Senate Bill No. 159

CHAPTER 40

An act to amend Sections 7903, 16310, 30026.5, and 100520.5 of, and to add and repeal Section 12536 of, the Government Code, to amend Sections 1212, 1214, 1214.1, 1266, 1266.5, 1341.45, 1389.25, 1728.1, 1749, 51312, 120956, 120960, 123322, and 129385 of, to add Section 120972.2 to, to add Chapter 5 (commencing with Section 131360) to Part 1 of Division 112 of, and to add and repeal Section 104751 of, the Health and Safety Code, to amend Section 10113.9 of, and to amend, repeal, and add Section 12693.74 of, the Insurance Code, to amend Sections 1182.14 and 1182.15 of, and to add Section 1182.16 to, the Labor Code, to amend Sections 1001.36, 1370, and 1372 of the Penal Code, to repeal Section 30130.59 of the Revenue and Taxation Code, to amend Section 14902 of the Vehicle Code, and to amend Sections 4361, 5014, 5349, 5813.5, 5840, 5840.6, 5845, 5845.1, 5847, 5849.35, 5886, 5890, 5891, 5892, 5892.5, 5893, 5895, 5899, 5961.4, 14105.192, 14105.201, 14105.467, 14124.12, 14131.05, 14154, 14184.10, 14197.4, 14197.7, 14199.72, 14705, 15840, 15853, and 15893 of, to amend, repeal, and add Sections 14105.200 and 15832 of, to add Sections 7296, 14105.468, 14197.6, and 15877 to, and to add and repeal Article 3.1 (commencing with Section 14124.160) of Chapter 7 of Part 3 of Division 9 of, and to repeal Sections 14105.202 and 14165.58 of, the Welfare and Institutions Code, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.

[Approved by Governor June 29, 2024. Filed with Secretary of State June 29, 2024.]

LEGISLATIVE COUNSEL'S DIGEST

SB 159, Committee on Budget and Fiscal Review. Health.

(1) Existing law establishes the Health Care Affordability Reserve Fund and authorizes the Controller to use funds in the Health Care Affordability Reserve Fund for cashflow loans to the General Fund. Existing law authorizes a loan from the Health Care Affordability Reserve Fund to the General Fund and requires the loan to be repaid in the 2025–26 fiscal year.

This bill would delay repayment of the loan and require 3 payments of $200,000,000 over 3 fiscal years beginning with the 2026–27 fiscal year.

(2) Existing law provides for the licensure and regulation of health facilities, clinics, home health agencies, and hospice agencies, as defined, by the State Department of Public Health. A violation of these provisions by a licensee is a crime. Existing law prescribes the method for determining licensing and certification fees and requires the department to annually post on its internet website a list of the estimated department fees for the facilities that it licenses.

This bill would require the posted fees to include, but not be limited to, annual licensing, report of change application, and written notification fees, and would make conforming changes to reflect the inclusion of fees other than annual fees. The bill would establish late payment penalties for delinquent fees, as specified. The bill would revise existing licensing provisions for those facilities, to replace references to the department and its Licensing and Certification Division with references to the Licensing and Certification Program (program). The bill would delete various obsolete provisions, including a related fee schedule, and would replace references to renewal fees with references to an annual license fee.

(3) Existing law requires any person, firm, association, partnership, or corporation desiring a license for clinics, home health agencies, and hospice agencies to submit an application containing specified information to the department.

This bill would require the application information to be provided to the program upon initial application for licensure. The bill would require any change in the information that requires the licensee to submit a report of change or written notification to the program to be provided within 10 business days of the change along with any applicable fee, unless otherwise specified.

Because a violation of the bill's requirements by those facilities would be a crime, the bill would impose a state-mandated local program.

(4) Existing law establishes the Office of Oral Health within the State Department of Public Health. Existing law requires the department to maintain a dental program in order to, among other things, develop comprehensive dental health plans to maximize utilization of all resources. Existing law, the Song-Brown Health Care Workforce Training Act, creates a state medical contract program with specified educational entities and programs to maximize the delivery of primary care to specific areas of California where there is a recognized unmet priority need for those services.

This bill would, until June 30, 2029, require the Office of Oral Health to support the establishment of community-based clinical education rotations for dental students in their final year or dental residents. The bill would require the office to compile data and prepare a report to be submitted to the Legislature on or before July 1, 2027, on specified desired outcomes.

(5) Existing law, the California Healthcare, Research and Prevention Tobacco Tax Act of 2016, an initiative measure approved as Proposition 56 at the November 8, 2016, statewide general election, increases taxes imposed on distributors of cigarettes and tobacco products and requires all revenues to be deposited into the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund, a continuously appropriated fund. That act allocates those revenues for specified purposes, including $30,000,000 to provide funding to the State Department of Public Health state dental program, as specified. Under existing law, if there is a reduction in revenues resulting from a reduction in the consumption of cigarettes and tobacco products due to the additional taxes imposed on cigarettes, the amount of funds allocated to specified programs, including the state dental

program, is required to be reduced proportionally. If the allocations to the state dental program are reduced, existing law backfills the reduced amount by continuously appropriating moneys from the General Fund in an amount equivalent to the reduction, so that the total funding for the state dental program remains at $30,000,000 annually.

This bill would repeal the continuous appropriation to the state dental program that occurs upon a reduction of allocated funds to the program.

(6) Existing law establishes within the State Treasury the Litigation Deposits Fund (LDF), under the control of the Department of Justice and consisting of moneys received as litigation deposits for which the state is a party to the litigation. The state is a party to a settlement related to electronic cigarettes through which it receives funds for nicotine use remediation.

This bill would establish the Electronic Cigarette Settlements Fund within the State Treasury and would require the State Department of Public Health to administer the fund. The bill would require the Controller, upon order of the Department of Finance, to transfer funds received in the LDF payable to the Department of Justice from the People of the State of California v. JUUL Labs, Inc., et al. settlement that are allocated to e-cigarette programs to the fund. The bill would require moneys in the fund, upon appropriation by the Legislature, to be used for activities in accordance with the terms of the settlement and specified department notices. The bill would specify that these provisions would remain operative only until July 1, 2035.

(7) Existing law requires the State Department of Public Health to examine the causes of communicable diseases occurring or likely to occur in the state, and to establish a list of reportable diseases. Existing law requires local health officers to immediately report to the department every discovered or known case or suspected case of those reportable diseases and, in the case of a local epidemic, to report, as requested by the department, all facts concerning the disease, and the measures taken to abate and prevent its spread.

This bill would authorize the department to develop and administer a syndromic surveillance program and, subject to an appropriation, to either designate an existing system or to create a new system that would be required, at a minimum, to provide public health practitioners access to an electronic health system to rapidly collect, evaluate, share, and store syndromic surveillance data, as specified. The bill would require general acute care hospitals with emergency departments to submit specified data electronically to the system in accordance with the schedule, standards, and requirements established by the department, unless the hospital reports its data to the local health department and the local health department reports that data to the department, as specified. The bill would authorize the sharing of collected data with specified entities, including the federal Centers for Disease Control, state and local government entities, and persons with a valid scientific interest, as specified, subject to specified confidentiality requirements.

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.

(8) Existing law prohibits a person from being tried or adjudged to punishment while that person is mentally incompetent. Existing law establishes a process by which, if the mental competency of a defendant is in doubt, the defendant's mental competency is evaluated and, if found to be mentally incompetent, the defendant may be committed to the State Department of State Hospitals (DSH) with the goal of returning the defendant to competency, as specified.

This bill would require DSH to coordinate with the sheriff in the county of commitment to transport a defendant who has been committed to a DSH facility once a placement in the facility is available and would require DSH to notify the sheriff and the court if the defendant has not been transported within 90 days from the date of commitment, as specified. The bill would, if the sheriff fails to deliver the defendant within the required period of time, stay the commitment and remove the defendant from the waiting list until notice is provided that the defendant is available for transportation.

(9) Under existing law, if a defendant is committed to a DSH facility, the court must provide specified documents to DSH, including the defendant's medical records, before the defendant is admitted to the facility.

This bill would also, if DSH determines that additional medical or mental health records are required for continuity of care, require any public or private entity holding such records to release the records to DSH upon request, as specified.

(10) Existing law requires DSH, upon a determination that the defendant has regained mental competence, to immediately certify that fact to the court by filing a certificate of restoration with the court. Existing law requires the sheriff to deliver the defendant to the court no later than 10 days following the filing of a certificate of restoration. Existing law provides that the state shall only pay for 10 hospital days following filing of the certificate

This bill would clarify that the state will only pay for 10 calendar days in which the defendant remains confined in a DSH facility following the filing of the certificate.

(11) Under existing law, if a defendant is issued a certificate of restoration or becomes mentally competent after conservatorship, but is not released either on bail or a promise to appear, the defendant may, as specified, be returned to a facility for continued treatment.

This bill would clarify that the defendant may be returned only on the recommendation of the person that issued the certificate of restoration and that the defendant shall be returned to a DSH facility at the discretion of, and as directed by, DSH. The bill would also require the recommendation to include a recommendation regarding the involuntary administration of medication and requires the court to review the recommendation, and, as appropriate, issue or continue an order for the involuntary administration of medication, as specified.

(12) Existing law authorizes the Department of Motor Vehicles (DMV) to issue an identification card to an eligible applicant, as specified. Existing law provides a procedure for a person being released from the custody of a county jail, federal correctional facility, or state hospital facility to obtain a replacement identification card. Existing law also provides a procedure for a person being released from a state correctional facility to obtain an original or replacement identification card.

This bill would provide a procedure for a patient being released from a state hospital facility to also obtain an original identification card. The bill would remove the requirement that an applicant for a replacement identification card have no outstanding identification card fees and would remove the requirement that an applicant for a replacement identification card have a usable photo on file with the DMV if the applicant has a new photo taken. The bill would require the State Department of State Hospitals to assist the applicant in applying for an identification card, as specified, including assistance with obtaining qualifying documentation.

(13) Existing law establishes 5 separate minimum wage schedules for covered health care employees, as defined, depending on the nature of the employer, and makes a violation of these minimum wage requirements a misdemeanor.

Existing law requires, for any covered health care facility employer, as defined, with 10,000 or more full-time equivalent employees (FTEE), as defined, any covered health care facility employer that is a part of an integrated health care delivery system or a health care system with 10,000 or more FTEEs, a covered health care facility employer that is a dialysis clinic or is a person that owns, controls, or operates a dialysis clinic, or a covered health facility owned, affiliated, or operated by a county with a population of more than 5,000,000 as of January 1, 2023, the minimum wage for covered health care employees to be $23 per hour from July 1, 2024, to June 30, 2025, inclusive, $24 per hour from July 1, 2025, to June 30, 2026, inclusive, and $25 per hour from July 1, 2026, and until as adjusted, as specified.

Existing law requires, for any hospital that is a hospital with a high governmental payor mix, an independent hospital with an elevated governmental payor mix, a rural independent covered health care facility, or a covered health care facility that is owned, affiliated, or operated by a county with a population of less than 250,000 as of January 1, 2023, as those terms are defined, the minimum wage for covered health care employees to be $18 per hour from July 1, 2024, to June 30, 2033, inclusive, and $25 per hour from July 1, 2033, and until as adjusted, as specified.

Existing law requires, for specified clinics that meet certain requirements, the minimum wage for covered health care employees to be $21 per hour from July 1, 2024, to June 30, 2026, inclusive, and $22 per hour from July 1, 2026, to June 30, 2027, inclusive, and $25 from July 1, 2027, and until as adjusted, as specified.

Existing law requires, for all other covered health care facility employers, the minimum wage for covered health care employees to be $21 per hour

from July 1, 2024, to June 30, 2026, inclusive, $23 per hour from July 1, 2026, to June 30, 2028, inclusive, and $25 per hour from July 1, 2028, and until as adjusted, as specified.

Existing law also separately requires, for a licensed skilled nursing facility, as described, in specified circumstances the minimum wage for certain other covered health care employees, as described, to be $21 per hour from July 1, 2024, to June 30, 2026, inclusive, $23 per hour from July 1, 2026, to June 30, 2028, inclusive, and $25 per hour from July 1, 2028, and until as adjusted, as specified.

This bill would provide for a delay of the implementation dates of the above-described minimum wage increases until either of 2 events occur, as specified.

(14) Existing law defines various terms for purposes of these provisions relating to minimum wage schedules for covered health care employees, including a covered health care employee, covered health care facility, and full-time equivalent employee. Existing law excludes certain characteristics from the definition of a covered health care employee, including any work performed in the public sector where the primary duties performed are not health care services. Existing law excludes certain entities from the definition of a covered health facility, including a skilled nursing facility owned, controlled, or operated by the state. Existing law defines a full-time equivalent employee as the total paid hours at a covered health care facility, as specified, as per Department of Health Care Access and Information guidance, divided by 2,080.

This bill would, instead, exclude from the definition of a covered health care employee any work performed by a public employee where the public employee is not primarily engaged in services, as described, performed for a covered health care facility. For purposes of the definition of a covered health care facility, the bill would, instead, delete the exclusion of a skilled nursing facility owned, controlled, or operated by the State Department of State Hospitals from that definition, and would additionally exclude from that definition any health care facility, as described, that is owned, controlled, or operated by the state or any state agency, as defined, of the executive branch. The bill would define full-time equivalent employee as the total hours paid at a covered health care facility, as specified, divided by 2,080 and would specify the determination of the number of full-time equivalent employees.

(15) Existing law requires a health care minimum wage to be enforceable by, among other things, the Labor Commissioner.

This bill would require a health care minimum wage to be enforceable by the Labor Commissioner through specified procedures. The bill would require the Department of Industrial Relations to amend, supplement, and republish the Industrial Welfare Commission’s wage orders to be consistent with these minimum wage provisions, as specified. The bill would require every employer subject to these provisions to post a copy of the order as amended, supplemented, and republished by the Department of Industrial

Relations, as specified, and to provide to each employee on the effective date of the earliest minimum wage increase a written notice, as provided.

For covered health care employment where the compensation of the employee is on a salary basis, existing law requires the employee to earn a monthly salary equivalent to no less than 150 percent of the health care worker minimum wage or 200 percent of the minimum wage, as described, for full-time employment in order to qualify as exempt from the payment of minimum wage and overtime under state law, including where the employer is the state, a political subdivision of the state, the University of California, or a municipality.

This bill would instead qualify an employee as exempt from the payment of minimum wage and overtime, as described above, if the employer is a political subdivision of the state, a health care district, the University of California, or a municipality.

(16) Existing law requires the Department of Health Care Access and Information to publish on their internet website a list of all covered health care facility employers, as specified, and a list of all hospitals that qualify as a hospital with a high governmental payor mix, independent hospital with an elevated governmental payor mix, or a rural independent covered health care facility. If a covered health care facility believes that they were inappropriately excluded from the list of hospitals that qualify as a hospital with a high governmental payor mix, independent hospital with an elevated governmental payor mix, or a rural independent covered health care facility, existing law authorizes the health facility to file a request with the Department of Health Care Access and Information to be classified as a hospital with a high governmental payor mix, independent hospital with an elevated governmental payor mix, or a rural independent covered health care facility. Existing law requires the requesting hospital to provide, among other things, the payor mix of the requesting hospital, as specified.

This bill would require the lists described above to only include those covered health care facility employers included in the Department of Health Care Access and Information's 2021 Pivot Table, as described. The bill would require the requesting hospital to provide, among other things, the revised Annual Disclosure Report, as provided, that reflects the payor mix of the requesting hospital, as specified.

(17) Existing law requires the Department of Industrial Relations, in collaboration with the State Department of Health Care Services and the Department of Health Care Access and Information, to develop, by March 1, 2024, a waiver program for covered health care facilities, as described, which would authorize a covered health care facility to apply for and receive a temporary pause or alternative phase in the schedule of the health care minimum wage requirements, as specified. In order to obtain a waiver, existing law requires a covered health care facility to demonstrate that compliance with the minimum wage requirements would raise doubts about the covered health care facility's ability to continue as a going concern under generally accepted accounting principles, as specified.

In order to obtain a waiver, this bill would instead require a covered health care facility to demonstrate at the time the waiver application is submitted that it includes, among other things, the covered health care facility's, and any parent or affiliated company's, most recent audited financial statements, as specified, and a declaration verifying that the contents of the documents contained in the waiver request are true and correct. The bill would require the Department of Industrial Relations to make approved financial information available on its internet website, and would require the Department of Health Care Access and Information to make the audited financial information submitted in conjunction with an approved waiver available on its internet website, as specified.

If a waiver is issued, the bill would require any covered health care facility affected by the waiver to, within 10 days of notice from the Department of Industrial Relations, to, among other things, provide to each covered health care employee, a specified written notice, informing the covered health care employee the covered health care facility had applied for and received a one-year waiver of the increase of the minimum wage and stating the applicable minimum wage. The bill would authorize the Department of Industrial Relations and Department of Health Care Access and Information to enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis, for purposes of implementing the minimum wage schedule provisions.

By expanding the requirements relating to health care minimum wages, the violation of which would be a crime, the bill would impose a state-mandated local program.

(18) Existing law authorizes the department to contract with a county to help fund the development or expansion of pretrial diversion, as specified. Existing law requires a county so contracted to quarterly report data and outcomes to the department, regarding those individuals targeted by the contract and in the program.

This bill would instead require the county to report monthly, as specified, and would make other conforming changes.

(19) Existing law, the Bronzan-McCorquodale Act, contains provisions governing the operation and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. Under existing law, mental health services are provided through contracts with county mental health programs and the department is authorized to temporarily withhold funds or impose monetary sanctions on a county behavioral health department that is not in compliance with the contract.

This bill would require that certain funds collected as a result of sanctions between July 1, 2024, and June 30, 2027, be deposited in the General Fund for use, upon an appropriation by the Legislature, for the nonfederal share of Medi-Cal costs for health care services furnished to specified groups.

(20) Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, funds a system of county mental health plans

for the provision of mental health services. The MHSA establishes the Mental Health Services Fund. Existing law, the Behavioral Health Services Act (BHSA), approved by the voters as Proposition 1 at the March 5, 2024, statewide primary election, commencing January 1, 2025, revises and recasts the MHSA by, among other things, creating the Behavioral Health Services Fund. Existing law requires that any moneys remaining in the Mental Health Services Fund on January 1, 2025, be transferred to the Behavioral Health Services Fund.

This bill would make conforming technical changes consistent with the creation of, and the transfer of moneys to, the Behavioral Health Services Fund, operative January 1, 2025. The bill would make technical, nonsubstantive changes.

