant to paragraph (2) of subdivision (b), of any unlawful or unauthorized access to, or use or disclosure of, a patient's medical information beyond 15 business days if a law enforcement agency or official provides the clinic, health facility, home health agency, or hospice with a written or oral statement that compliance with the reporting requirements of paragraph (2) of subdivision (b) would likely impede the law enforcement agency's investigation that relates to the unlawful or unauthorized access to, and use or disclosure of, a patient's medical information and specifies a date upon which the delay shall end, not to exceed 60 days after a written request is made, or 30 days after an oral request is made. A law enforcement agency or official may request an extension of a delay based upon a written declaration that there exists a bona fide, ongoing, significant criminal investigation of serious wrongdoing relating to the unlawful or unauthorized access to, and use or disclosure of, a

patient's medical information, that notification of patients will undermine the law enforcement agency's investigation, and that specifies a date upon which the delay shall end, not to exceed 60 days after the end of the original delay period.

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

(A) Document the oral statement, including, but not limited to, the identity of the law enforcement agency or official making the oral statement and the date upon which the oral statement was made.

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

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

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

(e) In enforcing subdivisions (a) and (d), the department shall take into consideration the special circumstances of small and rural hospitals, as defined in Section 124840, and primary care clinics, as defined in subdivision (a) of Section 1204, in order to protect access to quality care in those hospitals and clinics. When assessing

a penalty on a skilled nursing facility or other facility subject to Section 1423, 1424, 1424.1, or 1424.5, the department shall issue only the higher of either a penalty for the violation of this section or a penalty for violation of Section 1423, 1424, 1424.1, or 1424.5, not both.

(f) All penalties collected by the department pursuant to this section, Sections 1280.1, 1280.3, 1280.4, and 1280.19, shall be deposited into the Internal Departmental Quality Improvement Account, which is hereby 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:

1280.19. (a) Effective July 1, 2025, the Internal Health Information Integrity Quality Improvement Account is hereby abolished. All moneys in the fund shall be transferred to the Internal Departmental Quality Improvement Account created pursuant to subdivision (f) of Section 1280.15. Any remaining balance, assets, liabilities, and encumbrances of the Internal Health Information Integrity Quality Improvement Account as of July 1, 2025, shall be transferred to, and become part of, the Internal Departmental Quality Improvement Account. All administrative fines assessed by the department pursuant to Section 56.36 of the Civil Code shall be deposited into the Internal Departmental Quality Improvement Account. Notwithstanding Section 16305.7 of the Government Code, all interest earned on the moneys deposited in the account shall be retained in the account. Upon appropriation by the Legislature, moneys in the account shall be used for the purpose of supporting quality improvement activities in the Licensing and Certification Program.

(b) 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. 6. Section 1342.2 of the Health and Safety Code is amended to read:

1342.2. (a) Notwithstanding any other law, a health care service plan contract that covers medical, surgical, and hospital benefits, excluding a specialized health care service plan contract, shall cover the costs for COVID-19 diagnostic and screening testing and health care services related to diagnostic and screening testing approved or granted emergency use authorization by the federal Food and Drug Administration for COVID-19, regardless of whether the services are provided by an in-network or out-of-network provider. Coverage required by this section shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing. Services related to COVID-19 diagnostic

and screening testing include, but are not limited to, hospital or health care provider office visits for the purposes of receiving testing, products related to testing, the administration of testing, and items and services furnished to an enrollee as part of testing. Services related to COVID-19 diagnostic and screening testing do not include bonus payments for the use of specialized equipment or expedited processing.

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

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

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

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

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

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

(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 diagnostic and screening testing and health care services related to testing when delivered by an out-of-network provider, except as otherwise required by law. All other requirements of this subdivision shall remain in effect after the federal public health emergency expires.

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

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

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

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

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

(3) (A) A health care service plan subject to this subdivision shall not impose any cost-sharing requirements, including a copayment, coinsurance, or deductible, for any item, service, or immunization described in paragraph (1), regardless of whether

such service is delivered by an in-network or out-of-network provider.

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

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

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

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

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

(E) (i) For an out-of-network provider with whom a health care service plan does not have a negotiated rate for an item, service, or immunization described in paragraph (1), a health care service plan shall reimburse the provider for all related items or services, including any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1), in an amount that is reasonable, as determined in comparison to prevailing market rates for such items or services in the geographic region in which the item or service is rendered. 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 items, services, and immunizations described in subdivision (b), including any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1).

(ii) 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 any item, service, or immunization described in paragraph (1) and to cover items or services that are necessary for the furnishing of the items, services, or immunizations described in paragraph (1) when delivered by an out-of-network provider, except as otherwise required by law. All other requirements of this section shall remain in effect after the federal public health emergency expires.

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

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

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

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

(e) For purposes of this section:

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

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

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

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

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

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

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

(A) Workers in a workplace setting.

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

(C) A person before or after travel.

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

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

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

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

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

(3) For an out-of-network provider with whom a health care service plan does not have a negotiated rate for the therapeutics 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) 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.

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

1356.3. (a) For the 2025–26 to 2026–27 fiscal years, inclusive, a health care service plan licensed by the department shall be assessed an annual fee in an amount determined by the department, in consultation with the Department of Health Care Access and

Information. The annual fee shall be limited to the amount necessary to fund the actual and reasonably necessary expenses of the department to implement Article 6.1 (commencing with Section 1385.001) and the actual and reasonably necessary expenses of the Department of Health Care Access and Information pertaining to data reporting by pharmacy benefit managers, including that portion of the Health Care Payments Data Program established by Section 127671.1 that concerns pharmacy benefit managers.

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

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

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

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

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

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

(1) A licensed physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall

not prevent testing and diagnosis of infertility before the 12-month or 6-month period to establish infertility in paragraph (3).

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

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

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

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

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

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

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

(e) Consistent with Section 1365.5, coverage for the treatment of infertility and fertility services shall be provided without discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation. This subdivision shall not be construed to interfere with the clinical judgment of a physician and surgeon.

(f) This section does not apply to Medi-Cal managed care health care service plan contracts or any entity that enters into a contract with the State Department of Health Care Services for the delivery

of health care services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), Chapter 8.75 (commencing with Section 14591), or Chapter 8.9 (commencing with Section 14700) of Part 3 of Division 9 of the Welfare and Institutions Code.

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

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

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

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

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

Article 6.1. Pharmacy Benefit Managers

SEC. 10. Section 1385.001 of the Health and Safety Code is repealed.

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

1385.001. For the purposes of this article:

(a) "Department" means the Department of Managed Health Care.

(b) "Director" means the Director of the Department of Managed Health Care.

(c) "Drug" has the same meaning as defined in Section 4025 of the Business and Professions Code.

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

(e) "Manufacturer" has the same meaning as defined in Section 4033 of the Business and Professions Code.

(f) "Payer" means a health care service plan licensed by the department or a health insurer licensed by the Department of Insurance.

(g) "Pharmacist" has the same meaning as defined in Section 4036 of the Business and Professions Code.

(h) "Pharmacy" has the same meaning as defined in Section 4037 of the Business and Professions Code.

(i) (1) "Pharmacy benefit manager" means a person, business, or other entity that, either directly or through an intermediary, affiliate, or both, acts as a price negotiator or group purchaser on behalf of a payer, or manages the prescription drug coverage provided by the payer, including, but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies, 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) 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.

(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 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.

(c) Until June 30, 2028, for purposes of implementing this article, the department may contract with a consultant or 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 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.

(d) Contracts entered into pursuant to the authority in this 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, or, if licensure of the pharmacy benefit manager is required pursuant to this article, obtain a license and keep it in good standing with the department.

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

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

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

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

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

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

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

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

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

(1) The name of the pharmacy benefit manager.

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

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

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

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

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

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

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

(g) Within 30 days of a change in any of the information disclosed to the department on an application for a registration,

the pharmacy benefit manager shall notify the department of that change in writing.

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

(1) If the applicant is a partnership or other unincorporated 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 regulations, including Section 1351 and the forms and exhibits described in regulations, as amended, implementing that section. The application for licensure as a pharmacy benefit manager shall be accompanied by the fee prescribed by Section 1385.0016 and shall set forth or be accompanied by all of the following:

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

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

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

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

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

(f) Financial statements accompanied by a report, certificate, or opinion of an independent certified public accountant that demonstrates the financial viability of the applicant. Submission of financial statements may, at the direction of the department, be completed using the same forms and processes as required for health care service plans licensed pursuant to this chapter.

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

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

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

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

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

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

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

(n) A list of each payer with which the applicant is affiliated or has a contract for the provision of pharmacy benefit manager services, including a description of all services provided and the

number of individual enrollees covered under the contract or contracts with each payer.

(o) A statement describing how the applicant shall provide for separation of medical and clinical decisionmaking from fiscal and administrative management to ensure that medical and clinical decisions shall not be unduly influenced by fiscal and administrative management, including a description of what controls will be put into place to assure compliance with this requirement.

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

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

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

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

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

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

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

(e) If the report, certificate, or opinion of the independent accountant required pursuant to subdivision (a) is qualified, the director may require the pharmacy benefit manager to take action that the director deems appropriate to permit an independent accountant to remove the qualification from the report, certificate, or opinion.

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

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

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

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

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

1385.0012. (a) A pharmacy benefit manager licensed pursuant to this article shall submit to the Department of Health Care Access and Information all information required to be reported pursuant to Chapter 8.5 (commencing with Section 127671) of Part 2 of Division 107.

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

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

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

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

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

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

(c) A pharmacy benefit manager shall, within five days, give written notice to the director, in the form prescribed by rule by the

director, of a change in the officers, directors, partners, controlling shareholders, principal creditors, or persons occupying similar positions or performing similar functions, of the pharmacy benefit manager, any parent company of the pharmacy benefit manager, or a management company of the pharmacy benefit manager or its parent company. The director may define by rule the positions, duties, and relationships that shall be reported pursuant to this subdivision.

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

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

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

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

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

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

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

1385.0016. (a) A pharmacy benefit manager applying for licensure under this article shall reimburse the director for the actual cost of processing the application, including overhead, up to an amount not to exceed twenty-five thousand dollars ($25,000).

The cost shall be billed not more frequently than monthly and shall be remitted by the applicant to the director within 30 days of the date of billing. The director shall not issue a license to an applicant before receiving payment in full from that applicant for all amounts charged pursuant to this subdivision.

(b) (1) In addition to other fees, fines, penalties, and reimbursements required to be paid under this article, a licensed pharmacy benefit manager shall pay to the director an amount estimated by the director, in consultation with the Department of Health Care Access and Information, to be necessary to fund the actual and reasonably necessary expenses of the department to implement this article and the actual and reasonably necessary expenses of the Department of Health Care Access and Information pertaining to data reporting by pharmacy benefit managers, including for any portion of the Health Care Payments Data Program established by Section 127671.1 that is necessary to implement the provisions of this article, for the ensuing fiscal year. The amount may be paid in two equal installments. The first installment shall be paid on or before August 1 of each year, and the second installment shall be paid on or before December 15 of each year.

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

(3) A licensed pharmacy benefit manager shall, by January 31 of each year, file with the director a report stating the total number of claims it adjudicated for drugs in this state for the preceding calendar year. For purposes of this paragraph, adjudicated claims are claims for reimbursement for drugs dispensed by a provider to a beneficiary under the drug benefit administered by the pharmacy benefit manager for which payment was authorized and made by the pharmacy benefit manager. Reports submitted shall be in the form and manner directed by the department. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the

department may issue instructions on reporting without taking regulatory action.

(4) The amount paid by each pharmacy benefit manager shall be fixed by the director by notice to all licensed pharmacy benefit managers on or before June 15 of each year. A pharmacy benefit manager that is unable to report the number of adjudicated claims shall provide the director with an estimate of the number and the method used for determining the estimate. The director may, upon giving written notice to the pharmacy benefit manager, revise the estimate if the director determines that the method used for determining the estimate was not reasonable.

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

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

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

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

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

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

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

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

1385.0018. (a) The director may, after appropriate notice and opportunity for a hearing, by order suspend or revoke a license issued under this article to a pharmacy benefit manager or assess administrative penalties if the director determines that the licensee has committed an act or omission constituting grounds for disciplinary action.

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

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

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

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

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

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

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

(7) The pharmacy benefit manager, its management company, another affiliate of the pharmacy benefit manager, or a controlling person, officer, director, or other person occupying a principal management or supervisory position in the pharmacy benefit manager, management company, or affiliate, has been convicted of or pleaded nolo contendere to a crime, or committed an act involving dishonesty, fraud, or deceit, which crime or act is substantially related to the qualifications, functions, or duties of a person engaged in business in accordance with this chapter. The director may revoke or deny a license hereunder irrespective of a subsequent order under Section 1203.4 of the Penal Code.

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

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

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

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

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

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

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

1385.0019. (a) A pharmacy benefit manager whose license has been revoked, or suspended for more than one year, may petition the director to reinstate the license as provided by Section 11522 of the Government Code. A petition shall not be considered

if the petitioner is under criminal sentence for a violation of this chapter, or an offense that would constitute grounds for discipline or denial of licensure under this chapter, including any period of probation or parole.

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

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

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

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

(b) If the director finds that a pharmacy benefit manager is no longer in existence, has ceased to do business, has failed to initiate business activity as a licensee within six months after licensure,

or cannot be located after reasonable search, the director may, by order, summarily revoke the license of the pharmacy benefit manager.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1385.0025. The provisions of this article are severable. If any provision of this article or its application is held invalid, that

invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

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

1385.026. The Legislature finds and declares that Sections 19 and 29 of this act, which add Sections 1385.0011 and 1385.0021, respectively, to the Health and Safety Code, impose a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

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

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

1417.2. (a) Notwithstanding Section 1428, moneys collected as a result of state and federal civil penalties imposed under this chapter or federal law shall be deposited into the State Health Facilities Citation Penalties Account, hereby established in the State Treasury, into which moneys derived from civil penalties for violations of state law shall be deposited, and the Federal Health Facilities Citation Penalties Account, hereby established in the State Treasury, into which moneys derived from civil penalties for violations of federal law shall be deposited. Moneys from these accounts shall 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, including, but not limited to, the following:

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

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

(3) Reimbursing residents for personal funds lost. In the event that the loss is a result of the actions of a long-term health care

facility or its employees, the revenues of the facility shall first be used.

(4) The costs associated with informational meetings required 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 not limited to, emergency generators using fuel, large capacity batteries, and renewable electrical generation facilities.

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

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

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

(f) (1) A facility shall comply with the requirements of this section 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 of complying with the requirements of this section, to the extent required by any of the following:

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

(B) The California Medicaid State Plan.

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

(2) 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 State Department of Health Care Services may implement this subdivision by means of provider bulletins, policy letters, or other similar instructions, without taking regulatory action.

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

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

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

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

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

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

(b) Nothing in the financial eligibility standards shall prohibit drugs to an otherwise eligible person whose modified adjusted gross income does not exceed 500 percent of the federal poverty level per year based on family size and household income. However, the director may authorize drugs for persons with incomes higher than 500 percent of the federal poverty level per year based on family size and household income if the estimated cost of those drugs in one year is expected to exceed 20 percent

of the person's modified adjusted gross income. Beginning January 1, 2025, or as soon as technically feasible thereafter, the financial eligibility standard in this section shall increase to 600 percent of the federal poverty level per year based on family size and household income.

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

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

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

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

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

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

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

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

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

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

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

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

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

(E) Self-insured employers.

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

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

(H) Organized labor.

(I) Organizations representing consumers.

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

(2) The advisory committee shall consist of no fewer than 10 and no more than 12 persons.

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

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

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

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

(7) The advisory committee shall assist and advise the director in formulating program policies regarding data collection, management, use, and access, and development of public information to meet the goals of the program. The advisory committee shall, through its meetings, provide a forum for stakeholder and public engagement. Upon request of the director, the advisory committee may assist and advise on the department's other data programs.

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

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

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

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

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

127672.9. Until June 30, 2028, for purposes of implementing this chapter, including, but not limited to, hiring staff and consultants, facilitating and conducting meetings, conducting

research and analysis, and developing the required reports, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis. Contracts entered into or amended pursuant to this section are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and are exempt from the review or approval of any division of the Department of General Services.

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 pharmaceutical manufacturer to exclusively dispense or provide a drug to a health care service plan's or health insurer's employees, enrollees, or insureds.

(13) Information needed to calculate any of the following:

(A) The number of participants or beneficiaries who filled a prescription.

(B) Total out-of-pocket spending by participants or beneficiaries.

(C) Total net price by drug.

(D) Payer total net spending by drug.

(E) Payer average net spending per 30-day and 90-day supply.

(F) Percentage of prescriptions dispensed by pharmacies owned by, or under common control of, the pharmacy benefit manager.

(G) Comparisons of the amounts charged to patients and payers by pharmacies owned by, or under common control of, the pharmacy benefit manager, with the amounts charged by pharmacies not owned by, or under common control of, the pharmacy benefit manager.

(H) Average sales price of drugs dispensed at pharmacies owned by, or under common control of, the pharmacy benefit manager.

(I) Average wholesale acquisition cost of drugs dispensed at pharmacies owned by, or under common control of, the pharmacy benefit manager.

(J) Average drug acquisition cost per dosage unit of drugs dispensed at pharmacies owned by, or under common control of, the pharmacy benefit manager.

(K) Average drug acquisition cost per 30-day and 90-day supply.

(c) The department shall promulgate regulations for the purpose of carrying out this section, including regulations relating to the content, file formats, frequency, and timelines for data submission by pharmacy benefit managers. In the development of regulations, the department may consider national or regional standards and standards from other databases.

(d) Until January 1, 2028, any necessary rules and regulations for the purpose of implementing this section may be adopted as emergency regulations in accordance with the Administrative

Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of emergency regulations pursuant to this section shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

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

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

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

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

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

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

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

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

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

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

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

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

(b) For the purposes of this chapter, "certified wellness coach" means a new category of behavioral health provider trained specifically to help address the unmet mental health and substance use needs of children and youth. Recognizing that unmet mental health and substance use needs create learning barriers, certified wellness coaches shall engage and support children and youth in cultural, linguistic, and age-appropriate services with the ability to refer and link to higher levels of care, as needed. As a member of a care team, a behavioral health professional serving as a certified wellness coach receives appropriate supervision and coordination from staff who are licensed or who hold a pupil personnel services credential pursuant to Section 44266 of the Education Code, or school nurse services credential pursuant to Section 44267.5 of the Education Code. Training and qualifications include, but are not limited to, psychoeducation, system navigation, crisis referral, coping skills, and motivational interviewing.

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

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

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

(b) The State Department of Public Health shall 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.

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

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

(2) The grants shall be available to TGI-serving organizations for the purpose of facilitating evidence-based therapeutic arts programs.

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

(4) The grants shall be available to a hospital, health care clinic, or other medical provider that currently provides gender-affirming health care services, such as hormone therapy or gender reassignment surgery, to continue providing those services, or to a hospital, health care clinic, or other medical provider that will establish a program that offers gender-affirming health care services and has an established relationship with a TGI-serving organization that will lead in establishing the program.

(d) A hospital, health care clinic, or other medical provider that applies for a grant must apply in partnership with a TGI-serving organization and consult with the TGI-serving organization

throughout the process of creating and implementing its trans-inclusive health care program.

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

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

(1) "Health care" means all of the following:

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

(B) Evidence-based therapeutic arts programs.

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

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

(2) A "TGI-serving organization" means either of the following:

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

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

(3) "Transgender" is broad and inclusive of all gender identities different from the gender that a person was assigned at birth.

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

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

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

10119.6. (a) (1) A large group disability insurance policy, except a specialized disability insurance policy, that is issued, amended, or renewed on or after January 1, 2026, shall provide

coverage for the diagnosis and treatment of infertility and fertility services, including a maximum of three completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine (ASRM), using single embryo transfer when recommended and medically appropriate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1026. (a) If a defendant pleads not guilty by reason of insanity, and also joins with it another plea or pleas, the defendant shall first be tried as if only the other plea or pleas had been entered, and in that trial the defendant shall be conclusively presumed to have been sane at the time the offense is alleged to have been committed. If the jury finds the defendant guilty, or if the defendant pleads only not guilty by reason of insanity, the question whether the defendant was sane or insane at the time the offense was committed shall be promptly tried, either before the same jury or before a new jury in the discretion of the court. In that trial, the jury shall return a verdict either that the defendant was sane at the time the offense was committed or was insane at the time the offense was committed. If the verdict or finding is that the defendant was sane at the time the offense was committed, the court shall sentence the defendant as provided by law. If the verdict or finding is that the defendant was insane at the time the offense was committed, the court, unless it appears to the court that the sanity of the defendant has been recovered fully, shall direct that the defendant be committed to the State Department of State Hospitals for the care and treatment of persons with mental health disorders or any other appropriate public or private treatment facility approved by the community program director, or the court may order the defendant placed on outpatient status pursuant to Title 15 (commencing with Section 1600) of Part 2.

(b) Prior to making the order directing that the defendant be committed to the State Department of State Hospitals or other treatment facility or placed on outpatient status, the court shall

order the community program director or a designee to evaluate the defendant and to submit to the court within 15 judicial days of the order a written recommendation as to whether the defendant should be placed on outpatient status or committed to the State Department of State Hospitals or other treatment facility. A person shall not be admitted to a state hospital or other treatment facility or placed on outpatient status under this section without having been evaluated by the community program director or a designee. If, however, it appears to the court that the sanity of the defendant has been recovered fully, the defendant shall be remanded to the custody of the sheriff until the issue of sanity has been finally determined in the manner prescribed by law. A defendant committed to a state hospital or other treatment facility or placed on outpatient status pursuant to Title 15 (commencing with Section 1600) of Part 2 shall not be released from confinement, parole, or outpatient status unless and until the court that committed the person, after notice and hearing, finds and determines that the person's sanity has been restored, or meets the criteria for release pursuant to Section 4146 of the Welfare and Institutions Code. This section does not prohibit the transfer of the patient from one state hospital to any other state hospital by proper authority. This section does not prohibit the transfer of the patient to a hospital in another state in the manner provided in Section 4119 of the Welfare and Institutions Code.

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

approved by the community program director. If either the defendant or the prosecuting attorney chooses to contest either kind of order of transfer, a petition may be filed in the court requesting a hearing, which shall be held if the court determines that sufficient grounds exist. At that hearing, the prosecuting attorney or the defendant may present evidence bearing on the order of transfer. The court shall use the same procedures and standards of proof as used in conducting probation revocation hearings pursuant to Section 1203.2.

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

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

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

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

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

(4) State summary criminal history information.

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

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

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

(8) Any medical records.

(f) If the defendant is confined in a state hospital or other treatment facility as an inpatient, the medical director of the facility shall, at 12-month intervals, submit a report in writing to the court and the community program director of the county of commitment,

or a designee, setting forth the status and progress of the defendant. The court shall transmit copies of these reports to the prosecutor and defense counsel.

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

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

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

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

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

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

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

(b) Subject to subdivision (c), entities eligible to receive grants pursuant to this section may include counties, city mental health authorities, tribal entities, local educational agencies, institutions of higher education, publicly funded childcare and preschools, health care service plans, community-based organizations, and behavioral health providers.

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

(d) The department shall ensure that grant distribution includes, but is not limited to, rural, urban, and suburban regions and

geographic distribution among different age cohorts. Allowable activities shall include, but not be limited to, the following:

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

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

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

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

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

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

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

(1) "Comprehensive risk contract" has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

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

(3) "Institution of higher education" means the California Community Colleges, the California State University, or the University of California.

(4) "Local educational agency" means a school district, county office of education, charter school, the California Schools for the 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.

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

SEC. 51. Section 14000 of the Welfare and Institutions Code, as added by Section 2 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. 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.

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

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

14005.11. (a) To the extent required by federal law for qualified beneficiaries enrolled in the federal Medicare Program, the department shall pay the premiums, deductibles, and coinsurance for elderly and disabled persons entitled to benefits under Title XVIII of the federal Social Security Act, whose income does not exceed the federal poverty level and whose resources do not exceed the amount specified in subdivision (a) of Section 14005.62.

(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 federal 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 federal 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 January 1, 2026.

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

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

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

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

14005.20. (a) The 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 services for persons infected with tuberculosis.

(b) (1) Except as provided in paragraph (2), the income 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 of individuals eligible under this section 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)), as determined, counted, and valued in accordance with the requirements of Section 14005.64.

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

(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 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 obtained and the date that paragraph (3) shall be implemented. The director shall post the declaration on the department's internet website.

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

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

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

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

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

(5) Countable resources, as determined in accordance with subdivision (a) of Section 14005.62, do not exceed the maximum levels established in that section.

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

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

(2) The department shall adopt regulations by 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 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 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 community care facility and the SSI recipient retention amount exceed the sum of the individual's income level, the individual's PCS deduction, and twenty dollars ($20).

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

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

(i) The deduction prescribed by paragraph (3) of subdivision (g) shall be applied no later than the first day of the fourth month after the month in which the department receives approval for the federal financial participation specified in subdivision (h). Until

approval for federal financial participation is received, there shall be no deduction under paragraph (3) of subdivision (g).

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

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

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

SEC. 57. Section 14005.40 of the Welfare and Institutions Code, as added by Section 81 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 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 obtained and the date that paragraph (3) shall be implemented.

The director shall post the declaration on the department's internet website.

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

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

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

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

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

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

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

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

(2) The department shall adopt regulations by July 1, 2023, 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 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 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 community care facility and the SSI recipient retention amount exceed the sum of the individual's income level, the individual's PCS deduction, and twenty dollars ($20).

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

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

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

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

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

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

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

14005.62. (a) (1) Notwithstanding any other law, for an applicant or beneficiary whose eligibility is not determined using the modified adjusted gross income (MAGI)-based financial

methods, as specified in Section 1396a(e)(14) of Title 42 of the United States Code, resources, including property or other assets, shall not be used to determine eligibility under the Medi-Cal program to the extent permitted by federal law. The department shall seek federal authority to disregard all resources as authorized by the flexibilities provided under Section 1396a(r)(2) of Title 42 of the United States Code or other available authorities.

(b) (1) 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 this section by means of county letters, provider bulletins or notices, policy letters, or other similar instructions, without taking regulatory action.

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

(A) Adopt, amend, or repeal 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 and this section.

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

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

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

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

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

14005.62. (a) (1) Notwithstanding any other law, for an applicant or beneficiary whose eligibility is not determined using the modified adjusted gross income (MAGI)-based financial

methods, as specified in Section 1396a(e)(14) of Title 42 of the United States Code, the department shall seek federal approval to implement a disregard of one hundred thirty thousand dollars ($130,000) in nonexempt property for a case with one member and sixty five thousand dollars ($65,000) for each additional household member, up to a maximum of 10 members.

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

(b) (1) 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 this section by means of county letters, provider bulletins or notices, policy letters, or other similar instructions, without taking regulatory action. Such instructions shall include a list of all exempt property for use until such time that regulations are adopted.

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

(A) Adopt, amend, or repeal 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 and this section.

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

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

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

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

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

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

(b) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted.

(2) The department shall adopt regulations by 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.

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

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

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

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

(b) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted.

(2) The department shall adopt regulations by July 1, 2021, 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) For purposes of determining eligibility under this part, countable resources shall be determined in accordance with subdivision (a) of Section 14005.62. Resources exempt under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) shall not be considered in determining eligibility. A community spouse may retain nonexempt resources to the maximum extent permitted under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.). Medically needy individuals and families may retain nonexempt resources to the extent permitted under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.). In addition, the principal residence as defined in subdivision (b) shall be exempt.

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

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

(2) If the real property other than the home is not producing income reasonably consistent with its value, the applicant or recipient shall be allowed reasonable time to begin producing such income from the property. If the property cannot produce

reasonable income or be sold based on the market value, the applicant or recipient shall be allowed to submit evidence from a qualified real estate appraiser that indicates the value for which the property can be adequately utilized or sold. If the applicant or recipient provides evidence that the only method of adequately utilizing the property is sale, and the property has not been sold at market value during a reasonable period of time, the property shall be considered to be adequately utilized provided it is listed with a licensed real estate broker at the value determined to be the fair market value by a qualified real estate appraiser and the applicant or recipient provides evidence that a bona fide and continuous effort is being made to sell the property.

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

(f) Any mortgage or note secured by a deed of trust shall be deemed real property if its value does not exceed six thousand dollars ($6,000) and it is obtained by the applicant or recipient, or in combination with their spouse, through the sale of such real 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 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 operative on January 1, 2026.

SEC. 64. Section 14006.1 of the Welfare and Institutions Code is repealed.

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.