(21) Existing law, the California Special Supplemental Nutrition Food Program for Women, Infants, and Children (WIC Program), authorizes establishment of a statewide program, administered by the State Department of Public Health, for providing nutritional food supplements to low-income pregnant women, low-income postpartum and lactating women, and low-income infants and children under 5 years of age, who have been determined to be at nutritional risk.

Existing law requires the department, in order to effectively manage and administer the federal and state requirements for the vendors in the WIC Program, to establish requirements for peer groups and a corresponding reimbursement system, criteria used for vendor authorization, and WIC Program-authorized foods. Existing law authorizes the department to implement, interpret, or make specific these provisions by bulletin or similar instruction. Existing law requires the department to notify and consult with affected stakeholders in the process of implementing, interpreting, or making specific these provisions, and requires the notice to provide opportunity for written comment. Existing law requires any final action to be published on the department's internet website no later than 120 days after the consultation with stakeholders or the last day for comments, whichever is later, and deems the final action withdrawn if the department fails to meet this requirement.

This bill would require the department to additionally establish requirements for online shopping and retail food delivery systems. The bill would also require the department to publish the final action no later than 180 days after the consultation with stakeholders or the last day for comments, whichever is later.

The bill would authorize the department, without taking regulatory action, to implement, interpret, or make specific all of the above-mentioned provisions by means of all-county letters, plan letters, information notices, provider bulletins, or other similar instruction. The bill would authorize the department to modify or repeal specified WIC Program requirements by bulletin or similar instruction, without taking further regulatory action, if certain criteria are met.

(22) Existing law establishes the Children and Youth Behavioral Health Initiative, administered by the California Health and Human Services Agency

and its departments, as applicable. Under existing law, the purpose of the initiative is to transform the state's behavioral health system into an innovative ecosystem in which all children and youth 25 years of age or younger, regardless of payer, are screened, supported, and served for emerging and existing behavioral health needs.

Existing law requires the State Department of Health Care Services, or a contracted vendor, to provide competitive grants to qualified entities to build partnerships, capacity, and infrastructure supporting ongoing school-linked behavioral health services, among other purposes, for children and youth 25 years of age or younger. For these purposes, existing law requires the department to develop and maintain a school-linked statewide fee schedule for outpatient mental health or substance use disorder treatment provided to a student who is 25 years of age or younger at a schoolsite. Existing law requires the department to develop and maintain a school-linked statewide provider network of schoolsite behavioral health counselors.

This bill would authorize the department to contract with an entity to administer the school-linked statewide behavioral health provider network. The bill would require the entity that administers that network to create and administer a process for enrolling and credentialing eligible practitioners and providers and a process for the submission and reimbursement of their claims. The bill would require those practitioners and providers to comply with the enrollment, credentialing, and claims processes. The bill would also require a health care service plan, insurer, or Medi-Cal managed care plan that covers necessary schoolsite services, as specified, to comply with all administrative requirements to cover and reimburse the services set forth by the network administrator.

The bill would establish the Behavioral Health Schoolsite Fee Schedule Administration Fund in the State Treasury for specified purposes. The bill would require the department to establish and charge a fee for participating health care service plans, insurers, or Medi-Cal managed care plans to be used to cover the reasonable cost of administering the school-linked behavioral health provider network, as specified. The bill would authorize the department to periodically update the amount and structure of the fee, as specified. The bill would require revenues generated from the fees, less refunds, to be deposited into the fund. This bill would limit the money in the fund to be used upon appropriation by the Legislature, as specified, and would require interest and dividends earned on moneys in the fund to be retained in the fund for specified purposes.

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

This bill would, for dates of service no sooner than July 1, 2024, require the department to establish a directed payment reimbursement methodology, or revise one or more existing directed payment reimbursement methodologies, applicable to children's hospitals, as specified. The bill

would require Medi-Cal managed care plans to reimburse children's hospitals in accordance with the requirements of the directed payment arrangement established by the department and any guidance issued by the department to implement these provisions. The bill would, commencing no sooner than July 1, 2024, continuously appropriate $115,000,000 on an annual basis to the department from the General Fund to support payments implemented pursuant to these provisions. The bill would authorize the department to reduce the amount of reimbursements, as specified, if the Protect Access to Healthcare Act of 2024 is approved by the voters and if children's hospitals receive increased reimbursement rates or payments under certain provisions. The bill would include related legislative intent with regard to these provisions.

(24) Existing law imposes a managed care organization (MCO) provider tax, administered and assessed by the department, on licensed health care service plans and managed care plans contracted with the department. Under existing law, proceeds from the taxes are available, upon appropriation, for the purpose of funding specified subcomponents to support the Medi-Cal program, including certain payments to Medi-Cal managed care plan and transfers to the Medi-Cal Provider Payment Reserve Fund. Existing law requires the department, upon appropriation, to use moneys transferred to that fund for purposes of funding targeted increases to Medi-Cal payments or other investments, as specified.

This bill would remove, as one of the designated expenditures from that fund, a $75,000,000 annual transfer to the University of California for expanding graduate medical education programs.

The bill would instead add, as designated expenditures from that fund, a $40,000,000 transfer to support workforce investments, increased costs relating to continuous eligibility for children up to 5 years of age as described below, and departmental administrative costs for implementing the Medi-Cal Provider Payment Increases and Investments (PPI) Act described below. Under the bill, increased costs for targeted increases would instead be made pursuant to the PPI Act. The bill would repeal those additions if specified provisions relating to the MCO provider tax are approved by the voters at the November 5, 2024, statewide general election.

If those specified provisions are approved by the voters, the bill would instead remove, as a designated expenditure, increased costs for targeted increases to Medi-Cal payments or other investments based on a plan submitted by the department to the Legislature as part of the 2024–25 Governor's Budget. The bill would repeal provisions regarding that plan.

Under the bill, community health workers would be an eligible provider type for rate increases specified in related provisions under existing law.

(25) Existing law requires the department, upon appropriation, to establish a supplemental payment pool for nonhospital 340B community clinics, relating to discount drug purchasing.

This bill would require the department to establish and implement a directed payment program under which a qualifying nonhospital 340B community clinic may earn payments from contracted Medi-Cal managed

care plans, subject to an appropriation and any necessary federal approvals. The bill would set forth the criteria and methodologies for that program, including links to the Medi-Cal Provider Payment Reserve Fund.

Under the bill, for any calendar year in which this program is implemented, neither the department nor a Medi-Cal managed care plan would be required to make the payments specified in the above-described supplemental payment pool. The bill would make conforming changes by repealing the supplemental payment pool-related provisions if certain conditions are met.

(26) This bill would establish the Medi-Cal Provider Payment Increases and Investments (PPI) Act in order to, among other things, improve access to high-quality care for Medi-Cal members and promote provider participation in the Medi-Cal program. The bill would require the department to seek federal approval for various PPI components, including reimbursement increases for professional services, ground emergency medical transport services, abortion services, family planning services, and certain other applicable services, for updating the reimbursement methodology for optional hearing aid benefits, for eliminating certain rate reductions as described below, and for increases to the amount of directed payments for qualifying nonhospital 340B community clinics as described above.

The bill would set forth various provisions to implement those PPI components, including reimbursement methodologies and procedures involving Medi-Cal managed care plans.

Under the bill, payments implemented under PPI would be supported by MCO provider tax revenue or other state funds appropriated by the Legislature, as specified. Except for the portion related to abortion services, the bill would condition PPI implementation on receipt of any necessary federal approvals and the availability of federal financial participation. If a later enacted statute restricts the availability of moneys, including with regard to the MCO provider tax, the bill would require the department to implement PPI or related provisions to the extent that the department determines PPI remains feasible, as specified. The bill would authorize the Director of Health Care Services to make any necessary modifications, as specified.

(27) Existing law sets forth various Medi-Cal payment reductions by specified percentages, including a 10% reduction, for certain services and providers.

This bill would make an exception to some of those payment reductions for physician and professional services, and for abortion services, subject to implementation of the related PPI provisions described above.

(28) Existing law establishes the Healthy Families Program, the Medi-Cal Access Program, and the County Children’s Health Initiative Program. Existing law sets forth provisions, operative on January 1, 2025, or as otherwise specified, for the continuous eligibility of an applicable child under those programs up to 5 years of age.

This bill would shift implementation of that continuous eligibility from 2025 to 2026. The bill would also make some changes to the implementation criteria for that continued eligibility.

(29) Under this bill, if specified provisions relating to the MCO provider tax are approved by the voters at the November 5, 2024, statewide general election, most of the changes made by the bill to the provisions listed in paragraphs (24) through (28) would become inoperative, as specified.

(30) Existing law requires, for the duration of the COVID-19 emergency period, the State Department of Health Care Services to implement any federal Medicaid program waiver or flexibility approved by the federal Centers for Medicare and Medicaid Services related to that emergency. Existing law requires, upon expiration of the COVID-19 emergency period and subject to any necessary federal approvals, the department to continue to reimburse the administration of a COVID-19 vaccine at 100% of the Medicare national equivalent rate in effect at the time of vaccine administration without geographic adjustment.

This bill would instead require the department to align COVID-19 vaccine administration payments to payment reimbursement structures for vaccines administered in accordance with the Medi-Cal State Plan.

(31) Existing law requires the State Department of Health Care Services, subject to federal approval, to establish and implement a program or programs under which a designated public hospital system or a district and municipal public hospital, as defined, may earn performance-based quality incentive payments from the Medi-Cal managed care plan with which they contract, as specified. Existing law requires the department, subject to federal approval, to require each Medi-Cal managed care plan to increase contract services payments to designated public hospital systems by amounts determined under a directed payment methodology that meets certain federal requirements.

This bill would also apply the requirement for increased directed payments to district and municipal public hospitals commencing with the 2023 calendar year. The bill would make certain changes to the directed payment methodology and would make conforming changes to related provisions.

Under existing law, the nonfederal share of the portion of the capitation rates specifically associated with directed payments and for the quality incentive payments may consist of voluntary intergovernmental transfers (IGTs) of funds provided by the hospitals and their affiliated governmental entities, or other public entities, as specified. Existing law prohibits the department from assessing a specified fee on an IGT or any other similar fee.

This bill would remove that prohibition on a fee assessment and would instead authorize the department to assess a fee not to exceed 5% on IGTs to reimburse the department for the administrative costs of operating the programs under these provisions and for the support of the Medi-Cal program.

The bill would make various other changes to related provisions with regard to, among other things, fiscal or rate years during which payments are made.

(32) Existing law requires the State Department of Health Care Services, subject to federal approval, to design and implement an IGT program, with voluntary participation, relating to Medi-Cal managed care services provided by nondesignated public hospitals, as defined, in order to increase capitation payments for the purpose of increasing their reimbursement. Existing law requires that the increased capitation payments be actuarially equivalent to the increased fee-for-service payments made pursuant to a certain other IGT program to the extent permissible under federal law.

This bill would repeal the above-described provisions relating to capitation payments.

(33) Existing law establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative, subject to federal approval, to follow the predecessor California Medi-Cal 2020 Demonstration Project. Under CalAIM, a designated public hospital is defined as any one of the hospitals identified in the California Medi-Cal 2020 Demonstration Project, and any successor, that is operated by a county, a city and county, the University of California, or a special hospital authority, or any additional public hospital to the extent identified as a designated public hospital in the CalAIM Terms and Conditions.

This bill would make various changes to the definition of a designated public hospital, including changes to the name or scope of certain hospitals and the addition of other hospitals.

(34) Existing law requires the State Department of Health Care Services to establish and maintain a plan, known as the County Administrative Cost Control Plan, whereby costs for county administration of the determination of eligibility for Medi-Cal benefits are effectively controlled within the amounts annually appropriated for that administration. Existing law expresses the intent of the Legislature not to appropriate funds for certain cost-of-doing-business adjustments, as described, for specified fiscal years.

This bill would additionally express the intent of the Legislature not to appropriate funds for the cost-of-doing-business adjustment for the 2024–25 to 2027–28, inclusive, fiscal years.

(35) Existing law requires the State Department of Health Care Services, upon appropriation, to establish a clinic workforce stabilization retention payment program under Medi-Cal to provide funds to eligible qualified clinics, as defined, to make retention payments to their eligible employees for the public purposes of providing stability in the California qualified clinic workforce and retaining qualified health care workers. To the extent that any appropriated funds remain after the department has distributed funds to eligible qualified clinics for employee retention payments, existing law requires that those excess funds be used for qualified clinic workforce training, as described below.

Under existing law, upon the order of the Director of Finance, any retention payment funding returned under related provisions or unexpended

funds left over from a specified appropriation in the Budget Act of 2022 are transferred and available for expenditure or encumbrance through June 30, 2028, to fund workforce development programs that support primary care in clinics, as specified.

This bill would delete the provisions that require that excess funds be used for qualified clinic workforce training and the provisions that require the transfer of returned or unexpended funds and their availability for workforce development programs.

(36) Existing law establishes the Distressed Hospital Loan Program, administered by the Department of Health Care Access and Information, in order to provide interest-free cashflow loans to not-for-profit hospitals and public hospitals in significant financial distress or to governmental entities representing a closed hospital, except as otherwise provided, to prevent the closure of, or facilitate the reopening of, those hospitals. Existing law establishes the Distressed Hospital Loan Program Fund, with moneys in the fund being continuously appropriated for the department. Existing law authorizes the Department of Finance to transfer up to $150,000,000 from the General Fund and up to $150,000,000 from the Medi-Cal Provider Payment Reserve Fund to the Distressed Hospital Loan Program Fund in state fiscal year 2023–24 to implement the program.

Existing law authorizes the department to allocate an amount not to exceed 5% of total program funds to administer the program, as specified. Existing law requires any funds transferred to be available for encumbrance or expenditure until June 30, 2026.

This bill would instead require any funds transferred to be available for encumbrance or expenditure until December 31, 2031. By extending the amount of time continuously appropriated funds are available for encumbrance and expenditure, the bill would make an appropriation.

(37) Existing law creates the California Major Risk Medical Insurance Program (MRMIP), which is administered by the State Department of Health Care Services, to provide major risk medical coverage through participating health plans to eligible residents of the state who are unable to secure adequate private health care coverage. If a health care service plan or health insurer rejects a dependent to be added to an individual grandfathered health plan, rejects an applicant for a Medicare supplement policy due to the applicant having end-stage renal disease, or offers an individual grandfathered health plan to an applicant at a rate that is higher than the standard rate, existing law requires the plan or insurer to inform the applicant about MRMIP.

This bill would require the department to cease to provide coverage through MRMIP on December 31, 2024. The bill would require the department to direct participating health plans to inform subscribers of the transition of coverage at specified intervals, complete payments to, or payment reconciliations with, participating health plans or other contractors, process appeals, and conduct other necessary termination activities. Upon request of the California Health Benefit Exchange (HBEX) the bill would require the department to disclose information to HBEX to assist MRMIP

subscribers to transition to coverage through HBEX, as specified. Commencing November 1, 2024, and ending when the transition of coverage is complete, the bill would require the department to provide monthly updates to the Assembly Committees on Health and Budget and the Senate Committees on Health and Budget and Fiscal Review about the transition of subscribers. The bill would require a plan or insurer that rejects an above-described application or makes an above-described offer to inform the applicant about MRMIP only if the rejection or offer is before July 1, 2024.

Existing law establishes the Major Risk Medical Insurance Fund and the Health Care Services Plan Fines and Penalties Fund and continuously appropriates moneys in the funds, except as specified, to the department for purposes of MRMIP. Existing law also establishes the Managed Care Administrative Fines and Penalties Fund, from which certain amounts are to be transferred to the Health Care Services Plan Fines and Penalties Fund and continuously appropriated to the department for purposes of MRMIP.

This bill would instead continuously appropriate moneys in the Health Care Services Plan Fines and Penalties Fund to fund the nonfederal share of health care services for children, adults, seniors, persons with disabilities, and dual-eligible beneficiaries in the Medi-Cal program. By changing the purposes of a continuously appropriated fund, the bill would make an appropriation.

(38) Existing law establishes the Behavioral Health Services Oversight and Accountability Commission to promote transformational change in California's behavioral health system, among other things. Beginning January 1, 2025, existing law requires the commission to have an Executive Director, who is responsible for management over the administrative, fiscal, and program performance of the commission. Existing law requires the commission to award grants to county mental health or behavioral health departments to fund partnerships between educational and county mental health entities. Existing law authorizes the commission to exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis to implement that requirement. Until January 1, 2025, existing law exempts those contracts from contracting requirements applicable only to state contracts.

This bill would extend that exemption from contracting requirements indefinitely. The bill would authorize the commission to delegate to the Executive Director any power, duty, purpose, function, or jurisdiction that the commission may lawfully delegate, and would authorize the Executive Director to redelegate, as specified.

Beginning January 1, 2025, existing law creates the Behavioral Health Services Act Innovation Partnership Fund in the State Treasury to fund a program, administered by the commission, to award grants to private, public, and nonprofit partners to promote development of innovative mental health and substance use disorder programs and practices.

This bill would authorize private donations or grants, federal or state grants, any interest on amounts in the fund, and moneys previously allocated that are returned to the fund, as specified, to be paid into the fund.

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

This bill would, to the extent that the activities are an allowable use of the funds, authorize the State Department of Public Health to spend up to $23,000,000 to conduct other programs and grants related to the treatment and prevention of HIV and AIDS, such as increase the financial eligibility standards for ADAP, modify the ADAP formulary, and to create, develop, or contract for needs assessment analysis, as specified, among others. The bill would require the State Department of Public Health to report to the Legislature a plan for modernization and expansion of ADAP, as described. By adding to the purposes of a continuously appropriated fund, the bill would make an appropriation.

(40) 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.

(41) 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 7903 of the Government Code is amended to read:

7903. (a) "State subventions" shall, except as provided in subdivision (b), include only money received by a local agency from the state, the use of which is unrestricted by the statute providing the subvention.

(b) (1) Commencing with the 2021–22 fiscal year and each fiscal year thereafter, "state subventions" shall also include any money provided to a local agency pursuant to any of the following:

(A) Child support administration relating to local child support agencies (Sections 17306, subdivision (b) of Section 17704, and subdivision (a) of Section 17710 of the Family Code).

(B) Black Infant Health Program (Section 123255 of the Health and Safety Code).

(C) California Home Visiting Program (Section 123255 of the Health and Safety Code).

(D) Sexually transmitted disease prevention and control activities (Section 120511 of the Health and Safety Code).

(E) Support for vital public health activities (Article 7 (commencing with Section 101320) of Chapter 3 of Part 3 of Division 101 of the Health and Safety Code).

(F) County administration for Medi-Cal eligibility (Section 14154 of the Welfare and Institutions Code).

(G) Optional Targeted Low Income Children's Program (Section 14005.27 of the Welfare and Institutions Code).

(H) Case management services under the California Children's Services program (Section 123850 of the Health and Safety Code).

(I) Child Health and Disability Prevention Program (Article 6 (commencing with Section 124024) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code).

(J) Specialty Mental Health Services (Chapter 8.9 (commencing with Section 14700) of Part 3 of Division 9 of the Welfare and Institutions Code).

(K) Specified precare and postcare services for individuals treated in short-term residential therapeutic programs (Article 5 (commencing with Section 14680) of Chapter 8.8 of Part 3 of Division 9 of the Welfare and Institutions Code).

(L) Behavioral Health Quality Improvement Program (Section 14184.405 of the Welfare and Institutions Code).

(M) Mental health plan costs for Continuum of Care Reform (Sections 4096.5 and 11462.01 of the Welfare and Institutions Code).

(N) Mobile crisis services (Section 14132.57 of the Welfare and Institutions Code).

(O) Los Angeles County Justice-Involved Population Services and Supports (Provision 18 of Item 4260-101-0001 of the Budget Act of 2022).

(P) Funds distributed from the Behavioral Health Services Fund pursuant to Section 5892 of the Welfare and Institutions Code.

(Q) Drug Medi-Cal organized delivery system, excluding Narcotic Treatment Program services (Section 14184.401 of the Welfare and Institutions Code).

(R) Drug Medi-Cal, excluding Narcotic Treatment Program services (Section 14124.20 of the Welfare and Institutions Code).

(S) Behavioral Health Bridge Housing Program (Provision 17 of Item 4260-101-0001 of the Budget Act of 2022).

(T) Mental Health Student Services Act partnership grant program (Section 5886 of the Welfare and Institutions Code).

(U) CalFresh (Section 18906.55 of the Welfare and Institutions Code).

(V) In-Home Supportive Services (Sections 12306.16 and 12302.25 of the Welfare and Institutions Code).

(W) Community Care Expansion Program (Section 18999.97 of the Welfare and Institutions Code).

(X) Housing and Disability Income Advocacy Program (Chapter 25 of the Statutes of 2016 (Assembly Bill No. 1603) and Chapter 17 (commencing with Section 18999) of Part 6 of Division 9 of the Welfare and Institutions Code).

(Y) Project Roomkey (Executive Order No. N-32-20 and Item 5180-151-0001 of the Budget Act of 2019, Item 5180-151-0001 of the Budget Act of 2021, and Item 5180-493 of the Budget Act of 2022).

(Z) Bringing Families Home Program (Section 16523.1 of the Welfare and Institutions Code).

(AA) Home Safe Program (Section 15771 of the Welfare and Institutions Code).

(AB) CalWORKs Housing Support Program (Section 11330.5 of the Welfare and Institutions Code).

(AC) CalWORKs (Section 15204.3 of the Welfare and Institutions Code).

(AD) Automation (Section 10823 of the Welfare and Institutions Code and Item 5180-141-0001 of the Budget Act of 2022).

(AE) Adult Protective Services (Chapter 13 (commencing with Section 15750) of Part 3 of Division 9 of the Welfare and Institutions Code).

(AF) Adult corrections and rehabilitation operations—institution administration (Chapter 3 (commencing with Section 1228) of Title 8 of Part 2 of the Penal Code, Sections 1557 and 4750 of the Penal Code, and Section 26747 of the Government Code).

(AG) Corrections planning and grant programs (The Safe Neighborhoods and Schools Act (Proposition 47 approved at the November 4, 2014, general election), The Public Safety and Rehabilitation Act of 2016 (Proposition 57 approved at the November 8, 2016, general election), The Control, Regulate, and Tax Adult Use of Marijuana Act (Proposition 64 approved at the November 8, 2016, general election), Section 7599.1 of the Government Code, Title 10.2 (commencing with Section 14130) of the Penal Code, Chapter 337 of the Statutes of 2020 (Senate Bill No. 823), Items 5227-123-0001, 5227-117-0001, 5227-118-0001, 5227-120-0001, 5227-121-0001, 5227-125-0001, of the Budget Act of 2022, Items 5227-115-0001 and 5227-116-0001 of the Budget Act of 2021).

(AH) Office of the Small Business Advocate (Item 0509-103-0001 of the Budget Act of 2021).

(AI) Elections (Chapter 9 of the Statutes of 2022 (Senate Bill No. 119) and Item 0890-101-0001 of the Budget Act of 2021).

(AJ) County Subvention (Items 8955-101-0001 and 8955-101-3085 of the Budget Act of 2021).

(AK) Department of Cannabis Control grant (Item 1115-101-0001 of the Budget Act of 2021 and Item 1115-102-0001 of the Budget Act of 2022).

(AL) Agricultural land burning in San Joaquin Valley (Provision 1 of Item 3900-101-0001 of the Budget Act of 2021).

(AM) Carl Moyer Air Quality Standards Attainment Program (Provision 2g of Item 3970-101-0001 of the Budget Act of 2021).

(AN) Pre-positioning for fire and rescue (Provision 3 of Item 0690-101-0001 of the Budget Act of 2021 and the Budget Act of 2022).

(AO) Prepare California (Item 0690-106-0001 of the Budget Act of 2021).

(AP) Law Enforcement Mutual Aid (Provision 6 of Item 0690-101-0001 of the Budget Act of 2022).

(AQ) Los Angeles Regional Interoperable Communication Systems (Provision 9 of Item 0690-101-0001 of the Budget Act of 2022).

(AR) Homeless Housing, Assistance, and Prevention program grants (Chapter 6 (commencing with Sections 50216) of Part 1 of Division 31 of the Health and Safety Code).

(AS) Encampment resolution grants (Chapter 7 (commencing with Section 50250) and Chapter 8 (commencing with Section 50255) of Part 1 of Division 31 of the Health and Safety Code).

(AT) Operating subsidies for Homekey facilities (Sections 50675.1.1 to 50675.14, inclusive, of the Health and Safety Code).

(AU) Various programs contained in Control Sections 19.56 and 19.57 of the Budget Act of 2021, and Control Section 19.56 of the Budget Act of 2022.

(2) State subventions pursuant to programs listed in paragraph (1) shall be included within the appropriations limit of the local agency, up to the amount representing the difference between the total amount of proceeds of taxes of the local agency, calculated without application of this section, and the full appropriations limit of the local agency, as determined pursuant to Section 7902.

(c) (1) No later than February 1 of each year, the Department of Finance shall do both of the following:

(A) Calculate for each local agency the individual subvention amounts for each program listed in paragraph (1) of subdivision (b).

(B) Provide the information described in subparagraph (A) to the California State Association of Counties and the League of California Cities for distribution to local agencies.

(2) Local agencies shall utilize the amounts calculated by the Department of Finance and provided to them pursuant to this subdivision for purposes of Article XIII B of the California Constitution and this division.

(d) (1) Any portion of state subventions pursuant to programs listed in paragraph (1) of subdivision (b) that exceeds the amount representing the difference between the total amount of proceeds of taxes of the local agency, calculated without application of this section, and the appropriations limit of the local agency shall be identified and reported to the Director of Finance by November 1, 2022, and by that date annually thereafter.

(2) The Director of Finance shall calculate the total amounts reported by local agencies pursuant to this subdivision and shall include those amounts within the state appropriations limit determined pursuant to Section 7902.

(e) The determinations and calculations required pursuant to this section shall be in addition to any determinations and calculations required pursuant to Section 7902.2.2 of the Government Code.

SEC. 2. Section 12536 is added to the Government Code, to read:

12536. (a) The Electronic Cigarette Settlements Fund is hereby created in the State Treasury.

(b) The State Department of Public Health shall administer the Electronic Cigarette Settlements Fund.

(c) Upon order of the Department of Finance, the Controller shall transfer funds received in the Litigation Deposits Fund payable to the Department of Justice from the settlement of People of the State of California v. JUUL Labs Inc., et al. (Alameda County Superior Court, No. RG19043543, April 17, 2023) that are allocated for People v. JUUL Labs, Inc. E-Cigarette Programs to the Electronic Cigarette Settlements Fund.

(d) Upon appropriation by the Legislature, moneys from the Electronic Cigarette Settlements Fund shall be used for activities in accordance with the terms of the People of the State of California v. JUUL Labs, Inc., et al. settlement and the Department of Justice's Notices re: State of California JUUL Settlement Funding dated November 13, 2023.

(e) This section shall remain operative only until July 1, 2035, and as of January 1, 2036, is repealed.

SEC. 3. Section 16310 of the Government Code is amended to read:

16310. (a) When the General Fund in the Treasury is or will be exhausted, the Controller shall notify the Governor and the Pooled Money Investment Board. The Governor, or their designee, may order the Controller to direct the transfer of all or any part of the moneys not needed in other funds or accounts to the General Fund from those funds or accounts, as determined by the Pooled Money Investment Board, including the Surplus Money Investment Fund or the Pooled Money Investment Account. All moneys so transferred shall be returned to the funds or accounts from which they were transferred as soon as there are sufficient moneys in the General Fund to return them. No interest shall be charged or paid on any transfer authorized by this section, exclusive of the Pooled Money Investment Account, except as provided in this section. This section does not authorize any transfer that will interfere with the object for which a special fund was created or any transfer from the Central Valley Water Project Construction Fund, the Central Valley Water Project Revenue Fund, or the California Water Resources Development Bond Fund.

(b) (1) Interest shall be paid on all moneys transferred to the General Fund from the following funds:

(A) The Department of Food and Agriculture Fund.

(B) The DNA Identification Fund.

(C) The Behavioral Health Services Fund.

(D) All funds created pursuant to the California Children and Families Act of 1998, enacted by Proposition 10 at the November 3, 1998, statewide general election.

(E) Any funds retained by or in the possession of the California Exposition and State Fair pursuant to this section.

(2) With respect to all other funds, and unless otherwise specified, if the total moneys transferred to the General Fund in any fiscal year from any

special fund pursuant to this section exceed an amount equal to 10 percent of the total additions to surplus available for appropriation as shown in the statement of operations of a prior fiscal year as set forth in the most recent published annual report of the Controller, interest shall be paid on the excess. Interest payable under this section shall be computed at a rate determined by the Pooled Money Investment Board to be the current earning rate of the fund from which transferred.

(c) Notwithstanding any other provision of law, except as described in subdivision (d), all moneys in the State Treasury may be loaned for the purposes described in subdivision (a).

(d) Subdivision (c) shall not apply to any of the following:

(1) The Local Agency Investment Fund.

(2) Funds classified in the State of California Uniform Codes Manual as bond funds or retirement funds.

(3) All or part of the moneys not needed in other funds or accounts for purposes of subdivision (a) where the Controller is prohibited by the California Constitution, bond indenture, or case law from transferring all or any part of those moneys.

SEC. 4. Section 30026.5 of the Government Code is amended to read:

30026.5. (a) "2011 Realignment Legislation" means legislation enacted on or before September 30, 2012, to implement the state budget plan, that is entitled 2011 Realignment and provides for the assignment to local agencies of responsibilities for Public Safety Services, including related reporting responsibilities. The 2011 Realignment Legislation shall provide local agencies with maximum flexibility and control over the design, administration, and delivery of those services consistent with federal law and funding requirements, as determined by the Legislature. However, the 2011 Realignment Legislation shall include no new programs assigned to local agencies after January 1, 2012, except for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and mental health managed care, which may also be referred to as specialty mental health care services.

(b) Any mandate of a new program or higher level of service on a local agency imposed by the 2011 Realignment Legislation, or by any regulation adopted or any executive order or administrative directive issued to implement that legislation, shall, if it constitutes a mandate requiring the state to provide a subvention of funds within the meaning of the California Constitution, be paid from the moneys provided for that activity.

(1) A reimbursable mandate for any program or increased level of service initially created by the 2011 Realignment Legislation, as defined in subdivision (a), that may be funded from the Protective Services Subaccount or the Behavioral Health Subaccount or funding received from the Protective Services Growth Special Account or the Behavioral Health Services Growth Special Account shall be paid from the applicable subaccount, and no other funding shall be required unless the total amount received into the subaccount of any county, including optional reallocation pursuant to subparagraph (A)

of paragraph (4) of subdivision (f) of Section 30025, is insufficient to provide funding for any or all mandates funded from that subaccount.

(2) A reimbursable mandate for any program or service that may be funded from any of the subaccounts in the Law Enforcement Services Account or funding received from the Law Enforcement Services Growth Subaccount shall be paid from the applicable subaccount, and no other funding shall be required unless the total amount received into the subaccount of any county or city and county is insufficient to provide funding for that mandate.

(c) (1) Notwithstanding subdivision (b) or any other provision of law, legislation enacted after September 30, 2012, that has an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by the 2011 Realignment Legislation shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. Local agencies shall not be obligated to provide programs or levels of service required by legislation described in this paragraph above the level for which funding has been provided.

(2) Notwithstanding subdivision (b) or any other provision of law, regulations, executive orders, or administrative directives, implemented after October 9, 2011, that are not necessary to implement the 2011 Realignment Legislation and that have an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by the 2011 Realignment Legislation, shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. Local agencies shall not be obligated to provide programs or levels of service pursuant to new regulations, executive orders, or administrative directives described in this paragraph above the level for which funding has been provided.

(3) Notwithstanding subdivision (b) or any other provision of law, any new program or higher level of service provided by local agencies, as described in paragraphs (1) and (2), above the level for which funding has been provided, shall not require a subvention of funds by the state as those costs incurred at the local level shall be optional.

(d) Notwithstanding subdivision (b) or any other provision of law, the state shall not submit to the federal government any plans or waivers, or amendments to those plans or waivers, that have an overall effect of increasing the cost borne by a local agency for programs or levels of service mandated by the 2011 Realignment Legislation, except to the extent that the plans, waivers, or amendments are required by federal law, or the state provides annual funding for the cost increase.

(e) (1) Notwithstanding subdivisions (b), (c), and (d) or any other provision of law, the state shall not be required to provide a subvention of funds pursuant to this section for a mandate that is imposed by the state at the request of a local agency or to comply with federal law. Any state funds provided pursuant to subdivision (c) or (d) or this subdivision shall be from funding sources other than those described in subdivision (a) of Section

30025, ad valorem property taxes, or the Social Services Subaccount of the Sales Tax Account of the Local Revenue Fund.

(2) For programs described in paragraphs (3), (4), and (5) of subdivision (i) of Section 30025 and included in the 2011 Realignment Legislation, if there are subsequent changes in federal statutes or regulations that alter the conditions under which federal matching funds as described in the 2011 Realignment Legislation are obtained, and those changes have the overall effect of increasing the costs incurred by a local agency, the state shall annually provide at least 50 percent of the nonfederal share of those costs as determined by the state.

(3) When the state is a party to any complaint brought in a federal judicial or administrative proceeding that involves one or more of the programs described in paragraphs (3), (4), and (5) of subdivision (i) of Section 30025 and included in the 2011 Realignment Legislation, and there is a settlement or judicial or administrative order that imposes a cost in the form of a monetary penalty or has the overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by the 2011 Realignment Legislation, the state shall annually provide at least 50 percent of the nonfederal share of those costs as determined by the state. Payment is not required if the state determines that the settlement or order relates to one or more local agencies failing to perform a ministerial duty, failing to perform a legal obligation in good faith, or acting in a negligent or reckless manner.

(4) If the state or a local agency fails to perform a duty or obligation under this section or under the 2011 Realignment Legislation, an appropriate party may seek judicial relief. These proceedings shall have priority over all other civil matters.

(5) The funds deposited into a County Local Revenue Fund 2011 shall be spent in a manner designed to maintain the state's eligibility for federal matching funds and to ensure compliance by the state with applicable federal standards governing the state's provision of Public Safety Services.

(6) The funds deposited into a County Local Revenue Fund 2011 shall not be used by local agencies to supplant other funding for Public Safety Services.

(f) Any decision of a county or a city and county to eliminate or significantly reduce the levels or types of optional or discretionary behavioral health services, adult protective services, or child welfare services pursuant to Sections 11403.1 and 11403.2 of, Chapter 2.3 (commencing with Section 16135) of Part 4 of Division 9 of, Sections 16508.2 and 16508.3 of, Article 4 (commencing with Section 16522) of Chapter 5 of Part 4 of Division 9 of, Article 2 (commencing with Section 16525.10) of Chapter 5.3 of Part 4 of Division 9 of, and Section 16605 of, the Welfare and Institutions Code and Section 10609.3 of the Welfare and Institutions Code that the county or city and county is or has previously funded, in whole or in part, from allocations received from the Support Services Account of the Local Revenue Fund 2011 may, as a condition of the county or city and county receiving funding, only be made in open session, as an action item, at a duly noticed

meeting of the board of supervisors. For the purpose of this subdivision, "significant reduction" shall include a 10-percent reduction in funding in any one year or a cumulative 25-percent reduction over the previous three years.

(g) (1) Federal funding has been, and continues to be, provided for Public Safety Services described in the 2011 Realignment Legislation that are funded from the subaccounts within the Health and Human Services Account and its successor, the Support Services Account. Starting in the 2012–13 fiscal year, the state provided an additional source of funding for Specialty Mental Health Services, as described in clause (v) of subparagraph (B) of paragraph (16) of subdivision (f) of Section 30025, from the Local Revenue Fund 2011 in addition to providing funding to local government for mental health services from the Local Revenue Fund and the Behavioral Health Services Fund. Starting in the 2011–12 fiscal year, the state provided funding for other Public Safety Services from the Local Revenue Fund and the Local Revenue Fund 2011.

(2) Except as required by subdivisions (c) to (e), inclusive, the state shall not have a share of cost for the Public Safety Services described in the 2011 Realignment Legislation funded from the Local Revenue Fund or the subaccounts within the Health and Human Services Account or its successor, the Support Services Account, in the Local Revenue Fund 2011. Funds for the increased county share of cost shall be provided through the subaccounts in the Health and Human Services Account, and from successors to those subaccounts. Before local entities may spend funds from these subaccounts for any other purpose, these funds shall first be expended for activities and providing services that preserve federal funding and to pay for any state-mandated costs for increased costs, duties, or levels of service as the programs are described in statute enacted on or before September 30, 2012, or regulations, executive orders, or administrative directives implemented prior to October 9, 2011, or those regulations that are not necessary to implement the 2011 Realignment Legislation, or State Plan, or any amendments in effect on June 30, 2012. This funding is specifically intended to be in an amount sufficient to fund the cost of the state mandates.