(2) The appraised value of the principal residence determined by a qualified real estate appraiser who has been retained by the applicant or beneficiary, less any encumbrances of record.

(b) Notwithstanding subdivisions (b) and (c) of Section 14006, and except as provided in subdivision (c), an individual is not eligible for medical assistance for home and facility care if their equity interest in the principal residence exceeds seven hundred fifty thousand dollars ($750,000). No later than December 31, 2011, and each year thereafter, this amount shall be increased based on the percentage increase in the consumer price index for all urban consumers (all items, United States city average), rounded to the nearest one thousand dollars ($1,000).

(c) This section does not apply to an individual if any of the following circumstances exist:

(1) The spouse of the individual or the individual's child, who is under 21 years of age, or who is blind or who is disabled, as defined in paragraph (3) of subsection (a) of Section 1382c of Title 42 of the United States Code, is lawfully residing in the individual's home.

(2) The individual was determined eligible for medical assistance for home and facility care based on an application filed before January 1, 2006.

(3) The department determines that ineligibility for medical assistance for home and facility care would result in demonstrated hardship on the individual. For purposes of this section,

demonstrated hardship shall include, but need not be limited to, any of the following circumstances:

(A) The individual was receiving home and facility care prior to January 1, 2006.

(B) The individual has been determined to be eligible for medical assistance for home and facility care based on an application filed on or after January 1, 2006, and before the date that regulations adopted pursuant to this section are certified with the Secretary of State.

(C) The individual purchased and received benefits under a long-term care insurance policy certified by the department's California Partnership for Long-Term Care Program, established by Division 12 (commencing with Section 22000).

(D) The individual's equity interest in the principal residence exceeds the equity interest limit as provided in subdivision (b), but would not exceed the equity interest limit under that subdivision if it had been increased by using the quarterly House Price Index (HPI) for California, published by the Office of Federal Housing Enterprise Oversight (OFHEO).

(E) The applicant or beneficiary has been denied a home equity loan by at least three lending institutions, or is ineligible for any one Federal Housing Administration (FHA) approved loan or reverse mortgage.

(F) The applicant or beneficiary, with good cause, is unable to provide verification of the equity value.

(G) The applicant or beneficiary meets the criteria set forth in subdivision (b) of Section 14015.1.

(d) 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.

(e) 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.

(f) 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.

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

SEC. 66. Section 14006.2 of the Welfare and Institutions Code is amended to read:

14006.2. (a) In determining the eligibility of a married individual, pursuant to Section 14005.4 or 14005.7, who, in accordance with Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and regulations adopted pursuant thereto, is considered to be living separately from their spouse, the individual shall be considered to have made a transfer of resources for full and adequate consideration under Section 14006 or 14015 by reason of either of the following:

(1) Having entered into a written agreement with their spouse dividing their nonexempt community property into equal shares of separate property. Property so agreed to be separate property shall be considered by the department to be the separate property of the spouse who, pursuant to the agreement, is the owner of the property. Only in cases in which separate property owned by one spouse is actually made available to the other spouse, may the department count the separate property in the eligibility determination of the nonowner spouse.

(2) Having transferred to their spouse all of their interest in a home, whether the transfer was made before or after the individual became a resident in a nursing facility in accordance with and to the extent permitted by Title XIX of the federal Social Security Act and regulations promulgated pursuant thereto.

(b) The department shall furnish to all Medi-Cal applicants a clear and simple statement in writing advising them that (1) in the case of an individual who is an inpatient in a nursing facility, if the individual or the individual's conservator transferred to the individual's spouse all of the interest in a home, the individual shall not be considered ineligible for Medi-Cal by reason of the transfer; and that (2) if the individual and the individual's spouse execute a written interspousal agreement that divides and transmutes nonexempt community property into equal shares of separate property, the separate property of the individual's spouse shall not be considered available to the individual and need not be spent by the spouse for the individual's care in a nursing facility or other medical institution. The statement provided for in this

subdivision shall also be furnished to each individual admitted to a nursing facility, along with, but separately from, the statement required under Section 72527 of Title 22 of the California Code of Regulations.

(c) In order to qualify for Medi-Cal benefits pursuant to Section 14005.4 or 14005.7, a married individual who resides in a nursing facility, and who is in a Medi-Cal budget unit separate from that of their spouse, shall be required to expend their other resources for their own benefit, so that the amount that remains does not exceed the maximum levels established pursuant to subdivision (a) of Section 14005.62. In the event that the married individual expends their resources for expenses associated with or for improvements to property, those expenditures shall be considered to be for their own benefit only to the extent that the expenditures are proportionate to the ownership interest the individual has in the property. For purposes of this section, the term "their other resources" shall be limited to the following:

(1) All of their separate property that would not have been exempt under applicable Medi-Cal laws and regulations at the time when they entered a nursing facility, or at the date of execution of the agreement referred to in this section, whichever is earlier. For purposes of this paragraph, the mere change of residence from one facility to another shall not be deemed to be a new entry.

(2) One-half of all the community property, or the proceeds from the sale or exchange of that property, that would not have been exempt at the time described in paragraph (1).

(d) For purposes of subdivision (c), in the absence of an agreement such as that referred to in subdivision (a), there shall be a presumption, rebuttable by either spouse, that all property owned by either spouse was community property.

(e) The statement furnished pursuant to subdivision (b) shall advise all persons entering a long-term care facility, and all Medi-Cal applicants that only their half of the community property shall be taken into account in determining their eligibility for Medi-Cal, whether or not they execute the written interspousal agreement referred to in the statement.

(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 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, 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 certain circumstances under which an interest in a home may be transferred without affecting Medi-Cal eligibility.

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

SEC. 68. Section 14006.3 of the Welfare and Institutions Code, as added by Section 93 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 former Section 14006.6, and any nursing facility enrolled as a provider in the Medi-Cal program, 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 income requirements of the Medi-Cal

program, including, but not limited to, certain protections against spousal impoverishment.

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

SEC. 69. Section 14006.4 of the Welfare and Institutions Code, as amended by Section 94 of Chapter 42 of the Statutes of 2023, is amended to read:

14006.4. (a) The statement required by Sections 14006.2 and 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 have less than (insert amount of individual's resource allowance) in available resources. A home is an exempt resource and is not considered against the resource limit, as long as the resident states on the Medi-Cal application that they intend to return home. Clothes, household furnishings, irrevocable burial plans, burial plots, and an automobile are examples of other exempt resources.

If an unmarried resident is financially eligible for Medi-Cal reimbursement, they are allowed to keep from their monthly income a personal allowance of (insert amount of personal needs allowance) plus the amount of health insurance premiums paid monthly. The remainder of the monthly income is paid to the nursing facility as a monthly deductible called the "Medi-Cal long-term care patient liability."

MARRIED RESIDENT

If one spouse lives in a nursing facility, and the other spouse does not live in a nursing facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than (insert amount of Community Spouse Resource Allowance plus individual's resource allowance) in available assets. The couple's home will not be counted against this (insert amount of Community Spouse Resource Allowance plus individual's resource allowance), as long as one spouse or a dependent relative, or both, lives in the home, or the spouse in the nursing facility states on the Medi-Cal application that they intend to return to the couple's home to live.

If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least their individual monthly income or (insert amount of Minimum Monthly Maintenance Needs Allowance), whichever is greater. Of the couple's remaining monthly income, the spouse in the nursing facility is allowed to keep a personal allowance of (insert amount of personal needs allowance) plus the amount of health insurance premiums paid monthly. The remaining money, if any, generally must be paid to the nursing facility as the Medi-Cal long-term care patient liability. The Medi-Cal program will pay remaining nursing facility costs.

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge that will allow the at-home spouse to retain additional resources or income. Such an order can allow the couple to retain more than (insert amount of Community Spouse Resource Allowance plus individual's resource allowance) in available resources, if the income that could be generated by the retained resources would not cause the total monthly income available to the at-home spouse to exceed (insert amount of Monthly Maintenance Needs Allowance). Such an order also can allow the at-home spouse to retain more than (insert amount of Monthly Maintenance Needs Allowance) in monthly income, if the extra income is necessary "due to exceptional circumstances resulting in significant financial duress."

An at-home spouse also may obtain a court order to increase the amount of income and resources that they are allowed to retain, or to transfer property from the spouse in the nursing facility to

the at-home spouse. You should contact a knowledgeable attorney for further information regarding court orders.

The paragraphs above do not apply if both spouses live in a nursing facility and neither previously has been granted Medi-Cal eligibility. In this situation, the spouses may be able to hasten Medi-Cal eligibility by entering into an agreement that divides their community property. The advice of a knowledgeable attorney should be obtained prior to the signing of this type of agreement.

Note: For married couples, the resource limit ((insert amount of Community Spouse Resource Allowance plus individual's resource allowance) in (insert current year)) and income limit ((insert amount of Minimum Monthly Maintenance Needs Allowance) in (insert current year)) generally increase a slight amount on January 1 of every year.

TRANSFER OF HOME FOR BOTH A MARRIED AND AN UNMARRIED RESIDENT

A transfer of a property interest in a resident's home will not cause ineligibility for Medi-Cal reimbursement if either of the following conditions is met:

(a) At the time of transfer, the recipient of the property interest states in writing that the resident would have been allowed to return to the home at the time of the transfer, if the resident's medical condition allowed them to leave the nursing facility. This provision shall only apply if the home has been considered an exempt resource because of the resident's intent to return home.

(b) The home is transferred to one of the following individuals:

(1) The resident's spouse.

(2) The resident's minor or disabled child.

(3) A sibling of the resident who has an equity interest in the home, and who resided in the resident's home for at least one year immediately before the resident began living in institutions.

(4) A child of the resident who resided in the resident's home at least two years before the resident began living in institutions, and who provided care to the resident that permitted the resident to remain at home longer.

This is only a brief description of the Medi-Cal eligibility rules, for more detailed information, you should call your county welfare department. You will probably want to consult with the local

branch of the state long-term care ombudsman, an attorney, or a legal services program for seniors in your area.

I have read the above notice and have received a copy.
Dated: _____ Signature: _____"

(c) The statement required by subdivision (a) shall be printed in at least 10-point type, shall be clearly separate from any other document or writing, and shall be signed by the person to be admitted and that person's spouse, and legal representative, if any.

(d) 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.

(e) The department may revise this statement as necessary to maintain its consistency with state and federal law.

(f) 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.

If an unmarried resident is financially eligible for Medi-Cal reimbursement, they are allowed to keep from their monthly income a personal allowance of (insert amount of personal needs

allowance) plus the amount of health insurance premiums paid monthly. The remainder of the monthly income is paid to the nursing facility as a monthly deductible called the "Medi-Cal share of cost."

MARRIED RESIDENT

If one spouse lives in a nursing facility, and the other spouse does not live in a nursing facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together meets income requirements. Resources, including property and assets, are not considered in determining Medi-Cal eligibility.

If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least their individual monthly income or (insert amount of Minimum Monthly Maintenance Needs Allowance), whichever is greater. Of the couple's remaining monthly income, the spouse in the nursing facility is allowed to keep a personal allowance of (insert amount of personal needs allowance) plus the amount of health insurance premiums paid monthly. The remaining money, if any, generally must be paid to the nursing facility as the Medi-Cal share of cost. The Medi-Cal program will pay remaining nursing facility costs.

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge that will allow the at-home spouse to retain additional income. That order may allow the at-home spouse to retain more than (insert amount of Monthly Maintenance Needs Allowance) in monthly income, if the extra income is necessary "due to exceptional circumstances resulting in significant financial duress."

An at-home spouse also may obtain a court order to increase the amount of income that they are allowed to retain. You should contact a knowledgeable attorney for further information regarding court orders.

Note: For married couples, the income limit ((insert amount of Minimum Monthly Maintenance Needs Allowance) in (insert current year)) generally increase a slight amount on January 1 of every year.

This is only a brief description of the Medi-Cal eligibility rules, for more detailed information, you should call your county welfare

department. You will probably want to consult with the local branch of the state long-term care ombudsman, an attorney, or a legal services program for seniors in your area.

I have read the above notice and have received a copy.
Dated: _____ Signature: _____"

(b) The statement required by subdivision (a) shall be printed in at least 10-point type, shall be clearly separate from any other document or writing, and shall be signed by the person to be 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 January 1, 2026, and, as of January 1, 2027, is repealed.

SEC. 71. Section 14006.5 of the Welfare and Institutions Code, as amended by Section 96 of Chapter 42 of the Statutes of 2023, is amended to read:

14006.5. (a) The department shall include training regarding the treatment of separate and community income and resources in determining eligibility for Medi-Cal benefits, as part of the ongoing training offered to county welfare departments.

(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, 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 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 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 include all persons who are not citizens or nationals of the United States residing in the United States with the knowledge and permission of the United States Department of Homeland Security and whose departure the United States Department of Homeland Security does not contemplate enforcing and with respect to whom federal financial participation is not available under Title XIX of the federal Social Security Act.

(c) A person who has an immigration status described in Section 1641(b) of Title 8 of the United States Code, but who is subject to the limitation described in Section 1613(a) of Title 8 of the United States Code, or a person who is otherwise permanently residing in the United States under color of law, shall be eligible for the full scope, except as described in subdivision (*l*), of Medi-Cal benefits.

(d) Any person who is not a citizen or national of the United States who is otherwise eligible for Medi-Cal services, but who does not meet the requirements under subdivision (b) or (c), shall only be eligible for care and services that are necessary for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law, except as described in Sections 14007.65, 14007.7, and 14007.8. For purposes of this section, the term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(1) Placing the patient's health in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction to any bodily organ or part. It is the intent of this section to entitle eligible individuals to inpatient and outpatient services that are necessary for the treatment of the emergency medical condition in the same manner as administered by the department through regulations and provisions of federal law.

(e) (1) No sooner than July 1, 2027, except for individuals under 19 years of age, individuals over 59 years of age, and pregnant women, all individuals described in subdivisions (c) and (d) shall be required to pay a monthly premium as a condition of eligibility

for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(2) Monthly premiums imposed under this subdivision shall be thirty dollars ($30) per beneficiary.

(3) An individual required to pay premiums pursuant to this subdivision, after no more than 90 days of nonpayment of the monthly premium, is only 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. All outstanding premium balances shall be paid in full as a condition of continued eligibility for the full scope of Medi-Cal benefits.

(f) Pursuant to Section 14001.2, each county department shall require that each applicant for, or beneficiary of, Medi-Cal, including a child, shall provide their social security number account number, or numbers, if they have more than one social security number.

(g) (1) In order to be eligible for benefits under subdivision (b) or (c), an applicant or beneficiary shall present United States Citizenship and Immigration Services registration documentation or other proof of satisfactory immigration status from the United States Citizenship and Immigration Services.

(2) Any person who meets all other program requirements but who lacks documentation of United States Citizenship and Immigration Services registration or other proof of satisfactory immigration status shall be provided a reasonable opportunity to submit the evidence. For purposes of this paragraph, “reasonable opportunity” means 30 days or the time it actually takes the county to process the Medi-Cal application, whichever is longer.

(3) During the reasonable opportunity period under paragraph (2), the county department shall process the applicant’s application for medical assistance in a manner that conforms to its normal processing procedures and timeframes.

(h) (1) The county department shall grant only the Medi-Cal benefits set forth in subdivision (d) of this section or in Section 14007.65, 14007.7, or 14007.8 to any individual who, after 30 calendar days or the time it actually takes the county to process the Medi-Cal application, whichever is longer, has failed to submit documents constituting reasonable evidence indicating a satisfactory immigration status for Medi-Cal purposes, or who is

reported by the United States Citizenship and Immigration Services to lack a satisfactory immigration status for Medi-Cal purposes.

(2) If a person who is not a citizen or national of the United States has been receiving Medi-Cal benefits based on eligibility established prior to the effective date of this section and that individual, upon redetermination of eligibility for benefits, fails to submit documents constituting reasonable evidence indicating a satisfactory immigration status for Medi-Cal purposes, the county department shall discontinue the Medi-Cal benefits, except for the care and services set forth in subdivision (d) of this section or in Section 14007.65, 14007.7, or 14007.8. The county department shall provide adequate notice to the individual of any adverse action and shall accord the individual an opportunity for a fair hearing if the individual requests one.

(i) To the extent permitted by federal law and regulations, a person who is not a citizen or national of the United States applying for services under subdivisions (b) and (c) shall be granted eligibility for the scope of services to which they would otherwise be entitled if, at the time the county department makes the determination about their eligibility, the person meets either of the following requirements:

(1) The person has not had a reasonable opportunity to submit documents constituting reasonable evidence indicating satisfactory immigration status.

(2) The person has provided documents constituting reasonable evidence indicating a satisfactory immigration status, but the county department has not received timely verification of the person's immigration status from the United States Citizenship and Immigration Services.

(3) The verification process shall protect the privacy of all participants. A person's immigration status shall be subject to verification by the United States Citizenship and Immigration Services, to the extent required for receipt of federal financial participation in the Medi-Cal program.

(j) If a person does not declare status as a lawful permanent resident or person permanently residing under color of law, or as a person legalized under Section 210, 210A, or 245A of the federal Immigration and Nationality Act (Public Law 82-414), Medi-Cal coverage under subdivision (d) of this section or in Section

14007.65, 14007.7, or 14007.8 shall be provided to the individual if they are otherwise eligible.

(k) If a person subject to this section is not fluent in English, the county department shall provide an understandable explanation of the requirements of this section in a language in which the person is fluent.

(*l*) No sooner than July 1, 2026, all individuals described in subdivisions (c) and (d) who are 19 years of age or older shall not be eligible for dental services set forth in this chapter, except for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law.

(m) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement, interpret, or make specific this section, in whole or in part, by means of 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) 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 age or older, and who does not have satisfactory immigration status or is unable to establish satisfactory immigration status as required by Section 14011.2, shall be eligible for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(B) After the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of this subparagraph, but no later than January 1, 2024, an individual who is 26 to 49 years of age, inclusive, and who does not have satisfactory immigration status as required by Section 14011.2, shall be eligible for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(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 the initiation of the three-month cure period shall be a condition of reenrollment under this subdivision for individuals disenrolled from Medi-Cal due to nonpayment of premiums.

(d) The department shall provide monthly updates to the appropriate policy and fiscal committees of the Legislature on the status of the implementation of this section.

(e) To the extent permitted by state and federal law, an individual eligible for full-scope Medi-Cal pursuant to subdivision (a) shall be required to enroll in a Medi-Cal managed care health plan. Enrollment in a Medi-Cal managed care health plan shall not preclude a beneficiary from being enrolled in any other children's Medi-Cal specialty program that they would otherwise be eligible for.

(f) (1) The department shall maximize federal financial participation in implementing this section to the extent allowable. For purposes of implementing this section, the department shall claim federal financial participation to the extent that the department determines it is available.

(2) To the extent that federal financial participation is unavailable, the department shall implement this section using state funds appropriated for this purpose.

(g) This section shall be implemented only to the extent it is in compliance with Section 1621(d) of Title 8 of the United States Code.

(h) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(2) Notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(i) In implementing this section, the department may contract, as necessary, on a bid or nonbid basis. This subdivision establishes an accelerated process for issuing contracts pursuant to this section. Those contracts, and any other contracts entered into pursuant to this subdivision, may be on a noncompetitive bid basis and shall be exempt from both of the following:

(1) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part.

(2) Review or approval of contracts by the Department of General Services.

(j) (1) No sooner than July 1, 2026, except for individuals under 19 years of age, individuals over 59 years of age, and pregnant women, all individuals described in subdivision (a) shall be required to pay a monthly premium as a condition of eligibility for Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(2) Monthly premiums imposed under this section shall be thirty dollars ($30) per beneficiary.

(3) An individual described in paragraph (1), after no more than 90 days of nonpayment of the monthly premium, will 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. All outstanding premium balances shall be paid in full as a condition of continued eligibility for full-scope Medi-Cal coverage.

(k) No sooner than July 1, 2026, and notwithstanding subdivision (a) and paragraph (2) of subdivision (c), an individual who is 19 years of age or older, who is eligible for Medi-Cal benefits pursuant to subdivision (a), shall not be eligible for dental services set forth in this chapter, except for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law.

(*l*) Subdivisions (b), (c), (j), and (k) 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. 76. Section 14007.9 of the Welfare and Institutions Code, as amended by Section 99 of Chapter 42 of the Statutes of 2023, is repealed.

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.

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 engagement in, substantial gainful activity, as defined in Section

223(d)(4) of the federal Social Security Act (42 U.S.C. Sec. 423(d)(4)).

(C) The individual's countable resources shall not exceed the maximum levels established in subdivision (a) of Section 14005.62. The determination of countable resources shall follow the methodology used under Title XVI of the federal Social Security Act (42 U.S.C. Sec. 1381 et seq.), as applicable.

(2) To the extent federal financial participation is available, an individual otherwise eligible under this section, but who is temporarily unemployed, may elect to remain on Medi-Cal under this section for up to 26 weeks, provided the individual continues to pay premiums during the temporary period of unemployment, for coverage periods in which premiums are imposed.

(b) (1) Countable income shall be determined under Section 1612 of the federal Social Security Act (42 U.S.C. Sec. 1382a), except that the individual's disability income, including all federal and state disability benefits and private disability insurance, shall be exempted. Resources excluded under Section 1613 of the federal Social Security Act (42 U.S.C. Sec. 1382b) shall be disregarded.

(2) Resources in the form of employer or individual retirement arrangements authorized under the Internal Revenue Code shall be exempted as authorized by Section 1902(r) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)).

(3) (A) For the purposes of calculating countable income under this section, an income exemption shall be applied as necessary to adjust the income standard so that it is the same as the income standard that was in place on May 1, 2009.

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

(C) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this paragraph by means of an all-county letter or similar instruction without taking regulatory action.

(4) Retained earned income of an eligible individual who is receiving health care benefits under this section shall be considered an exempt resource when held in a separately identifiable account and not commingled with other resources, as authorized by Section

1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)).

(5) Social security disability income that converts to social security retirement income upon the retirement of an individual, including any increases in the amount of that income, shall be exempt. The department shall submit a state plan amendment for this specific exemption, and the exemption shall be implemented only if, and to the extent that, the state plan amendment is approved.

(c) All resources exempted pursuant to paragraph (2) of subdivision (b) for an individual who is receiving health care benefits under this section shall continue to be exempt under any other Medi-Cal program that is subject to Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)) under which the beneficiary later becomes eligible for medical assistance where that eligibility is based on age, blindness, or disability. The department shall submit a state plan amendment for this specific exemption, and the exemption shall be implemented only if, and to the extent that, the state plan amendment is approved.

(d) After an individual is determined eligible for Medi-Cal benefits under this section, the individual's countable income, as determined under Section 1612 of the federal Social Security Act (42 U.S.C. Sec. 1382a), shall be used to determine the amount of the individual's required premium payment, as described in subdivision (f), when applicable. Disability income and converted retirement income made exempt under paragraphs (1) and (5), respectively, of subdivision (b) for eligibility purposes shall be considered countable income for purposes of determining the amount of the required premium payment.

(e) Medi-Cal benefits provided under this chapter pursuant to this section shall be available in the same amount, duration, and scope as those benefits are available for persons who are eligible for Medi-Cal benefits as categorically needy persons and as specified in Section 14007.5.

(f) 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 (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.

(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 implemented. A determination of invalidity shall not affect other provisions or applications of this section that can be given effect without the implementation of the invalid provision or application.

(k) (1) 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.

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

SEC. 79. Section 14007.9 of the Welfare and Institutions Code, as added by Section 102 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 engagement in, substantial gainful activity, as defined in Section 223(d)(4) of the federal Social Security Act (42 U.S.C. Sec. 423(d)(4)).

(C) Resources that are not counted as income shall not be included in determinations of eligibility.

(2) To the extent federal financial participation is available, an individual otherwise eligible under this section, but who is temporarily unemployed, may elect to remain on Medi-Cal under this section for up to 26 weeks, provided the individual continues to pay premiums during the temporary period of unemployment, for coverage periods in which premiums are imposed.

(b) 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.

(1) 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.

(2) 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.

(3) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this paragraph by means of an all-county letter or similar instruction without taking regulatory action.

(4) Social security disability income that converts to social security retirement income upon the retirement of an individual, including any increases in the amount of that income, shall be exempt. The department shall submit a state plan amendment for this specific exemption, and the exemption shall be implemented only if, and to the extent that, the state plan amendment is approved.

(c) After an individual is determined eligible for Medi-Cal benefits under this section, the individual's countable income, as determined under Section 1612 of the federal Social Security Act (42 U.S.C. Sec. 1382a), shall be used to determine the amount of the individual's required premium payment, as described in subdivision (f), when applicable. Disability income and converted retirement income made exempt under paragraphs (1) and (3), respectively, of subdivision (b) for eligibility purposes shall be considered countable income for purposes of determining the amount of the required premium payment.

(d) Medi-Cal benefits provided under this chapter pursuant to this section shall be available in the same amount, duration, and scope as those benefits are available for persons who are eligible for Medi-Cal benefits as categorically needy persons and as specified in Section 14007.5.

(e) (1) Individuals eligible for Medi-Cal benefits under this section shall be subject to the payment of premiums determined under this subdivision, except as provided in subdivision (m). Each individual shall pay a monthly premium that is equal to 5 percent of their individual countable income, as described in subdivision (c), 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 (j).

(f) In order to implement the collection of premiums under this section, the department may develop and execute a contract with a public or private entity to collect premiums, or may amend any existing or future premium-collection contract that it has executed. Notwithstanding any other law, any contract developed and executed or amended pursuant to this subdivision is exempt from the approval of the Director of General Services and from the Public Contract Code.

(g) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement, without taking any regulatory action, this section by means of an all-county letter or similar instruction. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(h) Notwithstanding any other 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.

(i) If any provision of this section, or its application, is held invalid by a final judicial determination, it shall cease to be implemented. A determination of invalidity shall not affect other provisions or applications of this section that can be given effect without the implementation of the invalid provision or application.

(j) (1) Except as provided in paragraph (2), the amendments made to this section by Chapter 282 of the Statutes of 2009 shall not become operative until 30 days after the date that the increase in the state’s federal medical assistance percentage (FMAP)

pursuant to the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5) is no longer available under that act or any extension of that act.

(2) The amendments made to this section by Chapter 282 of the Statutes of 2009 contained in subdivisions (c) and (e) shall not become operative until 30 days after the date that the director executes a declaration stating that the implementation of subdivisions (c) and (e) will not jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148) or any amendment or extension of that act, any increase in the FMAP available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, determines would be advantageous to the state.

(3) If at any time the director determines that the statement in the declaration executed pursuant to paragraph (2) may no longer be accurate, the director shall give notice to the Joint Legislative Budget Committee and to the Department of Finance. After giving notice, the amendments made to this section by Chapter 282 of the Statutes of 2009 contained in subdivisions (c) and (e) shall become inoperative on the date that the director executes a declaration stating that the department has determined, in consultation with the Department of Finance, that it is necessary to cease to implement subdivisions (c) and (e) in order to receive federal financial participation, any increase in the FMAP available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, has determined would be advantageous to the state, in which case, subdivision (c) of this section, as stated by Section 32 of Chapter 5 of the Fourth Extraordinary Session of the Statutes of 2009, shall be operative.

(4) The director shall post a declaration made pursuant to paragraph (2) or (3) on the department's internet website and the director shall send the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(k) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement subdivision (j) by means of

all-county letters or similar instruction, without taking regulatory action.

(*l*) (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.

(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 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.

(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) (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.

(e) Any moneys received by the state pursuant to this section shall be deposited into the General Fund.

(f) 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.

(g) 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.

(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 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.

(C) The annuity provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made from the annuity.

(c) The individual or the community spouse, or both, shall bear the burden of demonstrating that the requirements of this section that limit the state's right to become a remainder beneficiary, as described in Section 14009.6, are met.

(d) 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.

(e) 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.

(f) 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.

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

SEC. 83. Section 14009.7 of the Welfare and Institutions Code, as added by Section 107 of Chapter 42 of the Statutes of 2023, is amended to read:

14009.7. (a) 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 before or 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.

(C) The annuity provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made from the annuity.

(b) The individual or the community spouse, or both, shall bear the burden of demonstrating that the requirements of this section that limit the state's right to become a remainder beneficiary, as described in Section 14009.6, are met.

(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 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 January 1, 2026, and, as of January 1, 2027, is repealed.

SEC. 84. Section 14011 of the Welfare and Institutions Code, as amended by Section 108 of Chapter 42 of the Statutes of 2023, is amended to read:

14011. (a) An applicant who is not a recipient of aid under Chapter 2 (commencing with Section 11200) or Chapter 3 (commencing with Section 12000) shall be required to file an affirmation setting forth facts about their annual income and other resources and qualifications for eligibility as may be required by the department. Those statements shall be on forms prescribed by the department.