(3) Prior to a county electing to use any of its own funds to pay for an increased cost, duty, or level of service above that required by the 2011 Realignment Legislation, or that is optional under the 2011 Realignment Legislation, the county shall first exhaust the funding available to it from the Local Revenue Fund established pursuant to Section 17600 of the Welfare and Institutions Code and the Local Revenue Fund 2011 for state-mandated costs, duties, and levels of service.

(h) (1) Federal funding has been, and continues to be, provided for Public Safety Services described in the 2011 Realignment Legislation that are funded from the subaccounts within the Health and Human Services Account and its successor, the Support Services Account. Starting in the 2012–13 fiscal year, the state provided an additional source of funding for Specialty Mental Health Services, as described in clause (v) of subparagraph (B) of paragraph (16) of subdivision (f) of Section 30025, from the Local Revenue

Fund 2011 in addition to providing funding to local government for mental health services from the Local Revenue Fund and the Behavioral Health Services Fund. Starting in the 2011–12 fiscal year, the state provided funding for other Public Safety Services from the Local Revenue Fund and the Local Revenue Fund 2011.

(2) Except as required by subdivisions (c) to (e), inclusive, the state shall not have a share of cost for the health and human services programs described in the 2011 Realignment Legislation funded from the Local Revenue Fund established pursuant to Section 17600 of the Welfare and Institutions Code or the subaccounts within the Health and Human Services Account, or its successor, the Support Services Account, in the Local Revenue Fund 2011. Funds for the increased county share of cost shall be provided through the subaccounts of the Health and Human Services Account and its successors within the Support Services Account.

(3) This subdivision shall become operative on November 7, 2012, if a constitutional amendment adding Section 36 to Article XIII of the California Constitution is approved by the voters at the November 6, 2012, statewide general election.

(i) (1) Every month, the Controller shall post on the Controller's internet website the amount received by the Local Revenue Fund 2011 from revenues raised by Sections 6051.15, 6201.15, 11001.5, and 11005 of the Revenue and Taxation Code. Additionally, every month, the Controller shall post the amounts allocated to every account, subaccount, and special account in the Local Revenue Fund 2011.

(2) Annually, the Controller shall post on the Controller's internet website the amounts allocated to each account, subaccount, and special account, and provide detailed information as to the source of that funding. The Controller shall also post the highest amount ever allocated to the Behavioral Health Subaccount, the Protective Services Subaccount, the Trial Court Security Subaccount, and the Juvenile Justice Subaccount, and, after the 2014–15 fiscal year, the highest amount ever allocated to the Community Corrections Subaccount, and the District Attorney and Public Defender Subaccount. In every fiscal year in which funding is not at the highest level for subaccounts specifically named in this paragraph, the Controller shall note how much growth funding may need to be provided as restoration funding in a future fiscal year to achieve that level.

(3) Annually, the Controller shall post on the Controller's internet website the amount each county received pursuant to paragraph (1) of subdivision (a), paragraph (2) of subdivision (b), and paragraph (2) of subdivision (c) of Section 30027.9 for each of the county's or city and county's subaccounts.

(j) The enactment of the 2011 Realignment Legislation is not intended to, nor does it in any way, affect rights provided by federal entitlement programs. Nothing in the 2011 Realignment Legislation places any additional restrictions on eligibility, coverage, or access to services and care for any federal or state entitlement program.

(k) Counties, cities, and city and counties shall fund Medi-Cal Specialty Mental Health Services, including Early and Periodic Screening, Diagnosis

and Treatment (EPSDT), from moneys received from the Behavioral Health Subaccount and the Behavioral Health Growth Special Account, both created pursuant to Section 30025, the Mental Health Subaccount created pursuant to Section 17600 of the Welfare and Institutions Code, the Mental Health Account created pursuant to Section 17600.10 of the Welfare and Institutions Code, and to the extent permissible under the Mental Health Services Act, the Behavioral Health Services Fund created pursuant to Section 19602.5 of the Revenue and Taxation Code. Because this is a federal entitlement program, the provision of services shall be based on statute, regulation, the managed care waiver provisions of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396n), or the State Plan or its amendment or amendments.

(*l*) Subdivisions (a), (b), and (g) shall become inoperative on November 7, 2012, if a constitutional amendment adding Section 36 to Article XIII of the California Constitution is approved by the voters at the November 6, 2012, statewide general election.

SEC. 5. Section 100520.5 of the Government Code is amended to read:

100520.5. (a) The Health Care Affordability Reserve Fund is hereby created in the State Treasury.

(b) Notwithstanding any other law, the Controller may use the funds in the Health Care Affordability Reserve Fund for cashflow loans to the General Fund as provided in Sections 16310 and 16381.

(c) Upon the enactment of the Budget Act of 2021, and upon order of the Director of Finance, the Controller shall transfer three hundred thirty-three million four hundred thirty-nine thousand dollars ($333,439,000) from the General Fund to the Health Care Affordability Reserve Fund.

(d) Upon appropriation by the Legislature, the Health Care Affordability Reserve Fund shall be utilized, in addition to any other appropriations made by the Legislature for the same purpose, for the purpose of health care affordability programs operated by the California Health Benefit Exchange.

(e) (1) The California Health Benefit Exchange shall, in consultation with stakeholders and the Legislature, develop options for providing cost sharing reduction subsidies to reduce cost sharing for low- and middle-income Californians. On or before January 1, 2022, the Exchange shall report those developed options to the Legislature, Governor, and the Healthy California for All Commission, established pursuant to Section 1001 of the Health and Safety Code, for consideration in the 2022–23 budget process.

(2) In developing the options, the Exchange shall do all of the following:

(A) Include options for all Covered California enrollees with income up to 400 percent of the federal poverty level to reduce cost sharing, including copays, deductibles, coinsurance, and maximum out-of-pocket costs.

(B) Include options to provide zero deductibles for all Covered California enrollees with income under 400 percent of the federal poverty level and upgrading those with income between 200 percent and 400 percent, inclusive, of the federal poverty level to gold-tier cost sharing.

(C) Address any operational issues that might impede implementation of enhanced cost-sharing reductions for the 2023 calendar year.

(D) Maximize federal funding and address interactions with federal law regarding federal cost-sharing reduction subsidies.

(3) The Exchange shall make the report publicly available on its internet website.

(4) The Exchange shall submit the report in compliance with Section 9795 of the Government Code.

(f) Upon order of the Department of Finance, a loan of six hundred million dollars ($600,000,000) is authorized from the Health Care Affordability Reserve Fund to the General Fund in the 2023–24 fiscal year. The loan shall be repaid in annual installments of two hundred million dollars ($200,000,000) over the 2026–27, 2027–28, and 2028–29 fiscal years.

SEC. 6. Section 1212 of the Health and Safety Code is amended to read:

1212. (a) Any person, firm, association, partnership, or corporation desiring a license for a clinic or a special permit for special services under the provisions of this chapter, shall file with the department a verified application on forms prescribed and furnished by the department, containing the following:

(1) Evidence satisfactory to the department that the applicant is of reputable and responsible character. If the applicant is a firm, association, partnership, trust, corporation, or other artificial or legal entity, like evidence shall be submitted as to the members, partners, trustees or shareholders, directors, and officers thereof and as to the person who is to be the administrator of, and exercise control, management, and direction of the clinic for which application is made.

(2) If the applicant is a partnership, the name and principal business address of each partner, and, if any partner is a corporation, the name and principal business address of each officer and director of the corporation and name and business address of each stockholder owning 10 percent or more of the stock thereof.

(3) If the applicant is a corporation, the name and principal business address of each officer and director of the corporation, and if the applicant is a stock corporation, the name and principal business address of each stockholder holding 10 percent or more of the applicant’s stock and, if any stockholder is a corporation, the name and principal business address of each officer and director of the corporate stockholder.

(4) Evidence satisfactory to the department of the ability of the applicant to comply with the provisions of this chapter and rules and regulations promulgated under this chapter by the department.

(5) The name and address of the clinic, and if the applicant is a professional corporation, firm, partnership, or other form of organization, evidence that the applicant has complied with the requirements of the Business and Professions Code governing the use of fictitious names by practitioners of the healing arts.

(6) The name and address of the professional licentiate responsible for the professional activities of the clinic and the licentiate's license number and professional experience.

(7) The class of clinic to be operated, the character and scope of advice and treatment to be provided, and a complete description of the building, its location, facilities, equipment, apparatus, and appliances to be furnished and used in the operation of the clinic.

(8) Sufficient operational data to allow the department to determine the class of clinic that the applicant proposes to operate and the initial license fee to be charged.

(9) Any other information as may be required by the department for the proper administration and enforcement of this chapter, including, but not limited to, evidence that the clinic has a written policy relating to the dissemination of the following information to patients:

(A) A summary of current state laws requiring child passenger restraint systems to be used when transporting children in motor vehicles.

(B) A listing of child passenger restraint system programs located within the county, as required by Section 27360 or 27362 of the Vehicle Code.

(C) Information describing the risks of death or serious injury associated with the failure to utilize a child passenger restraint system.

(10) The information required pursuant to this section shall be provided to the Licensing and Certification Program upon initial application for licensure. Unless otherwise specified, any change in the information that requires the licensee to submit a report of change or written notification to the Licensing and Certification Program shall be provided within 10 business days of the change along with any applicable fee according to subdivision (b) of Section 1266.

(b) (1) No application is required if a licensed primary care clinic adds a service that is not a special service, as defined in Section 1203, or any regulation adopted under that section, or remodels or modifies, or adds an additional physical plant maintained and operated on separate premises to, an existing primary care clinic site. However, the clinic shall notify the department, in writing, of the change in service or physical plant no less than 60 days prior to adding the service or remodeling or modifying, or adding an additional physical plant maintained and operated on a separate premises to, an existing primary care clinic site. Nothing in this subdivision shall be construed to limit the authority of the department to conduct an inspection at any time pursuant to Section 1227, in order to ensure compliance with, or to prevent a violation of, this chapter, or any regulation adopted under this chapter.

(2) If applicable city, county, or state law obligates the primary care clinic to obtain a building permit with respect to the remodeling or modification to be performed by the clinic, or the construction of a new physical plant, the primary care clinic shall provide a signed certification or statement as described in Section 1226.3 to the department within 60 days following completion of the remodeling, modification, or construction project covered by the building permit.

(c) In the course of fulfilling its obligations under Section 1221.09, the department shall ensure that any application form utilized by a primary care clinic, requiring information of the type specified in paragraph (1), (4), (8), or (9) of subdivision (a), is consistent with the requirements of Section 1225, including the requirement that rules and regulations for primary care clinics be separate and distinct from the rules and regulations for specialty clinics. Nothing in this section shall be construed to require the department to issue a separate application form for primary care clinics.

(d) (1) The department, upon written notification by a primary care clinic or an affiliate clinic of its intent to add an additional physical plant maintained and operated on separate premises, as described in paragraph (1) of subdivision (b) and upon payment of a licensing fee for each additional physical plant added, shall review the information provided in the notification, and if the information submitted is in compliance with the requirements specified in this subdivision, the department shall approve the additional physical plant within 30 days of all information being submitted and shall amend the primary care clinic or affiliate clinic's license to include the additional physical plant as part of a single consolidated license. If the notification does not include the information required by this subdivision, the department shall notify the licensee of the need for additional information and shall not amend the license to add the additional physical plant until the additional information is received and reviewed by the department.

(2) Written notification shall include evidence that the primary care clinic or affiliate clinic is licensed in good standing and otherwise meets the criteria specified in this subdivision. In issuing the single consolidated license, the department shall specify the location of each physical plant.

(3) The written notification shall demonstrate compliance with all of the following criteria:

(A) There is a single governing body for all the facilities maintained and operated by the licensee.

(B) There is a single administration for all the facilities maintained and operated by the licensee.

(C) There is a single medical director for all the facilities maintained and operated by the licensee, with a single set of bylaws, rules, and regulations.

(D) The additional physical plant meets minimum construction standards of adequacy and safety for clinics found in the most recent version of the California Building Standards Code and prescribed by the Office of Statewide Health Planning and Development, as required in subdivision (b) of Section 1226. Compliance with the minimum construction standards of adequacy and safety may be established as specified in Section 1226.3.

(E) The additional physical plant meets fire clearance standards.

(4) The written notification required to be submitted pursuant to this subdivision shall include all of the following documentation:

(A) The name and address of the licensee's corporation administrative office, including the name and contact information for the corporation's chief executive officer or executive director.

(B) The name and address of, and the hours of operation and services provided by, the additional physical plant.

(C) A copy of any document confirming the corporation's authority to control the additional physical plant. Examples of acceptable documentation include, but shall not be limited to, a lease or purchase agreement, grant deed, bill of sale, sublease, rental agreement, or memorandum of understanding between the owner of the property and the proposed licensee.

(5) A primary care clinic or an affiliate clinic may add additional physical plants pursuant to this section that are no more than one-half mile from the licensed clinic adding the additional physical plant under a consolidated license.

(6) Upon renewal of a consolidated license approved pursuant to this subdivision, a licensee fee shall be required for each additional physical plant approved on the license.

SEC. 7. Section 1214 of the Health and Safety Code is amended to read:

1214. Each application under this chapter for an initial license, renewal license, license upon change of ownership, or special permit shall be accompanied by a Licensing and Certification Program fee, as follows:

(a) For all primary care clinics licensed pursuant to this chapter, the fee shall be set in accordance with Section 1266.

(b) For all specialty clinics licensed pursuant to this chapter, the fee shall be set in accordance with Section 1266.

(c) For all rehabilitation clinics, the fee shall be set in accordance with Section 1266.

SEC. 8. Section 1214.1 of the Health and Safety Code is amended to read:

1214.1. Notwithstanding the provisions of Section 1214, each application for a surgical clinic or a chronic dialysis clinic under this chapter for an initial license, renewal license, license upon change of ownership, or special permit shall be accompanied by a Licensing and Certification Program fee set in accordance with Section 1266.

SEC. 9. Section 1266 of the Health and Safety Code is amended to read:

1266. (a) The Licensing and Certification Program shall be supported entirely by federal funds and special funds by no earlier than the beginning of the 2009–10 fiscal year unless otherwise specified in statute, or unless funds are specifically appropriated from the General Fund in the annual Budget Act or other enacted legislation.

(b) Commencing February 1, 2007, and every February 1 thereafter, the Licensing and Certification Program shall publish a list of estimated program fees, including, but not limited to, annual licensing, report of change application, and written notification fees pursuant to this section. The calculation of estimated fees and the publication of the report and list of estimated fees shall not be subject to the rulemaking requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) Notwithstanding Section 10231.5 of the Government Code, by February 1 of each year, the department shall prepare the following reports

and shall make those reports, and the list of estimated fees required to be published pursuant to subdivision (b), available to the public by submitting them to the Legislature and posting them on the department's internet website:

(1) A report of all costs for activities of the Licensing and Certification Program. At a minimum, this report shall include a narrative of all baseline adjustments and their calculations, a description of how each category of facility was calculated, descriptions of assumptions used in any calculations, and shall recommend Licensing and Certification Program fees in accordance with the following:

(A) Projected workload and costs shall be grouped for each fee category, including workload costs for facility categories that have been established by statute and for which licensing regulations and procedures are under development.

(B) Cost estimates, and the estimated fees, shall be based on the appropriation amounts in the Governor's proposed budget for the next fiscal year, with and without policy adjustments to the fee methodology.

(C) The allocation of program, operational, and administrative overhead, and indirect costs to fee categories shall be based on generally accepted cost allocation methods. Significant items of costs shall be directly charged to fee categories if the expenses can be reasonably identified to the fee category that caused them. Indirect and overhead costs shall be allocated to all fee categories using a generally accepted cost allocation method.

(D) The amount of federal funds and General Fund moneys to be received in the budget year shall be estimated and allocated to each fee category based upon an appropriate metric.

(E) The fee for each category shall be determined by dividing the aggregate state share of all costs for the Licensing and Certification Program by the appropriate metric for the category of licensure. Amounts received for new licensure applications, including change of ownership applications, and late payment penalties, pursuant to Section 1266.5, during each fiscal year shall be calculated and 95 percent shall be applied to the appropriate fee categories in determining Licensing and Certification Program fees for the second fiscal year following receipt of those funds. The remaining 5 percent shall be retained in the fund as a reserve until appropriated.

(2) (A) A staffing and systems analysis to ensure efficient and effective utilization of fees collected, proper allocation of departmental resources to licensing and certification activities, survey schedules, complaint investigations, enforcement and appeal activities, data collection and dissemination, surveyor training, and policy development.

(B) The analysis under this paragraph shall be made available to interested persons and shall include all of the following:

(i) The number of surveyors and administrative support personnel devoted to the licensing and certification of health care facilities.

(ii) The percentage of time devoted to licensing and certification activities for the various types of health facilities.

(iii) The number of facilities receiving full surveys and the frequency and number of followup visits.

(iv) The number and timeliness of complaint investigations, including data on the department's compliance with the requirements of paragraphs (3), (4), and (5) of subdivision (a) of Section 1420.

(v) Data on deficiencies and citations issued, and numbers of arbitration hearings.

(vi) Other applicable activities of the Licensing and Certification Program.

(3) The annual program fee report described in subdivision (d) of Section 1416.36.

(d) The reports required pursuant to subdivision (c) shall be submitted in compliance with Section 9795 of the Government Code.

(e) Commencing in the 2015–16 fiscal year, the fees for skilled nursing facilities shall be increased so as to generate four hundred thousand dollars ($400,000) for the California Department of Aging's Long-Term Care Ombudsman Program for its work related to investigating complaints made against skilled nursing facilities and increasing visits to those facilities.

(f) Commencing in the 2018–19 fiscal year, the Licensing and Certification Program may assess a supplemental program fee on facilities located in the County of Los Angeles for all facility types set forth in this section. This supplemental program fee shall be in addition to the program fees set forth in the estimated program fee list described in subdivision (b). The Licensing and Certification Program shall calculate the supplemental program fee based upon the difference between the estimated costs of regulating facility types licensed in the County of Los Angeles, including, but not limited to, the costs associated with the Licensing and Certification Program's contract for licensing and certification activities with the County of Los Angeles and the costs of the Licensing and Certification Program conducting the licensing and certification activities for facilities located in the County of Los Angeles. The supplemental program fees shall be used to cover the costs to administer and enforce state licensure standards and other federal compliance activities for facilities located in the County of Los Angeles, as described in the annual report. The supplemental program fee shall be based upon the fee methodology published in the annual report described in subdivision (b).