(b) To the extent permitted by federal law, eligibility for medical assistance for applicants shall not be granted until the applicant or designated representative provides independent documentation verifying statements of the following:

(1) Gross income by type and source.

(2) Income amounts withheld for taxes.

(3) Health care benefits available through employment, retirement, military service, work related injuries or settlements from prior injuries.

(4) Employee retirement contributions, and other employee benefit contributions, deductible expenses for maintenance or improvement of income-producing property and status and value of property owned, other than property exempt under Section 14006. The director may prescribe those items of exempt property that the director deems should be verified as to status and value in order to reasonably assure a correct designation of those items as exempt.

(c) The verification requirements of subdivision (b) apply to income, income deductions and property both of applicants for medical assistance, excluding applicants for public assistance, and to persons whose income, income deductions, expenses or property holdings must be considered in determining the applicant's eligibility and spend down of excess income.

(d) A determination of eligibility and spend down of excess income may be extended beyond otherwise prescribed timeframes if, in the county department's judgment, and subject to standards of the director, the applicant or designated representative has good cause for failure to provide the required verification and continues to make a good faith effort to provide verification.

(e) To the extent permitted by federal law, in addition to the other verification requirements of this section, a county department may require verification of any other applicant statements, or conduct a full and complete investigation of the statements, whenever a verification or investigation is warranted in the judgment of the county department.

(f) If documentation is unavailable, as defined in regulations promulgated by the department, the applicant's signed statement as to the value or amount shall be deemed to constitute verification.

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

SEC. 85. Section 14011 of the Welfare and Institutions Code, as added by Section 109 of Chapter 42 of the Statutes of 2023, is amended to read:

14011. (a) An applicant who is not a recipient of aid under Chapter 2 (commencing with Section 11200) or Chapter 3 (commencing with Section 12000) shall be required to file an affirmation setting forth facts about their annual income and qualifications for eligibility as may be required by the department. Those statements shall be on forms prescribed by the department.

(b) To the extent permitted by federal law, eligibility for medical assistance for applicants shall not be granted until the applicant or designated representative provides independent documentation verifying statements of all of the following:

(1) Gross income by type and source.

(2) Income amounts withheld for taxes.

(3) Health care benefits available through employment, retirement, military service, work-related injuries or settlements from prior injuries.

(c) The verification requirements of subdivision (b) apply to income and income deductions of applicants for medical assistance, excluding applicants for public assistance, and to persons whose income, income deductions, or expenses must be considered in determining the applicant's eligibility and spend down of excess income.

(d) A determination of eligibility and spend down of excess income may be extended beyond otherwise prescribed timeframes if, in the county department's judgment, and subject to standards of the director, the applicant or designated representative has good cause for failure to provide the required verification and continues to make a good faith effort to provide verification.

(e) To the extent permitted by federal law, in addition to the other verification requirements of this section, a county department may require verification of any other applicant statements, or conduct a full and complete investigation of the statements, whenever a verification or investigation is warranted in the judgment of the county department.

(f) If documentation is unavailable, as defined in regulations promulgated by the department, the applicant's signed statement as to the value or amount shall be deemed to constitute verification.

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

SEC. 86. Section 14013.3 of the Welfare and Institutions Code, as amended by Section 113 of Chapter 42 of the Statutes of 2023, is amended to read:

14013.3. (a) When determining whether an individual is eligible for Medi-Cal benefits, the department shall verify the 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) 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 department shall accept the information provided by or on behalf of the individual as being accurate.

(2) If the income information obtained by the department is not reasonably compatible with the information provided by or on behalf of the individual, the department shall require that the individual provide additional information that reasonably explains the discrepancy.

(3) For the purposes of this subdivision, income information obtained by the department is reasonably compatible with information provided by or on behalf of an individual if any of the following conditions are met:

(A) Both state that the individual's income is above the applicable income standard or other relevant income threshold for eligibility.

(B) Both state that the individual's income is at or below the applicable income standard or other relevant income threshold for eligibility.

(C) The information provided by or on behalf of the individual states that the individual's income is above, and the information obtained by the department states that the individual's income is at or below, the applicable income standard or other relevant income threshold for eligibility.

(4) If subparagraph (C) of paragraph (3) applies, the individual shall be informed that the income information provided by them was higher than the information that was electronically verified and that they may request a reconciliation of the difference. This paragraph shall be implemented no later than January 1, 2015.

(d) (1) The department shall accept the attestation of the individual regarding whether they are pregnant unless the department has information that is not reasonably compatible with the attestation.

(2) If the information obtained by the department is not reasonably compatible with the information provided by or on behalf of the individual under paragraph (1), the department shall require that the individual provide additional information that reasonably explains the discrepancy.

(e) If any information not described in subdivision (c) or (d) that is needed for an eligibility determination or redetermination and is obtained by the department is not reasonably compatible with the information provided by or on behalf of the individual, the department shall require that the individual provide additional information that reasonably explains the discrepancy.

(f) The department shall develop, and update as it is modified, a verification plan describing the verification policies and procedures adopted by the department to verify eligibility information. If the department determines that any state or federal agencies or programs not previously identified in the verification plan are useful 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, the department shall update the verification plan to identify those additional agencies or programs. The development and modification of the verification plan shall be undertaken in consultation with representatives from county human services departments, legal aid advocates, and the Legislature. This verification plan shall conform to all federal requirements and shall be posted on the department's internet website.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(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 January 1, 2026.

SEC. 87. Section 14013.3 of the Welfare and Institutions Code, as added by Section 114 of Chapter 42 of the Statutes of 2023, is amended to read:

14013.3. (a) When determining whether an individual is eligible for Medi-Cal benefits, the department shall verify the 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) 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, and unearned income 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 department shall accept the information provided by or on behalf of the individual as being accurate.

(2) If the income information obtained by the department is not reasonably compatible with the information provided by or on behalf of the individual, the department shall require that the individual provide additional information that reasonably explains the discrepancy.

(3) For the purposes of this subdivision, income information obtained by the department is reasonably compatible with information provided by or on behalf of an individual if any of the following conditions are met:

(A) Both state that the individual's income is above the applicable income standard or other relevant income threshold for eligibility.

(B) Both state that the individual's income is at or below the applicable income standard or other relevant income threshold for eligibility.

(C) The information provided by or on behalf of the individual states that the individual's income is above, and the information obtained by the department states that the individual's income is

at or below, the applicable income standard or other relevant income threshold for eligibility.

(4) If subparagraph (C) of paragraph (3) applies, the individual shall be informed that the income information provided by them was higher than the information that was electronically verified and that they may request a reconciliation of the difference. This paragraph shall be implemented no later than January 1, 2015.

(d) (1) The department shall accept the attestation of the individual regarding whether they are pregnant unless the department has information that is not reasonably compatible with the attestation.

(2) If the information obtained by the department is not reasonably compatible with the information provided by or on behalf of the individual under paragraph (1), the department shall require that the individual provide additional information that reasonably explains the discrepancy.

(e) If any information not described in subdivision (c) or (d) that is needed for an eligibility determination or redetermination and is obtained by the department is not reasonably compatible with the information provided by or on behalf of the individual, the department shall require that the individual provide additional information that reasonably explains the discrepancy.

(f) The department shall develop, and update as it is modified, a verification plan describing the verification policies and procedures adopted by the department to verify eligibility information. If the department determines that any state or federal agencies or programs not previously identified in the verification plan are useful 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, the department shall update the verification plan to identify those additional agencies or programs. The development and modification of the verification plan shall be undertaken in consultation with representatives from county human services departments, legal aid advocates, and the Legislature. This verification plan shall conform to all federal requirements and shall be posted on the department's internet website.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall

implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(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 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 showing that assets transferred exclusively for a purpose other

than to qualify for medical assistance shall not result in ineligibility for Medi-Cal and shall include, but not be limited to, the following:

(1) Assets that would have been considered exempt for purposes of establishing eligibility pursuant to federal or state laws at the time of transfer.

(2) Property with a net market value that, when the property is transferred, if included in the property reserve, would not result in ineligibility.

(3) Assets for which adequate consideration is received.

(4) Property upon which foreclosure or repossession was imminent at the time of transfer, provided there is no evidence of collusion.

(5) Assets transferred in return for an enforceable contract for life care that does not include complete medical care.

(6) Assets transferred without adequate consideration, provided that the applicant or beneficiary provides convincing evidence to overcome the presumption that the transfer was for the purpose of establishing eligibility or reducing the spend down of excess income.

(c) In administering this section, it shall be presumed that assets transferred by the applicant or beneficiary prior to the look-back period established by the department preceding the date of initial application were not transferred to establish eligibility or reduce the spend down of excess income. These assets shall not be considered in determining eligibility.

(d) Any item of durable medical equipment that is purchased for a recipient pursuant to this chapter exclusively with Medi-Cal program funds shall be returned to the department when the department determines that the item is no longer medically necessary for the recipient. Items of durable medical equipment shall include, but are not limited to, wheelchairs and special hospital beds.

(e) 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.

(f) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall

implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until regulations are adopted.

(2) The department shall adopt regulations by 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.

(g) 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 section are filed with the Secretary of State. Transfers or gifts of assets prior to the implementation of this section are exempt, to the extent allowed under federal law and regulations.

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

SEC. 89. Section 14051 of the Welfare and Institutions Code, as amended by Section 120 of Chapter 42 of the Statutes of 2023, is amended to read:

14051. (a) "Medically needy person" means any of the following:

(1) An aged, blind, or disabled person who meets the definition of aged, blind, or disabled under the Supplemental Security Income program and whose income and resources are insufficient to provide for the costs of health care or coverage.

(2) A child in foster care for whom public agencies are assuming financial responsibility, in whole or in part, or a person receiving aid under Chapter 2.1 (commencing with Section 16115) of Part 4.

(3) A child who is eligible to receive Medi-Cal benefits pursuant to interstate agreements for adoption assistance and related services and benefits entered into under Chapter 2.6 (commencing with Section 16170) of Part 4, to the extent federal financial participation is available.

(b) "Medically needy family person" means a parent or caretaker relative of a child or a child under 21 years of age or a pregnant woman of any age with a confirmed pregnancy, exclusive of those persons specified in subdivision (a), whose income and resources are insufficient to provide for the costs of health care or coverage.

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

SEC. 90. Section 14051 of the Welfare and Institutions Code, as added by Section 121 of Chapter 42 of the Statutes of 2023, is amended to read:

14051. (a) "Medically needy person" means any of the following:

(1) An aged, blind, or disabled person who meets the definition of aged, blind, or disabled under the Supplemental Security Income program and whose income is insufficient to provide for the costs of health care or coverage.

(2) A child in foster care for whom public agencies are assuming financial responsibility, in whole or in part, or a person receiving aid under Chapter 2.1 (commencing with Section 16115) of Part 4.

(3) A child who is eligible to receive Medi-Cal benefits pursuant to interstate agreements for adoption assistance and related services and benefits entered into under Chapter 2.6 (commencing with Section 16170) of Part 4, to the extent federal financial participation is available.

(b) "Medically needy family person" means a parent or caretaker relative of a child or a child under 21 years of age or a pregnant woman of any age with a confirmed pregnancy, exclusive of those persons specified in subdivision (a), whose income is insufficient to provide for the costs of health care or coverage.

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

SEC. 91. Section 14051.5 of the Welfare and Institutions Code, as amended by Section 122 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 and resources are insufficient to provide for the costs of health care or coverage.

(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 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 an invoice to each manufacturer for the state rebate, including supporting utilization data from the department's prescription drug paid claims tapes within 30 days of receipt of the federal Centers for Medicare and Medicaid Services' file of manufacturer rebate information. In lieu of paying the entire invoiced amount, a manufacturer may contest the invoiced amount pursuant to procedures established by the federal Centers for Medicare and Medicaid Services' Medicaid Drug Rebate Program Releases or regulations by mailing a notice, that shall set forth its grounds for contesting the invoiced amount, to the department within 38 days of the department's mailing of the state invoice and supporting utilization data. For purposes of state accounting practices only, the contested balance shall not be considered an accounts receivable amount until final resolution of the dispute pursuant to procedures established by the federal Centers for Medicare and Medicaid Services' Medicaid Drug Rebate Program Releases or regulations that results in a finding of an underpayment by the manufacturer. Manufacturers may request, and the department shall timely provide, at cost, Medi-Cal provider level drug utilization data, and other Medi-Cal utilization data necessary to resolve a contested department-invoiced rebate amount.

(2) The department shall provide for an annual audit of utilization data used to calculate the state rebate to verify the

accuracy of that data. The findings of the audit shall be documented in a written audit report to be made available to manufacturers within 90 days of receipt of the report from the auditor. Any manufacturer may receive a copy of the audit report upon written request. Contracts between the department and manufacturers shall provide for any equalization payment adjustments determined necessary pursuant to an audit.

(3) (A) Utilization data used to determine the state rebate shall exclude data from both of the following:

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

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

(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 contract pursuant to Section 1396b(m) of Title 42 of the United States Code.

(7) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific paragraph (5) by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, until the time regulations are adopted. The department shall adopt regulations by October 1, 2017, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Notwithstanding Section 10231.5 of the Government Code, beginning six months after the effective date of this section, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

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

sufficient representation of single-source and multiple-source drugs, as appropriate, in each major therapeutic category.

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

(e) (1) In order to fully implement subdivision (d), the department shall, to the extent necessary, negotiate or renegotiate contracts to ensure there are as many single-source drugs within each therapeutic category or subcategory as the department determines necessary to meet the health needs of the Medi-Cal population. The department may determine in selected therapeutic categories or subcategories that no single-source drugs are necessary because there are currently sufficient multiple-source drugs in the therapeutic category or subcategory on the list of contract drugs to meet the health needs of the Medi-Cal population. However, in no event shall a beneficiary be denied continued use of a drug that is part of a prescribed therapy in effect as of September 2, 1992, until the prescribed therapy is no longer prescribed.

(2) In the development of decisions by the department on the required number of single-source drugs in a therapeutic category or subcategory, and the relative therapeutic merits of each drug in a therapeutic category or subcategory, the department shall consult with the Medi-Cal Contract Drug Advisory Committee. The committee members shall communicate their comments and recommendations to the department within 30 business days of a request for consultation, and shall disclose any associations with pharmaceutical manufacturers or any remuneration from pharmaceutical manufacturers.

(f) In order to achieve maximum cost savings, the Legislature declares that an expedited process for contracts under this section is necessary. Therefore, contracts entered into on a nonbid basis shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(g) In no event shall a beneficiary be denied continued use of a drug that is part of a prescribed therapy in effect as of September 2, 1992, until the prescribed therapy is no longer prescribed.

(h) Contracts executed pursuant to this section shall be confidential and shall be exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

(i) The department shall provide individual notice to Medi-Cal beneficiaries at least 60 calendar days prior to the effective date of the deletion or suspension of any drug from the list of contract drugs. The notice shall include a description of the beneficiary's right to a fair hearing and shall encourage the beneficiary to consult a physician to determine if an appropriate substitute medication is available from Medi-Cal.

(j) In carrying out the provisions of this section, the department may contract either directly, or through the fiscal intermediary, for pharmacy consultant staff necessary to initially accomplish the treatment authorization request reviews.

(k) (1) Manufacturers shall calculate and pay interest on late or unpaid rebates. The interest shall not apply to any prior period adjustments of unit rebate amounts or department utilization adjustments.

(2) For state rebate payments, manufacturers shall calculate and pay interest on late or unpaid rebates for quarters that begin on or after the effective date of the act that added this subdivision.

(3) Following final resolution of any dispute pursuant to procedures established by the federal Centers for Medicare and Medicaid Services' Medicaid Drug Rebate Program Releases or regulations regarding the amount of a rebate, any underpayment by a manufacturer shall be paid with interest calculated pursuant to subdivisions (m) and (n), and any overpayment, together with interest at the rate calculated pursuant to subdivisions (m) and (n), shall be credited by the department against future rebates due.

(*l*) Interest pursuant to subdivision (k) shall begin accruing 38 calendar days from the date of mailing of the invoice, including supporting utilization data sent to the manufacturer. Interest shall continue to accrue until the date of mailing of the manufacturer's payment.

(m) Except as specified in subdivision (n), interest rates and calculations pursuant to subdivision (k) for Medicaid rebates and state rebates shall be identical and shall be determined by the federal Centers for Medicare and Medicaid Services' Medicaid Drug Rebate Program Releases or regulations.

(n) If the date of mailing of a state rebate payment is 69 days or more from the date of mailing of the invoice, including supporting utilization data sent to the manufacturer, the interest rate and calculations pursuant to subdivision (k) shall be as specified in subdivision (m), however the interest rate shall be increased by 10 percentage points. This subdivision shall apply to payments for amounts invoiced for any quarters that begin on or after the effective date of the act that added this subdivision.

(o) If the rebate payment is not received, the department shall send overdue notices to the manufacturer at 38, 68, and 98 days after the date of mailing of the invoice, and supporting utilization data. If the department has not received a rebate payment, including interest, within 180 days of the date of mailing of the invoice, including supporting utilization data, the manufacturer's contract with the department shall be deemed to be in default and the contract may be terminated in accordance with the terms of the contract. For all other manufacturers, if the department has not received a rebate payment, including interest, within 180 days of the date of mailing of the invoice, including supporting utilization data, all of the drug products of those manufacturers shall be made available only through prior authorization effective 270 days after the date of mailing of the invoice, including utilization data sent to manufacturers.

(p) If the manufacturer provides payment or evidence of payment to the department at least 40 days prior to the proposed date the drug is to be made available only through prior authorization pursuant to subdivision (o), the department shall terminate its actions to place the manufacturers' drug products on prior authorization.

(q) The department shall direct the state's fiscal intermediary to remove prior authorization requirements imposed pursuant to subdivision (o) and notify providers within 60 days after payment by the manufacturer of the rebate, including interest. If a contract was in place at the time the manufacturers' drugs were placed on prior authorization, removal of prior authorization requirements shall be contingent upon good faith negotiations and a signed contract with the department.

(r) Beginning January 1, 2026, a beneficiary may obtain covered drugs placed on prior authorization pursuant to subdivision (o) only if their pharmacy provider or prescriber initiates a prior

authorization request that is subsequently approved by the department.

(s) Beginning January 1, 2026, a beneficiary may 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.

(t) Drugs covered pursuant to Sections 14105.43 and 14133.2 shall not be subject to prior authorization pursuant to subdivision (o), and any other drug may be exempted from prior authorization by the department if the director determines that an essential need exists for that drug, and there are no other drugs currently available without prior authorization that meet that need.

(u) It is the intent of the Legislature in enacting subdivisions (k) to (t), inclusive, that the department and manufacturers shall cooperate and make every effort to resolve rebate payment disputes within 90 days of notification by the manufacturer to the department of a dispute in the calculation of rebate payments.

SEC. 94. Section 14105.38 of the Welfare and Institutions Code is repealed.

SEC. 95. Section 14105.38 is added to the Welfare and Institutions Code, to read:

14105.38. When the department determines that a drug should be removed from the list of contract drugs, the department shall provide individual notice to impacted beneficiaries, at least 60 calendar days prior to the drug being removed from the list of contract drugs, that the drug is only obtainable through the prior authorization process. The notice shall include a description of the beneficiary's right to a fair hearing and shall encourage the beneficiary to consult a physician to determine if an appropriate substitute medication is available from Medi-Cal. The department shall also provide provider notice about the removal at least 60 calendar days prior to the drug being removed from the list of contract drugs on the department's internet website.

SEC. 96. Section 14105.436 of the Welfare and Institutions Code is amended 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.

(d) Upon implementation of paragraphs (4) and (5) of subdivision (b) of Section 14105.33 for drugs pursuant to this section, subdivisions (a) and (c) shall become inoperative and "utilization data" shall be described pursuant to subdivision (b) of Section 14105.33. The department shall post on its internet website a notice that it has implemented paragraphs (4) and (5) of subdivision (b) of Section 14105.33 for drugs pursuant to this section.

(e) Effective July 1, 2009, all pharmaceutical manufacturers shall provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal law, equal to an amount not less than 10 percent 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 pursuant to Section 14105.43 or 14133.2.

(f) Pharmaceutical manufacturers shall, by January 1, 2010, enter into a supplemental rebate agreement for the rebate required in subdivision (e) for drug products added to the Medi-Cal list of contract drugs on or before December 31, 2009.

(g) Effective January 1, 2010, all pharmaceutical manufacturers who have not entered into a supplemental rebate agreement pursuant to subdivisions (e) and (f) shall provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal law, equal to an amount not less than 20 percent 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 pursuant to Section 14105.43 or 14133.2 prior to January 1, 2010. If the pharmaceutical manufacturer does not enter into a supplemental rebate agreement by March 1, 2010, the manufacturer's drug product shall be made available only through an approved treatment authorization request pursuant to subdivision (i).

(h) For a drug product added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 on or after January 1, 2010, a pharmaceutical manufacturer shall provide to the department a state rebate pursuant to subdivision (e). 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 shall provide to the department a state rebate equal to not less than 20 percent 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 pursuant to Section 14105.43 or 14133.2. If the pharmaceutical manufacturer does not enter into a supplemental rebate agreement within 120 days after the addition of the drug to the Medi-Cal list of contract drugs, the pharmaceutical manufacturer's drug product shall be made available only through an approved treatment authorization request pursuant to subdivision (i). For supplemental rebate agreements executed more than 120 days after the addition of the drug product to the Medi-Cal list of contract drugs, the state rebate shall equal an amount not less than 20 percent 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 pursuant to Section 14105.43 or 14133.2.

(i) Notwithstanding any other law, drug products added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 of manufacturers who do not execute an agreement to pay additional rebates pursuant to this section shall be available only through an approved treatment authorization request.

(j) Changes made to the Medi-Cal list of contract drugs under this section shall be exempt from the requirements of the 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.

(d) Upon implementation of paragraphs (4) and (5) of subdivision (b) of Section 14105.33 for drugs pursuant to this section, subdivisions (a) and (c) shall become inoperative and "utilization data" shall be described pursuant to subdivision (b) of Section 14105.33. The department shall post on its internet website a notice that it has implemented paragraphs (4) and (5) of subdivision (b) of Section 14105.33 for drugs pursuant to this section.

(e) Effective January 1, 2026, all pharmaceutical manufacturers renewing or entering new state rebate agreements shall provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal law, in the following amounts based on Medi-Cal utilization data for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2:

(1) An amount not less than 20 percent of the average manufacturer price if the federal rebate is less than 50 percent of the average manufacturer price.

(2) An amount not less than 15 percent of the average manufacturer price if the federal rebate is 50 percent or greater of the average manufacturer price.

(f) Pharmaceutical manufacturers shall, by January 1, 2010, enter into a supplemental rebate agreement for the rebate required in subdivision (e) for drug products added to the Medi-Cal list of contract drugs on or before December 31, 2009.

(g) Effective January 1, 2010, all pharmaceutical manufacturers who have not entered into a supplemental rebate agreement pursuant to subdivisions (e) and (f) shall provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal law, equal to an amount not less than 20 percent 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 pursuant to Section 14105.43 or 14133.2 prior to January 1, 2010. If the pharmaceutical manufacturer does not enter into a supplemental rebate agreement by March 1, 2010, the manufacturer's drug product shall be made available only through an approved treatment authorization request pursuant to subdivision (i).

(h) For a drug product added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 on or after January 1, 2026, a pharmaceutical manufacturer shall provide to the department a state rebate pursuant to subdivision (e). 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 shall provide to the department a state rebate equal to not less than 25 percent 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 pursuant to Section 14105.43 or 14133.2. If the pharmaceutical manufacturer does not enter into a supplemental rebate agreement within 120 days after the addition of the drug to the Medi-Cal list of contract drugs, the pharmaceutical manufacturer's drug product shall be made available only through an approved treatment authorization request pursuant to subdivision (i). For supplemental rebate agreements executed more than 120 days after the addition of the drug product to the Medi-Cal list of contract drugs, the state rebate shall equal an amount not less than 25 percent 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 pursuant to Section 14105.43 or 14133.2.

(i) Notwithstanding any other law, drug products added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 of manufacturers who do not execute an agreement to pay additional rebates pursuant to this section shall be available only through an approved treatment authorization request.

(j) Changes made to the Medi-Cal list of contract drugs under this section shall be exempt from the requirements of the 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 become operative on January 1, 2026.

SEC. 98. Section 14107.115 is added to the Welfare and Institutions Code, immediately following Section 14107.11, to read:

14107.115. (a) The Medi-Cal Anti-Fraud Special Deposit Fund is hereby created in the State Treasury.

(b) All outstanding Medi-Cal payments intercepted by the State Controller's Office at the direction of the department, as a result of a payment suspension imposed on a Medi-Cal provider pursuant to Section 14107.11, shall be deposited into the Medi-Cal Anti-Fraud Special Deposit Fund.

(c) All moneys deposited into the Medi-Cal Anti-Fraud Special Deposit Fund shall be continuously appropriated and allocated in accordance with subdivision (d), but shall remain in the fund until the department lifts the suspension pursuant to subdivision (c) of Section 14107.11.

(d) Upon the lifting of a suspension, the department may return the intercepted Medi-Cal payments to the Medi-Cal provider or may offset the payments against any liabilities or restitution owed by the Medi-Cal provider to the department, including, but not limited to, any liabilities described in paragraph (1) of subdivision (a) of Section 14107.11.

SEC. 99. Section 14126.024 of the Welfare and Institutions Code is amended to read:

14126.024. (a) For managed care rating periods that begin between January 1, 2023, and December 31, 2025, inclusive, the department, in consultation with representatives from the long-term care industry, organized labor, consumer advocates, and Medi-Cal managed care plans, shall establish and implement the Workforce and Quality Incentive Program under which a network provider furnishing skilled nursing facility services to a Medi-Cal managed care enrollee may earn performance-based directed payments from the Medi-Cal managed care plan they contract with in accordance with this section.

(b) Subject to appropriation by the Legislature in the annual Budget Act, the department shall do all of the following:

(1) Set the amount of performance-based directed payments to target an aggregate amount of two hundred eighty million dollars ($280,000,000) for the 2023 calendar year.

(2) For the 2024 through 2025 calendar years, the department shall set the amount of the performance-based directed payments to target the previous calendar year's target plus the annual increase specified by clause (ii) of subparagraph (A) of paragraphs (18), (19), and (20) of subdivision (c) of Section 14126.033.

(3) No sooner than December 31, 2023, the department shall make a one-time increase to the performance-based directed payment target amount by the amounts described in subdivision (f) of Section 14126.032. This one-time increase shall not be factored into the amount calculated for a subsequent calendar year pursuant to paragraph (2).

(c) The department, in consultation with stakeholders listed in subdivision (a), shall establish the methodology or methodologies, parameters, and eligibility criteria for the directed payments pursuant to this section. This shall include, but is not limited to, the milestones and metrics that network providers of skilled nursing facility services must meet in order to receive a directed payment from a Medi-Cal managed care plan pursuant to this section, with at least two of these milestones and metrics tied to workforce measures. Subject to subdivision (j), the department may implement the directed payment described in this section using one or more of the models authorized at Section 438.6(c)(1)(i)-(iii), inclusive, of Title 42 of the Code of Federal Regulations.

(d) A freestanding pediatric subacute care facility, as defined in Section 51215.8 of Title 22 of the California Code of Regulations, shall be exempt from the directed payments described in this section.

(e) Notwithstanding any other law, special program services for the mentally disordered that are entitled to receive the supplemental payment under Section 51511.1 of Title 22 of the California Code of Regulations shall be exempt from the directed payments described in this section.

(f) Directed payments made pursuant to this section shall be in addition to any other payments made by the a Medi-Cal managed care plan to applicable network providers of skilled nursing facility services and shall not supplant amounts that would otherwise be payable by a Medi-Cal managed care plan to a provider of skilled

nursing facility services, including those payments made in accordance with paragraph (2) of subdivision (b) of Section 14184.201.

(g) For managed care rating periods during which this section is implemented, capitation rates paid by the department to a Medi-Cal managed care plan shall be actuarially sound and shall account for the directed payments described in this section.

(h) The department may require Medi-Cal managed care plans and network providers of skilled nursing facility services to submit information the department deems necessary to implement this section, at the times and in the form and manner specified by the department.

(i) Payments pursuant to this section shall be made in accordance with the requirements for directed payment arrangements described in Section 438.6(c) of Title 42 of the Code of Federal Regulations and any associated federal guidance.