(g) (1) The Licensing and Certification Program shall adjust the list of estimated fees published pursuant to subdivision (b) if the annual Budget Act or other enacted legislation includes an appropriation that differs from those proposed in the Governor's proposed budget for that fiscal year.

(2) The Licensing and Certification Program shall publish a final fee list, with an explanation of any adjustment, by the issuance of an all facilities letter, by posting the list on the department's internet website, and by including the final fee list as part of the licensing application package, within 14 days of the enactment of the annual Budget Act. The adjustment of fees and the publication of the final fee list shall not be subject to the rulemaking requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(h) Fees shall not be assessed or collected pursuant to this section from any state department, authority, bureau, commission, or officer, unless federal financial participation would become available by doing so and an appropriation is included in the annual Budget Act for that state department, authority, bureau, commission, or officer for this purpose. Fees shall not be assessed or collected pursuant to this section from any clinic that is certified only by the federal government and is exempt from licensure under Section 1206, unless federal financial participation would become available by doing so.

(i) The Licensing and Certification Program may change annual license expiration renewal dates to provide for efficiencies in operational processes or to provide for sufficient cashflow to pay for expenditures. If an annual license expiration date is changed, the annual license fee shall be prorated accordingly. Facilities shall be provided with a 60-day notice of any change in their annual license renewal date. If a licensee voluntarily surrenders its license, they shall not be entitled to a refund for the remainder of the license period.

(j) Commencing with the 2018–19 November Program estimate, the Licensing and Certification Program shall evaluate the feasibility of reducing investigation timelines based on experience with implementing paragraphs (3), (4), and (5) of subdivision (a) of Section 1420.

SEC. 10. Section 1266.5 of the Health and Safety Code is amended to read:

1266.5. (a) Whenever any entity required to pay fees pursuant to Section 1266 continues to operate beyond its license expiration date, without the Licensing and Certification Program annual license fees first having been paid as required by this division, those fees are delinquent.

(b) A late payment penalty shall be added to any delinquent annual license fees made later than midnight of the license expiration date. The late payment penalty shall be computed as follows:

(1) For a delinquency period of 30 days or less, the penalty shall be 10 percent of the fee.

(2) For a delinquency period of more than 30 days to and including 60 days, the penalty shall be 20 percent of the fee.

(3) For a delinquency period of more than 60 days, the penalty shall be 60 percent of the fee.

(c) A license may not be renewed without payment of the Licensing and Certification Program annual license fee plus any late payment penalty.

(d) Whenever any entity required to pay a report of change or written notification fee pursuant to Section 1266 fails to both submit a timely report of change or written notification and pay the applicable fee, those fees are delinquent.

(e) A late payment penalty shall be added to any delinquent fees due with a report of change or written notification made later than midnight of the required submission date. The late payment penalty shall be computed as follows:

(1) For a delinquency period of 30 days or less, the penalty shall be 10 percent of the fee.

(2) For a delinquency period of more than 30 days to and including 60 days, the penalty shall be 20 percent of the fee.

(3) For a delinquency period of more than 60 days, the penalty shall be 60 percent of the fee.

(f) The Licensing and Certification Program may, upon written notification to the licensee, offset any moneys owed to the licensee by the Medi-Cal program or any other payment program administered by the department to recoup any annual license, report of change, or written notification fee along with any associated late payment penalties.

SEC. 11. Section 1341.45 of the Health and Safety Code is amended to read:

1341.45. (a) There is hereby created in the State Treasury the Managed Care Administrative Fines and Penalties Fund.

(b) The fines and administrative penalties collected pursuant to this chapter, on and after September 30, 2008, shall be deposited into the Managed Care Administrative Fines and Penalties Fund.

(c) The fines and administrative penalties deposited into the Managed Care Administrative Fines and Penalties Fund shall be transferred by the department, beginning September 1, 2009, and annually thereafter, as follows:

(1) The first one million dollars ($1,000,000) shall be transferred to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) or Chapter 5 of Part 3 of Division 107 and, notwithstanding Section 128555, shall not be used to provide funding for the Physician Volunteer Program.

(2) Any amount over the first one million dollars ($1,000,000), including accrued interest, in the fund shall be transferred to the Health Care Services Plan Fines and Penalties Fund created pursuant to Section 15893 of the Welfare and Institutions Code.

(d) Notwithstanding subdivision (b) of Section 1356 and Section 1356.1, the fines and administrative penalties authorized pursuant to this chapter shall not be used to reduce the assessments imposed on health care service plans pursuant to Section 1356.

(e) The amendments made to this section by the act adding this subdivision shall become operative on July 1, 2014.

(f) The amendments made to this section by the act adding this subdivision shall become operative on July 1, 2017.

SEC. 12. Section 1389.25 of the Health and Safety Code is amended to read:

1389.25. (a) (1) This section shall apply only to a full service health care service plan offering health coverage in the individual market in California and shall not apply to a specialized health care service plan, a

health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), a health care service plan conversion contract offered pursuant to Section 1373.6, a health care service plan contract in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), or a health care service plan contract offered to a federally eligible defined individual under Article 4.6 (commencing with Section 1366.35).

(2) A local initiative, as defined in subdivision (w) of Section 53810 of Title 22 of the California Code of Regulations, that is awarded a contract by the State Department of Health Care Services pursuant to subdivision (b) of Section 53800 of Title 22 of the California Code of Regulations, shall not be subject to this section unless the plan offers coverage in the individual market to persons not covered by Medi-Cal or the Healthy Families Program.

(b) (1) No change in the premium rate or coverage for an individual plan contract shall become effective unless the plan has provided a written notice of the change at least 10 days prior to the start of the annual enrollment period applicable to the contract or 60 days prior to the effective date of the contract renewal, whichever occurs earlier in the calendar year.

(2) The written notice required pursuant to paragraph (1) shall be provided to the individual contractholder at their last address known to the plan. The notice shall state in italics and in 12-point type the actual dollar amount of the premium rate increase and the specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the plan design or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface, the reason for a premium rate change or a change to the plan design or benefits.

(c) (1) If the department determines that a rate is unreasonable or not justified consistent with Article 6.2 (commencing with Section 1385.01), the plan shall notify the contractholder of this determination. This notification may be included in the notice required in subdivision (b). The notification to the contractholder shall be developed by the department. The development of the notification required under this subdivision 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 notification to the contractholder shall include the following statements in 14-point type:

(A) The Department of Managed Health Care has determined that the rate for this product is unreasonable or not justified after reviewing information submitted to it by the plan.

(B) During the open enrollment period, the contractholder has the option to obtain other coverage from this plan or another plan, or to keep this coverage.

(C) The contractholder may want to contact Covered California at www.coveredca.com for help in understanding available options.

(D) Many Californians are eligible for financial assistance from Covered California to help pay for coverage.

(3) The plan may include in the notification to the contractholder the internet website address at which the plan's final justification for implementing an increase that has been determined to be unreasonable by the director may be found pursuant to Section 154.230 of Title 45 of the Code of Federal Regulations.

(4) The notice shall also be provided to the solicitor for the contractholder, if any, so that the solicitor may assist the purchaser in finding other coverage.

(5) In developing the notification, the department shall take into consideration that this notice is required to be provided to an individual applicant pursuant to subdivision (g) of Section 1385.03.

(d) (1) Before July 1, 2024, if a plan rejects a dependent of a subscriber applying to be added to the subscriber's individual grandfathered health plan, rejects an applicant for a Medicare supplement plan contract due to the applicant having end-stage renal disease, or offers an individual grandfathered health plan to an applicant at a rate that is higher than the standard rate, the plan shall inform the applicant about the California Major Risk Medical Insurance Program (MRMIP) (Chapter 4 (commencing with Section 15870) of Part 3.3 of Division 9 of the Welfare and Institutions Code) and about new coverage options and the potential for subsidized coverage through Covered California. The plan shall direct persons seeking more information to MRMIP, Covered California, plan or policy representatives, insurance agents, or an entity paid by Covered California to assist with health coverage enrollment, such as a navigator or an assister.

(2) On or after July 1, 2024, if a plan rejects a dependent of a subscriber applying to be added to the subscriber's individual grandfathered health plan, rejects an applicant for a Medicare supplement plan contract due to the applicant having end-stage renal disease, or offers an individual grandfathered health plan to an applicant at a rate that is higher than the standard rate, the plan shall inform the applicant about new coverage options and the potential for subsidized coverage through Covered California. The plan shall direct persons seeking more information to Covered California, plan or policy representatives, insurance agents, or an entity paid by Covered California to assist with health coverage enrollment, such as a navigator or an assister.

(e) A notice provided pursuant to this section is a private and confidential communication and, at the time of application, the plan shall give the individual applicant the opportunity to designate the address for receipt of the written notice in order to protect the confidentiality of any personal or privileged information.

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

(1) "Covered California" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(2) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(3) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 13. Section 1728.1 of the Health and Safety Code is amended to read:

1728.1. (a) To qualify for a home health agency license, the following requirements shall be met:

(1) Every applicant shall satisfy the following conditions:

(A) Be of good moral character. If the applicant is a firm, association, organization, partnership, business trust, corporation, or company, all principal managing members thereof, and the person in charge of the agency for which application for license is made, shall satisfy this requirement. If the applicant is a political subdivision of the state or other governmental agency, the person in charge of the agency for which application for license is made, shall satisfy this requirement.

(B) Possess and demonstrate the ability to comply with this chapter and the rules and regulations adopted under this chapter by the state department.

(C) File their application pursuant to and in full compliance with this chapter.

(2) (A) The following persons shall submit to the State Department of Public Health an application and shall submit electronic fingerprint images to the Department of Justice for the furnishing of the person's criminal record to the state department, at the person's expense as provided in subdivision (b), for the purpose of a criminal record review:

(i) The owner or owners of a private agency if the owners are individuals.

(ii) If the owner of a private agency is a corporation, partnership, or association, any person having a 10 percent or greater interest in that corporation, partnership, or association.

(iii) The administrator of a home health agency.

(B) When the conditions set forth in paragraph (3) of subdivision (a) of Section 1265.5, subparagraph (A) of paragraph (1) of subdivision (a) of Section 1338.5, and paragraph (1) of subdivision (a) of Section 1736.6 are met, the licensing and certification program shall issue an All Facilities Letter (AFL) informing facility licensees. After the AFL is issued, facilities must not allow newly hired administrators, program directors, and fiscal officers to have direct contact with clients or residents of the facility prior to completion of the criminal record clearance. A criminal record clearance shall be complete when the department has obtained the person's criminal offender record information search response from the Department of Justice and has determined that the person is not disqualified from engaging in the activity for which clearance is required.

(3) The information required pursuant to this section shall be provided to the Licensing and Certification Program upon initial application for licensure. Unless otherwise specified, any change in the information that requires the licensee to submit a report of change or written notification to the Licensing and Certification Program shall be provided within 10 business

days of the change along with any applicable fee according to subdivision (b) of Section 1266.

(b) The persons specified in paragraph (2) of subdivision (a) shall be responsible for any costs associated with transmitting the electronic fingerprint images. The fee to cover the processing costs of the Department of Justice, not including the costs associated with capturing or transmitting the fingerprint images and related information, shall not exceed thirty-two dollars ($32) per submission.

(c) If the criminal record review conducted pursuant to paragraph (2) of subdivision (a) discloses a conviction for a felony or any crime that evidences an unfitness to provide home health services, the application for a license shall be denied or the person shall be prohibited from providing service in the home health agency applying for a license. This subdivision shall not apply to deny a license or prohibit the provision of service if the person presents evidence satisfactory to the state department that the person has been rehabilitated and presently is of such good character as to justify the issuance of the license or the provision of service in the home health agency.

(d) An applicant and any other person specified in this section, as part of the background clearance process, shall provide information as to whether or not the person has any prior criminal convictions, has had any arrests within the past 12-month period, or has any active arrests, and shall certify that, to the best of their knowledge, the information provided is true. This requirement is not intended to duplicate existing requirements for individuals who are required to submit fingerprint images as part of a criminal background clearance process. Every applicant shall provide information on any prior administrative action taken against them by any federal, state, or local government agency and shall certify that, to the best of their knowledge, the information provided is true. An applicant or other person required to provide information pursuant to this section that knowingly or willfully makes false statements, representations, or omissions may be subject to administrative action, including, but not limited to, denial of their application or exemption or revocation of any exemption previously granted.

SEC. 14. Section 1749 of the Health and Safety Code is amended to read:

1749. (a) To qualify for a license under this chapter, an applicant shall satisfy all of the following:

(1) Be of good moral character. If the applicant is a franchise, franchisee, firm, association, organization, partnership, business trust, corporation, company, political subdivision of the state, or governmental agency, the person in charge of the hospice for which the application for a license is made shall be of good moral character.

(2) Demonstrate the ability of the applicant to comply with this chapter and any rules and regulations promulgated under this chapter by the department.

(3) File a completed application with the department that was prescribed and furnished pursuant to Section 1748.

(4) The information required pursuant to this section shall be provided to the Licensing and Certification Program upon initial application for licensure. Unless otherwise specified, any change in the information that requires the licensee to submit a report of change or written notification to the Licensing and Certification Program shall be provided within 10 business days of the change along with any applicable fee according to subdivision (b) of Section 1266.

(b) (1) A hospice agency shall have an administrator, administrator designee, director of patient care services, director of patient care services designee, and medical director or contracted medical director, and shall submit to the department all of the following information for each individual on an initial application:

(A) An HS 215A form or its successor form.

(B) A résumé.

(C) A list of all hospice agencies the individual is currently serving as an administrator, administrator designee, director of patient care services, director of patient care services designee, or medical director or contracted medical director.

(2) In addition to the information required pursuant to paragraph (1), a hospice agency shall submit to the department information on whether its medical director, or contracted medical director, is certified as a hospice medical director according to the requirements established by the Hospice Medical Director Certification Board, or certified in hospice and palliative medicine according to the requirements established by a member board of the American Board of Medical Specialties, or by the American Osteopathic Association, or an equivalent organization as determined by the department.

(3) A hospice agency shall notify the department of any change in the administrator, administrator designee, director of patient care services, director of patient care services designee, or medical director or contracted medical director by submitting the information described in paragraphs (1) and (2) within 10 business days of the change.

(4) All hospice agencies shall report to the department the name of the agency's administrator, administrator designee, director of patient care services, director of patient care services designee, and medical director or contracted medical director by submitting the information required by paragraphs (1) and (2), no later than March 31, 2023.

(c) (1) The department shall verify the status of professional licensure for hospice agency management personnel.

(2) The department may also verify the following:

(A) Association of hospice agency management personnel listed on the licensing application with the hospice agency.

(B) Work history of hospice agency management personnel.

(3) For purposes of this subdivision, verification may include contacting the hospice agency personnel or previous employers by telephone.

(d) In order for a person, political subdivision of the state, or other governmental agency to be licensed as a hospice agency, it shall satisfy the

definition of a hospice contained in Section 1746, and also provide, or make provision for, the following basic services:

(1) Skilled nursing services.

(2) Social services/counseling services.

(3) Medical direction.

(4) Bereavement services.

(5) Volunteer services.

(6) Inpatient care arrangements.

(7) Home health aide services.

(e) The services required to be provided pursuant to subdivision (d) shall be provided in compliance with the "Standards for Quality Hospice Care, 2003," as available from the California Hospice and Palliative Care Association, until the department adopts regulations establishing alternative standards pursuant to subdivision (h).

(f) (1) Except as provided in paragraph (2), the applicant shall demonstrate and provide evidence of an unmet need of hospice services in the geographic area that a hospice agency would serve.

(2) An applicant for a hospice agency change of ownership need not comply with paragraph (1) for the previously approved service area if the license has been continually held by the previous licensee for five years and one of the following conditions are met:

(A) The hospice agency has previously qualified for licensure after demonstrating and providing evidence of unmet need of hospice services in the hospice agency's geographic area.

(B) The hospice agency can demonstrate it is meeting a need for hospice services.

(3) If the hospice agency's approved geographic service area will change upon the change in ownership, the new applicant for licensure shall demonstrate unmet need for hospice services for any new service area.

(g) (1) Notwithstanding any law to the contrary, to meet the unique needs of the community, licensed hospice agencies may provide, in addition to hospice services authorized in this chapter, any of the following preliminary services for any person in need of those services, as determined by the physician and surgeon, if any, in charge of the care of a patient, or at the request of the patient or family:

(A) Preliminary palliative care consultations.

(B) Preliminary counseling and care planning.

(C) Preliminary grief and bereavement services.

(2) Preliminary services authorized pursuant to this subdivision may be provided concurrently with curative treatment to a person who does not have a terminal prognosis or who has not elected to receive hospice services only by licensed and certified hospices. These services shall be subject to the schedule of benefits under the Medi-Cal program, pursuant to subdivision (w) of Section 14132 of the Welfare and Institutions Code.

(h) The department may adopt regulations establishing standards for any or all of the services required to be provided under subdivision (d). The regulations of the department adopted pursuant to this subdivision shall

supersede the standards referenced in subdivision (e) to the extent the regulations duplicate or replace those standards.

SEC. 15. Section 51312 of the Health and Safety Code is amended to read:

51312. (a) The primary purpose of this chapter is to provide an additional method of financing special needs housing.

(b) (1) For purposes of this chapter, "special needs housing" means any housing, including supportive housing, intended to benefit, in whole or in part, persons identified as having special needs relating to any of the following:

(A) Mental health.

(B) Physical disabilities.

(C) Developmental disabilities, including, but not limited to, intellectual disability, cerebral palsy, epilepsy, and autism.

(D) The risk of homelessness.

(2) Special needs housing shall also mean housing intended to meet the housing needs of persons eligible for mental health services funded in whole or in part by the Behavioral Health Services Fund, created by Section 5890 of the Welfare and Institutions Code.

SEC. 16. Section 104751 is added to the Health and Safety Code, to read:

104751. (a) The Office of Oral Health, in consultation with the Dental Board of California, the California Dental Association, California dental schools, and other stakeholders, shall support the establishment of community-based clinical education (CBCE) rotations for dental students in their final year or dental residents.

(b) To implement this provision, the Office of Oral Health may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code 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.

(c) Eligible community clinical settings include, but are not limited to, federally qualified health centers (FQHCs), private dental offices, and mobile dentistry, and shall be located in a designated dental health professional shortage area (DHPSA).

(d) The Office of Oral Health shall compile data and prepare a report to be submitted to the Legislature on or before July 1, 2027, on all of the following desired outcomes:

(1) The number of underserved children and adults served by students and residents.

(2) The total number of student and resident trainees.

(3) The number of and types of community-based preventative and treatment procedures provided by students.