(j) In implementing this section, the department may contract, as necessary, with California's Medicare Quality Improvement Organization, or other entities deemed qualified by the department, not associated with a skilled nursing facility, to assist with development, collection, analysis, and reporting of the performance data pursuant to this section. The department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis for purposes of implementing this subdivision. Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and State Administrative Manual, and the State Contracting Manual, and shall be exempt from the review or approval of any division of the State Department of General Services.

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

(*l*) For purposes of this section, the following definitions apply:

(1) "Medi-Cal managed care plan" has the same meaning as set forth in subdivision (j) of Section 14184.101.

(2) "Network provider" has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(3) "Skilled nursing facility" has the same meaning as set forth in subdivision (c) of Section 1250 of the Health and Safety Code, excluding a nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital as described in subdivision (a) of Section 1250 of the Health and Safety Code.

(m) (1) This section shall become inoperative on January 1, 2026. The department may conduct all necessary closeout activities applicable to any managed care rating period before January 1, 2026.

(2) This section shall be repealed on January 1, 2027, or on the date that the director certifies to the Secretary of State that all necessary closeout activities have been completed pursuant to paragraph (1), whichever is later.

SEC. 100. Section 14126.033 of the Welfare and Institutions Code is amended to read:

14126.033. (a) The Legislature finds and declares all of the following:

(1) Costs within the Medi-Cal program continue to grow due to the rising cost of providing health care throughout the state and also due to increases in enrollment, which are more pronounced during difficult economic times.

(2) In order to minimize the need for drastically cutting enrollment standards or benefits during times of economic crisis, it is crucial to find areas within the program where reimbursement levels are higher than required under the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and can be reduced in accordance with federal law.

(3) The Medi-Cal program delivers its services and benefits to Medi-Cal beneficiaries through a wide variety of health care providers, under multiple delivery systems, including managed care, other contract models, or fee-for-service arrangements.

(4) The setting of rates within the Medi-Cal program is complex and is subject to close supervision by the United States Department of Health and Human Services.

(5) As the single state agency for the Medicaid program in California, the State Department of Health Care Services has unique expertise that can inform decisions that set or adjust reimbursement methodologies and levels consistent with the requirements of federal law.

(b) Therefore, it is the intent of the Legislature for the department to analyze and identify where reimbursement levels can be reduced consistent with the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and federal and state law and policies, including any exemptions contained in the act that added this section, provided that the reductions in reimbursement shall not exceed 10 percent on an aggregate basis for all providers, services, and products.

(c) 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.

(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 2011–12 weighted average Medi-Cal reimbursement rate increase.

(C) The department may recalculate and publish the weighted average Medi-Cal reimbursement rate increase for the 2011–12 rate year if the difference in the projected quality assurance fee collections from the 2011–12 rate year, compared to the projected quality assurance fee collections for the 2010–11 rate year, would result in any additional General Fund expense to pay for the 2011–12 rate year weighted average reimbursement rate increase.

(5) To the extent that rates are projected to exceed the adjusted limits calculated pursuant to subparagraphs (A) to (D), inclusive, of paragraph (2) and, as applicable, paragraphs (3) and (4), the department shall adjust each skilled nursing facility's projected rate for the applicable rate year by an equal percentage.

(6) (A) (i) Notwithstanding any other law, and except as provided in subparagraph (B), payments resulting from the application of paragraphs (3) and (4), the provisions of paragraph (5), and all other applicable adjustments and limits as required by this section, shall be reduced by 10 percent for dates of service on and after June 1, 2011, through July 31, 2012. This one-time reduction shall be evenly distributed across all facilities to ensure long-term stability of nursing homes serving the Medi-Cal population.

(ii) Notwithstanding any other law, the director may adjust the percentage reductions specified in clause (i), as long as the resulting reductions, in the aggregate, total no more than 10 percent.

(iii) The adjustments authorized under this subparagraph shall be implemented only if the director determines that the payments resulting from the adjustments comply with paragraph (7).

(B) Payments to facilities owned or operated by the state shall be exempt from the payment reduction required by this paragraph.

(7) (A) Notwithstanding this section, the payment reductions and adjustments required by paragraph (6) shall be implemented only if the director determines that the payments that result from the application of paragraph (6) shall comply with applicable federal Medicaid requirements and that federal financial participation will be available.

(B) In determining whether federal financial participation is available, the director shall determine whether the payments comply with applicable federal Medicaid requirements, including those set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code.

(C) To the extent that the director determines that the payments do not comply with applicable federal Medicaid requirements or that federal financial participation is unavailable with respect to any payment that is reduced pursuant to this section, the director retains the discretion to not implement the particular payment reduction or adjustment and may adjust the payment as necessary to comply with federal Medicaid requirements.

(8) For managed care health plans that contract with the department pursuant to this chapter and Chapter 8 (commencing with Section 14200), except for contracts with the Senior Care Action Network and AIDS Healthcare Foundation, and to the extent that these services are provided through any of those contracts, payments shall be reduced by the actuarial equivalent amount of the reduced provider reimbursements specified in paragraph (6) pursuant to contract amendments or change orders effective on July 1, 2011, or thereafter.

(9) (A) For the 2012–13 rate year, all of the following shall apply:

(i) The department shall determine the amounts of reduced payments for each skilled nursing facility, as defined in subdivision (c) of Section 1250 of the Health and Safety Code, resulting from the 10-percent reduction imposed pursuant to clause (i) of subparagraph (A) of paragraph (6) for the period beginning on June 1, 2011, through July 31, 2012.

(ii) For claims adjudicated through October 1, 2012, each skilled nursing facility as defined in subdivision (c) of Section 1250 of the Health and Safety Code that is reimbursed under the Medi-Cal fee-for-service program, shall receive the total payments calculated by the department in clause (i), not later than December 31, 2012.

(iii) For managed care plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), except contracts with Senior Care Action Network and AIDS Healthcare Foundation, and to the extent that skilled nursing services are provided through any of those contracts, payments shall be adjusted by the actuarial equivalent amount of the reimbursements calculated in clause (i) pursuant to contract amendments or change orders effective on July 1, 2012, or thereafter.

(B) Notwithstanding subparagraph (A), beginning on August 1, 2012, through July 31, 2013, the department shall pay the facility specific Medi-Cal reimbursement rate that was on file and applicable to the specific skilled nursing facility on August 1, 2011, prior to and excluding any rate reduction implemented pursuant to clause (i) of subparagraph (A) of paragraph (6) for the period beginning on June 1, 2011, to July 31, 2012, inclusive, and adjusted for the projected costs of complying with new state or federal mandates. These rates are deemed to be sufficient to meet operating expenses.

(C) The weighted average Medi-Cal reimbursement rate increase specified in subparagraph (B) shall be adjusted by the department if the federal Centers for Medicare and Medicaid Services does not approve any proposed modification to the methodology for calculation of the skilled nursing quality assurance fee pursuant to Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code.

(D) Notwithstanding any other law, beginning on January 1, 2013, Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code, which imposes a skilled nursing facility quality assurance fee, shall be unenforceable against any skilled nursing facility unless each skilled nursing facility is paid the rate provided for in subparagraphs (A) and (B). Any amount collected during the 2012–13 rate year by the department pursuant to Article 7.6 (commencing with Section

1324.20) of Chapter 2 of Division 2 of the Health and Safety Code shall be refunded to each facility not later than February 1, 2013.

(E) The provisions of this paragraph shall also be included as part of a state plan amendment implementing the 2011–12 and 2012–13 Medi-Cal reimbursement rates authorized under this article.

(10) (A) Subject to the following provisions, for the 2013–14 and 2014–15 rate years, the annual increase in the weighted average 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 be 3 percent for each rate year, respectively, plus the projected cost of complying with new state or federal mandates.

(B) (i) For the 2013–14 rate year, if there is a rate increase in the weighted average Medi-Cal reimbursement rate, the department shall set aside 1 percent of the increase in the weighted average Medi-Cal reimbursement rate, from which the department shall transfer the nonfederal portion into the Skilled Nursing Facility Quality and Accountability Special Fund, to be used for the supplemental rate pool.

(ii) For the 2014–15 rate year, if there is a rate increase in the weighted average Medi-Cal reimbursement rate, the department shall set aside at least one-third of the weighted average Medi-Cal reimbursement rate increase, up to a maximum of 1 percent, from which the department shall transfer the nonfederal portion of this amount into the Skilled Nursing Facility Quality and Accountability Special Fund.

(C) 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.

(11) The director shall seek any necessary federal approvals for the implementation of this section. This section shall not be implemented until federal approval is obtained. When federal approval is obtained, the payments resulting from the application

of paragraph (6) shall be implemented retroactively to June 1, 2011, or on any other date or dates as may be applicable.

(12) (A) (i) Beginning with the 2015–16 rate year, and through the conclusion of the rate period from August 1, 2020, to December 31, 2020, inclusive, the annual increase in the weighted average Medi-Cal reimbursement rate, required for the purposes of this article, shall be 3.62 percent, plus the projected cost of complying with new state or federal mandates.

(ii) The reimbursement rates established for the rate period of August 1, 2020, to December 31, 2020, inclusive, shall be no less than the amounts that would have been established under the reimbursement methodology pursuant to this section for the 2019–20 rate year, subject to subparagraph (B).

(B) The weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) may be adjusted by the department as it deems necessary to obtain any applicable federal approval and shall not exceed the applicable federal upper payment limit.

(C) (i) Only to the extent any necessary federal approvals are obtained for this subparagraph, the department may condition a facility's receipt of the annual increase in the weighted average Medi-Cal reimbursement rate pursuant to this paragraph for the rate period of August 1, 2020, to December 31, 2020, inclusive, upon that facility's good faith efforts to comply with any requirements related to the COVID-19 Public Health Emergency described in All Facility Letters issued by the State Department of Public Health. The department shall consult with the State Department of Public Health in determining a facility's compliance for purposes of this subparagraph.

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

(13) (A) For the 2021 calendar year, the annual aggregate increase in the weighted average Medi-Cal reimbursement rate that is required for the purposes of this article shall be 3.5 percent plus the projected cost of complying with new state or federal mandates.

(B) The aggregate, weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) may be adjusted by the department as it deems necessary to obtain any applicable federal approval, and shall not exceed the applicable federal upper payment limit.

(C) (i) Only to the extent any necessary federal approvals are obtained for this subparagraph, the department may condition a facility's receipt of the annual increase in the weighted average Medi-Cal reimbursement rate pursuant to this paragraph for the 2021 calendar year upon that facility's good faith efforts to comply with any requirements related to the COVID-19 Public Health Emergency described in All Facility Letters issued by the State Department of Public Health. The department shall consult with the State Department of Public Health in determining a facility's compliance for purposes of this subparagraph.

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

(14) (A) For the 2022 calendar year, the annual aggregate increase in the weighted average Medi-Cal reimbursement rate that is required for the purposes of this article shall be 2.4 percent plus the projected cost of complying with new state or federal mandates.

(B) The aggregate, weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) may be adjusted by the department as it deems necessary to obtain any applicable federal approval, and shall not exceed the applicable federal upper payment limit.

(C) (i) Only to the extent any necessary federal approvals are obtained for this subparagraph, the department may condition a facility's receipt of the annual increase in the weighted average Medi-Cal reimbursement rate pursuant to this paragraph for the 2022 calendar year upon that facility's good faith efforts to comply with any requirements related to the COVID-19 Public Health Emergency described in All Facility Letters issued by the State Department of Public Health. The department shall consult with

the State Department of Public Health in determining a facility's compliance for purposes of this subparagraph.

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

(15) (A) For the 2022 and 2023 calendar years, inclusive, the reimbursement rate established for a skilled nursing facility pursuant to this section shall continue to be increased by the temporary Medicaid payments associated with the COVID-19 Public Health Emergency in effect for that facility on July 31, 2020, or an amount equivalent to those temporary increased Medicaid payments should the COVID-19 Public Health Emergency expire prior to December 31, 2023.

(B) For the 2023 calendar year, 85 percent of the amount of temporary Medicaid payments associated with the COVID-19 Public Health Emergency, or amounts equivalent to those temporary increased Medicaid payments should the COVID-19 Public Health Emergency expire prior to December 31, 2023, received by a facility shall be spent on additional labor costs, including, but not limited to, increased wages or benefits, shift incentive payments, staff retention bonuses, pay differential for workers employed by more than one facility, and overtime payments to nonmanagerial workers. Such increased wages or benefits, shift incentive payments, staff retention bonuses, pay differential for workers employed by more than one facility, overtime payments to nonmanagerial workers or other additional labor costs shall qualify for this purpose if they were either of the following:

(i) Implemented prior to January 1, 2023, and continued during the 2023 calendar year.

(ii) Implemented on or after January 1, 2023.

(C) If the COVID-19 Public Health Emergency is renewed past December 31, 2023, the temporary Medicaid payments for skilled nursing facilities associated with the COVID-19 Public Health Emergency, as authorized in the Medi-Cal State Plan, shall cease on December 31, 2023, subject to subdivision (h).

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

(16) (A) For the 2023 calendar year, the maximum annual aggregate increase in the weighted average Medi-Cal reimbursement rate required for the purposes of this article shall be the following, plus the projected cost of complying with new state or federal mandates:

(i) For the labor cost category as specified in paragraph (1) of subdivision (a) of Section 14126.023, the annual aggregate increase shall be 5 percent.

(ii) For each of the indirect care nonlabor cost, administrative cost, capital cost, and direct passthrough categories as specified in paragraphs (2) to (5), inclusive, of subdivision (a) of Section 14126.023, the annual aggregate increase shall be 2 percent.

(B) The aggregate, weighted average Medi-Cal reimbursement rate increases specified in subparagraph (A) may be adjusted by the department as it deems necessary to obtain any applicable federal approval, and shall not exceed the applicable federal upper payment limit.

(17) (A) Beginning in the 2024 calendar year, the department shall establish a workforce adjustment, as further described in paragraphs (18), (19) and (20), for a skilled nursing facility that meets workforce standards, as determined by the department in consultation with representatives from the long-term care industry, organized labor, and consumer advocates.

(B) The workforce standards may include, but need not be limited to, criteria such as maintaining a collective bargaining agreement or comparable, legally binding, written commitment with its direct and indirect care staff, payment of a prevailing wage for its direct and indirect care staff, payment of an average salary above minimum wage, participation in a statewide, multiemployer joint labor-management committee of skilled nursing facility employers and workers, or other factors, as determined by the department in consultation with the stakeholders listed above. The criteria may vary for facilities based on facility demographics or

other factors such as facility size, location or other factor, as determined by the department in consultation with the stakeholders listed above.

(18) (A) For the 2024 calendar year, the maximum annual increase in the Medi-Cal reimbursement rate required for the purposes of this article shall be the following, plus the projected cost of complying with new state or federal mandates:

(i) For the labor cost category specified in paragraph (1) of subdivision (a) of Section 14126.023, the annual increase shall be determined as follows:

(I) If the department determines the facility meets the criteria described in paragraph (17), the annual increase for the facility shall not have a percentage growth limit applied to the facility's audited costs within the labor cost category trended to the 2024 calendar year.

(II) If the facility does not meet the criteria described in paragraph (17), an annual increase of up to 5 percent shall be applied to the labor cost category rate included in the facility's 2023 calendar year rate based on audited cost reports trended to the calendar 2024 year.

(ii) For the 2024 calendar year, for each of the indirect care nonlabor cost, administrative cost, capital cost, and direct passthrough categories as specified in paragraphs (2) through (5), inclusive, of subdivision (a) of Section 14126.023, the annual aggregate increase in the weighted average Medi-Cal reimbursement rate for those categories shall be 1 percent. Additionally, for the 2024 calendar year, an amount equivalent to the annual aggregate increase of 1 percent calculated pursuant to this clause, as determined by the department, shall be used to supplement the funds available for payments made pursuant to subdivision (a) of Section 14126.024.

(B) The Medi-Cal reimbursement rate specified in subparagraph (A) may be adjusted by the department as it deems necessary to obtain any applicable federal approval, and shall not exceed the applicable federal upper payment limit.

(19) (A) For the 2025 calendar year, the Medi-Cal reimbursement rate required for the purposes of this article shall be the following, plus the projected cost of complying with new state or federal mandates:

(i) The rate for the labor cost category as specified in paragraph (1) of subdivision (a) of Section 14126.023 shall be determined as follows:

(I) If the department determines the facility meets the criteria described in paragraph (17), the facility's rate for the labor cost category shall equal the facility's audited costs for the labor cost category that would have been used for calculating the facility's 2024 calendar year rate had the facility met the criteria described in paragraph (17) in the 2024 calendar year increased by up to 5 percent for the 2025 calendar year based on audited cost reports trended to the 2025 calendar year.

(II) If the facility does not meet the criteria described in paragraph (17), the facility's rate for the labor cost category shall equal the labor cost category rate included in the facility's 2023 calendar year rate increased by up to 5 percent for each of the 2024 and 2025 calendar years based on audited cost reports trended to the applicable calendar year.

(ii) For the 2025 calendar year, for each of the indirect care nonlabor cost, administrative cost, capital cost, and direct passthrough categories as specified in paragraphs (2) through (5), inclusive, of subdivision (a) of Section 14126.023, the facility's rate for those categories shall equal the reimbursement included in the facility's 2024 calendar year rate for those categories increased by an aggregate of 1 percent in the weighted average Medi-Cal reimbursement rate for those categories. Additionally, for the 2025 calendar year, an amount equivalent to the annual aggregate increase of 1 percent calculated pursuant to this clause, as determined by the department, shall be used to supplement the funds available for payments made pursuant to subdivision (a) of Section 14126.024.

(B) The Medi-Cal reimbursement rate specified in subparagraph (A) may be adjusted by the department as it deems necessary to obtain any applicable federal approval, and shall not exceed the applicable federal upper payment limit.

(20) (A) For the 2026 calendar year, the Medi-Cal reimbursement rate required for the purposes of this article shall be the following, plus the projected cost of complying with new state or federal mandates:

(i) The rate for labor cost category as specified in paragraph (1) of subdivision (a) of Section 14126.023 shall be determined as follows:

(I) If the department determines the facility meets the criteria described in paragraph (17), the facility's rate for the labor cost category shall equal the facility's audited costs within the labor cost category that would have been used for calculating the facility's 2024 calendar year rate had the facility met the criteria in the 2024 calendar year increased by up to 5 percent for each of the 2025 and 2026 calendar years based on audited cost reports trended to the applicable calendar year.

(II) If the facility does not meet the criteria described in paragraph (17), the facility's rate for the labor cost category shall equal the labor cost category rate included in the facility's 2023 calendar year rate increased by up to 5 percent for each of the 2024, 2025, and 2026 calendar years based on audited cost reports trended to the applicable calendar year.

(ii) For the 2026 calendar year, for each of the indirect care nonlabor cost, administrative cost, capital cost, and direct passthrough categories as specified in paragraphs (2) through (5), inclusive, of subdivision (a) of Section 14126.023, the facility's rate for those categories shall equal the reimbursement included in the facility's 2025 calendar year rate for those categories increased by an aggregate of 1 percent in the weighted average Medi-Cal reimbursement rate for those categories.

(B) The Medi-Cal reimbursement rate specified in subparagraph (A) may be adjusted by the department as it deems necessary to obtain any applicable federal approval, and shall not exceed the applicable federal upper payment limit.

(d) (1) The department may modify any methodology or other provision specified in this article to the extent it deems necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure federal financial participation is available or is not otherwise jeopardized, provided the modification does not violate the spirit, purposes, and intent of this article.

(2) If the department determines that a modification is necessary pursuant to paragraph (1), the department shall consult with affected providers and stakeholders to the extent practicable.

(3) In the event of a modification made pursuant to this subdivision, the department shall notify affected providers, the Joint Legislative Budget Committee, and the relevant policy and fiscal committees of the Legislature within 10 business days of the modification.

(e) The rate methodology shall cease to be implemented after December 31, 2026.

(f) (1) It is the intent of the Legislature that the implementation of this article result in individual access to appropriate long-term care services, quality resident care, decent wages and benefits for nursing home workers, a stable workforce, provider compliance with all applicable state and federal requirements, and administrative efficiency.

(2) Not later than December 1, 2006, the California State Auditor's Office shall conduct an accountability evaluation of the department's progress toward implementing a facility-specific reimbursement system, including a review of data to ensure that the new system is appropriately reimbursing facilities within specified cost categories and a review of the fiscal impact of the new system on the General Fund.

(3) Not later than January 1, 2007, to the extent information is available for the three years immediately preceding the implementation of this article, the department shall provide baseline information in a report to the Legislature on all of the following:

(A) The number and percent of freestanding skilled nursing facilities that complied with minimum staffing requirements.

(B) The staffing levels before the implementation of this article.

(C) The staffing retention rates before the implementation of this article.

(D) The numbers and percentage of freestanding skilled nursing facilities with findings of immediate jeopardy, substandard quality of care, or actual harm, as determined by the certification survey of each freestanding skilled nursing facility conducted before the implementation of this article.

(E) The number of freestanding skilled nursing facilities that received state citations and the number and class of citations issued during calendar year 2004.

(F) The average wage and benefits for employees before the implementation of this article.

(4) Not later than January 1, 2009, the department shall provide a report to the Legislature that does both of the following:

(A) Compares the information required in paragraph (2) to that same information two years after the implementation of this article.

(B) Reports on the extent to which residents who had expressed a preference to return to the community, as provided in Section 1418.81 of the Health and Safety Code, were able to return to the community.

(5) The department may contract for the reports required under 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:

14132. The following is the schedule of benefits under this chapter:

(a) Outpatient services are covered as follows:

Physician, hospital or clinic outpatient, surgical center, respiratory care, optometric, chiropractic, psychology, podiatric, occupational therapy, physical therapy, speech therapy, audiology, acupuncture to the extent federal matching funds are provided for acupuncture, and services of persons rendering treatment by prayer or healing by spiritual means in the practice of any church or religious denomination insofar as these can be encompassed by federal participation under an approved plan, subject to utilization controls.

(b) (1) Inpatient hospital services, including, but not limited to, physician and podiatric services, physical therapy, and occupational therapy, are covered subject to utilization controls.

(2) For a Medi-Cal fee-for-service beneficiary, emergency services and care that are necessary for the treatment of an emergency medical condition and medical care directly related to the emergency medical condition. This paragraph does not change the obligation of Medi-Cal managed care plans to provide emergency services and care. For the purposes of this paragraph, "emergency services and care" and "emergency medical condition" have the same meanings as those terms are defined in Section 1317.1 of the Health and Safety Code.

(c) Nursing facility services, subacute care services, and services provided by any category of intermediate care facility for the developmentally disabled, including podiatry, physician, nurse practitioner services, and prescribed drugs, as described in subdivision (d), are covered subject to utilization controls. Respiratory care, physical therapy, occupational therapy, speech therapy, and audiology services for patients in nursing facilities

and any category of intermediate care facility for persons with developmental disabilities are covered subject to utilization controls.

(d) (1) Purchase of prescribed drugs is covered subject to the Medi-Cal List of Contract Drugs and utilization controls.

(2) Purchase of drugs used to treat erectile dysfunction or any off-label uses of those drugs are covered only to the extent that 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 services are covered, subject to utilization controls. This subdivision does not require prior authorization for anesthesiologist services provided as part of an outpatient medical procedure or for portable x-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses that are lost or destroyed due to circumstances beyond the beneficiary's control. Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions that preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children's Services program.

(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:

(A) Periodontal treatment is not a benefit.

(B) Endodontic therapy is not a benefit except for vital pulpotomy.

(C) Laboratory processed crowns are not a benefit.

(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.

(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

(F) Notwithstanding the conditions specified in subparagraphs (A) to (E), inclusive, the department may approve services for persons with special medical disorders subject to utilization review.

(3) Paragraph (2) shall become inoperative on July 1, 1995.

(i) Medical transportation is covered, subject to utilization controls.

(j) Home health care services are covered, subject to utilization controls.

(k) (1) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

(2) Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated is covered, subject to utilization controls. If there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.

(3) Therapeutic shoes and inserts are covered when provided to a beneficiary with a diagnosis of diabetes, subject to utilization controls, to the extent that federal financial participation is available.

(*l*) Hearing aids are covered, subject to utilization controls. Utilization controls shall allow replacement of hearing aids necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls shall allow the replacement of durable medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary's control. The utilization controls shall allow authorization of durable medical equipment needed to assist a disabled beneficiary in caring for a

child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian, subject to the availability of federal financial participation. The department shall adopt emergency regulations to define and establish criteria for assistive durable medical equipment in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(n) Family planning services are covered, subject to utilization controls. However, for Medi-Cal managed care plans, utilization controls shall be subject to Section 1367.25 of the Health and Safety Code.

(o) Inpatient intensive rehabilitation hospital services, including respiratory rehabilitation services, in a general acute care hospital are covered, subject to utilization controls, when either of the following criteria are met:

(1) A patient with a permanent disability or severe impairment requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to develop function beyond the limited amount that would occur in the normal course of recovery.

(2) A patient with a chronic or progressive disease requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to maintain the patient's present functional level as long as possible.

(p) (1) Adult day health care is covered in accordance with Chapter 8.7 (commencing with Section 14520).

(2) Commencing 30 days after the effective date of the act that added this paragraph, and notwithstanding the number of days previously approved through a treatment authorization request, adult day health care is covered for a maximum of three days per week.

(3) As provided in accordance with paragraph (4), adult day health care is covered for a maximum of five days per week.

(4) As of the date that the director makes the declaration described in subdivision (g) of Section 14525.1, paragraph (2) shall become inoperative and paragraph (3) shall become operative.

(q) (1) Application of fluoride, or other appropriate fluoride treatment as defined by the department, and other prophylaxis treatment for children 17 years of age and under are covered.

(2) All dental hygiene services provided by a registered dental hygienist, registered dental hygienist in extended functions, and registered dental hygienist in alternative practice licensed pursuant to Sections 1753, 1917, 1918, and 1922 of the Business and Professions Code may be covered as long as they are within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental hygienist, registered dental hygienist in extended functions, or registered dental hygienist in 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.

(I) Home health agency personnel benefits that permit coverage of care during periods when regular personnel are on vacation or using sick leave.

(J) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.

(K) Emergency and nonemergency medical transportation.

(L) Medical supplies.

(M) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.

(N) Utility use directly attributable to the requirements of home care activities that are in addition to normal utility use.

(O) Special drugs and medications.

(P) Home health agency supervision of visiting staff that is medically necessary, but not included in the home health agency rate.

(Q) Therapy services.

(R) Household appliances and household utensil costs directly attributable to home care activities.

(S) Modification of medical equipment for home use.

(T) Training and orientation for use of life-support systems, including, but not limited to, support of respiratory functions.

(U) Respiratory care practitioner services as defined in Sections 3702 and 3703 of the Business and Professions Code, subject to prescription by a physician and surgeon.

(4) A beneficiary receiving in-home medical care services is entitled to the full range of services within the Medi-Cal scope of benefits as defined by this section, subject to medical necessity and applicable utilization control. Services provided pursuant to this subdivision, which 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 a home- and community-based services waiver.

(t) Home- and community-based services approved by the United States Department of Health and Human Services are covered to the extent that federal financial participation is available for those services under the state plan or waivers granted in accordance with Section 1315 or 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and community-based services approvable under Section 1315 or 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers.

(u) Comprehensive perinatal services, as provided through an agreement with a health care provider designated in Section 14134.5 and meeting the standards developed by the department pursuant to Section 14134.5, subject to utilization controls.

The department shall seek any federal waivers necessary to implement the provisions of this subdivision. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained or for which waivers are not required shall be implemented notwithstanding any inability to obtain federal waivers for the other provisions. No provision of this subdivision shall be implemented unless matching funds from Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are available.

(v) Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(w) (1) Hospice services are covered, in accordance with Medicare requirements, and are subject to utilization controls. Coverage shall be available only to the extent that no additional net program costs are incurred.

(2) This subdivision 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.

(3) Notwithstanding any other law, 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.

(x) When a claim for treatment provided to a beneficiary includes both services that are authorized and reimbursable under this chapter and services that are not reimbursable under this chapter, that portion of the claim for the treatment and services authorized and reimbursable under this chapter shall be payable.

(y) Home- and community-based services approved by the 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 terms, conditions, and duration of the waiver. Under the state plan amendment, which shall replace the waiver and shall be known as the Family PACT successor state plan amendment, the program shall be operated only in accordance with this subdivision and the statutes and regulations in paragraph (4). The state shall use the standards and processes imposed by the state on January 1, 2007, including the application of an eligibility discount factor to the extent required by the federal Centers for Medicare and Medicaid Services, for purposes of determining eligibility as permitted under Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code. To the extent that federal financial participation is available, the program shall continue to conduct education, outreach, enrollment, service delivery, and evaluation services as specified under the waiver. The services shall be provided under the program only if the waiver and, when applicable, the successor state plan amendment are approved by the federal Centers for Medicare and Medicaid Services and only to the extent that federal financial participation is available for the services. This section does not prohibit the department from seeking the Family PACT successor state plan amendment during the operation of the waiver.

(3) Solely for the purposes of the waiver or Family PACT successor state plan amendment and notwithstanding any other law, the collection and use of an individual's social security number shall be necessary only to the extent required by federal law.

(4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005, and 24013, and any regulations adopted under these statutes shall apply to the program provided for under this subdivision. No other law under the Medi-Cal program or the State-Only Family Planning Program shall apply to the program provided for under this subdivision.

(5) 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, without taking regulatory action, the provisions of the waiver after its approval by the federal Centers for Medicare and Medicaid Services and the provisions of this section by means of an all-county letter or similar instruction to providers. Thereafter, the department shall adopt regulations to implement this section and the approved waiver in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of the act adding this subdivision, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(6) If the Department of Finance determines that the program operated under the authority of the waiver described in paragraph (2) or the Family PACT successor state plan amendment is no longer cost effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no spend down of excess income, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a spend down of excess income or if they are otherwise eligible under Section 24003.

(8) For purposes of this subdivision, “comprehensive clinical family planning services” means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These

means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies, natural family planning, abstinence methods, and basic, limited fertility management. Comprehensive clinical family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Comprehensive clinical family planning services shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that is not incident to the diagnosis of pregnancy. Comprehensive clinical family planning services shall be subject to utilization control and include all of the following:

(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

(B) All United States Department of Agriculture, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.

(C) Culturally and linguistically appropriate health education and counseling services, including informed consent, that include all of the following:

(i) Psychosocial and medical aspects of contraception.

(ii) Sexuality.

(iii) Fertility.

(iv) Pregnancy.

(v) Parenthood.

(vi) Infertility.

(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

(x) Use of contraceptive methods, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies.

(xi) Possible contraceptive consequences and followup.

(xii) Interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(D) A comprehensive health history, updated at the next periodic visit (between 11 and 24 months after initial examination) that includes a complete obstetrical history, gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.

(E) A complete physical examination on initial and subsequent periodic visits.

(F) Services, drugs, devices, and supplies deemed by the federal Centers for Medicare and Medicaid Services to be appropriate for inclusion in the program.

(G) (i) Home test kits for sexually transmitted diseases, including any laboratory costs of processing the kit, that are deemed medically necessary or appropriate and ordered directly by an enrolled Medi-Cal or Family PACT clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.

(ii) For purposes of this subparagraph, "home test kit" means a product used for a test recommended by the federal Centers for Disease Control and Prevention guidelines or the United States Preventive Services Task Force that has been CLIA-waived, FDA-cleared or -approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting.

(iii) Reimbursement under this subparagraph shall be contingent upon the addition of codes specific to home test kits in the Current Procedural Terminology or Healthcare Common Procedure Coding System to comply with Health Insurance Portability and Accountability Act requirements. The home test kit shall be sent by the enrolled Family PACT provider to a Medi-Cal-enrolled

laboratory with fee based on Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule.

(9) In order to maximize the availability of federal financial participation under this subdivision, the director shall have the discretion to implement the Family PACT successor state plan amendment retroactively to July 1, 2010.

(ab) (1) Purchase of prescribed enteral nutrition products is covered, subject to the Medi-Cal list of enteral nutrition products and utilization controls.

(2) Purchase of enteral nutrition products is limited to those products to be administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube. A beneficiary under the Early and Periodic Screening, Diagnostic, and Treatment Program shall be exempt from this paragraph.

(3) Notwithstanding paragraph (2), the department may deem an enteral nutrition product, not administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube, a benefit for patients with diagnoses, including, but not limited to, malabsorption and inborn errors of metabolism, if the product has been shown to be neither investigational nor experimental when used as part of a therapeutic regimen to prevent serious disability or death.

(4) 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 the amendments to this subdivision made by the act that added this paragraph by means of all-county letters, provider bulletins, or similar instructions, without taking regulatory action.

(5) The amendments made to this subdivision by the act that added this paragraph shall be implemented June 1, 2011, or on the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later.

(ac) Diabetic testing supplies are covered when provided by a pharmacy, subject to utilization controls.

(ad) (1) Nonmedical transportation is covered, subject to utilization controls and permissible time and distance standards, for a beneficiary to obtain covered Medi-Cal services.

(2) (A) (i) Nonmedical transportation includes, at a minimum, round trip transportation for a beneficiary to obtain covered

Medi-Cal services by passenger car, taxicab, or any other form of public or private conveyance, and mileage reimbursement when conveyance is in a private vehicle arranged by the beneficiary and not through a transportation broker, bus passes, taxi vouchers, or train tickets.

(ii) Nonmedical transportation does not include the transportation of a sick, injured, invalid, convalescent, infirm, or otherwise incapacitated beneficiary by ambulance, litter van, or wheelchair van licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations.

(B) Nonmedical transportation shall be provided for a beneficiary who can attest in a manner to be specified by the department that other currently available resources have been reasonably exhausted. For a beneficiary enrolled in a managed care plan, nonmedical transportation shall be provided by the beneficiary's managed care plan. For a Medi-Cal fee-for-service beneficiary, the department shall provide nonmedical transportation when those services are not available to the beneficiary under Sections 14132.44 and 14132.47.

(3) Nonmedical transportation shall be provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the beneficiary and consistent with applicable state and federal disability rights laws.

(4) It is the intent of the Legislature in enacting this subdivision to affirm the requirement under Section 431.53 of Title 42 of the Code of Federal Regulations, in which the department is required to provide necessary transportation, including nonmedical transportation, for recipients to and from covered services. This subdivision shall not be interpreted to add a new benefit to the Medi-Cal program.

(5) The department shall seek any federal approvals that may be required to implement this subdivision, including, but not limited to, approval of revisions to the existing state plan that the department determines are necessary to implement this subdivision.

(6) This subdivision 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.

(7) Prior to the effective date of any necessary federal approvals, nonmedical transportation was not a Medi-Cal managed care

benefit with the exception of when provided as an Early and Periodic Screening, Diagnostic, and Treatment service.

(8) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. By July 1, 2018, 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. Commencing January 1, 2018, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(9) This subdivision shall not be implemented until July 1, 2017.

(ae) (1) No sooner than January 1, 2022, Rapid Whole Genome Sequencing, including individual sequencing, trio sequencing for a parent or parents and their baby, and ultra-rapid sequencing, is a covered benefit for any Medi-Cal beneficiary who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit.

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

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

(af) (1) Home test kits for sexually transmitted diseases that are deemed medically necessary or appropriate and ordered directly by an enrolled Medi-Cal clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.

(2) For purposes of this subdivision, “home test kit” means a product used for a test recommended by the federal Centers for Disease Control and Prevention guidelines or the United States

Preventive Services Task Force that has been CLIA-waived, FDA-cleared or -approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting.

(3) Reimbursement under this subparagraph shall be contingent upon the addition of codes specific to home test kits in the Current Procedural Terminology or Healthcare Common Procedure Coding System to comply with Health Insurance Portability and Accountability Act requirements. The home test kit shall be sent by the enrolled Medi-Cal provider to a Medi-Cal-enrolled laboratory with fee based on Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule.

(4) This subdivision 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.

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking any further regulatory action.

(ag) (1) Violence prevention services are covered, subject to medical necessity and utilization controls.

(2) 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.

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

(4) The department shall post on its internet website the date upon which violence prevention services may be provided and billed pursuant to this subdivision.

(5) “Violence prevention services” means evidence-based, trauma-informed, and culturally responsive preventive services provided to reduce the incidence of violent injury or reinjury,

trauma, and related harms and promote trauma recovery, stabilization, and improved health outcomes.

SEC. 102. Section 14132.36 of the Welfare and Institutions Code is amended to read:

14132.36. (a) Community health worker services are a covered Medi-Cal benefit.

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

(1) "Community health worker" means a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. A community health worker is a frontline health worker either trusted by, or who has a close understanding of, the community served. Community health workers include Promotores, Promotores de Salud, Community Health Representatives, navigators, and other nonlicensed health workers, including violence prevention professionals. A community health worker's lived experience shall align with and provide a connection to the community being served.

(2) "Supervising provider" is an enrolled Medi-Cal provider that is authorized to supervise a community health worker pursuant to the federally approved Medicaid state plan amendment and that ensures that a community health worker meets the qualifications as required by the department. The supervising provider directly or indirectly oversees community health workers and the services that they deliver to Medi-Cal members.

(c) A Medi-Cal managed care plan shall engage in outreach and education efforts to enrollees in a form and manner as directed by the department. At a minimum, the department shall require a Medi-Cal managed care plan to provide the following information to an enrollee:

(1) A description of the community health worker services benefit, including eligibility and coverage criteria.

(2) A list of providers that are authorized to refer an enrollee to community health worker services, and an explanation of how to request a referral.

(3) A list of contracted community health worker entities, including community-based organizations, community clinics, local health jurisdictions, licensed providers, clinics, or hospitals available to provide community health worker services, updated at least annually.

(4) An email address, internet website, and telephone number for an enrollee to access to request additional information regarding community health worker services.

(d) The outreach and education efforts conducted by a Medi-Cal managed care plan pursuant to subdivision (c) shall meet cultural and linguistic appropriateness standards, as determined by the 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.

(c) Federally qualified health center services and rural health clinic services shall be reimbursed on a per-visit basis in accordance with the definition of "visit" set forth in subdivision (g).

(d) Effective October 1, 2004, and on each October 1 thereafter, until no longer required by federal law, federally qualified health center (FQHC) and rural health clinic (RHC) per-visit rates shall be increased by the Medicare Economic Index applicable to primary care services in the manner provided for in Section 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to January 1, 2004, FQHC and RHC per-visit rates shall be adjusted by the Medicare Economic Index in accordance with the methodology set forth in the state plan in effect on October 1, 2001.

(e) (1) An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC. Rate changes based on a change in the scope of services provided by an FQHC or RHC shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(2) Subject to the conditions set forth in subparagraphs (A) to (D), inclusive, of paragraph (3), a change in scope of service means any of the following:

(A) The addition of a new FQHC or RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate.

(B) A change in service due to amended regulatory requirements or rules.

(C) A change in service resulting from relocating or remodeling an FQHC or RHC.

(D) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.

(E) An increase in service intensity attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

(F) Any changes in any of the services described in subdivision (a) or (b), or in the provider mix of an FQHC or RHC or one of its sites.

(G) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in subdivision (a) or (b), including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(H) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.

(I) Any changes in the scope of a project approved by the federal Health Resources and Services Administration (HRSA).

(3) A change in costs is not, in and of itself, a scope-of-service change, unless all of the following apply:

(A) The increase or decrease in cost is attributable to an increase or decrease in the scope of services defined in subdivisions (a) and (b), as applicable.

(B) The cost is allowable under Medicare reasonable cost principles set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(C) The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof.

(D) The net change in the FQHC's or RHC's rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75-percent threshold shall be applied to the average per-visit rate of all sites for the purposes of calculating the cost associated with a scope-of-service change. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

(4) An FQHC or RHC may submit requests for scope-of-service changes once per fiscal year, only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any approved

increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(5) An FQHC or RHC shall submit a scope-of-service rate change request within 90 days of the beginning of any FQHC or RHC fiscal year occurring after the effective date of this section, if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope of services provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If an FQHC or RHC discontinues providing onsite pharmacy or dental services, it shall submit a scope-of-service rate change request within 90 days of the beginning of the following fiscal year. The rate change shall be effective as provided for in paragraph (4). As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent.

(6) Notwithstanding paragraph (4), if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of-service change, the adjusted reimbursement rate for that scope-of-service change shall be made retroactive to the date the scope-of-service change was initially implemented. Scope-of-service changes under this paragraph shall be required to be submitted within the later of 150 days after the adoption and issuance of the written instructions by the department, or 150 days after the end of the FQHC's or RHC's fiscal year ending in 2003.

(7) All references in this subdivision to "fiscal year" shall be construed to be references to the fiscal year of the individual FQHC or RHC, as the case may be.

(f) (1) An FQHC or RHC may request a supplemental payment if extraordinary circumstances beyond the control of the FQHC or RHC occur after December 31, 2001, and PPS payments are insufficient due to these extraordinary circumstances. Supplemental payments arising from extraordinary circumstances under this subdivision shall be solely and exclusively within the discretion of the department and shall not be subject to subdivision (*l*). These supplemental payments shall be determined separately from the scope-of-service adjustments described in subdivision (e).

Extraordinary circumstances include, but are not limited to, acts of nature, changes in applicable requirements in the Health and Safety Code, changes in applicable licensure requirements, and changes in applicable rules or regulations. Mere inflation of costs alone, absent extraordinary circumstances, shall not be grounds for supplemental payment. If an FQHC's or RHC's PPS rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, then a supplemental payment is not warranted.

(2) The department shall accept requests for supplemental payment at any time throughout the prospective payment rate year.

(3) Requests for supplemental payments shall be submitted in writing to the department and shall set forth the reasons for the request. Each request shall be accompanied by sufficient documentation to enable the department to act upon the request. Documentation shall include the data necessary to demonstrate that the circumstances for which supplemental payment is requested meet the requirements set forth in this section. Documentation shall include both of the following:

(A) A presentation of data to demonstrate reasons for the FQHC's or RHC's request for a supplemental payment.

(B) Documentation showing the cost implications. The cost impact shall be material and significant, two hundred thousand dollars ($200,000) or 1 percent of a facility's total costs, whichever is less.

(4) A request shall be submitted for each affected year.

(5) Amounts granted for supplemental payment requests shall be paid as lump-sum amounts for those years and not as revised PPS rates, and shall be repaid by the FQHC or RHC to the extent that it is not expended for the specified purposes.

(6) The department shall notify the provider of the department's discretionary decision in writing.

(g) (1) An FQHC or RHC "visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, 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.

(2) (A) A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist.

(B) Notwithstanding subdivision (e), if an FQHC or RHC that currently includes the cost of the services of a dental hygienist in alternative practice, or a marriage and family therapist for the purposes of establishing its FQHC or RHC rate chooses to bill these services as a separate visit, the FQHC or RHC shall apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, shall bill these services as a separate visit. However, multiple encounters with dental professionals or marriage and family therapists that take place on the same day shall constitute a single visit. The department shall develop the appropriate forms to determine which FQHC's or RHC's rates shall be adjusted and to facilitate the calculation of the adjusted rates. An FQHC's or RHC's application for, or the department's approval of, a rate adjustment pursuant to this subparagraph shall not constitute a change in scope of service within the meaning of subdivision (e). An FQHC or RHC that applies for an adjustment to its rate pursuant to this subparagraph may continue to bill for all other FQHC or RHC visits at its existing per-visit rate, subject to reconciliation, until the rate adjustment for visits between an FQHC or RHC patient and a dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist has been approved. Any approved increase or decrease in the provider's rate shall be made within six months after the date of receipt of the department's rate adjustment forms pursuant to this subparagraph and shall be retroactive to the beginning of the fiscal year in which the FQHC or RHC submits the request, but in no case shall the effective date be earlier than January 1, 2008.

(C) An FQHC or RHC that does not provide dental hygienist or dental hygienist in alternative practice services, and later elects to add these services and bill these services as a separate visit, shall process the addition of these services as a change in scope of service pursuant to subdivision (e).

(3) Notwithstanding any other provision of this section, no later than July 1, 2018, a visit shall include a marriage and family therapist.

(4) (A) (i) Subject to subparagraphs (C) and (D), a visit shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, licensed professional clinical counselor, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using video synchronous interaction, when services delivered through that interaction meet the applicable standard of care. A visit described in this clause shall be reimbursed at the applicable FQHC's or RHC's per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter. An FQHC or RHC is not precluded from establishing a new patient relationship through video synchronous interaction. An FQHC patient who receives telehealth services shall otherwise be eligible to receive in-person services from that FQHC pursuant to HRSA requirements.

(ii) Subject to subparagraphs (C) and (D), a visit shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, licensed professional clinical counselor, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using audio-only synchronous interaction, when services delivered through that modality meet the applicable standard of care. A visit described in this clause shall be reimbursed at the applicable FQHC's or RHC's per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

(iii) Subject to subparagraphs (C) and (D), a visit shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, licensed professional clinical counselor, visiting nurse,

comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using an asynchronous store and forward modality, when services delivered through that modality meet the applicable standard of care. A visit described in this clause shall be reimbursed at the applicable FQHC's or RHC's per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

(iv) (I) An FQHC or RHC may not establish a new patient relationship using an audio-only synchronous interaction.

(II) Notwithstanding subclause (I), the department may provide for exceptions to the prohibition established by subclause (I), including, but not limited to, the exceptions described in sub-subclauses (ia) and (ib), which shall be developed in consultation with affected stakeholders and published in departmental guidance.

(ia) Notwithstanding the prohibition in subclause (I) and subject to subparagraphs (C) and (D), an FQHC or RHC may establish a new patient relationship using an audio-only synchronous interaction when the visit is related to sensitive services, as defined in subdivision (n) of Section 56.05 of the Civil Code, and when established in accordance with department-specific requirements and consistent with federal and state laws, regulations, and guidance.

(ib) Notwithstanding the prohibition in subclause (I) and subject to subparagraphs (C) and (D), an FQHC or RHC may establish a new patient relationship using an audio-only synchronous interaction when the patient requests an audio-only modality or attests they do not have access to video, and when established in accordance with department-specific requirements and consistent with federal and state laws, regulations, and guidance.

(v) An FQHC or RHC is not precluded from establishing a new patient relationship through an asynchronous store and forward modality, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, if the visit meets all of the following conditions:

(I) The patient is physically present at the FQHC or RHC, or at an intermittent site of the FQHC or RHC, at the time the service is performed.

(II) The individual who creates the patient records at the originating site is an employee or contractor of the FQHC or RHC, or other person lawfully authorized by the FQHC or RHC to create a patient record.

(III) The FQHC or RHC determines that the billing provider is able to meet the applicable standard of care.

(IV) An FQHC patient who receives telehealth services shall otherwise be eligible to receive in-person services from that FQHC pursuant to HRSA requirements.

(B) (i) Pursuant to an effective date designated by the department that is no sooner than January 1, 2024, an FQHC or RHC furnishing applicable health care services via audio-only synchronous interaction shall also offer those same health care services via video synchronous interaction to preserve beneficiary choice.

(ii) The department may provide specific exceptions to the requirement specified in clause (i), based on an FQHC's or RHC's access to requisite technologies, which shall be developed in consultation with affected stakeholders and published in departmental guidance.

(iii) Effective on the date designated by the department pursuant to clause (i), an FQHC or RHC furnishing services through video synchronous interaction or audio-only synchronous interaction shall also do one of the following:

(I) Offer those services via in-person, face-to-face contact.

(II) Arrange for a referral to, and a facilitation of, in-person care that does not require a patient to independently contact a different provider to arrange for that care.

(iv) In addition to any existing law requiring beneficiary consent to telehealth, including, but not limited to, subdivision (b) of Section 2290.5 of the Business and Professions Code, all of the following shall be communicated by an FQHC or RHC to a Medi-Cal beneficiary, in writing or verbally, on at least one occasion prior to, or concurrent with, initiating the delivery of one or more health care services via telehealth to a Medi-Cal beneficiary: an explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit; an explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without

affecting their ability to access covered Medi-Cal services in the future; an explanation of the availability of Medi-Cal coverage for nonmedical transportation services to in-person visits when other available resources have been reasonably exhausted; and the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the FQHC or RHC.

(I) The FQHC or RHC shall document in the patient record the provision of this information and the patient's verbal or written acknowledgment that the information was received.

(II) The department shall develop, in consultation with affected stakeholders, model language for purposes of the communication described in this subparagraph.

(C) The department shall seek any federal approvals it deems necessary to implement this paragraph. This paragraph shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and not otherwise jeopardized.

(D) This paragraph shall be operative on January 1, 2023, or on the operative date or dates reflected in the applicable federal approvals obtained by the department pursuant to subparagraph (C), whichever is later. This paragraph shall not be construed to limit coverage of, and reimbursement for, covered telehealth services provided before the operative date of this paragraph.

(E) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, and make specific this paragraph by means of all-county letters, plan letters, provider manuals, information notices, provider bulletins, and similar instructions, without taking any further regulatory action.

(F) Telehealth modalities authorized pursuant to this paragraph shall be subject to the billing, reimbursement, and utilization management policies imposed by the department.

(G) Services delivered via telehealth modalities described in this paragraph shall comply with the privacy and security requirements contained in the federal Health Insurance Portability and Accountability Act of 1996 found in Parts 160 and 164 of Title 45 of the Code of Federal Regulations, the Medicaid state plan, and any other applicable state and federal statutes and regulations.

(5) For purposes of this section, "physician" shall be interpreted in a manner consistent with the federal Centers for Medicare and Medicaid Services' Medicare Rural Health Clinic and Federally Qualified Health Center Manual (Publication 27), or its successor, only to the extent that it defines the professionals whose services are reimbursable on a per-visit basis and not as to the types of services that these professionals may render during these visits and shall include a physician and surgeon, osteopath, podiatrist, dentist, optometrist, and chiropractor.

(h) If FQHC or RHC services are partially reimbursed by a third-party payer, such as a managed care entity, as defined in Section 1396u-2(a)(1)(B) of Title 42 of the United States Code, the Medicare Program, or the Child Health and Disability Prevention (CHDP) Program, the department shall reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate, and may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

(i) (1) Provided that the following entities are not operating as intermittent clinics, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, each entity shall have its reimbursement rate established in accordance with one of the methods outlined in paragraph (2) or (3), as selected by the FQHC or RHC:

(A) An entity that first qualifies as an FQHC or RHC in 2001 or later.

(B) A newly licensed facility at a new location added to an existing FQHC or RHC.

(C) An entity that is an existing FQHC or RHC that is relocated to a new site.

(2) (A) An FQHC or RHC that adds a new licensed location to its existing primary care license under paragraph (1) of subdivision (b) of Section 1212 of the Health and Safety Code may elect to have the reimbursement rate for the new location established in accordance with paragraph (3), or notwithstanding subdivision (e), an FQHC or RHC may choose to have one PPS rate for all locations that appear on its primary care license determined by submitting a change in scope of service request if both of the following requirements are met:

(i) The change in scope of service request includes the costs and visits for those locations for the first full fiscal year immediately following the date the new location is added to the FQHC's or RHC's existing licensee.

(ii) The FQHC or RHC submits the change in scope of service request within 90 days after the FQHC's or RHC's first full fiscal year.

(B) The FQHC's or RHC's single PPS rate for those locations shall be calculated based on the total costs and total visits of those locations and shall be determined based on the following:

(i) An audit in accordance with Section 14170.

(ii) Rate changes based on a change in scope of service request shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successors.

(iii) Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(C) Except as specified in subdivision (j), this paragraph does not apply to a location that was added to an existing primary care clinic license by the State Department of Public Health, whether by a regional district office or the centralized application unit, prior to January 1, 2017.

(3) If an FQHC or RHC does not elect to have the PPS rate determined by a change in scope of service request, the FQHC or RHC shall have the reimbursement rate established for any of the entities identified in paragraph (1) or (2) in accordance with one of the following methods at the election of the FQHC or RHC:

(A) The rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or adjacent area with a similar caseload.

(B) In the absence of three comparable FQHCs or RHCs with a similar caseload, the rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or an adjacent service area, or in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics.

(C) At a new entity's one-time election, the department shall establish a reimbursement rate, calculated on a per-visit basis, that is equal to 100 percent of the projected allowable costs to the FQHC or RHC of furnishing FQHC or RHC services during the first 12 months of operation as an FQHC or RHC. After the first 12-month period, the projected per-visit rate shall be increased by the Medicare Economic Index then in effect. The projected allowable costs for the first 12 months shall be cost settled and the prospective payment reimbursement rate shall be adjusted based on actual and allowable cost per visit.

(D) The department may adopt any further and additional methods of setting reimbursement rates for newly qualified FQHCs or RHCs as are consistent with Section 1396a(bb)(4) of Title 42 of the United States Code.

(4) In order for an FQHC or RHC to establish the comparability of its caseload for purposes of subparagraph (A) or (B) of paragraph (1), the department shall require that the FQHC or RHC submit its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report. FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit to the department a completed report in the format applicable to the prior calendar year. FQHCs or RHCs that have not previously submitted an annual utilization report shall submit to the department a completed report in the format applicable to the prior calendar year. The FQHC or RHC shall not be required to submit the annual utilization report for the comparable FQHCs or RHCs to the department, but shall be required to identify the comparable FQHCs or RHCs.

(5) The rate for any newly qualified entity set forth under this subdivision shall be effective retroactively to the later of the date that the entity was first qualified by the applicable federal agency as an FQHC or RHC, the date a new facility at a new location was added to an existing FQHC or RHC, or the date on which an existing FQHC or RHC was relocated to a new site. The FQHC or RHC shall be permitted to continue billing for Medi-Cal covered benefits on a fee-for-service basis under its existing provider number until it is informed of its FQHC or RHC enrollment approval, and the department shall reconcile the difference between

the fee-for-service payments and the FQHC's or RHC's prospective payment rate at that time.

(j) (1) Visits occurring at an intermittent clinic site, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, of an existing FQHC or RHC, in a mobile unit as defined 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 under contract with the FQHC or RHC pursuant to paragraph (4), costs associated with providing Drug Medi-Cal services shall not be included in the FQHC's or RHC's per-visit PPS rate. For purposes of this subdivision, the costs associated with providing Drug Medi-Cal services shall not be considered to be within the FQHC's or RHC's clinic base PPS rate if in delivering Drug Medi-Cal services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver Drug Medi-Cal services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering Drug Medi-Cal services, including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing Drug Medi-Cal services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the Drug Medi-Cal services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a scope-of-service change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering Drug Medi-Cal services outside of the PPS rate. Notwithstanding subdivision (e), the scope-of-service change request shall include a full fiscal year of activity that does not include Drug Medi-Cal services costs.

(B) An FQHC or RHC may submit requests for scope-of-service change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any scope-of-service change request under this subdivision approved by the department shall be retroactive to the first day that Drug Medi-Cal services were rendered and reimbursement for Drug Medi-Cal services was received outside of the PPS rate, but in no case shall the effective date be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for Drug Medi-Cal services outside of the PPS rate when the FQHC or RHC obtains approval

as a Drug Medi-Cal provider and enters into a contract with a county or the department to provide these services pursuant to paragraph (4).

(D) Within 90 days of receipt of the request for a scope-of-service change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for scope-of-service change under this subdivision shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(F) For purposes of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and Drug Medi-Cal services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate and the FQHC or RHC is approved as a Drug Medi-Cal provider, an FQHC or RHC shall not bill the PPS rate for any Drug Medi-Cal services provided pursuant to a contract entered into with a county or the department pursuant to paragraph (4).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with the applicable scope-of-service adjustments as provided for in subdivision (e).

(4) Reimbursement for Drug Medi-Cal services shall be determined according to subparagraph (A) or (B), depending on whether the services are provided in a county that participates in the Drug Medi-Cal organized delivery system (DMC-ODS).

(A) In a county that participates in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon contract entered into between the county or county designee and the FQHC or RHC. If the county or county designee refuses to contract with the FQHC or RHC, the FQHC or RHC may follow

the contract denial process set forth in the Special Terms and Conditions.

(B) In a county that does not participate in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon contract entered into between the county and the FQHC or RHC. If the county refuses to contract with the FQHC or RHC, the FQHC or RHC may request to contract directly with the department and shall be reimbursed for those services at the Drug Medi-Cal fee-for-service rate.

(5) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments for Drug Medi-Cal services made pursuant to this subdivision.

(6) For purposes of this subdivision, the following definitions apply:

(A) "Drug Medi-Cal organized delivery system" or "DMC-ODS" means the Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services and described in the Special Terms and Conditions.

(B) "Special Terms and Conditions" has the same meaning as set forth in subdivision (o) of Section 14184.10.

(m) Reimbursement for specialty mental health services shall be provided pursuant to this subdivision.

(1) An FQHC or RHC and one or more mental health plans that contract with the department pursuant to Section 14712 may mutually elect to enter into a contract to have the FQHC or RHC provide specialty mental health services to Medi-Cal beneficiaries as part of the mental health plan's network.