(4) The proportion of graduating dental students and residents rotating in CBCE sites who express interest in working in a DHPSA.

(5) The proportion of graduating dental students with CBCE training who will be recruited to FQHCs or other rural and community health clinics through state loan repayment programs, including the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program.

(e) This section shall remain in effect only until June 30, 2029, and as of that date is repealed.

SEC. 17. 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 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. 18. 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 power 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 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. 19. Section 120972.2 is added to the Health and Safety Code, to read:

120972.2. (a) The State Department of Public Health's Office of AIDS may expend moneys from the AIDS Drug Assistance Program Rebate Fund to support prevention services for individuals most vulnerable to HIV, including, but not limited to, harm reduction services, internal and external condoms, or other preventative measures to limit individuals from contracting HIV.

(b) To the extent that funds are available for these purposes, the State Department of Public Health's Office of AIDS may allocate funds to local health departments and community-based organizations to support HIV prevention.

SEC. 20. Section 123322 of the Health and Safety Code is amended to read:

123322. (a) In order to effectively manage and administer the federal and state requirements for the vendors in the WIC Program, and remain in compliance with the conditions of federal funding, the department shall establish requirements for all of the following:

(1) Retail food delivery systems, as set forth in Section 246.12 of Title 7 of the Code of Federal Regulations, including, but not limited to, all of the following:

(A) Peer groups and a corresponding reimbursement system.
(B) Criteria used for vendor authorization and management.
(C) Online shopping.
(2) The WIC Program authorized foods.

(b) Notwithstanding any other law, including the requirement in Section 123315 for enacting regulations to implement that section, Section 123310, and Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of all-county letters, plan letters, information notices, provider bulletins, or other similar instructions, without taking any further regulatory action. The department shall provide notice to, and consult with, affected stakeholders, including vendors, manufacturers, local agencies, participants, advocates, consumer groups, and their respective associations, in the process of implementing, interpreting, or making specific this statute, and meet all of the following requirements:

(1) The notice shall be provided electronically to the stakeholders identified in this subdivision and shall also be posted on the program's internet website. The notice shall state the reason for the change, the authority for the change, and the nature of the change. The notice shall provide opportunity for written comment by indicating the address to which to send the comment. The address may be an electronic site. The notice shall allow for at least 20 calendar days for comments to be submitted. The notice shall also provide the date of a consultation meeting with a stakeholder workgroup consisting of, but not limited to, representatives of stakeholder associations, stakeholder representatives, and consumer groups, to ensure stakeholder participation in the implementation of this section.

(2) The department shall consider all comments submitted before the due date, though it may withdraw the proposed action at any time by notification on its internet website or notification by electronic means. Unless the department withdraws the action, it shall publish the final action on its internet website no later than 180 days after the consultation with stakeholders or the last day for comments, whichever is later. If the department fails to issue a final action within 180 days from the consultation with stakeholders or the last day for comments, whichever is later, the proposed action will be deemed withdrawn. The department may finalize a proposed action that has been withdrawn by renoticing the proposed action for comment pursuant to paragraphs (1) to (3), inclusive.

(3) The department shall provide at least 30 days' advance notice of the final action. In the final action, the department shall respond to the comments received.

(4) WIC authorized vendors approved for online shopping shall maintain a fixed physical location in California.

(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 modify or repeal WIC Program requirements set forth in Title 22 of the California Code of Regulations pursuant to this section by bulletin or similar

instruction, without taking further regulatory action, if the modification or repeal is filed with the Secretary of State and printed in Title 22 of the California Code of Regulations.

(6) (A) The department shall establish a process to collect stakeholder feedback regarding the impact of the final action taken pursuant to the amendments to this section resulting from the Budget Act of 2024 or related trailer bill.

(B) To the extent feasible within existing resources, the department shall regularly monitor the impact that online purchases made through the WIC Program have on reducing barriers to healthy food for people who live in food deserts as well as the impact that online WIC purchases have on increasing the size of food deserts or the number of food deserts in California.

SEC. 21. Section 129385 of the Health and Safety Code is amended to read:

129385. (a) The Distressed Hospital Loan Program Fund is hereby established in the State Treasury. The fund shall be administered by the department consistent with this chapter.

(b) Notwithstanding Section 13340 of the Government Code, all moneys in the fund are continuously appropriated, without regard to fiscal years, for the department and the authority to implement this chapter.

(c) The authority shall make secured loans from the Distressed Hospital Loan Program Fund to a hospital or to a governmental entity representing a closed hospital, for purposes of preventing the closure, or facilitating the reopening, of the hospital.

(d) The department may allocate an amount not to exceed 5 percent of total program funds to administer the program, including, but not limited to, administrative costs to the authority. Any funds transferred shall be available for encumbrance or expenditure until December 31, 2031.

(e) (1) The Department of Finance may transfer up to one hundred fifty million dollars ($150,000,000) from the General Fund to the Distressed Hospital Loan Program Fund between state fiscal years 2022–23 and 2023–24 to implement this chapter.

(2) The Department of Finance may transfer, subject to Section 14105.200 of the Welfare and Institutions Code, up to one hundred fifty million dollars ($150,000,000) from the Medi-Cal Provider Payment Reserve Fund to the Distressed Hospital Loan Program Fund in state fiscal year 2023–24 to implement this chapter.

(f) All moneys accruing to the authority and the department under this chapter from any source shall be deposited into the fund.

(g) The Treasurer may invest moneys in the fund that are not required for its current needs in eligible securities specified in Section 16430 of the Government Code and may transfer moneys in the fund to the Surplus Money Investment Fund for investment pursuant to Article 4 (commencing with Section 16470) of Chapter 3 of Part 2 of Division 4 of Title 2 of the Government Code.

(h) Notwithstanding Section 16305.7 of the Government Code, all interest or other increment resulting from the investment or deposit of moneys from the fund shall be deposited in the fund.

(i) Moneys in the fund shall not be subject to transfer to any other funds pursuant to any provision of Part 2 (commencing with Section 16300) of Division 4 of Title 2 of the Government Code, except to the Surplus Money Investment Fund.

(j) Effective December 31, 2031, the Distressed Hospital Loan Program Fund in the State Treasury, created pursuant to this chapter, is hereby abolished. After accounting for all final program transactions, any remaining Distressed Hospital Loan Program Fund reserves shall be returned to the source of origin, in the amounts of up to one hundred fifty million dollars ($150,000,000) to the General Fund, and up to one hundred fifty million dollars ($150,000,000) to the Medi-Cal Provider Payment Reserve Fund. Any other remaining balance, assets, liabilities, and encumbrances of the Distressed Hospital Loan Program Fund shall revert to the General Fund. The department shall deposit all subsequent loan repayments or Medi-Cal reimbursements withheld for due cause pursuant to subdivision (b) of Section 129384 to the Treasurer, to the credit of the General Fund.

(k) The department and the authority may require any hospital receiving a loan under this chapter to provide the department and the authority with an independent financial audit of the hospital's operations for any fiscal year in which a loan is outstanding.

SEC. 22. Chapter 5 (commencing with Section 131360) is added to Part 1 of Division 112 of the Health and Safety Code, to read:

Chapter 5. Syndromic Surveillance System

131360. For purposes of this chapter, the following terms have the following meanings:

(a) "Centers for Disease Control and Prevention" or "CDC" means the national public health agency of the United States. It is a United States federal agency within the Department of Health and Human Services, and is headquartered in Atlanta, Georgia.

(b) "Department" means the State Department of Public Health.

(c) "Local health department" has the same meaning as defined in Section 101185.

(d) "Specified entity" means a general acute care hospital, as defined in Section 1250, with an emergency department, as defined in Section 128700.

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

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

event and support to responses to emerging public health threats and conditions impacting the health of California residents.

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

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

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

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

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

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

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

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

(C) The department may adopt regulations, in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of the Government Code), to specify any other entity that is required to provide data pursuant to this section.

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

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

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

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

(3) This subdivision does not limit the ability of a local health department to require a specified entity to submit additional data to the local health department in addition to the data required to be submitted to the department.

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

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

131375. (a) To support local public health activities, the department shall provide each local health department as near as possible to real-time access to its jurisdiction's data entered into the state syndromic surveillance system.

(b) The department, at its discretion, may approve the sharing of data collected pursuant to Section 131370 with all of the following entities:

(1) State governmental entities.

(2) Local health departments.

(3) Specified entities as defined in Section 131360 authorized by the department, if access is limited to the specified entity's own data.

(c) The department, at its discretion, may approve the sharing of data collected pursuant to Section 131370 with persons with a valid scientific interest who are engaged in demographic, epidemiological, or other similar studies related to health. Persons with a valid scientific interest who are engaged in demographic, epidemiological, or other similar studies related to health that are interested in receiving data collected pursuant to Section 131370 shall submit a request to and obtain the approval of the Committee for the Protection of Human Subjects.

(d) Notwithstanding Section 1798.24 of the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4

of Division 3 of the Civil Code), the department, at its discretion, may approve the sharing of data collected pursuant to Section 131370 with the CDC, if the CDC agrees in writing to maintain the confidentiality of the data before confidential data is disclosed.

131380. (a) All data collected pursuant to this chapter shall be confidential.

(b) For any disclosure authorized by Section 131375, the disclosing entity shall only include data relevant and necessary for the approved purpose of the requested disclosure.

(c) An entity authorized pursuant to subdivisions (a) and (b) of Section 131375 that receives confidential data from the department shall do all of the following:

(1) Agree in writing to maintain the confidentiality of the data before confidential data is disclosed.

(2) Ensure that a patient's rights to confidentiality shall not be violated in any manner.

(3) Not disclose the data to any other entity.

(4) Safeguard the confidential data from unauthorized disclosure.

(5) Only use the disclosed data for an approved purpose.

(d) An entity authorized pursuant to subdivision (c) of Section 131375 that receives confidential data from the department shall comply with the requirements set forth by the Center for Data Insights and Innovation in Sections 130206, 103206.1, and 103206.2.

(e) The furnishing of confidential data to an entity in accordance with this section will not expose any person, agency, or entity furnishing data to liability, and shall not be considered a waiver of any privilege or a violation of a confidential relationship.

(f) (1) The department shall maintain an accurate record of all persons who are given access to confidential data. The record shall include all of the following:

(A) The name of the person authorizing access.

(B) The name, title, address, and organizational affiliation of the person given access.

(C) The dates of access.

(D) The specific purpose for which the data is to be used.

(2) The record of access shall be open to public inspection during normal operating hours of the department.

(g) The confidential data 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) and from subpoena. The confidential data shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding, and shall not be deemed admissible as evidence in any civil, criminal, administrative, or other tribunal or court for any reason.

(h) This section does not prohibit the publication by the department of reports and statistical compilations that do not in any way identify individual cases or individual sources of information.

SEC. 23. Section 10113.9 of the Insurance Code is amended to read:

10113.9. (a) This section shall not apply to vision-only, dental-only, or CHAMPUS supplement insurance, or to hospital indemnity, hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

(b) (1) A change in the premium rate or coverage for an individual health insurance policy shall not become effective unless the insurer has provided a written notice of the change at least 10 days before the start of the annual enrollment period applicable to the policy or 60 days before the effective date of the policy renewal, whichever occurs earlier in the calendar year.

(2) The written notice required pursuant to paragraph (1) shall be provided to the individual policyholder at their last address known to the insurer. The notice shall state in italics and in 12-point type the actual dollar amount of the premium increase and the specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the policy or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface, the reason for a premium rate change or a change in coverage or benefits.

(c) (1) If the department determines that a rate is unreasonable or not justified consistent with Article 4.5 (commencing with Section 10181), the insurer shall notify the policyholder of this determination. This notification may be included in the notice required in subdivision (b). The notification to the policyholder shall be developed by the department. The development of the notification required under this subdivision 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 notification to the policyholder shall include the following statements in 14-point type:

(A) The Department of Insurance has determined that the rate for this product is unreasonable or not justified after reviewing information submitted to it by the insurer.

(B) During the open enrollment period, the policyholder has the option to obtain other coverage from this insurer or another insurer, or to keep this coverage.

(C) The policyholder may want to contact Covered California at www.coveredca.com for help in understanding available options.

(D) Many Californians are eligible for financial assistance from Covered California to help pay for coverage.

(3) The insurer may include in the notification to the policyholder the internet website address at which the insurer’s final justification for implementing an increase that has been determined to be unreasonable by the commissioner may be found pursuant to Section 154.230 of Title 45 of the Code of Federal Regulations.

(4) The notice shall also be provided to the agent of record for the policyholder, if any, so that the agent may assist the purchaser in finding other coverage.

(5) In developing the notification, the department shall take into consideration that this notice is required to be provided to an individual applicant pursuant to subdivision (g) of Section 10181.3.

(d) (1) Before July 1, 2024, if an insurer rejects a dependent of a policyholder applying to be added to the policyholder's individual grandfathered health plan, rejects an applicant for a Medicare supplement policy due to the applicant having end-stage renal disease, or offers an individual grandfathered health plan to an applicant at a rate that is higher than the standard rate, the insurer shall inform the applicant about the California Major Risk Medical Insurance Program (MRMIP) (Chapter 4 (commencing with Section 15870) of Part 3.3 of Division 9 of the Welfare and Institutions Code) and about new coverage options and the potential for subsidized coverage through Covered California. The insurer shall direct persons seeking more information to MRMIP, Covered California, plan or policy representatives, insurance agents, or an entity paid by Covered California to assist with health coverage enrollment, such as a navigator or an assister.

(2) On or after July 1, 2024, if an insurer rejects a dependent of a policyholder applying to be added to the policyholder's individual grandfathered health plan, rejects an applicant for a Medicare supplement policy due to the applicant having end-stage renal disease, or offers an individual grandfathered health plan to an applicant at a rate that is higher than the standard rate, the insurer shall inform the applicant about new coverage options and the potential for subsidized coverage through Covered California. The insurer shall direct persons seeking more information to Covered California, plan or policy representatives, insurance agents, or an entity paid by Covered California to assist with health coverage enrollment, such as a navigator or an assister.

(e) A notice provided pursuant to this section is a private and confidential communication and, at the time of application, the insurer shall give the applicant the opportunity to designate the address for receipt of the written notice in order to protect the confidentiality of personal or privileged information.

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

(1) "Covered California" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(2) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(3) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and rules, regulations, or guidance issued pursuant to that law.

SEC. 24. Section 12693.74 of the Insurance Code, as amended by Section 35 of Chapter 47 of the Statutes of 2022, is amended to read:

12693.74. (a) Subscribers shall continue to be eligible for the program for a period of 12 months from the month eligibility is established.

(b) (1) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of Division 9 of the Welfare and Institutions Code at the November 5, 2024, statewide general election and the conditions described in paragraph (1) of subdivision (b) of Section 12693.74, as added by Section 36 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2025, or the date certified by the State Department of Health Care Services pursuant to paragraph (2) of subdivision (b) of Section 12693.74, as added by Section 36 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

(2) If the voters do not approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of Division 9 of the Welfare and Institutions Code at the November 5, 2024, statewide general election and the conditions described in paragraph (1) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2026, or the date certified by the department pursuant to paragraph (2) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

SEC. 25. Section 12693.74 of the Insurance Code, as added by Section 36 of Chapter 47 of the Statutes of 2022, is amended to read:

12693.74. (a) To the extent federal financial participation is available, and subject to subdivision (e), the child shall remain continuously eligible for the program up to five years of age. The department shall seek any federal approvals that may be necessary to implement this subdivision.

(b) (1) Implementation of this section is contingent on all of the following conditions:

(A) All necessary federal approvals have been obtained by the department pursuant to subdivision (e).

(B) The Legislature has appropriated funding to implement this section after a determination that ongoing General Fund resources are available to support the ongoing implementation of this section in the 2024–25 fiscal year and subsequent fiscal years.

(C) The department has determined that systems have been programmed to implement this section.

(2) The department shall issue a declaration certifying the date that all conditions in paragraph (1) have been met. The department shall post the declaration on its internet website and provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(c) If at any time the director determines that the eligibility criteria established under this section for the program may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), any amendment

or extension of that act, or any similar federal legislation affecting federal financial participation, the director may alter the eligibility criteria to the extent necessary for the state to receive that federal financial participation.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and Chapter 4 (commencing with Section 12693.25) and Part 6.1 (commencing with Section 12670), the department may implement, interpret, or make specific this section, in whole or in part, through all-county letters or similar instructions, without taking any further regulatory action.

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

(f) (1) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of Division 9 of the Welfare and Institutions Code at the November 5, 2024, statewide general election, this section shall become operative on January 1, 2025, or the date certified by the department pursuant to paragraph (2) of subdivision (b), whichever is later.

(2) If the voters do not approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of Division 9 of the Welfare and Institutions Code at the November 5, 2024, statewide general election, this section shall be repealed as of January 1, 2025.

SEC. 26. Section 12693.74 is added to the Insurance Code, to read:

12693.74. (a) To the extent federal financial participation is available, and subject to subdivision (e), the child shall remain continuously eligible for the program up to five years of age. The department shall seek any federal approvals that may be necessary to implement this subdivision.

(b) (1) Implementation of this section is contingent on both of the following conditions:

(A) All necessary federal approvals have been obtained by the department pursuant to subdivision (e).

(B) The department has determined that systems have been programmed to implement this section.

(2) The department shall issue a declaration certifying the date that all conditions in paragraph (1) have been met. The department shall post the declaration on its internet website and provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(c) If at any time the director determines that the eligibility criteria established under this section for the program may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), any amendment or extension of that act, or any similar federal legislation affecting federal financial participation, the director may alter the eligibility criteria to the extent necessary for the state to receive that federal financial participation.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and Part 6.1

(commencing with Section 12670) and Chapter 4 (commencing with Section 12693.25) of Part 6.2, the department may implement, interpret, or make specific this section, in whole or in part, through all-county letters or similar instructions, without taking any further regulatory action.

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

(f) (1) If the voters do not approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of Division 9 of the Welfare and Institutions Code at the November 5, 2024, statewide general election, this section shall become operative on January 1, 2026, or the date certified by the department pursuant to paragraph (2) of subdivision (b), whichever is later.

(2) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of Division 9 of the Welfare and Institutions Code at the November 5, 2024, statewide general election, this section shall be repealed as of January 1, 2025.

SEC. 27. Section 1182.14 of the Labor Code is amended to read:

1182.14. (a) The Legislature finds and declares as follows:

(1) Workers in the health care industry, including workers at general acute care hospitals, acute psychiatric hospitals, medical offices and clinics, behavioral health centers, and residential care centers provide vital health care services to California residents, including emergency care, labor and delivery, cancer treatments, and primary and specialty care. Similarly, dialysis clinics provide life-preserving care to patients with end-stage renal disease and are part of the continuum of kidney care that also includes hospitals and health systems. Residents and visitors to the state rely on access to this high-quality health care.