(2) (A) For an FQHC or RHC to receive reimbursement for specialty mental health services pursuant to a contract entered into with the mental health plan under paragraph (1), the costs associated with providing specialty mental health services shall not be included in the FQHC's or RHC's per-visit PPS rate. For purposes of this subdivision, the costs associated with providing specialty mental health services shall not be considered to be within the FQHC's or RHC's clinic base PPS rate if in delivering specialty mental health services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver specialty mental health services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering specialty mental health services, including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing specialty mental health services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the specialty mental health services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a scope-of-service change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering specialty mental health services outside of the PPS rate. Notwithstanding subdivision (e), the scope-of-service change request shall include a full fiscal year of activity that does not include specialty mental health costs.

(B) An FQHC or RHC may submit requests for a scope-of-service change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any scope-of-service change request under this subdivision approved by the department is retroactive to the first day that specialty mental health services were rendered and reimbursement for specialty mental health services was received outside of the PPS rate, but the effective date shall not be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for specialty mental health services outside of the PPS rate when the FQHC or RHC contracts with a mental health plan to provide these services pursuant to paragraph (1).

(D) Within 90 days of receipt of the request for a scope-of-service change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for scope-of-service change under this subdivision shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(F) For the purpose of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and specialty mental health services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate, an FQHC or RHC shall not bill the PPS rate for any specialty mental health services that are provided pursuant to a contract entered into with a mental health plan pursuant to paragraph (1).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with the applicable scope-of-service adjustments as provided for in subdivision (e).

(4) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments made for specialty mental health services under this subdivision.

(n) The department shall seek any necessary federal approvals and issue appropriate guidance to allow an FQHC or RHC to bill, under a supervising licensed behavioral health practitioner, for an encounter between an FQHC or RHC patient and a psychological associate, associate professional clinical counselor, associate clinical social worker, or associate marriage and family therapist when all of the following conditions are met:

(1) The psychological associate, associate professional clinical counselor, associate clinical social worker, or associate marriage and family therapist is supervised by the designated licensed behavioral health practitioner, as required by their applicable clinical licensing board.

(2) The behavioral health visit is billed under the supervising licensed practitioner of the FQHC or RHC, pursuant to paragraph (1).

(3) The FQHC or RHC is otherwise authorized to bill for services provided by the supervising licensed behavioral health practitioner as a separate visit.

(o) FQHCs and RHCs may appeal a grievance or complaint concerning ratesetting, scope-of-service changes, and settlement of cost report audits, in the manner prescribed by Section 14171. The rights and remedies provided under this subdivision are cumulative to the rights and remedies available under all other provisions of law of this state.

(p) The department shall promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for Medicare and Medicaid Services for any waivers that would be necessary to implement this section.

(q) The department shall implement this section only to the extent that federal financial participation is available.

(r) Notwithstanding any other law, the director may, without taking regulatory action pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, implement, interpret, or make specific this section by means of a provider bulletin or similar instruction. The department shall notify and consult with interested parties and appropriate stakeholders in implementing, interpreting, or making specific the provisions of this section, including all of the following:

(1) Notifying provider representatives in writing of the proposed action or change. The notice shall occur, and the applicable draft provider bulletin or similar instruction, shall be made available at least 10 business days prior to the meeting described in paragraph (2).

(2) Scheduling at least one meeting with interested parties and appropriate stakeholders to discuss the proposed action or change.

(3) Allowing for written input regarding the proposed action or change, to which the department shall provide summary written responses in conjunction with the issuance of the applicable final written provider bulletin or similar instruction.

(4) Providing at least 60 days advance notice of the effective date of the proposed action or change.

(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.

(C) A change in service resulting from relocating or remodeling an FQHC or RHC.

(D) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.

(E) An increase in service intensity attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

(F) Any changes in any of the services described in subdivision (a) or (b), or in the provider mix of an FQHC or RHC or one of its sites.

(G) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in subdivision (a) or (b), including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(H) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.

(I) Any changes in the scope of a project approved by the federal Health Resources and Services Administration (HRSA).

(3) A change in costs is not, in and of itself, a scope-of-service change, unless all of the following apply:

(A) The increase or decrease in cost is attributable to an increase or decrease in the scope of services defined in subdivisions (a) and (b), as applicable.

(B) The cost is allowable under Medicare reasonable cost principles set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(C) The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof.

(D) The net change in the FQHC's or RHC's rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75-percent threshold shall be applied to the average per-visit rate of all sites for the purposes of calculating the cost associated with a scope-of-service change. "Net change" means

the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

(4) An FQHC or RHC may submit requests for scope-of-service changes once per fiscal year, only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(5) An FQHC or RHC shall submit a scope-of-service rate change request within 90 days of the beginning of any FQHC or RHC fiscal year occurring after the effective date of this section, if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope of services provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If an FQHC or RHC discontinues providing onsite pharmacy or dental services, it shall submit a scope-of-service rate change request within 90 days of the beginning of the following fiscal year. The rate change shall be effective as provided for in paragraph (4). As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent.

(6) Notwithstanding paragraph (4), if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of-service change, the adjusted reimbursement rate for that scope-of-service change shall be made retroactive to the date the scope-of-service change was initially implemented. Scope-of-service changes under this paragraph shall be required to be submitted within the later of 150 days after the adoption and issuance of the written instructions by the department, or 150 days after the end of the FQHC's or RHC's fiscal year ending in 2003.

(7) All references in this subdivision to "fiscal year" shall be construed to be references to the fiscal year of the individual FQHC or RHC, as the case may be.

(f) (1) An FQHC or RHC may request a supplemental payment if extraordinary circumstances beyond the control of the FQHC or RHC occur after December 31, 2001, and PPS payments are insufficient due to these extraordinary circumstances. Supplemental

payments arising from extraordinary circumstances under this subdivision shall be solely and exclusively within the discretion of the department and shall not be subject to subdivision (*l*). These supplemental payments shall be determined separately from the scope-of-service adjustments described in subdivision (e). Extraordinary circumstances include, but are not limited to, acts of nature, changes in applicable requirements in the Health and Safety Code, changes in applicable licensure requirements, and changes in applicable rules or regulations. Mere inflation of costs alone, absent extraordinary circumstances, shall not be grounds for supplemental payment. If an FQHC's or RHC's PPS rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, then a supplemental payment is not warranted.

(2) The department shall accept requests for supplemental payment at any time throughout the prospective payment rate year.

(3) Requests for supplemental payments shall be submitted in writing to the department and shall set forth the reasons for the request. Each request shall be accompanied by sufficient documentation to enable the department to act upon the request. Documentation shall include the data necessary to demonstrate that the circumstances for which supplemental payment is requested meet the requirements set forth in this section. Documentation shall include both of the following:

(A) A presentation of data to demonstrate reasons for the FQHC's or RHC's request for a supplemental payment.

(B) Documentation showing the cost implications. The cost impact shall be material and significant, two hundred thousand dollars ($200,000) or 1 percent of a facility's total costs, whichever is less.

(4) A request shall be submitted for each affected year.

(5) Amounts granted for supplemental payment requests shall be paid as lump-sum amounts for those years and not as revised PPS rates, and shall be repaid by the FQHC or RHC to the extent that it is not expended for the specified purposes.

(6) The department shall notify the provider of the department's discretionary decision in writing.

(g) (1) An FQHC or RHC "visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife,

clinical psychologist, licensed clinical social worker, licensed professional clinical counselor, or a visiting nurse that is eligible for federal financial participation. 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 that is eligible for federal financial participation.

(2) (A) A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist that is eligible for federal financial participation.

(B) Notwithstanding subdivision (e), if an FQHC or RHC that currently includes the cost of the services of a dental hygienist in alternative practice, or a marriage and family therapist for the purposes of establishing its FQHC or RHC rate chooses to bill these services as a separate visit, the FQHC or RHC shall apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, shall bill these services as a separate visit. However, multiple encounters with dental professionals or marriage and family therapists that take place on the same day shall constitute a single visit. The department shall develop the appropriate forms to determine which FQHC's or RHC's rates shall be adjusted and to facilitate the calculation of the adjusted rates. An FQHC's or RHC's application for, or the department's approval of, a rate adjustment pursuant to this subparagraph shall not constitute a change in scope of service within the meaning of subdivision (e). An FQHC or RHC that applies for an adjustment to its rate pursuant to this subparagraph may continue to bill for all other FQHC or RHC visits at its existing per-visit rate, subject to reconciliation, until the rate adjustment for visits between an FQHC or RHC patient and a dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist has been approved. Any approved increase or decrease in the provider's rate shall be made within six months after the date of receipt of the department's rate adjustment forms pursuant to this subparagraph and shall be retroactive to the beginning of the fiscal year in which the FQHC or RHC submits the request,

but in no case shall the effective date be earlier than January 1, 2008.

(C) An FQHC or RHC that does not provide dental hygienist or dental hygienist in alternative practice services, and later elects to add these services and bill these services as a separate visit, shall process the addition of these services as a change in scope of service pursuant to subdivision (e).

(3) Notwithstanding any other provision of this section, no later than July 1, 2018, a visit shall include a marriage and family therapist that is eligible for federal financial participation.

(4) (A) (i) Subject to subparagraphs (C) and (D), a visit shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, licensed professional clinical counselor, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using video synchronous interaction, when services delivered through that interaction meet the applicable standard of care and are eligible for federal financial participation. A visit described in this clause shall be reimbursed at the applicable FQHC's or RHC's per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter. An FQHC or RHC is not precluded from establishing a new patient relationship through video synchronous interaction. An FQHC patient who receives telehealth services shall otherwise be eligible to receive in-person services from that FQHC pursuant to HRSA requirements.

(ii) Subject to subparagraphs (C) and (D), a visit shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, licensed professional clinical counselor, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using audio-only synchronous interaction, when services delivered through that modality meet the applicable standard of care and are eligible for federal financial participation. A visit described in this clause shall be reimbursed at the applicable

FQHC's or RHC's per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

(iii) Subject to subparagraphs (C) and (D), a visit shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, licensed professional clinical counselor, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using an asynchronous store and forward modality, when services delivered through that modality meet the applicable standard of care and are eligible for federal financial participation. A visit described in this clause shall be reimbursed at the applicable FQHC's or RHC's per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

(iv) (I) An FQHC or RHC may not establish a new patient relationship using an audio-only synchronous interaction.

(II) Notwithstanding subclause (I), the department may provide for exceptions to the prohibition established by subclause (I), including, but not limited to, the exceptions described in sub-subclauses (ia) and (ib), which shall be developed in consultation with affected stakeholders and published in departmental guidance.

(ia) Notwithstanding the prohibition in subclause (I) and subject to subparagraphs (C) and (D), an FQHC or RHC may establish a new patient relationship using an audio-only synchronous interaction when the visit is related to sensitive services, as defined in subdivision (n) of Section 56.05 of the Civil Code, and when established in accordance with department-specific requirements and consistent with federal and state laws, regulations, and guidance.

(ib) Notwithstanding the prohibition in subclause (I) and subject to subparagraphs (C) and (D), an FQHC or RHC may establish a new patient relationship using an audio-only synchronous interaction when the patient requests an audio-only modality or attests they do not have access to video, and when established in

accordance with department-specific requirements and consistent with federal and state laws, regulations, and guidance.

(v) An FQHC or RHC is not precluded from establishing a new patient relationship through an asynchronous store and forward modality, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, if the visit meets all of the following conditions:

(I) The patient is physically present at the FQHC or RHC, or at an intermittent site of the FQHC or RHC, at the time the service is performed.

(II) The individual who creates the patient records at the originating site is an employee or contractor of the FQHC or RHC, or other person lawfully authorized by the FQHC or RHC to create a patient record.

(III) The FQHC or RHC determines that the billing provider is able to meet the applicable standard of care.

(IV) An FQHC patient who receives telehealth services shall otherwise be eligible to receive in-person services from that FQHC pursuant to HRSA requirements.

(B) (i) Pursuant to an effective date designated by the department that is no sooner than January 1, 2024, an FQHC or RHC furnishing applicable health care services via audio-only synchronous interaction shall also offer those same health care services via video synchronous interaction to preserve beneficiary choice.

(ii) The department may provide specific exceptions to the requirement specified in clause (i), based on an FQHC's or RHC's access to requisite technologies, which shall be developed in consultation with affected stakeholders and published in departmental guidance.

(iii) Effective on the date designated by the department pursuant to clause (i), an FQHC or RHC furnishing services through video synchronous interaction or audio-only synchronous interaction shall also do one of the following:

(I) Offer those services via in-person, face-to-face contact.

(II) Arrange for a referral to, and a facilitation of, in-person care that does not require a patient to independently contact a different provider to arrange for that care.

(iv) In addition to any existing law requiring beneficiary consent to telehealth, including, but not limited to, subdivision (b) of

Section 2290.5 of the Business and Professions Code, all of the following shall be communicated by an FQHC or RHC to a Medi-Cal beneficiary, in writing or verbally, on at least one occasion prior to, or concurrent with, initiating the delivery of one or more health care services via telehealth to a Medi-Cal beneficiary: an explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit; an explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future; an explanation of the availability of Medi-Cal coverage for nonmedical transportation services to in-person visits when other available resources have been reasonably exhausted; and the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the FQHC or RHC.

(I) The FQHC or RHC shall document in the patient record the provision of this information and the patient's verbal or written acknowledgment that the information was received.

(II) The department shall develop, in consultation with affected stakeholders, model language for purposes of the communication described in this subparagraph.

(C) The department shall seek any federal approvals it deems necessary to implement this paragraph. This paragraph shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and not otherwise jeopardized.

(D) This paragraph shall be operative on January 1, 2023, or on the operative date or dates reflected in the applicable federal approvals obtained by the department pursuant to subparagraph (C), whichever is later. This paragraph shall not be construed to limit coverage of, and reimbursement for, covered telehealth services provided before the operative date of this paragraph.

(E) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, and make specific this paragraph by means of all-county letters, plan letters, provider manuals, information notices, provider bulletins, and similar instructions, without taking any further regulatory action.

(F) Telehealth modalities authorized pursuant to this paragraph shall be subject to the billing, reimbursement, and utilization management policies imposed by the department.

(G) Services delivered via telehealth modalities described in this paragraph shall comply with the privacy and security requirements contained in the federal Health Insurance Portability and Accountability Act of 1996 found in Parts 160 and 164 of Title 45 of the Code of Federal Regulations, the Medicaid state plan, and any other applicable state and federal statutes and regulations.

(5) For purposes of this section, "physician" shall be interpreted in a manner consistent with the federal Centers for Medicare and Medicaid Services' Medicare Rural Health Clinic and Federally Qualified Health Center Manual (Publication 27), or its successor, only to the extent that it defines the professionals whose services are reimbursable on a per-visit basis and not as to the types of services that these professionals may render during these visits and shall include a physician and surgeon, osteopath, podiatrist, dentist, optometrist, and chiropractor.

(h) If FQHC or RHC services are partially reimbursed by a third-party payer, such as a managed care entity, as defined in Section 1396u-2(a)(1)(B) of Title 42 of the United States Code, the Medicare Program, or the Child Health and Disability Prevention (CHDP) Program, the department shall reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate, and may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

(i) (1) Provided that the following entities are not operating as intermittent clinics, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, each entity shall have its reimbursement rate established in accordance with one of the methods outlined in paragraph (2) or (3), as selected by the FQHC or RHC:

(A) An entity that first qualifies as an FQHC or RHC in 2001 or later.

(B) A newly licensed facility at a new location added to an existing FQHC or RHC.

(C) An entity that is an existing FQHC or RHC that is relocated to a new site.

(2) (A) An FQHC or RHC that adds a new licensed location to its existing primary care license under paragraph (1) of subdivision (b) of Section 1212 of the Health and Safety Code may elect to have the reimbursement rate for the new location established in accordance with paragraph (3), or notwithstanding subdivision (e), an FQHC or RHC may choose to have one PPS rate for all locations that appear on its primary care license determined by submitting a change in scope of service request if both of the following requirements are met:

(i) The change in scope of service request includes the costs and visits for those locations for the first full fiscal year immediately following the date the new location is added to the FQHC's or RHC's existing licensee.

(ii) The FQHC or RHC submits the change in scope of service request within 90 days after the FQHC's or RHC's first full fiscal year.

(B) The FQHC's or RHC's single PPS rate for those locations shall be calculated based on the total costs and total visits of those locations and shall be determined based on the following:

(i) An audit in accordance with Section 14170.

(ii) Rate changes based on a change in scope of service request shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successors.

(iii) Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(C) Except as specified in subdivision (j), this paragraph does not apply to a location that was added to an existing primary care clinic license by the State Department of Public Health, whether by a regional district office or the centralized application unit, prior to January 1, 2017.

(3) If an FQHC or RHC does not elect to have the PPS rate determined by a change in scope of service request, the FQHC or RHC shall have the reimbursement rate established for any of the entities identified in paragraph (1) or (2) in accordance with one of the following methods at the election of the FQHC or RHC:

(A) The rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable

FQHCs or RHCs located in the same or adjacent area with a similar caseload.

(B) In the absence of three comparable FQHCs or RHCs with a similar caseload, the rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or an adjacent service area, or in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics.

(C) At a new entity's one-time election, the department shall establish a reimbursement rate, calculated on a per-visit basis, that is equal to 100 percent of the projected allowable costs to the FQHC or RHC of furnishing FQHC or RHC services during the first 12 months of operation as an FQHC or RHC. After the first 12-month period, the projected per-visit rate shall be increased by the Medicare Economic Index then in effect. The projected allowable costs for the first 12 months shall be cost settled and the prospective payment reimbursement rate shall be adjusted based on actual and allowable cost per visit.

(D) The department may adopt any further and additional methods of setting reimbursement rates for newly qualified FQHCs or RHCs as are consistent with Section 1396a(bb)(4) of Title 42 of the United States Code.

(4) In order for an FQHC or RHC to establish the comparability of its caseload for purposes of subparagraph (A) or (B) of paragraph (1), the department shall require that the FQHC or RHC submit its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report. FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit to the department a completed report in the format applicable to the prior calendar year. FQHCs or RHCs that have not previously submitted an annual utilization report shall submit to the department a completed report in the format applicable to the prior calendar year. The FQHC or RHC shall not be required to submit the annual utilization report for the comparable FQHCs or RHCs to the department, but shall be required to identify the comparable FQHCs or RHCs.

(5) The rate for any newly qualified entity set forth under this subdivision shall be effective retroactively to the later of the date that the entity was first qualified by the applicable federal agency as an FQHC or RHC, the date a new facility at a new location was added to an existing FQHC or RHC, or the date on which an existing FQHC or RHC was relocated to a new site. The FQHC or RHC shall be permitted to continue billing for Medi-Cal covered benefits on a fee-for-service basis under its existing provider number until it is informed of its FQHC or RHC enrollment approval, and the department shall reconcile the difference between the fee-for-service payments and the FQHC's or RHC's prospective payment rate at that time.

(j) (1) Visits occurring at an intermittent clinic site, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, of an existing FQHC or RHC, in a mobile unit as defined 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 under contract with the FQHC or RHC pursuant to paragraph (4), costs associated with providing Drug Medi-Cal services shall not be included in the FQHC's or RHC's per-visit PPS rate. For purposes of this subdivision, the costs associated with providing Drug Medi-Cal services shall not be considered to be within the FQHC's or RHC's clinic base PPS rate if in delivering Drug Medi-Cal services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver Drug Medi-Cal services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering Drug Medi-Cal services, including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing Drug Medi-Cal services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the Drug Medi-Cal services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a scope-of-service change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering Drug Medi-Cal services outside of the PPS rate. Notwithstanding subdivision (e), the scope-of-service change request shall include a full fiscal year of activity that does not include Drug Medi-Cal services costs.

(B) An FQHC or RHC may submit requests for scope-of-service change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any scope-of-service change request under this subdivision approved by the department shall be retroactive to the first day that Drug Medi-Cal services were rendered and reimbursement for Drug Medi-Cal services was received outside of the PPS rate, but in no case shall the effective date be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for Drug Medi-Cal services outside of the PPS rate when the FQHC or RHC obtains approval as a Drug Medi-Cal provider and enters into a contract with a county or the department to provide these services pursuant to paragraph (4).

(D) Within 90 days of receipt of the request for a scope-of-service change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for scope-of-service change under this subdivision shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(F) For purposes of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and Drug Medi-Cal services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate and the FQHC or RHC is approved as a Drug Medi-Cal provider, an FQHC or RHC shall not bill the PPS rate for any Drug Medi-Cal services provided pursuant to a contract entered into with a county or the department pursuant to paragraph (4).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or

decrease associated with the applicable scope-of-service adjustments as provided for in subdivision (e).

(4) Reimbursement for Drug Medi-Cal services shall be determined according to subparagraph (A) or (B), depending on whether the services are provided in a county that participates in the Drug Medi-Cal organized delivery system (DMC-ODS).

(A) In a county that participates in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon contract entered into between the county or county designee and the FQHC or RHC. If the county or county designee refuses to contract with the FQHC or RHC, the FQHC or RHC may follow the contract denial process set forth in the Special Terms and Conditions.

(B) In a county that does not participate in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon contract entered into between the county and the FQHC or RHC. If the county refuses to contract with the FQHC or RHC, the FQHC or RHC may request to contract directly with the department and shall be reimbursed for those services at the Drug Medi-Cal fee-for-service rate.

(5) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments for Drug Medi-Cal services made pursuant to this subdivision.

(6) For purposes of this subdivision, the following definitions apply:

(A) "Drug Medi-Cal organized delivery system" or "DMC-ODS" means the Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services and described in the Special Terms and Conditions.

(B) "Special Terms and Conditions" has the same meaning as set forth in subdivision (o) of Section 14184.10.

(m) Reimbursement for specialty mental health services shall be provided pursuant to this subdivision.

(1) An FQHC or RHC and one or more mental health plans that contract with the department pursuant to Section 14712 may mutually elect to enter into a contract to have the FQHC or RHC

provide specialty mental health services to Medi-Cal beneficiaries as part of the mental health plan's network.

(2) (A) For an FQHC or RHC to receive reimbursement for specialty mental health services pursuant to a contract entered into with the mental health plan under paragraph (1), the costs associated with providing specialty mental health services shall not be included in the FQHC's or RHC's per-visit PPS rate. For purposes of this subdivision, the costs associated with providing specialty mental health services shall not be considered to be within the FQHC's or RHC's clinic base PPS rate if in delivering specialty mental health services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver specialty mental health services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering specialty mental health services, including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing specialty mental health services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the specialty mental health services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a scope-of-service change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering specialty mental health services outside of the PPS rate. Notwithstanding subdivision (e), the scope-of-service change request shall include a full fiscal year of activity that does not include specialty mental health costs.

(B) An FQHC or RHC may submit requests for a scope-of-service change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any scope-of-service change request under this subdivision approved by the department is retroactive to the first day that specialty mental health services were rendered and reimbursement for specialty mental health services was received outside of the

PPS rate, but the effective date shall not be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for specialty mental health services outside of the PPS rate when the FQHC or RHC contracts with a mental health plan to provide these services pursuant to paragraph (1).

(D) Within 90 days of receipt of the request for a scope-of-service change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for scope-of-service change under this subdivision shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(F) For the purpose of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and specialty mental health services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate, an FQHC or RHC shall not bill the PPS rate for any specialty mental health services that are provided pursuant to a contract entered into with a mental health plan pursuant to paragraph (1).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with the applicable scope-of-service adjustments as provided for in subdivision (e).

(4) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments made for specialty mental health services under this subdivision.

(n) The department shall seek any necessary federal approvals and issue appropriate guidance to allow an FQHC or RHC to bill, under a supervising licensed behavioral health practitioner, for an

encounter between an FQHC or RHC patient and a psychological associate, associate professional clinical counselor, associate clinical social worker, or associate marriage and family therapist when all of the following conditions are met:

(1) The psychological associate, associate professional clinical counselor, associate clinical social worker, or associate marriage and family therapist is supervised by the designated licensed behavioral health practitioner, as required by their applicable clinical licensing board.

(2) The behavioral health visit is billed under the supervising licensed practitioner of the FQHC or RHC, pursuant to paragraph (1).

(3) The FQHC or RHC is otherwise authorized to bill for services provided by the supervising licensed behavioral health practitioner as a separate visit.

(o) FQHCs and RHCs may appeal a grievance or complaint concerning ratesetting, scope-of-service changes, and settlement of cost report audits, in the manner prescribed by Section 14171. The rights and remedies provided under this subdivision are cumulative to the rights and remedies available under all other provisions of law of this state.

(p) The department shall promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for Medicare and Medicaid Services for any waivers that would be necessary to implement this section.

(q) The department shall implement this section only to the extent that federal financial participation is available.

(r) Notwithstanding any other law, the director may, without taking regulatory action pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, implement, interpret, or make specific this section by means of a provider bulletin or similar instruction. The department shall notify and consult with interested parties and appropriate stakeholders in implementing, interpreting, or making specific the provisions of this section, including all of the following:

(1) Notifying provider representatives in writing of the proposed action or change. The notice shall occur, and the applicable draft provider bulletin or similar instruction, shall be made available at least 10 business days prior to the meeting described in paragraph (2).

(2) Scheduling at least one meeting with interested parties and appropriate stakeholders to discuss the proposed action or change.

(3) Allowing for written input regarding the proposed action or change, to which the department shall provide summary written responses in conjunction with the issuance of the applicable final written provider bulletin or similar instruction.

(4) Providing at least 60 days advance notice of the effective date of the proposed action or change.

(s) This section shall become operative on July 1, 2026.

SEC. 105. Section 14132.171 of the Welfare and Institutions Code is amended to read:

14132.171. (a) (1) An annual cognitive health assessment for Medi-Cal beneficiaries who are 65 years of age or older is a covered benefit if they are otherwise ineligible for a similar assessment as part of an annual wellness visit under the Medicare Program. Subject to paragraph (3), the department shall provide reimbursement to a Medi-Cal provider who renders this service.

(2) The payment for the cognitive health assessment developed pursuant to paragraph (1) shall only be available upon appropriation by the Legislature for these purposes.

(3) (A) A Medi-Cal provider shall only be eligible to receive the payment for the benefit specified in paragraph (1) if the provider conducts the cognitive health assessment using validated tools, as recommended by the department.

(B) (i) The department shall determine the cognitive health assessment validated tools, as described in subparagraph (A), in consultation with the State Department of Public Health's Alzheimer's Disease Program (Article 4 (commencing with Section 125275) of Chapter 2 of Part 5 of Division 106 of the Health and Safety Code), that program's 10 California Alzheimer's Disease Centers, representatives of primary care physician specialties, including, but not limited to, family medicine, and the Alzheimer's Disease and Related Disorders Advisory Committee of the California Health and Human Services Agency (Chapter 3.1

(commencing with Section 1568.15) of Division 2 of the Health and Safety Code).

(ii) With respect to the validated tools, the department shall select multiple tools. To improve overall accessibility of these tools and minimize access barriers, at least one of those tools shall not carry any restrictions on copyright or trademark.

(b) An annual cognitive health assessment shall identify signs of Alzheimer's disease or dementia, consistent with the standards for detecting cognitive impairment under the federal Centers for Medicare and Medicaid Services and the recommendations by the American Academy of Neurology.

(c) By January 1, 2024, the department shall do both of the following:

(1) Consolidate and analyze the data on the administration of the cognitive health assessment in the Medi-Cal managed care and fee-for-service delivery systems.

(2) Post information on the utilization of, and payment for, this benefit on its internet website.

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

(e) This section shall be implemented only to the extent any necessary federal approvals are obtained and federal financial participation is available.

SEC. 106. Section 14132.994 is added to the Welfare and Institutions Code, to read:

14132.994. A Medi-Cal managed care plan, as defined in subdivision (j) of Section 14184.101, shall 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 pursuant to this chapter or Chapter 8 (commencing with Section 14200), and other guidance.

SEC. 107. Section 14133.85 of the Welfare and Institutions Code is amended to read:

14133.85. (a) (1) Except as otherwise provided in this subdivision, prior authorization shall not be required for hospice services.

(2) Paragraph (1) shall not apply to any admission that violates federal law.

(b) Prior authorization shall be required for inpatient hospice services.