(2) Higher wages are an important means of retaining an experienced workforce and attracting new workers. A stable workforce benefits patients and improves quality of care.

(3) Employers across multiple industries are raising wages. The health care sector in California must offer higher wages to remain competitive.

(4) Members of the health care team such as certified nursing assistants, patient aides, technicians, and food service workers, among many others, are essential to both routine medical care and emergency response efforts.

(5) Even before the COVID-19 pandemic, California was facing an urgent and immediate shortage of health care workers, adversely impacting the health and well-being of Californians, especially economically disadvantaged Californians. The pandemic has worsened these shortages. Higher wages are needed to attract and retain health care workers to treat patients, including being prepared to provide necessary care in an emergency.

(6) The Legislature finds and declares that laws that establish, require, impose, limit or otherwise relate to wages, salary, or compensation affect access to quality health care for all residents of, and visitors to, the state provided by licensed health care facilities, which serve as a critical part of the state's ability to respond to catastrophic emergencies. The Legislature

also finds and declares that the time limitations and other provisions established by this section are necessary to stabilize the health care system following the state and federal public health emergencies related to COVID-19, the closure and bankruptcy of licensed health care facilities, and the reduction in vital services by licensed health care facilities due to financial distress and the health care workforce crisis that has resulted in staffing shortages and strain for health care workers. The Legislature further finds and declares that access to quality health care and the stability of the health care system is a matter of statewide concern and is not a municipal affair as that term is used in Section 5 of Article XI of the California Constitution. Therefore, this section occupies the whole field of wages, salary, or compensation for covered health care facility employees, and applies to all cities and counties, including charter cities, charter counties, and charter cities and counties during the stabilization period provided by this section.

(7) The Legislature finds and declares that it is the intent of the Legislature that subclause (I) of clause (ii) of subparagraph (B) of paragraph (2) of subdivision (b) is declarative of existing law.

(b) As used in this section:

(1) "Adjusted patient days" means the total gross patient revenue, divided by gross revenue provided for inpatient services, multiplied by the number of patient days.

(2) (A) "Covered health care employee" means any of the following:

(i) An employee of a health care facility employer who provides patient care, health care services, or services supporting the provision of health care, which includes, but is not limited to, employees performing work in the occupation of a nurse, physician, caregiver, medical resident, intern or fellow, patient care technician, janitor, housekeeping staff person, groundskeeper, guard, clerical worker, nonmanagerial administrative worker, food service worker, gift shop worker, technical and ancillary services worker, medical coding and medical billing personnel, scheduler, call center and warehouse worker, and laundry worker, regardless of formal job title.

(ii) A contracted or subcontracted employee described in subparagraph (B).

(B) "Covered health care employee" includes a contracted or subcontracted employee, if clauses (i) and (ii) apply:

(i) The employee's employer contracts with the covered health care facility employer, or with a contractor or subcontractor to the covered health care facility employer, to provide health care services, or services supporting the provision of health care.

(ii) (I) Consistent with the definitions of "employ" and "employer" in the Industrial Welfare Commission wage orders, the covered health care facility employer directly or indirectly, or through an agent or any other person, engages, suffers, or permits an employee to work, or exercises control over the employee's wages, hours or working conditions, or

(II) The employee performs contracted or subcontracted work primarily on the premises of a covered health care facility. For purposes of this

subparagraph, "primarily" means more than one-half of the employee's work time during a workweek.

(iii) A contracted or subcontracted employee shall be paid the applicable minimum wage in this section for all hours worked providing patient care, health care services, or services supporting the provision of health care.

(C) Notwithstanding subparagraph (A), "covered health care employee" does not include:

(i) Employment as an outside salesperson.

(ii) Any work performed by a public employee where the public employee is not primarily engaged in services described in clause (i) of subparagraph (A) performed for a covered health care facility. For purposes of this subparagraph, "primarily" means more than one-half of the employee's work time during a workweek.

(iii) Delivery or waste collection work on the premises of a covered health care facility, provided that the delivery or waste collection worker is not an employee of any person that owns, controls, or operates a covered health care facility.

(iv) Medical transportation services in or out of a covered health care facility, provided that the medical transportation services worker is not an employee of any person that owns, controls, or operates a covered health care facility.

(3) (A) "Covered health care facility" means any of the following:

(i) A facility or other work site that is part of an integrated health care delivery system.

(ii) A licensed general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, including a distinct part of any such hospital.

(iii) A licensed acute psychiatric hospital, as defined in subdivision (b) of Section 1250 of the Health and Safety Code, including a distinct part of any such hospital.

(iv) A special hospital, as defined in subdivision (f) of Section 1250 of the Health and Safety Code.

(v) A licensed skilled nursing facility, as defined in subdivision (c) of Section 1250 of the Health and Safety Code, if owned, operated, or controlled by a hospital or integrated health care delivery system or health care system.

(vi) A patient's home when health care services are delivered by an entity owned or operated by a general acute care hospital or acute psychiatric hospital.

(vii) A licensed home health agency, as defined in subdivision (a) of Section 1727 of the Health and Safety Code.

(viii) A clinic, as defined in subdivision (b) of Section 1204 of the Health and Safety Code, including a specialty care clinic, or a dialysis clinic.

(ix) A psychology clinic, as defined in Section 1204.1 of the Health and Safety Code.

(x) A clinic as defined in subdivision (d), (g), or (*l*) of Section 1206 of the Health and Safety Code.

(xi) A licensed residential care facility for the elderly, as defined in Section 1569.2 of the Health and Safety Code, if affiliated with an acute care provider or owned, operated, or controlled by a general acute care hospital, acute psychiatric hospital, or the parent entity of a general acute care hospital or acute psychiatric hospital.

(xii) A psychiatric health facility, as defined in Section 1250.2 of the Health and Safety Code.

(xiii) A mental health rehabilitation center, as defined in Section 5675 of the Welfare and Institutions Code.

(xiv) A community clinic licensed under subdivision (a) of Section 1204 of the Health and Safety Code, an intermittent clinic exempt from licensure under subdivision (h) of Section 1206 of the Health and Safety Code, or a clinic operated by any political subdivisions of the state, including the University of California or a city or county that is exempt from licensure under subdivision (b) of Section 1206 of the Health and Safety Code.

(xv) A rural health clinic, as defined in paragraph (1) of subdivision (*l*) of Section 1396d of Title 42 of the United States Code, that is not license exempt.

(xvi) An urgent care clinic.

(xvii) An ambulatory surgical center that is certified to participate in the Medicare Program under Title XVIII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act.

(xviii) A physician group.

(xix) A county correctional facility that provides health care services.

(xx) A county mental health facility.

(B) "Covered health care facility" does not include either of the following:

(i) Any health care facility described in subparagraph (A) that is owned, controlled, or operated by the state or any state agency of the executive branch. As used in this subparagraph, "state agency" includes every state office, officer, department, division, bureau, board, and commission under the executive branch, including any constitutional offices or officers, California State University, or California Community College, but does not include a health care district or the University of California.

(ii) A tribal clinic exempt from licensure under subdivision (c) of Section 1206 of the Health and Safety Code, or an outpatient setting conducted, maintained, or operated by a federally recognized Indian tribe, tribal organization, or urban Indian organization, as defined in Section 1603 of Title 25 of the United States Code.

(4) "Employ" means to engage, suffer, or permit to work.

(5) "Employee" means any person employed by an employer.

(6) "Employer" means a person who directly or indirectly, or through an agent or any other person, employs or exercises control over the wages, hours, or working conditions of any person. "Employer" includes political subdivisions of the state, health care districts, the University of California, and municipalities.

(7) "Full-time equivalent employee" means the total paid hours at a covered health care facility, including an integrated health care delivery

system, as of January 1, 2022,, divided by 2,080. The number of full-time equivalent employees shall be determined as follows:

(A) The number of full-time equivalent employees shall be as detailed in the Department of Health Care Access and Information's 2021 Pivot Table – Hospital Annual Selected File (April 2023 Extract) and published online at https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables. For purposes of determining the number of full-time equivalent employees under this subparagraph, published data in the pivot table shall be aggregated to determine the total full-time equivalent employees for an integrated health care delivery system or health system. As provided by paragraph (1) of subdivision (c), any covered health care facility employer that is part of these systems shall be subject to the minimum wage schedule described in paragraph (1) of subdivision (c).

(B) Any covered health care facility employer that does not report the data referenced in subparagraph (A), but had 10,000 or more full-time equivalent employees as of January 1, 2022, shall be subject to the minimum wage schedule described in paragraph (1) of subdivision (c). For the purposes of this paragraph, "full-time equivalent employees" means the total number of paid hours at a nonreporting covered health care facility employer divided by 2,080. This subparagraph does not apply to county entities, except as counties that are specifically covered in subdivision (c).

(8) "Health care services" means patient care-related services including nursing; caregiving; services provided by medical residents, interns, or fellows; technical and ancillary services; janitorial work; housekeeping; groundskeeping; guard duties; business office clerical work; food services; laundry; medical coding and billing; call center and warehouse work; scheduling; and gift shop work; but only where such services support patient care.

(9) "Health care worker minimum wage" means the minimum wage rate established by this section.

(10) "Health care system" means a parent entity that owns, controls, or operates two or more separately licensed hospitals.

(11) "Hospital with a high governmental payor mix" means a licensed acute care hospital, as defined in subdivision (a) or (b) of Section 1250 of the Health and Safety Code, where the combined Medicare and Medi-Cal payor mix is 90 percent or greater, as determined by using the adjusted patient days from the Department of Health Care Access and Information annual financial disclosure report, as recorded and calculated as of January 1, 2022, as per the Department of Health Care Access and Information guidance. A hospital shall qualify pursuant to this paragraph only if the combined payor mix of both the hospital and the health care system to which it belongs, if any, is 90 percent or greater.

(12) "Independent hospital with an elevated governmental payor mix" means all of the following:

(A) A hospital, as defined in subdivision (a) or (b) of Section 1250 of the Health and Safety Code, where the combined Medicare and Medi-Cal

payor mix is 75 percent or greater, as determined by using the adjusted patient days from the Department of Health Care Access and Information annual financial disclosure report, as recorded and calculated as of January 1, 2022, as per the Department of Health Care Access and Information guidance.

(B) The hospital is not owned, controlled, or operated by any parent entity with two or more separately licensed hospitals.

(13) "Integrated health care delivery system" means an entity or group of related entities that includes both of the following: (A) one or more hospitals and (B) one or more physician groups, health care service plans, medical foundation clinics, other health care facilities, or other entities, providing health care or supporting the provision of health care, where the hospital or hospitals and other entities are related through one of the following:

(A) Parent and subsidiary relationships, joint or common ownership or control, common branding, or common boards of directors and shared senior management.

(B) A contractual relationship in which affiliated covered physician groups or medical foundation clinics contract with a health care service plan, hospital or other part of the system, all operating under a common trade name.

(C) A contractual relationship in which a nonprofit health care service plan provides medical services to enrollees in a specific geographic region of the state through an affiliated hospital system, and contracts with a single covered physician group in each geographic region of the state to provide medical services to a majority of the plan's enrollees in that region.

(14) "Physician group" means a medical group practice, including a professional medical corporation, as defined in Section 2406 of the Business and Professions Code, another form of corporation controlled by physicians and surgeons, or a medical partnership, provided that the group includes a total of 25 or more physicians.

(15) "Rural independent covered health care facility" means a hospital that is not part of an integrated health care delivery system and is not owned, controlled, or operated by any parent entity with two or more separately licensed hospitals and any of the following:

(A) A hospital that is located in a county that is not designated as a metropolitan core-based statistical area as of March 2020.

(B) A small and rural hospital, as defined in Section 124840 of the Health and Safety Code.

(C) A rural general acute care hospital, as described in Section 1250 of the Health and Safety Code.

(16) "Urgent care clinic" means a facility or clinic that provides immediate, nonemergent ambulatory medical care to patients, including, but not limited to, facilities known as walk-in clinics or centers or urgent care centers.

(c) (1) For any covered health care facility employer with 10,000 or more full-time equivalent employees, any covered health care facility

employer that is a part of an integrated health care delivery system or health care system with 10,000 or more full-time equivalent employees, any covered health care facility employer that is a dialysis clinic as defined in subdivision (b) of Section 1204 of the Health and Safety Code or that is a person that owns, controls, or operates a dialysis clinic, or a covered health facility owned, affiliated, or operated by a county with a population of more than 5,000,000 as of January 1, 2023, the minimum wage for all covered health care employees shall be as follows:

(A) From July 1, 2024, to June 30, 2025, inclusive, twenty-three dollars ($23) per hour.

(B) From July 1, 2025, to June 30, 2026, inclusive, twenty-four dollars ($24) per hour.

(C) From July 1, 2026, and until adjusted pursuant to subdivision (d), twenty-five dollars ($25) per hour.

(2) For any hospital that is a hospital with a high governmental payor mix, an independent hospital with an elevated governmental payor mix, a rural independent covered health care facility, or a covered health care facility that is owned, affiliated, or operated by a county with a population of less than 250,000 as of January 1, 2023, the minimum wage for all covered health care employees shall be as follows:

(A) From July 1, 2024, to June 30, 2033, inclusive, eighteen dollars ($18) per hour, with 3.5 percent increases annually.

(B) From July 1, 2033, and until adjusted pursuant to subdivision (d), twenty-five ($25) per hour.

(3) (A) For any health care facility specified in clauses (i) to (iv), inclusive, the minimum wage for all covered health care employees shall be as set forth in subparagraph (B).

(i) A clinic as defined in subdivision (h) of Section 1206 of the Health and Safety Code, that is not operated by or affiliated with a clinic described in subdivision (b) of Section 1206 of the Health and Safety Code.

(ii) A community clinic licensed under subdivision (a) of Section 1204 of the Health and Safety Code, and any associated intermittent clinic exempt from licensure under subdivision (h) of Section 1206 of the Health and Safety Code.

(iii) A rural health clinic, as defined in paragraph (1) of subdivision (*l*) of Section 1396d of Title 42 of the United States Code, that is not license-exempt.

(iv) An urgent care clinic that is owned by or affiliated with a facility defined in clause (ii) or (iii).

(B) (i) From July 1, 2024, to June 30, 2026, inclusive, twenty-one dollars ($21) per hour.

(ii) From July 1, 2026, to June 30, 2027, inclusive, twenty-two dollars ($22) per hour.

(iii) From July 1, 2027, and until adjusted by subdivision (d), twenty-five dollars ($25) per hour.

(4) For all other covered health care facility employers, the minimum wage for all covered health care employees shall be as follows:

(A) From July 1, 2024, to June 30, 2026, inclusive, twenty-one dollars ($21) per hour.

(B) From July 1, 2026, to June 30, 2028, inclusive, twenty-three dollars ($23) per hour.

(C) From July 1, 2028, and until adjusted pursuant to subdivision (d), twenty-five dollars ($25) per hour.

(5) Notwithstanding any other provision of this subdivision, a covered health care facility that is county owned, affiliated, or operated shall not be required to comply with this subdivision before January 1, 2025. Commencing January 1, 2025, a covered health care facility that is county owned, affiliated, or operated shall comply with the appropriate schedule described in this subdivision.

(d) (1) Following the implementation of the minimum wage increase specified in the following portions of subdivision (c): subparagraph (C) of paragraph (1), subparagraph (B) of paragraph (2), clause (iii) of subparagraph (B) of paragraph (3), or subparagraph (C) of paragraph (4), on or before August 1 of the following year, and on or before each August 1 thereafter, the Director of Finance shall calculate an adjusted minimum wage. The calculation shall increase the health care worker minimum wage by the lesser of 3.5 percent or the rate of change in the averages of the most recent July 1 to June 30, inclusive, period over the preceding July 1 to June 30, inclusive, period for the United States Bureau of Labor Statistics nonseasonally adjusted United States Consumer Price Index for Urban Wage Earners and Clerical Workers (U.S. CPI-W). The result shall be rounded to the nearest ten cents ($0.10). Each adjusted health care worker minimum wage increase calculated under this subdivision shall take effect on the following January 1.

(2) If the rate of change in the averages of the most recent July 1 to June 30, inclusive, period over the preceding July 1 to June 30, inclusive, period for the United States Bureau of Labor Statistics nonseasonally adjusted U.S. CPI-W is negative, there shall be no increase or decrease in the health care worker minimum wage pursuant to this subdivision on the following January 1.

(e) The health care worker minimum wages shall constitute the state minimum wages for covered health care employment for all purposes under this code and the wage orders of the Industrial Welfare Commission.

(f) (1) A health care worker minimum wage shall be enforceable by the Labor Commissioner through the procedures set forth in Section 98, 98.1, 98.2, 98.3, 98.7, 98.74, or 1197.1, or by a covered worker through a civil action, through the same means and with the same relief available for violation of any other state minimum wage requirement.

(2) (A) The Department of Industrial Relations shall amend, supplement, and republish the Industrial Welfare Commission’s wage orders to be consistent with this section. The Department of Industrial Relations shall not make other changes to the wage orders of the Industrial Welfare Commission that are in existence on the effective date of this section. The

Department of Industrial Relations shall meet the requirements set forth in Section 1183.

(B) Every employer that is subject to this section shall comply with both of the following:

(i) Post a copy of the order as amended, supplemented and republished by the Department of Industrial Relations under this section and keep it posted in a conspicuous location frequented by employees during the hours of the workday, as required by Section 1183.

(ii) Provide to each employee on the effective date of the earliest minimum wage increase pursuant to subdivision (c), a written notice, in the language the employer normally uses to communicate employment-related information to the employee, indicating the paragraph of subdivision (c) that applies to the employer and the health care worker minimum wage schedule applicable to the employee.

(C) Notwithstanding paragraph (6) of subdivision (h), any amendment, supplement, and republication pursuant to this section shall be exempt from 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), and from the procedures set forth in Sections 1177, 1178.5, 1181, 1182, and 1182.1.

(g) For covered health care employment where the compensation of the employee is on a salary basis, the employee shall earn a monthly salary equivalent to no less than 150 percent of the health care worker minimum wage or 200 percent of the minimum wage, as described in Section 1182.12, whichever is greater, for full-time employment in order to qualify as exempt from the payment of minimum wage and overtime under the law of this state, including where the employer is a political subdivision of the state, a health care district, the University of California, or a municipality.