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

SEC. 108. Section 14148.5 of the Welfare and Institutions Code, as amended by Section 152 of Chapter 42 of the Statutes of 2023, is amended to read:

14148.5. (a) State-funded perinatal services shall be provided under the Medi-Cal program to pregnant persons and state-funded medical services to infants up to one year of age in families with incomes above 185 percent, but not more than 208 percent, of the federal poverty level, in the same manner that these services are being provided to the Medi-Cal population, including eligibility requirements and integration of eligibility determinations and payment of claims. When determining eligibility under this section, an applicant's or beneficiary's income and resources shall be determined, counted, and valued in accordance with the methodology set forth in Section 14005.64.

(b) Services provided under this section shall not be subject to any spend down of excess income requirements.

(c) (1) The department, in implementing the Medi-Cal program and public health programs, may provide for outreach activities in order to enhance participation and access to perinatal services. Funding received pursuant to the federal provisions shall be used to expand perinatal outreach activities. These outreach activities shall be implemented if funding is provided for this purpose by an appropriation in the annual Budget Act or other statute.

(2) Those outreach activities authorized by paragraph (1) shall be targeted toward both Medi-Cal and non-Medi-Cal eligible high risk or uninsured pregnant persons and infants. Outreach activities may include, but not be limited to, all of the following:

(A) Education of the targeted persons on the availability and importance of early prenatal care and referral to Medi-Cal and other programs.

(B) Information provided through toll-free telephone numbers.

(C) Recruitment and retention of perinatal providers.

(d) Notwithstanding any other law, contracts required to implement this section shall be exempt from the approval of the Director of General Services and from the Public Contract Code.

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

SEC. 109. Section 14148.5 of the Welfare and Institutions Code, as added by Section 153 of Chapter 42 of the Statutes of 2023, is amended to read:

14148.5. (a) State-funded perinatal services shall be provided under the Medi-Cal program to pregnant persons and state-funded medical services to infants up to one year of age in families with incomes above 185 percent, but not more than 208 percent, of the federal poverty level, in the same manner that these services are being provided to the Medi-Cal population, including eligibility requirements and integration of eligibility determinations and payment of claims. When determining eligibility under this section, an applicant's or beneficiary's income shall be determined, counted, and valued in accordance with the methodology set forth in Section 14005.64.

(b) Services provided under this section shall not be subject to any spend down of excess income requirements.

(c) (1) The department, in implementing the Medi-Cal program and public health programs, may provide for outreach activities in order to enhance participation and access to perinatal services. Funding received pursuant to the federal provisions shall be used to expand perinatal outreach activities. These outreach activities shall be implemented if funding is provided for this purpose by an appropriation in the annual Budget Act or other statute.

(2) Those outreach activities authorized by paragraph (1) shall be targeted toward both Medi-Cal and non-Medi-Cal eligible high risk or uninsured pregnant persons and infants. Outreach activities may include, but not be limited to, all of the following:

(A) Education of the targeted persons on the availability and importance of early prenatal care and referral to Medi-Cal and other programs.

(B) Information provided through toll-free telephone numbers.

(C) Recruitment and retention of perinatal providers.

(d) Notwithstanding any other law, contracts required to implement this section shall be exempt from the approval of the Director of General Services and from the Public Contract Code.

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

SEC. 110. Section 14165.57 of the Welfare and Institutions Code is amended to read:

14165.57. (a) The IGT allocation formula shall use data from each nondesignated public hospital's latest Hospital Annual Financial Disclosure Report on file with OSHPD as of March 1 of each prior fiscal year and shall be as follows:

(1) The Nondesignated Public Hospital IGT Pool shall be allocated into two allocations: the Contract Hospitals allocation and the Non-Contract Hospitals allocation. This allocation shall be made to each group, respectively, based upon the ratio of Medi-Cal fee-for-service acute patient days listed in the latest OSHPD Annual Financial Disclosure Report for Contract Hospitals and Non-Contract Hospitals to the total Medi-Cal fee-for-service acute patient days provided by all Contract Hospitals and Non-Contract Hospitals. Medi-Cal fee-for-service acute patient days for converted hospitals and new hospitals will not be included in this allocation.

(2) The department shall determine if a nondesignated public hospital provides services in either a federally recognized Health Professional Shortage Area or to a federally recognized Medically Underserved Area or Population. The department shall also determine if the nondesignated public hospital is federally recognized as either a Critical Access Hospital or a Sole Community Provider. If any of these conditions apply, the hospital shall score one point. Otherwise, the hospital shall score zero points.

(3) The department shall calculate for each nondesignated public hospital the charity care charges as a percentage of the hospital's total gross revenue. If the charity care charges are greater than or equal to 3 percent of the total gross revenue, the hospital shall score three points. If the charity care charges are less than 3 percent, but more than or equal to 1 percent, of the total gross revenue, the hospital shall score two points. If the charity care charges are less than 1 percent, but greater than 0 percent, of the total gross revenue, the hospital shall score one point. If charity care charges are less than or equal to 0 percent, of the total gross revenue, the hospital shall score zero points.

(4) The department shall calculate for each nondesignated public hospital the bad debt charges as a percentage of the hospital's other payer's gross revenue, as disclosed in the Hospital Annual Financial Disclosure Report. If the bad debt charges are greater than or equal to 40 percent of the other gross revenue, the hospital shall score two points. If the bad debt charges are less than 40 percent, but greater than 0 percent, of the other gross revenue, the hospital shall score one point. If the bad debt charges are less than or equal to 0 percent, of the other gross revenue, the hospital shall score zero points.

(5) The department shall calculate for each nondesignated public hospital the Medi-Cal charges as a percentage of the hospital's total gross revenue. If the Medi-Cal charges are greater than or equal to 25 percent of the total gross revenue, the hospital shall score three points. If the Medi-Cal charges are less than 25 percent, but more than or equal to 12 percent, of the total gross revenue, the hospital shall score two points. If the Medi-Cal charges are less than 12 percent, but greater than 0 percent, of the total gross revenue, the hospital shall score one point. If the Medi-Cal charges are less than or equal to 0 percent of total gross revenue, the hospital shall score zero points.

(6) The sum of each nondesignated public hospital's points accumulated pursuant to paragraphs (2) to (5), inclusive, shall constitute the hospital's IGT Formula Score. The IGT Formula Score for a new hospital or a converted hospital shall be equal to zero.

(7) The Contract Hospital allocation shall be allocated among Contract Hospitals and the Non-Contract Hospital allocation shall be allocated among Non-Contract Hospitals to determine preliminary allocations in accordance with the following:

(A) Each Contract Hospital that has an IGT Formula Score of between seven and nine, inclusive, shall be allocated three times the amount of the Contract Hospital allocation that is allocated to each Contract Hospital that has a score of one to three, inclusive.

(B) Each Contract Hospital that has an IGT Formula Score of between four and six, inclusive, shall be allocated two times the amount of the Contract Hospital allocation that is allocated to each Contract Hospital that has an IGT Formula Score of one to three, inclusive.

(C) Each Non-Contract Hospital that has an IGT Formula Score of between seven and nine, inclusive, shall be allocated three times the amount of the Non-Contract Hospital allocation that is allocated to each Non-Contract Hospital that has an IGT Formula Score of one to three, inclusive.

(D) Each Non-Contract Hospital that has an IGT Formula Score of between four and six, inclusive, shall be allocated two times the amount of the Non-Contract Hospital allocation that is allocated to each Non-Contract Hospital that has an IGT Formula Score of one to three, inclusive.

(E) No amount shall be allocated to a nondesignated public hospital with an IGT Formula Score of zero points.

(8) The sum of the preliminary allocation determined under paragraph (7) for all hospitals within each IGT Formula Group shall be reallocated among the hospitals within each IGT Formula Group based on the ratio of each hospital's staffed acute beds listed in the latest OSHPD Annual Financial Disclosure Report, to the total staffed acute beds of all hospitals in the IGT Formula Group.

(b) By no later than September 1 of the 2011–12 fiscal year or as soon thereafter as federal approvals are obtained, and by no later than September 1 of each fiscal year thereafter, the department shall provide each nondesignated public hospital with an estimated IGT allocation notice that includes the calculations and data sources used to calculate the estimated IGT allocation, as described in this section.

(c) Each nondesignated public hospital shall have 30 days from receipt of the estimated IGT allocation notice from the department to review the department's hospital-specific estimated IGT allocation and to notify the department of any data or calculation errors. If the hospital does not respond within 30 days, the information will be deemed accurate. No later than November 30 of each fiscal year, the department shall incorporate all appropriate corrections or data updates for all of the nondesignated public hospitals and then recalculate the IGT allocations using the IGT allocation formula to obtain a final IGT allocation for each nondesignated public hospital.

(d) Beginning with the 2011–12 fiscal year, on or before December 1 or as soon thereafter as federal approvals are obtained, and by no later than December 1 of each fiscal year thereafter, the department shall send each nondesignated public hospital a notice

of eligibility indicating the final IGT allocation for the nondesignated public hospital. The nondesignated public hospital shall have 20 business days after receipt of the notice to either accept or decline the offer. If a nondesignated public hospital accepts the offer, the nondesignated public hospital may enter into an IGT agreement with the department. If the department receives no response, the offer will be considered declined.

(e) Before the later of December 31 of the 2011–12 fiscal year, the date upon which all federal approvals are obtained, and by no later than January 15 of each state fiscal year thereafter, the department shall document all nondesignated public hospital IGT allocation offers that are either accepted or declined. After the department has recorded all IGT allocations as being either accepted or declined, any remaining unsubscribed IGT allocations will be allocated to all the other participating nondesignated public hospitals on a pro rata basis based on the final IGT allocations calculated pursuant to subdivision (b) during January of each fiscal year. The department shall inform each nondesignated public hospital participating in the program of the revised final IGT allocation assigned to that hospital by January 30. At that time, the department shall give each nondesignated public hospital participant five days to accept or decline participation in the program.

(f) The state may accept all public funds in the amount of the final IGT allocation from a transferring entity pursuant to this section, provided that any funds from a transferring entity must be permitted by law to be used for these purposes. The transferring entity shall certify to the department that the funds it proposes to transfer satisfy the requirements of this subdivision, and are in compliance with all federal rules and regulations.

(g) The state shall deposit the funds received from the transferring entities pursuant to this article into the Medi-Cal Inpatient Payment Adjustment Fund established in accordance with Section 14163.

(h) Nondesignated public hospitals participating in the program shall inform the public entity funding the IGT to transfer the appropriate IGT allocation, by February 5 of each fiscal year, to the state according to the time schedule specified in the written agreement specified in subdivision (d). By March 31 of each fiscal year, the department shall make the supplemental payment to the

nondesignated public hospital including the associated federal financial participation. The deadlines set forth in this subdivision shall be implemented beginning with the 2011–12 fiscal year or as soon thereafter as federal approvals are obtained.

(i) The department shall establish written policies and procedures for transferring entity intergovernmental transfers and payments made to nondesignated public hospitals pursuant to this section. The department shall effectively communicate these policies and procedures to nondesignated public hospitals and the public entities that will be funding the IGTs in order to facilitate a smooth process using local public entity moneys for purposes of drawing down federal financial participation for supplemental payments to nondesignated public hospitals.

(j) (1) A nondesignated public hospital participating in the program, as a condition of receiving supplemental payment pursuant to this section, shall reimburse the department for the costs of administering this section.

(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 (o). 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.

(4) All private moneys donated by private individuals or entities to the department for deposit in the fund as permitted under applicable federal Medicaid laws.

(5) Any interest that accrues on amounts in the fund.

(e) The department may accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal financial participation to the full extent permitted by law. With respect to funds transferred or donated from private individuals or entities, the department shall accept only those funds that are certified by the transferring or donating entity as qualifying for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable. The department may return any funds transferred or donated in error.

(f) Moneys in the funds shall be used as the source for the nonfederal share of payments to hospitals under this section.

(g) Any funds remaining in the fund at the end of a fiscal year shall be carried forward for use in the following fiscal year.

(h) Moneys shall be allocated from the fund by the department and shall be applied to obtain federal financial participation in accordance with customary Medi-Cal accounting procedures for purposes of payments under this section. Distributions from the fund shall be supplemental to any other Medi-Cal reimbursement

received by the hospitals, including amounts that hospitals receive under the selective provider contracts negotiated under Article 2.6 (commencing with Section 14081), and shall not affect provider rates paid under the selective provider contracting program.

(i) Each nondesignated public hospital that was a nondesignated public hospital during the 2002–03 fiscal year, received payments for the 2002–03 fiscal year from any of the prior supplemental funds, and, during the project year satisfies the criteria in subdivision (o) to be eligible to negotiate for distributions under any of those sections shall receive no less from the Nondesignated Public Hospital Supplemental Fund for the project year than 100 percent of the amount the hospital received from the prior supplemental funds for the 2002–03 fiscal year, minus the total amount of intergovernmental transfers made by or on behalf of the hospital pursuant to subdivision (o) for the same fiscal year. Each hospital described in this subdivision shall be eligible for additional payments from the fund pursuant to subdivision (j).

(j) (1) For each fiscal year up to and including the 2024–25 fiscal year, all amounts that are in the fund for a project year in excess of the amount necessary to make the payments under subdivision (i) shall be available for negotiation by the California Medical Assistance Commission, along with corresponding federal financial participation, for supplemental payments to nondesignated public hospitals that for the project year satisfy the criteria under subdivision (o) to be eligible to negotiate for distributions under any of those sections, and paid for services rendered during the project year pursuant to the selective provider contracting program under Article 2.6 (commencing with Section 14081).

(2) For the 2025–26 fiscal year, all amounts that are in the fund for a project year in excess of the amount necessary to make the payments under subdivision (i) shall be available for supplemental payments to nondesignated public hospitals, as follows:

(A) Additional supplemental payments shall be made to nondesignated public hospitals that meet the criteria for supplemental payments pursuant to paragraph (1) such that the payments under this subparagraph together with the payments under subdivision (i) to those hospitals are equal to the amounts transferred to the fund pursuant to paragraph (1) of subdivision (d) plus the applicable amount of federal financial participation

that is available for the nonfederal share of payments described in paragraph (1) of subdivision (d).

(B) All remaining amounts in the fund, including any funds that have been carried forward pursuant to subdivision (g), shall be used for supplemental payments to nondesignated public hospitals pursuant to a methodology developed by the department that is based on all Medi-Cal inpatient days, as described in Section 1396r-4(b)(2) of Title 42 of the United States Code, in the numerator of the Medi-Cal inpatient utilization rate for each hospital, as determined in the most recent final calculation of the Medi-Cal inpatient utilization rate pursuant to paragraph (4) of subdivision (f) of Section 14105.98 as of July 1, 2025.

(k) The amount of any stabilization funding transferred to the fund with respect to a project year may in the discretion of the California Medical Assistance Commission, until its dissolution 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.

(2) The date specified in the hospital's contract, if applicable.

(o) In order for a hospital to receive distributions pursuant to Article 2.6 (commencing with Section 14081), the hospital shall satisfy the eligibility criteria in paragraph (1), (2), (3), or (4) of this subdivision.

(1) The hospital meets all of the following criteria:

(A) The hospital is contracting under Article 2.6 (commencing with Section 14081).

(B) The hospital meets the criteria contained in the Medicaid State Plan for disproportionate share hospital status.

(C) The hospital is one of the following:

(i) A licensed provider of basic emergency services as described in Section 70411 of Title 22 of the California Code of Regulations.

(ii) A licensed provider of comprehensive emergency medical services as defined in Section 70451 of Title 22 of the California Code of Regulations.

(iii) A children's hospital, as defined in Section 14087.21, that satisfies clause (i) or (ii), or that jointly provides basic or comprehensive emergency services in conjunction with another licensed hospital.

(iv) A hospital owned and operated by a public agency that operates two or more hospitals that qualify under subparagraph (A) or (B) with respect to the particular state fiscal year.

(v) A hospital designated by the National Cancer Institute as a comprehensive or clinical cancer research center that primarily treats acutely ill cancer patients and that is exempt from the federal Medicare prospective payment system pursuant to Section 1886(d)(1)(B)(v) of the federal Social Security Act (42 U.S.C. Sec. 1395ww(d)(1)(B)(v)).

(D) (1) The hospital is able to demonstrate a purpose for additional funding under the selective provider contracting program including proposals relating to emergency services and other health care services, including infrequent yet high-cost services, such as anti-AB human antitoxin treatment for infant botulism (human botulinum immune globulin (HBIG), commonly referred to as "Baby-BIG"), that are made available, or will be made available, to Medi-Cal beneficiaries.

(2) The hospital is contracting under Article 2.6 (commencing with Section 14081) and meets the definition of a university teaching hospital or major, nonuniversity, teaching hospital as set forth on page 51 and as listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping." Payments from the fund shall be used solely for the purposes identified in the contract between the hospital and the state.

(3) The hospital is contracting under Article 2.6 (commencing with Section 14081) and meets the definition of any of the following:

(A) A large teaching emphasis hospital, as set forth on page 51 and listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping," and also meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(B) A children's hospital pursuant to Section 10727, and also meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(C) Notwithstanding the requirement in subparagraph (A) of paragraph (3) that a hospital must be listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping," any hospital whose license pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code was consolidated during the 1999 calendar year with a large teaching emphasis hospital that is listed on page 57 of the

above-described report shall be eligible. All other requirements of paragraph (3) shall continue to apply.

(4) The hospital meets all of the following criteria:

(A) The hospital is contracting under Article 2.6 (commencing with Section 14081).

(B) The hospital satisfies the Medicaid State Plan criteria for disproportionate share hospital status.

(C) The hospital is a small and rural hospital as defined in Section 124840 of the Health and Safety Code.

(D) The hospital is a licensed provider of standby emergency services as described in Section 70649 of Title 22 of the California Code of Regulations.

(E) The hospital is able to demonstrate a purpose for additional funding under the selective provider contracting program with proposals relating to health care services that are made available, or will be made available, to Medi-Cal beneficiaries.

(F) The hospital is determined by the California Medical Assistance Commission to be a hospital that provides an important community service that otherwise would not be provided in the community.

(p) This section shall become inoperative on June 30, 2026, and, as of July 1, 2030, is repealed. The department may conduct any necessary and remaining duties related to this section even after the section becomes inoperative.

SEC. 112. Section 14184.200 of the Welfare and Institutions Code is amended to read:

14184.200. (a) Notwithstanding any other law, the department may standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, subject to a Medi-Cal managed care plan readiness, continuity of care transition plan, and disenrollment process developed in consultation with stakeholders, in accordance with the CalAIM Terms and Conditions and as described in this section.

(1) (A) The department shall ensure the Medi-Cal managed care plan’s readiness for network adequacy includes a geographic access review of rural ZIP Codes to ensure time or distance standards are met, or alternative access standard requests are approved, as applicable, and the plan’s ability to meet existing

federal and state mandatory provider type requirements, where available.

(B) The department shall not require a population to enroll in managed care if Medi-Cal managed care plans fail to meet the Medi-Cal managed care plan readiness requirements detailed in this paragraph for that population.

(2) The Medi-Cal managed care plan shall comply with the continuity of care requirements in Section 1373.96 of the Health and Safety Code and shall be consistent with and no more restrictive than existing or future policy and guidance issued by the department, including All Plan Letter 22-032, any superseding all plan letter, and related guidance.

(3) The disenrollment process for an enrollee in any county shall be consistent with and no more restrictive than existing federal and state statutes and regulations, including Section 53889 and subdivision (c) of Section 53891 of Title 22 of the California Code of Regulations. The beneficiary may request a medical exemption from mandatory enrollment in a Medi-Cal managed care plan in 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 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.

(E) A beneficiary with satisfactory immigration status, including a noncitizen that is lawfully present, who is eligible for only pregnancy-related Medi-Cal coverage and who received services through the Medi-Cal fee-for-service delivery system prior to January 1, 2022, as identified by the department, but only through the end of the postpartum period.

(F) A beneficiary without satisfactory immigration status or who is unable to establish satisfactory immigration status as required by Section 14011.2, who is eligible for only pregnancy-related Medi-Cal coverage, excluding a beneficiary enrolled in the Medi-Cal Access Program described in Chapter 2 (commencing Section 15810) of Part 3.3.

(G) A non-dual-eligible beneficiary who is an Indian, as defined in subdivision (a) of Section 438.14 of Title 42 of the Code of Federal Regulations, and who elects to forego voluntary enrollment in a Medi-Cal managed care plan.

(H) A non-dual-eligible beneficiary eligible on the basis of their receipt of services through a state foster care program, or eligible pursuant to Section 14005.28, who elects to forego voluntary enrollment in a Medi-Cal managed care plan, except for a non-dual beneficiary described in this subparagraph who resides in a county

that is authorized to operate COHS, as described in Article 2.8 (commencing with Section 14087.5), or, effective January 1, 2025, in a county operating a Single Plan model of managed care established under Article 2.7 (commencing with Section 14087.3) and Article 2.8 (commencing with Section 14087.5). For the purpose of this subdivision, the following requirements shall apply to non-dual-eligible beneficiaries eligible on the basis of their receipt of services through a state foster care program, or eligible pursuant to Section 14005.28, who are transitioning to mandatory enrollment in a Medi-Cal managed care plan in a county operating a Single Plan model of managed care:

(i) Medi-Cal managed care plans shall comply with the access requirements in Section 14197 and in accordance with All Plan Letter 23-001, any superseding all plan letter, and any related guidance.

(ii) The department shall use the Intercounty Transfer process as outlined in All County Welfare Directors Letter 18-02E to provide for immediate access to care and treatment services in the month of enrollment when a beneficiary moves from one county to another.

(iii) The department shall issue guidance with input from stakeholders, including county child welfare departments.

(I) A non-dual-eligible beneficiary enrolled with an entity with a contract with the department pursuant to the Program of All-Inclusive Care for the Elderly (PACE), as described in Chapter 8.75 (commencing with Section 14591).

(J) Any other non-dual-eligible beneficiary, as identified by the department, for whom federal law prohibits mandatory enrollment in a Medi-Cal managed care plan.

(K) A beneficiary residing in one of the Veterans' Homes of California, as described in Chapter 1 (commencing with Section 1010) of Division 5 of the Military and Veterans Code.

(c) (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, 2023, and subject to subdivision (f) of Section 14184.102, a dual eligible beneficiary, except as provided in paragraph (2) of subdivision (b) or paragraph (2) of this subdivision, 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) The following dual eligible beneficiary groups, as identified by the department, shall be exempt from mandatory enrollment in Medi-Cal managed care as described in paragraph (1):

(A) A dual eligible beneficiary made eligible on the basis of a share of cost, including, but not limited to, a dual eligible beneficiary residing in a county that is authorized to operate COHS, as described in Article 2.8 (commencing with Section 14087.5), except for a dual eligible beneficiary who is eligible on the basis of their need for long-term care services with a share of cost, as determined by the department.

(B) A dual eligible beneficiary enrolled with an entity with a contract with the department pursuant to PACE as described in Chapter 8.75 (commencing with Section 14591).

(C) A dual eligible beneficiary enrolled with an entity with a Senior Care Action Network (SCAN) contract with the department.

(D) A dual eligible beneficiary who is an Indian, as defined in subsection (a) of Section 438.14 of Title 42 of the Code of Federal Regulations, and who elects to forego voluntary enrollment in a Medi-Cal managed care plan.

(E) A dual eligible beneficiary with HIV/AIDS who elects to forego voluntary enrollment in a Medi-Cal managed care plan.

(F) A dual eligible beneficiary eligible on the basis of their receipt of services through a state foster care program, or eligible pursuant to Section 14005.28, who elects to forego voluntary enrollment in a Medi-Cal managed care plan, except for a dual beneficiary described in this subparagraph who resides in a county that is authorized to operate COHS, as described in Article 2.8 (commencing with Section 14087.5), or, effective January 1, 2025, in a county operating a Single Plan model of managed care established under Article 2.7 (commencing with Section 14087.3) and Article 2.8 (commencing with Section 14087.5). For the purpose of this subdivision, the following requirements shall apply to non-dual-eligible beneficiaries eligible on the basis of their receipt of services through a state foster care program, or eligible pursuant to Section 14005.28, who are transitioning to mandatory enrollment in a Medi-Cal managed care plan in a county operating a Single Plan model of managed care:

(i) Medi-Cal managed care plans shall comply with the access requirements in Section 14197 and in accordance with All Plan Letter 23-001, any superseding all plan letter, and any related guidance.

(ii) The department shall use the Intercounty Transfer process as outlined in All County Welfare Directors Letter 18-02E to provide for immediate access to care and treatment services in the month of enrollment when a beneficiary moves from one county to another.

(iii) The department shall issue guidance with input from stakeholders, including county child welfare departments.

(G) A dual eligible beneficiary residing in one of the Veterans' Homes of California, as described in Chapter 1 (commencing with Section 1010) of Division 5 of the Military and Veterans Code.

(H) Any other dual eligible beneficiary, as identified by the department, for whom federal law prohibits mandatory enrollment in a Medi-Cal managed care plan.

(d) (1) This section shall not prohibit a Medi-Cal beneficiary from receiving covered benefits on a temporary basis through the Medi-Cal fee-for-service delivery system pending enrollment into an individual Medi-Cal managed care plan in accordance with this section and the CalAIM Terms and Conditions.

(2) This section shall not prohibit certain Medi-Cal beneficiaries eligible for full-scope benefits under the Medi-Cal State plan, as identified by the department, from voluntarily enrolling in a Medi-Cal managed care plan, in accordance with the CalAIM Terms and Conditions.

(e) (1) No later than January 1, 2023, in all non-County Organized Health System counties, in areas where a PACE plan is available, the PACE plan shall be presented as an enrollment option, included in enrollment materials, and made available to an applicable beneficiary whenever enrollment choices and options are presented. Outreach and enrollment materials shall enable a Medi-Cal beneficiary to understand what PACE provides, that, if eligible, they may be assessed for PACE eligibility and enroll in PACE, and how they can receive additional information and request to be assessed for PACE eligibility. A person meeting the age qualifications for PACE and who chooses PACE shall not be assigned to a Medi-Cal managed care plan for the lesser of 60 days or until they are assessed for eligibility for PACE and determined

not to be eligible for PACE. A person enrolled in a PACE plan shall receive all Medicare and Medi-Cal services from the PACE plan pursuant to the three-way agreement between the PACE plan, the department, and the federal Centers for Medicare and Medicaid Services.

(2) In areas of the state where a presentation on Medi-Cal managed care plan enrollment options is unavailable, the department, or its contracted vendor, shall provide informational, outreach, and enrollment materials about the PACE program.

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

(1) "Dual eligible beneficiary" means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or both, and is eligible for medical assistance under the Medi-Cal State Plan. For purposes of this article, "dual eligible beneficiary" shall include both a "full-benefit dual eligible beneficiary" and a "partial-benefit dual eligible beneficiary," as those terms are defined in this subdivision.

(2) "Full-benefit dual eligible beneficiary" means an individual 21 years or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.), Medicare Part B (42 U.S.C. Sec. 1395j et seq.), and Medicare Part D (42 U.S.C. Sec. 1395w-101), and is eligible for medical assistance under the Medi-Cal State Plan.

(3) "Non-dual-eligible beneficiary" means an individual eligible for medical assistance under the Medi-Cal State plan, as determined by the department, that is not eligible for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.).

(4) "Partial-benefit dual eligible beneficiary" means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.), but not Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or who is enrolled for Medicare Part B (42 U.S.C. Sec. 1395j et seq.), but not Medicare Part A (42 U.S.C. Sec. 1395c et seq.), and is eligible for medical assistance under the Medi-Cal State Plan.

SEC. 113. Section 14197.7 of the Welfare and Institutions Code is amended to read:

14197.7. (a) (1) Notwithstanding any other law, if the director finds that an entity that contracts with the department for the

delivery of health care services (contractor), including a Medi-Cal managed care plan or a prepaid health plan, fails to comply with contract requirements, state or federal law or regulations, or the state plan or approved waivers, or for other good cause, the director may terminate the contract or impose sanctions as set forth in this section.

(2) Good cause includes, but is not limited to, a finding of deficiency that results in improper denial or delay in the delivery of health care services, potential endangerment to patient care, disruption in the contractor's provider network, failure to approve continuity of care, that claims accrued or to accrue have not or will not be recompensed, or a delay in required contractor reporting to the department.

(b) The director may identify findings of noncompliance or good cause through any means, including, but not limited to, findings in audits, investigations, contract compliance reviews, quality improvement system monitoring, routine monitoring, facility site surveys, encounter and provider data submissions, grievances and appeals, network adequacy reviews, assessments of timely access requirements, reviews of utilization data, health plan rating systems, fair hearing decisions, complaints from beneficiaries and other stakeholders, whistleblowers, and contractor self-disclosures.

(c) (1) Except when the director determines there is an immediate threat to the health of Medi-Cal beneficiaries receiving health care services from the contractor, at the request of the contractor, the department shall hold a public hearing to commence 30 days after notice of intent to terminate the contract has been received by the contractor.

(2) The department shall present evidence at the hearing showing good cause for the termination.

(3) The department shall assign an administrative law judge who shall provide a written recommendation to the department on the termination of the contract within 30 days after conclusion of the hearing.

(4) (A) Reasonable notice of the hearing shall be given to the contractor, Medi-Cal beneficiaries receiving services through the contractor, and other interested parties, including any other person and organization the director may deem necessary.

(B) The notice shall state the effective date of, and the reason for, the termination.

(d) In lieu of contract termination, the director shall have the power and authority to require or impose a plan of correction and issue one or more of the following sanctions against a contractor for findings of noncompliance or good cause, including, but not limited to, those specified in subdivision (a):

(1) Temporarily or permanently suspend enrollment and marketing activities.

(2) Require the contractor to suspend or terminate contractor personnel or subcontractors.

(3) Issue one or more of the temporary suspension orders set forth in subdivision (j).

(4) Impose temporary management consistent with the requirements specified in Section 438.706 of Title 42 of the Code of Federal Regulations.

(5) Suspend default enrollment of enrollees who do not select a contractor for the delivery of health care services.

(6) Impose civil monetary sanctions consistent with the dollar amounts and violations specified in Section 438.704 of Title 42 of the Code of Federal Regulations, as follows:

(A) A limit of twenty-five thousand dollars ($25,000) for each determination of the following:

(i) The contractor fails to provide medically necessary services that the contractor is required to provide, under law or under its contract with the department, to an enrollee covered under the contract.

(ii) The contractor misrepresents or falsifies information to an enrollee, potential enrollee, or health care provider.

(iii) The contractor distributes directly, or indirectly through an agent or independent contractor, marketing materials that have not been approved by the state or that contain false or materially misleading information.

(B) A limit of one hundred thousand dollars ($100,000) for each determination of the following:

(i) The contractor conducts an act of discrimination against an enrollee on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or a practice that would reasonably be expected to

discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.

(ii) The contractor misrepresents or falsifies information that it furnishes to the federal Centers for Medicare and Medicaid Services or to the department.

(C) A limit of fifteen thousand dollars ($15,000) for each beneficiary the director determines was not enrolled because of a discriminatory practice under clause (i) of subparagraph (B). This sanction is subject to the overall limit of one hundred thousand dollars ($100,000) under subparagraph (B).

(e) Notwithstanding the monetary sanctions imposed for the violations set forth in paragraph (6) of subdivision (d), the director may impose monetary sanctions in accordance with this section based on any of the following:

(1) The contractor violates a federal or state statute or regulation.

(2) The contractor violates a provision of its contract with the department.

(3) The contractor violates a provision of the state plan or approved waivers.

(4) The contractor fails to meet quality metrics or benchmarks established by the department. Any changes to the minimum quality metrics or benchmarks made by the department that are effective on or after January 1, 2020, shall be established in advance of the applicable reporting or performance measurement period, unless required by the federal government.

(5) The contractor fails to demonstrate that it has an adequate network to meet anticipated utilization in its service area.

(6) The contractor fails to comply with network adequacy standards, including, but not limited to, time and distance, timely access, and provider-to-beneficiary ratio requirements pursuant to standards and formulae that are set forth in federal or state law, regulation, state plan, or contract and that are posted in advance to the department’s internet website.

(7) The contractor fails to comply with the requirements of a corrective action plan.

(8) The contractor fails to submit timely and accurate network provider data.

(9) The director identifies deficiencies in the contractor’s delivery of health care services.

(10) The director identifies deficiencies in the contractor's operations, including the timely payment of claims.

(11) The contractor fails to comply with reporting requirements, including, but not limited to, those set forth in Section 53862 of Title 22 of the California Code of Regulations.

(12) The contractor fails to timely and accurately process grievances or appeals.

(f) (1) Monetary sanctions imposed pursuant to subdivision (e) may be separately and independently assessed and may also be assessed for each day the contractor fails to correct an identified deficiency. For a deficiency that impacts beneficiaries, each beneficiary impacted constitutes a separate violation. Monetary sanctions shall be assessed in the following amounts:

(A) Up to twenty-five thousand dollars ($25,000) for a first violation.

(B) Up to fifty thousand dollars ($50,000) for a second violation.

(C) Up to one hundred thousand dollars ($100,000) for each subsequent violation.

(2) For monetary sanctions imposed on a contractor that is funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive, of subdivision (n), the department shall calculate a percentage of the funds attributable to the contractor to be offset per month pursuant to paragraphs (2) to (4), inclusive, of subdivision (n) until the amount offset equals the amount of the penalty imposed pursuant to paragraph (1).

(g) When assessing sanctions pursuant to this section, the director shall determine the appropriate amount of the penalty for each violation based upon one or more of the following nonexclusive factors:

(1) The nature, scope, and gravity of the violation, including the potential harm or impact on beneficiaries.

(2) The good or bad faith of the contractor.

(3) The contractor's history of violations.

(4) The willfulness of the violation.

(5) The nature and extent to which the contractor cooperated with the department's investigation.

(6) The nature and extent to which the contractor aggravated or mitigated any injury or damage caused by the violation.

(7) The nature and extent to which the contractor has taken corrective action to ensure the violation will not recur.

(8) The financial status of the contractor, including whether the sanction will affect the ability of the contractor to come into compliance.

(9) The financial cost of the health care service that was denied, delayed, or modified.

(10) Whether the violation is an isolated incident.

(11) The amount of the penalty necessary to deter similar violations in the future.

(12) Other mitigating factors presented by the contractor.

(h) (1) Except in exigent circumstances in which there is an immediate risk to the health of beneficiaries, as determined by the department, the director shall give reasonable written notice to the contractor of the intention to impose any of the sanctions authorized by this section and others who may be directly interested, including any other persons and organizations the director may deem necessary.

(2) The notice shall include the effective date for, the duration of, and the reason for each sanction proposed by the director.

(3) A contractor may request the department to meet and confer with the contractor to discuss information and evidence that may impact the director's final decision to impose sanctions authorized by this section.

(4) The director shall grant a request to meet and confer prior to issuance of a final sanction if the contractor submits the request in writing to the department no later than two business days after the contractor's receipt of the director's notice of intention to impose sanctions.

(i) Notwithstanding subdivision (d), the director shall terminate a contract with a contractor that the United States Secretary of Health and Human Services has determined does not meet the requirements for participation in the Medicaid program contained in Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(j) (1) The department may make one or more of the following temporary suspension orders as an immediate sanction:

(A) Temporarily suspend enrollment activities.

(B) Temporarily suspend marketing activities.

(C) Require the contractor to temporarily suspend specified personnel of the contractor.

(D) Require the contractor to temporarily suspend participation by a specified subcontractor.

(2) The temporary suspension orders shall be effective no earlier than 20 days after the notice specified in subdivision (k).

(k) (1) Prior to issuing a temporary suspension order, or temporarily withholding funds pursuant to subdivision (o), the department shall provide the contractor with a written notice.

(2) The notice shall state the department's intent to impose a temporary suspension or temporary withhold and specify the nature and effective date of the temporary suspension or temporary withhold.

(3) The contractor shall have 30 calendar days from the date of receipt of the notice to file a written appeal with the department.

(4) Upon receipt of a written appeal filed by the contractor, the department shall, within 15 days, set the matter for hearing, which shall be held as soon as possible but not later than 30 days after receipt of the notice of hearing by the contractor.

(5) The hearing may be continued at the request of the contractor if a continuance is necessary to permit presentation of an adequate defense.

(6) The temporary suspension order shall remain in effect until the hearing is completed and the department has made a final determination on the merits. However, the temporary suspension order shall be deemed vacated if the director fails to make a final determination on the merits within 60 days of the close of the record for the matter.

(7) The department shall stay imposition of a temporary withhold, pursuant to subdivision (o), until the hearing is completed and the department has made a final determination on the merits within 60 days of the close of the record for the matter.

(*l*) (1) A contractor may request a hearing in connection with sanctions applied pursuant to subdivision (d) or (e) within 15 working days after the notice of the effective date of the sanctions has been given by sending a letter so stating to the address specified in the notice.

(2) The department shall stay collection of monetary sanctions upon receipt of the request for a hearing.

(3) Collection of the sanction shall remain stayed until the effective date of the final decision of the department.

(m) Except as otherwise provided in this section, all hearings to review the imposition of sanctions, including temporary suspension orders, the withholding or offsetting of funds pursuant to subdivision (n), or the temporary withholding of funds pursuant to subdivision (o) shall be held pursuant to the procedures set forth in Section 100171 of the Health and Safety Code.

(n) (1) If the director imposes monetary sanctions pursuant to this section on a contractor, except for a contractor described in paragraphs (2) to (5), inclusive, the amount of the sanction may be collected by withholding the amount from capitation or other associated payments owed to the contractor.

(2) If the director imposes monetary sanctions on a contractor that is funded from the Mental Health Subaccount, the Mental Health Equity Subaccount, the Vehicle License Collection Account of the Local Revenue Fund, or the Mental Health Account, the director may offset the monetary sanctions from the respective account. The offset is subject to paragraph (2) of subdivision (q).

(3) If the director imposes monetary sanctions on a contractor that is funded from the Behavioral Health Subaccount of the Local Revenue Fund 2011, the director may offset the monetary sanctions from that account from the distribution attributable to the applicable contractor. The offset is subject to paragraph (2) of subdivision (q).

(4) If the director imposes monetary sanctions on a contractor that is funded from another mental health or substance use disorder realignment fund from which the Controller is authorized to make distributions to the contractor, the director may offset the monetary sanctions from these funds if the funds described in paragraphs (2) and (3) are insufficient for the purposes described in this subdivision, as appropriate. The offset is subject to paragraph (2) of subdivision (q).

(5) (A) If the director imposes monetary sanctions pursuant to subdivision (e) of Section 5963.04, the director may offset the monetary sanctions from the Behavioral Health Services Fund from the distribution attributable to the applicable contractor.

(B) With respect to an individual contractor, the department shall not collect via offset more than 25 percent of the total amount of the funds distributed from the Behavioral Health Services Fund that are attributable to the contractor in a given month.

(C) If the department is not able to collect the full amount of monetary sanctions imposed on a contractor in a given month, the department shall continue to offset the amounts attributable to the contractor in subsequent months until the full amount of monetary sanctions has been collected. The offset is subject to paragraph (3) of subdivision (q).

(o) (1) (A) Whenever the department determines that a mental health plan or an entity that contracts with the department to provide Drug Medi-Cal services has violated state or federal law, a requirement of this chapter, Chapter 8 (commencing with Section 14200), Chapter 8.8 (commencing with Section 14600), or Chapter 8.9 (commencing with Section 14700), or any regulations, the state plan, a term or condition of an approved waiver, or a provision of its contract with the department, the department may temporarily withhold payments of federal financial participation and payments from the accounts listed in paragraphs (2) to (4), inclusive, of subdivision (n).

(B) The department shall temporarily withhold amounts it deems necessary to ensure the mental health plan or the entity that contracts with the department to provide Drug Medi-Cal services promptly corrects the violation.

(C) The department shall release the temporarily withheld funds when it determines the mental health plan or the entity that contracts with the department to provide Drug Medi-Cal services has come into compliance.

(2) (A) A mental health plan or an entity that contracts with the department to provide Drug Medi-Cal services may appeal the imposition of a temporary withhold pursuant to this subdivision in accordance with the procedures described in subdivisions (k) and (m).

(B) Imposition of a temporary withhold shall be stayed until the effective date of the final decision of the department.

(p) This section shall be read in conjunction with, and apply in addition to, any other applicable law that authorizes the department to impose sanctions or otherwise take remedial action upon contractors.

(q) (1) (A) Notwithstanding any other law, nonfederal moneys collected by the department pursuant to this section, except for moneys collected from a contractor funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive,

of subdivision (n), shall be deposited into the General Fund for use and, upon appropriation by the Legislature, to address workforce issues in the Medi-Cal program and improve access to care in the Medi-Cal program.

(B) Beginning July 1, 2024, and continuing until June 30, 2027, unless otherwise specified in law, nonfederal moneys collected by the department pursuant to this section, except for moneys collected from a contractor funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive, of subdivision (n), shall be deposited into the General Fund for use and, upon appropriation by the Legislature, for the nonfederal share of Medi-Cal costs for health care services furnished to children, adults, seniors, and persons with disabilities, and persons dually eligible for the Medi-Cal program and the Medicare Program.

(2) (A) Monetary sanctions imposed via offset on a contractor that is funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive, of subdivision (n) shall be redeposited into the account from which the monetary sanctions were offset pursuant to paragraphs (2) to (4), inclusive, of subdivision (n).

(B) The department shall notify the Department of Finance of the percentage reduction for the affected county.

(C) The Department of Finance shall subsequently notify the Controller, and the Controller shall redistribute the monetary sanction amount to nonsanctioned counties based on each county's prorated share of the monthly base allocations from the realigned account.

(D) With respect to an individual contractor, the department shall not collect via offset more than 25 percent of the total amount of the funds distributed from the applicable account or accounts that are attributable to the contractor in a given month.

(E) If the department is not able to collect the full amount of monetary sanctions imposed on a contractor funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive, of subdivision (n) in a given month, the department shall continue to offset the amounts attributable to the contractor in subsequent months until the full amount of monetary sanctions has been collected.

(3) Monetary sanctions imposed via offset on a contractor pursuant to subdivision (e) of Section 5963.04 shall be redeposited into the account from which the monetary sanctions were offset pursuant to paragraph (5) of subdivision (n).

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

(s) This section shall be implemented only to the extent that necessary federal approvals have been obtained and that federal financial participation is available.

(t) For purposes of this section, "contractor" means an individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries or other individuals receiving behavioral health services, as applicable, pursuant to any of the following:

(1) Article 2.7 (commencing with Section 14087.3), including dental managed care programs developed pursuant to Section 14087.46.

(2) Article 2.8 (commencing with Section 14087.5).

(3) Article 2.81 (commencing with Section 14087.96).

(4) Article 2.82 (commencing with Section 14087.98).

(5) Article 2.9 (commencing with Section 14088).

(6) Article 2.91 (commencing with Section 14089).

(7) Chapter 8 (commencing with Section 14200), including dental managed care plans.

(8) Chapter 8.9 (commencing with Section 14700).

(9) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration pursuant to Article 5.5 (commencing with Section 14184) or a successor demonstration or waiver, as applicable.

(10) Chapter 2 (commencing with Section 5650) of Part 2 of Division 5, solely for purposes of imposition of corrective action plans, monetary sanctions, or temporary withholds pursuant to subdivision (e) of Section 5963.04.

(11) Section 12534 of the Government Code.

(12) The Home- and Community-Based Alternatives (HCBA) Waiver pursuant to state law and Section 1915(c) of the federal Social Security Act (42 U.S.C. Sec. 1396n(c)).

(13) The Program of All-Inclusive Care for the Elderly (PACE) pursuant to Chapter 8.75 (commencing with Section 14591).

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

SEC. 114. Section 14199.128 of the Welfare and Institutions Code is amended to read:

14199.128. Definitions

For purposes of this chapter, as used in both the singular and plural form, the following definitions shall apply:

(a) "Abortion" has the same meaning as set forth in subdivision (a) of Section 123464 of the Health and Safety Code.

(b) "Acute psychiatric hospital" has the same meaning as set forth in subdivision (b) of Section 1250 of the Health and Safety Code.

(c) "Advanced practice clinicians and allied health care professionals" shall be defined by the department, subject to the stakeholder input requirements of Section 14199.121, to include appropriate health profession careers.

(d) "Article 7.1" means Article 7.1 (commencing with Section 14199.80) of Chapter 7, as added by Chapter 13 of the Statutes of 2023.

(e) "Base data source" means the most recent available quarterly financial statement filings or annual enrollment data submitted by health plans to the Department of Managed Health Care for that updated base year, retrieved by the department, and supplemented by, as necessary, Medi-Cal enrollment data for the updated base year as maintained by the department, and as modified by the department to account for known or anticipated contracting changes that will affect Medi-Cal enrollment.

(f) "Base year" means a 12-month period running from January 1 through December 31 of a calendar year selected by the department. The department may elect to update the base year to the extent it deems necessary to meet the requirements of federal statute or regulations, to obtain or maintain federal approval, or to ensure federal financial participation is available or is not otherwise jeopardized.

(g) "Bona fide labor-management cooperation committee" or "bona fide LMCC" means a joint labor-management committee that is established pursuant to the federal Labor Management Cooperation Act of 1978 (29 U.S.C. Sec. 175a) and meets the following criteria:

(1) The bona fide LMCC is not involved in the governance of a health care entity but exists to promote worker training, workforce expansion, and support for workers during training.

(2) The bona fide LMCC has the following composition:

(A) Fifty percent of the committee consists of representatives of organized labor unions that represent health workers in the state.

(B) Fifty percent of the committee consists of representatives of health care employers that primarily serve Medi-Cal patients located in the state.

(h) "CalHealthCares Program" means the Medi-Cal Physicians and Dentists Loan Repayment Program Act established pursuant to Section 14114.

(i) "California Affordable Drug Manufacturing Act of 2020" means the program established pursuant to Chapter 10 (commencing with Section 127690) of Part 2 of Division 107 of the Health and Safety Code.

(j) "Clinic" means any of the following:

(1) Federally qualified health centers (FQHC), including FQHC look-alike clinics designated by the federal Health Resources and Services Administration as meeting FQHC program requirements as set forth in Sections 1395x(aa)(4)(B) and 1396d(1)(2)(B) of Title 42 of the United States Code.

(2) Rural health clinics (RHC) meeting the definition set forth in Section 1396d(*l*)(1) of Title 42 of the United States Code.

(3) Clinics licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code.

(4) Tribal clinics exempt from licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code.

(5) Intermittent clinics exempt from licensure pursuant to subdivision (h) of Section 1206 of the Health and Safety Code.

(6) Clinics exempt from licensure pursuant to subdivision (b) of Section 1206 of the Health and Safety Code. If clinics exempt from licensure pursuant to subdivision (b) of Section 1206 of the Health and Safety Code choose to participate in a directed payment program described in Section 14199.120.5, the directed payment

program will use the "classes of provider" functionality at a minimum to create a tier for those clinics and allow for payments to those clinics to be based on an amount allocated to their class's pool.

(7) Indian health clinics that provide services in California pursuant to the Indian Health Program, as set forth in Chapter 4 (commencing with Section 124575) of Part 4 of Division 106 of the Health and Safety Code.

(k) "Committee" or "stakeholder advisory committee" means the Protect Access to Health Care Act Stakeholder Advisory Committee established pursuant to Section 14199.129.

(*l*) "Community-based organization" means a nonprofit organization of demonstrated effectiveness that is representative of a community or significant segments of a community and promotes access to, or provides physical or mental health or related services to, individuals in the community.

(m) "Community health worker" shall have the same meaning as defined in paragraph (1) of subdivision (b) of Section 14132.36.

(n) "Community provider" means a holder of a certificate described in Section 2050 of the Business and Professions Code who serves Medi-Cal patients.

(o) "Comprehensive clinical family planning services" means the services set forth in subdivision (aa) of Section 14132.

(p) "Countable enrollee" means an individual enrolled in a health plan during a month of the base year according to the base data source. "Countable enrollee" does not include an individual enrolled in a Medicare plan, a plan-to-plan enrollee, or an individual enrolled in a health plan pursuant to the Federal Employees Health Benefits Act of 1959 (Public Law 86-382) to the extent the imposition of the tax under Article 6 (commencing with Section 14199.123) of this chapter or Article 7.1 (commencing with Section 14199.80) of Chapter 7 is preempted pursuant to Section 8909(f) of Title 5 of the United States Code.

(q) "County mental health plan" means an entity or local agency that contracts with the department to provide covered specialty mental health services pursuant to Section 14184.400 and Chapter 8.9 (commencing with Section 14700).

(r) "Department" means the State Department of Health Care Services.

(s) "Designated public hospital system" means a designated public hospital as defined in paragraph (1) of subdivision (f) of Section 14184.10 and its affiliated governmental providers and contracted governmental and nongovernmental entities that constitute a hospital and health care system. A single designated public hospital system may include multiple designated public hospitals under common government ownership.

(t) (1) "Directed payment" means a payment arrangement whereby the department directs certain expenditures made by a Medi-Cal managed care plan that is approved by the federal Centers for Medicare and Medicaid Services as described in Section 438(c) of Title 42 of the Code of Federal Regulations, established pursuant to Section 438(c) of Title 42 of the Code of Federal Regulations, or otherwise required by the Medi-Cal managed care plan contract, and documented in a rate certification approved by the federal Centers for Medicare and Medicaid Services as applicable.

(2) References in this subdivision to Section 438(c) of Title 42 of the Code of Federal Regulations shall include any subsequent amendments thereto.

(u) "Director" means the director of the State Department of Health Care Services.

(v) "Emergency air ambulance transport" means emergency medical transportation by air, as described in paragraph (1) of subdivision (c) of Section 51323 of Title 22 of the California Code of Regulations, by air ambulance, as defined in Section 100280 of Title 22 of the California Code of Regulations.

(w) "Family PACT" means the Family Planning, Access, Care, and Treatment Program established pursuant to subdivision (aa) of Section 14132.

(x) "Family planning services and family planning-related services in the Medi-Cal program" means the services covered by the Medi-Cal program pursuant to subdivision (n) of Section 14132.

(y) "Family planning services in the State-Only Family Planning Program" means the services covered by that program pursuant to Division 24 (commencing with Section 24000).

(z) "Fund" means the Protect Access to Health Care Fund established in the State Treasury pursuant to Section 14199.103.

(aa) "General acute care hospital" has the same meaning as in subdivision (a) of Section 1250 of the Health and Safety Code.

(ab) "Ground emergency medical transports" means emergency medical transports, as defined in Section 14129, that originate from a 911 call center or equivalent public safety answering point.

(ac) "Health care service plan" or "health plan" means a health care service plan, other than a plan that provides only specialized or discount services, that is licensed by the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) or a Medi-Cal managed care plan contracted with the department to provide full-scope Medi-Cal services.

(ad) "Medi-Cal patient" means a Medi-Cal beneficiary as defined in Section 14252.

(ae) "Medi-Cal enrollee" means an individual enrolled in a health plan, as defined in subdivision (ac), who is a Medi-Cal patient for whom the department directly pays the health plan a capitated payment.

(af) "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a comprehensive risk contract with the department to provide covered full-scope health care services to enrolled Medi-Cal patients pursuant to this chapter or Chapter 8 (commencing with Section 14200).

(ag) "Medi-Cal per enrollee tax amount" means the amount of tax assessed per countable Medi-Cal enrollee within a Medi-Cal taxing tier.

(ah) "Medi-Cal taxing tier" means a range of cumulative enrollment of countable Medi-Cal enrollees for the base year.

(ai) "Net reimbursement" or "net reimbursement levels" means the total payments to Medi-Cal providers for the applicable services and procedures received as of January 1, 2024, less any amounts financed by Medi-Cal providers as the nonfederal share of those payments via provider taxes or fees, certified public expenditures, or intergovernmental transfers.

(aj) "Network provider" has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(ak) "Other enrollee" means an individual enrolled in a health plan who is not a Medi-Cal enrollee.

(al) "Other per enrollee tax amount" means the amount of tax assessed per countable other enrollee within an other taxing tier.

(am) "Other taxing tier" means a range of cumulative enrollment of countable other enrollees for the base year.

(an) "Plan-to-plan enrollee" means an individual who receives their health care services through a health plan pursuant to a subcontract from another health plan.

(ao) "Primary care" has the same meaning as in Section 51170.5 of Title 22 of the California Code of Regulations.

(ap) "Private ground emergency medical transport provider" means a provider of ground emergency medical transports that does not meet the definition of paragraph (1) of subdivision (a) of Section 14105.945.

(aq) "Qualified family planning provider" means a Medi-Cal provider that meets all of the following conditions:

(1) Is a community clinic licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code.

(2) Is enrolled in the Family PACT program, as described in subdivision (aa) of Section 14132.

(3) Provides both abortion and contraception services.

(ar) "Specialist" means a physician or surgeon or other licensee pursuant to the Medical Practice Act (Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code) or the Osteopathic Act (Chapter 8 (commencing with Section 3600) of Division 2 of the Business and Professions Code) who delivers to Medi-Cal patients health care services, treatment, or procedures at least some of which do not qualify as primary care.

(as) "Specialty care" means health care services provided by a specialist.

(at) "State-Only Family Planning Program" means the program established pursuant to Division 24 (commencing with Section 24000).

(au) "Tax period" means a period of not more than 12 months for which the tax imposed pursuant to Article 6 (commencing with Section 14199.123) is assessed.

SEC. 115. Chapter 16.5 (commencing with Section 18998) of Part 6 of Division 9 of the Welfare and Institutions Code is repealed.

SEC. 116. Section 83 of Chapter 40 of the Statutes of 2024 is amended to read:

SEC. 83. (a) To the extent that these activities are an allowable use of the AIDS Drug Assistance Program Rebate Fund, this

section authorizes the State Department of Public Health to spend up to twenty-three million dollars ($23,000,000) from the AIDS Drug Assistance Program Rebate Fund to implement the following programs, consistent with Sections 120955, 120956, 120960, 120972, 120972.1, and 120972.2 of the Health and Safety Code:

(1) Beginning January 1, 2025, or as soon as technically feasible thereafter, increase AIDS Drug Assistance Program (ADAP) and PrEP-Assistance Program financial eligibility standards from a modified adjusted gross income that does not exceed 500 percent of the federal poverty level per year based on family size and household income to 600 percent of the federal poverty level per year based on family size and household income.

(2) Beginning January 1, 2025, or as soon as technically feasible thereafter, increase the cap on premium payments from one thousand nine hundred thirty-eight dollars ($1,938) per month to two thousand nine hundred ninety-six dollars ($2,996) per month for the Office of AIDS Health Insurance Premium Payment program, the Employer-Based HIPP program, and the Medicare Premium Payment Program.

(3) Beginning January 1, 2025, or as soon as is technically feasible thereafter, modify the ADAP formulary to an open formulary.

(4) Allocate five million dollars ($5,000,000) annually for three years, beginning July 1, 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, 2028, to distribute funding to a community-based organization to make internal and external condoms 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 district because, in that regard, this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 118. (a) The State Department of Public Health may spend up to seventy-five million dollars ($75,000,000) from the AIDS Drug Assistance Program Rebate Fund to support current or eligible services and programs, consistent with Sections 120955, 120956, 120960, 120972, 120972.1, and 120972.2 of the Health and Safety Code and with the following:

(1) Beginning July 1, 2025, up to sixty-five million dollars ($65,000,000) is available to supplement or fund services, programs, or initiatives funded by the AIDS Drug Assistance

Program Rebate Fund for which federal funding has been reduced or eliminated as a result of federal policy actions to cancel, delay, or reduce funding for HIV and AIDS prevention and treatment programs.

(A) Upon notification to the department of federal action, or the nonreceipt of Notices of Award, that result in reductions to or elimination of federal funding for those services, programs, or initiatives, the department shall notify the Department of Finance. The Department of Finance shall authorize funding allocations that are equivalent to the amount, to the extent these amounts are within the amount of funds appropriated for this purpose, and correspond to services that would have otherwise been funded by the reduced or eliminated federal funds as soon as practicable, but no later than 30 days following notification from the department.

(B) (i) If the federal funding that was reduced or eliminated is restored by the federal government, funding made available under this paragraph shall be repaid to the AIDS Drug Assistance Program Rebate Fund within 180 days. A repayment process shall be established by the department, in consultation with the Department of Finance.

(ii) A local public health agency or community-based organization that has received funding made available under this paragraph shall not be required to repay the funding until it has received the restored federal funding.

(2) Beginning July 1, 2025, nine million dollars ($9,000,000) is available to fund state and local disease intervention specialists.

(3) Beginning July 1, 2025, one million dollars ($1,000,000) is available for the department to purchase rapid Hepatitis C Virus (HCV) testing equipment for distribution to local health departments and community-based organizations. The department shall establish a process for local health departments and community-based organizations to receive HCV testing equipment based on need in the specific geographic area.

(b) The department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts and grants entered into or amended pursuant to this 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, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code,

the State Administrative Manual, and the State Contracting Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(c) The department may, in consultation with the Department of Finance, use an alternative local fiscal agent that is not identified in this section, if necessary, to achieve the intended legislative purpose.

SEC. 119. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.

Approved _____, 2025

_____

Governor