(h) (1) On or before January 31, 2024, the Department of Health Care Access and Information shall publish the following information on their internet website:

(A) A list of all covered health care facility employers with 10,000 or more full-time equivalent employees, or covered health care facility employers that are a part of an integrated health care delivery system or health care system with 10,000 or more full-time equivalent employees. This list shall only include those covered health care facility employers included in the Department of Health Care Access and Information's 2021 Pivot Table – Hospital Annual Selected File (April 2023 Extract) and published online at https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables. For purposes of determining the number of full-time equivalent employees under this subparagraph, published data in the pivot table shall be aggregated to determine the total full-time equivalent employees for an integrated health care delivery system or health system.

(B) A list of all hospitals that qualify as a hospital with a high governmental payor mix, independent hospital with an elevated governmental payor mix, or a rural independent covered health care facility. This list shall

only include those covered health care facility employers included in the Department of Health Care Access and Information's 2021 Pivot Table – Hospital Annual Selected File (April 2023 Extract) and published online at https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables. For purposes of determining the number of full-time equivalent employees under this subparagraph, published data in the pivot table shall be aggregated to determine the total full-time equivalent employees for an integrated health care delivery system or health system.

(2) If a covered health care facility believes that they were inappropriately excluded from the list of hospitals that qualify as a hospital with a high governmental payor mix, independent hospital with an elevated governmental payor mix, or a rural independent covered health care facility, the health facility may file a request with the Department of Health Care Access and Information to be classified as a hospital with a high governmental payor mix, independent hospital with an elevated governmental payor mix, or a rural independent covered health care facility. The requesting hospital shall provide the following:

(A) The physical location of the requesting hospital.

(B) The revised Annual Disclosure Report pursuant to Section 128755 of the Health and Safety Code that reflects the payor mix of the requesting hospital, including the percent of uninsured patients and patients covered by Medi-Cal and Medicare.

(C) Any other information as determined necessary by the Department of Health Care Access and Information.

(3) The Department of Health Care Access and Information shall classify a requesting hospital as a hospital with a high governmental payor mix, independent hospital with an elevated governmental payor mix, or a rural independent covered health care facility if they meet the definitions provided under this section.

(4) The rules and regulations process described in paragraph (6) shall require the Department of Health Care Access and Information to consider input by stakeholders including health care employees, their representatives, consumers, and health care employers as to the accuracy of the classification of covered health care facility employers according to the numbers of full-time equivalent employees, system affiliation, payor mix, and any other relevant information.

(5) The Department of Health Care Access and Information shall not accept any requests for classification as a hospital with a high governmental payor mix, independent hospital with an elevated governmental payor mix, or a rural independent covered health care facility after January 31, 2025.

(6) Until January 1, 2025, 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.

(i) (1) The Department of Industrial Relations shall, in collaboration with the Department of Health Care Access and Information, administer a waiver program for covered health care facilities described in clauses (i) to (iv), inclusive, of subparagraph (A) of paragraph (3) of subdivision (c), which will allow a covered health care facility to apply for a 12-month delay in schedule of the health care minimum wage requirements in this section. The issuance of waivers pursuant to this subdivision shall be solely and exclusively within the authority of the Department of Industrial Relations pursuant to paragraph (3). The authority regarding whether the covered health care facility demonstrates that it meets the requirements to obtain a waiver, set forth in paragraphs (2) and (3) shall be solely and exclusively within the authority of the Department of Health Care Access and Information.

(2) In order to obtain a waiver, a covered health care facility shall demonstrate at the time the waiver application is submitted that it meets the criteria as set forth in subparagraphs (A) and (B) of this paragraph.

(A) Each request for a waiver shall include the covered health care facility's, and any parent or affiliated company's, most recent audited financial statements and year-to-date internally prepared financial statements no older than 45 days prior to the date of submission; examined level forecasting with an attestation from an independent certified public accountant demonstrating that compliance with this section would raise doubt about the covered health care facility's and its parent company's ability to maintain a positive cashflow over the next 12 months; and balance sheets showing that the covered health care facility and its parent company have less than 45 days cash on hand and a current ratio of current assets to current liabilities of one or less.

(B) The covered health care facility shall provide a declaration verifying that the contents of the documents contained in the waiver request are true and correct. The declaration shall be in a form and manner specified by the Department of Health Care Access and Information and signed by an authorized executive officer of the covered health care facility.

(C) The Department of Industrial Relations shall make approved information available on its internet website within 15 working days of the issuance of the waiver. The Department of Health Care Access and Information shall make the audited financial information submitted in conjunction with an approved waiver available on its internet website within 15 working days of the issuance of the waiver.

(3) If, following review of the documentation submitted pursuant to subparagraphs (A) and (B) of paragraph (2), the Department of Health Care Access and Information determines that the covered health care facility has demonstrated that it meets the criteria for a waiver set forth in subdivision (i), the Department of Industrial Relations shall issue a waiver for the covered health care facility. If a covered health care facility is issued a waiver, all dates in clauses (i) to (iii), inclusive, of subparagraph (B) of paragraph (3)

of subdivision (c), or any superseding dates pursuant to a previously issued waiver that are on or after the effective date of the issued waiver, are postponed by 12 months for that covered health care facility.

(4) Notwithstanding 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), the Department of Industrial Relations and the Department of Health Care Access and Information may implement, interpret, or make specific this subdivision, in whole or in part, by means of information notices or other similar instructions, without taking any further regulatory action.

(5) If a waiver is issued, any covered health care facility affected by the waiver shall within 10 days of notice from the Department of Industrial Relations:

(A) Post a copy of the waiver, including the applicable minimum wage, in a conspicuous location frequented by employees during the hours of the workday.

(B) Provide to each covered health care employee, a written notice, in the language the covered health care facility normally uses to communicate employment-related information to the covered health care employee, informing the covered health care employee the covered health care facility had applied for and received a one-year waiver of the increase of the minimum wage and stating the applicable minimum wage.

(6) A covered health care facility may apply for and be issued a waiver pursuant to this subdivision in consecutive years. However, a waiver shall not be available after July 1, 2032, and every covered health care facility described in clauses (i) to (iv), inclusive, of subparagraph (A) of paragraph (3) of subdivision (c) shall pay the adjusted wage required by subdivision (d) beginning July 1, 2033, regardless of whether the facility received any waivers.

(7) A waiver issued pursuant to this subdivision shall not exempt a covered health care facility from complying with any and all federal, state, or local laws and regulations, except to the extent that such local laws and regulations are preempted in accordance with subdivision (j).

(8) Notwithstanding paragraph (3) of subdivision (b), for purposes of this subdivision only, “covered health care facility” shall mean the clinics described in clauses (i) to (iv), inclusive, of subparagraph (A) of paragraph (3) of subdivision (c).

(j) (1) An ordinance, regulation, or administrative action applicable to a covered health care facility, as defined in this section, that establishes, requires, imposes, limits, or otherwise relates to wages or compensation for covered health care facility employees, as defined in this section, shall not be enacted or enforced in or by any city, county, city and county, including charter cities, charter counties, and charter cities and counties.

(2) Any ordinance, regulation, or administrative action taken by any city, county, or city and county, including charter cities, charter counties, and charter cities and counties, that is enacted or takes effect after September 6, 2023, related to covered health facilities, that establishes, requires,

imposes, limits, or otherwise relates to wages, salaries, or compensation for covered health care facility employees, as defined in this section, is void.

(3) This subdivision does not preclude any employer, including a city, county, city and county, including charter cities, charter counties, and charter cities and counties, that employs health care employees, from establishing higher wage, salary, or compensation rates for its employees or contracted or subcontracted employees.

(4) This subdivision does not preclude a city, county, city and county, including charter cities, charter counties, and charter cities and counties from establishing a minimum wage that would apply uniformly to all employees across all industries and sectors and not exclusively to employees employed by covered health care facilities.

(5) This subdivision does not preclude a city, county, city and county, including charter cities, charter counties, and charter cities and counties, from establishing or enforcing a minimum wage applicable to covered health care facility employees, as defined in this section, after January 1, 2034. Any such ordinance, regulation, or administrative action shall be evaluated under ordinary preemption principles.

(6) This subdivision does not preclude a city, county, city and county, including charter cities, charter counties, and charter cities and counties, from enacting an ordinance or regulation, or taking administrative action, limiting or otherwise relating to compensation for covered health care facility employees, as defined in this section, after January 1, 2030. Any such ordinance, regulation, or administrative action shall be evaluated under ordinary preemption principles.

(7) This subdivision shall be effective only if the provisions of this section that require health care worker minimum wages take effect.

(k) For purposes of implementing this section, the Department of Industrial Relations and the Department of Health Care Access and Information may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

SEC. 28. Section 1182.15 of the Labor Code is amended to read:

1182.15. (a) The Legislature finds and declares as follows:

(1) Workers in the health care industry, including workers at general acute care hospitals, acute psychiatric hospitals, medical offices and clinics, behavioral health centers, and residential care centers provide vital health care services to California residents, including emergency care, labor and delivery, cancer treatments, and primary and specialty care. Similarly, dialysis clinics provide life-preserving care to patients with end-stage renal disease and are part of the continuum of kidney care that also includes

hospitals and health systems. Residents and visitors to the state rely on access to this high-quality health care.

(2) Higher wages are an important means of retaining an experienced workforce and attracting new workers. A stable workforce benefits patients and improves quality of care.

(3) Employers across multiple industries are raising wages. The health care sector in California must offer higher wages to remain competitive.

(4) Members of the health care team such as certified nursing assistants, patient aides, technicians, and food service workers, among many others, are essential to both routine medical care and emergency response efforts.

(5) Even before the COVID-19 pandemic, California was facing an urgent and immediate shortage of health care workers, adversely impacting the health and well-being of Californians, especially economically disadvantaged Californians. The pandemic has worsened these shortages. Higher wages are needed to attract and retain health care workers to treat patients, including being prepared to provide necessary care in an emergency.

(6) The Legislature finds and declares that laws that establish, require, impose, limit or otherwise relate to wages, salary, or compensation affect access to quality health care for all residents of, and visitors to, the state provided by licensed health care facilities, which serve as a critical part of the state's ability to respond to catastrophic emergencies. The Legislature also finds and declares that the time limitations and other provisions established by this section are necessary to stabilize the health care system following the state and federal public health emergencies related to COVID-19, the closure and bankruptcy of licensed health care facilities, and the reduction in vital services by licensed health care facilities due to financial distress and the health care workforce crisis that has resulted in staffing shortages and strain for health care workers. The Legislature further finds and declares that access to quality health care and the stability of the health care system is a matter of statewide concern and is not a municipal affair as that term is used in Section 5 of Article XI of the California Constitution. Therefore, this section occupies the whole field of wages, salary, or compensation for covered health care facility employees, and applies to all cities and counties, including charter cities, charter counties, and charter cities and counties during the stabilization period provided by this section.

(7) The Legislature finds and declares that it is the intent of the Legislature that subclause (I) of clause (ii) of subparagraph (B) of paragraph (2) of subdivision (b) of this section is declarative of existing law.

(b) As used in this section:

(1) (A) "Covered health care employee" means any of the following:

(i) An employee of a health care facility employer who provides patient care, health care services, or services supporting the provision of health care, which includes, but is not limited to, employees performing work in the occupation of a nurse, physician, caregiver, medical resident, intern or fellow, patient care technician, janitor, housekeeping staff person, groundskeeper, guard, clerical worker, nonmanagerial administrative worker,

food service worker, gift shop worker, technical and ancillary services worker, medical coding and medical billing personnel, scheduler, call center and warehouse worker, and laundry worker, regardless of formal job title.

(ii) A contracted or subcontracted employee described in subparagraph (B).

(B) "Covered health care employee" includes a contracted or subcontracted employee, if clauses (i) and (ii) apply:

(i) The employee's employer contracts with the covered health care facility employer, or with a contractor or subcontractor to the covered health care facility employer, to provide health care services, or services supporting the provision of health care.

(ii) (I) Consistent with the definitions of "employ" and "employer" in the Industrial Welfare Commission wage orders, the covered health care facility employer directly or indirectly, or through an agent or any other person, engages, suffers, or permits an employee to work, or exercises control over the employee's wages, hours or working conditions, or

(II) The employee performs contracted or subcontracted work primarily on the premises of a covered health care facility. For purposes of this subparagraph, "primarily" means more than one-half of the employee's work time during a workweek.

(iii) A contracted or subcontracted employee shall be paid the applicable minimum wage in this section for all hours worked providing patient care, health care services, or services supporting the provision of health care.

(C) Notwithstanding subparagraph (A), "covered health care employee" does not include:

(i) Employment as an outside salesperson.

(ii) Any work performed by a public employee where the public employee is not primarily engaged in services described in clause (i) of subparagraph (A) performed for a covered health care facility. For purposes of this subparagraph, "primarily" means more than one-half of the employee's work time during a workweek.

(iii) Delivery or waste collection work on the premises of a covered health care facility, provided that the delivery or waste collection worker is not an employee of any person that owns, controls, or operates a covered health care facility.

(iv) Medical transportation services in or out of a covered health care facility, provided that the medical transportation services worker is not an employee of any person that owns, controls, or operates a covered health care facility.

(2) (A) "Covered health care facility" means a licensed skilled nursing facility, as defined in subdivision (c) of Section 1250 of the Health and Safety Code, that is not covered by Section 1182.14.

(B) "Covered health care facility" does not include either of the following:

(i) A health care facility, as described in subparagraph (A), that is owned, controlled, or operated by the state or any state agency of the executive branch. As used in this subparagraph, "state agency" includes every state office, officer, department, division, bureau, board, and commission under

the executive branch, including any constitutional offices or officers, California State University, or California Community College, but does not include a health care district or the University of California.

(ii) A tribal clinic exempt from licensure under subdivision (c) of Section 1206 of the Health and Safety Code, or an outpatient setting conducted, maintained, or operated by a federally recognized Indian tribe, tribal organization, or urban Indian organization, as defined in Section 1603 of Title 25 of the United States Code.

(3) "Employ" means to engage, suffer, or permit to work.

(4) "Employee" means any person employed by an employer.

(5) "Employer" means a person who directly or indirectly, or through an agent or any other person, employs or exercises control over the wages, hours, or working conditions of any person.

(6) "Health care services" means patient care-related services including nursing; caregiving; services provided by medical residents, interns, or fellows; technical and ancillary services; janitorial work; housekeeping; groundskeeping; guard duties; business office clerical work; food services; laundry; medical coding and billing; call center and warehouse work; scheduling; and gift shop work; but only where such services support patient care.

(7) "Health care worker minimum wage" means the minimum wage rate established by this section.

(c) For any covered health care facility employer covered by this section, the minimum wage for all covered health care employees shall be as follows:

(1) From July 1, 2024, to June 30, 2026, inclusive, twenty-one dollars ($21) per hour.

(2) From July 1, 2026, to June 30, 2028, inclusive, twenty-three dollars ($23) per hour.

(3) From July 1, 2028, and until adjusted pursuant to subdivision (d), twenty-five dollars ($25) per hour.

(d) (1) Following the implementation of the minimum wage increase specified in subdivision (c), on or before August 1 of the following year, and on or before each August 1 thereafter, the Director of Finance shall calculate an adjusted minimum wage. The calculation shall increase the health care worker minimum wage by the lesser of 3.5 percent or the rate of change in the averages of the most recent July 1 to June 30, inclusive, period over the preceding July 1 to June 30, inclusive, period for the United States Bureau of Labor Statistics nonseasonally adjusted United States Consumer Price Index for Urban Wage Earners and Clerical Workers (U.S. CPI-W). The result shall be rounded to the nearest ten cents ($0.10). Each adjusted health care worker minimum wage increase calculated under this subdivision shall take effect on the following January 1.

(2) If the rate of change in the averages of the most recent July 1 to June 30, inclusive, period over the preceding July 1 to June 30, inclusive, period for the United States Bureau of Labor Statistics nonseasonally adjusted U.S. CPI-W is negative, there shall be no increase or decrease in the health care

worker minimum wage pursuant to this subdivision on the following January 1.

(e) The health care worker minimum wages shall constitute the state minimum wages for covered health care employment for all purposes under this code and the wage orders of the Industrial Welfare Commission.

(f) (1) A health care worker minimum wage shall be enforceable by the Labor Commissioner in accordance with the procedures set forth in Section 98, 98.1, 98.2, 98.3, 98.7, 98.74, or 1197.1, or by a covered worker through a civil action, through the same means and with the same relief available for violation of any other state minimum wage requirement.

(2) (A) The Department of Industrial Relations shall amend, supplement, and republish the Industrial Welfare Commission's wage orders to be consistent with this section. The Department of Industrial Relations shall make no other changes to the wage orders of the Industrial Welfare Commission that are in existence on the effective date of this section. The Department of Industrial Relations shall meet the requirements set forth in Section 1183.

(B) Every employer that is subject to this section shall comply with all of the following:

(i) Post a copy of the order as amended, supplemented and republished by the Department of Industrial Relations under this section and keep it posted in a conspicuous location frequented by employees during the hours of the workday, as required by Section 1183.

(ii) Provide to each employee on the effective date of the earliest minimum wage increase pursuant to subdivision (c), a written notice, in the language the employer normally uses to communicate employment-related information to the employee, indicating the paragraph of subdivision (c) that applies to the employer and the health care worker minimum wage schedule applicable to the employee.

(C) Any amendment, supplement, and republication pursuant to this section shall be exempt from 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), and from the procedures set forth in Sections 1177, 1178.5, 1181, 1182, and 1182.1.

(g) For covered health care employment where the compensation of the employee is on a salary basis, the employee shall earn a monthly salary equivalent to no less than 150 percent of the health care worker minimum wage or 200 percent of the minimum wage, as described in Section 1182.12, whichever is greater, for full-time employment in order to qualify as exempt from the payment of minimum wage and overtime under the law of this state, including where the employer is a political subdivision of the state, a health care district, the University of California, or a municipality.

(h) (1) An ordinance, regulation, or administrative action applicable to a covered health care facility, as defined in this section, that establishes, requires, imposes, limits, or otherwise relates to wages or compensation for covered health care facility employees, as defined in this section, shall not

be enacted or enforced in or by any city, county, city and county, including charter cities, charter counties, and charter cities and counties.

(2) Any ordinance, regulation, or administrative action taken by any city, county, or city and county, including charter cities, charter counties, and charter cities and counties, that is enacted or takes effect after September 6, 2023, related to covered health facilities, that establishes, requires, imposes, limits, or otherwise relates to wages, salaries, or compensation for covered health care facility employees, as defined in this section, is void.

(3) This subdivision does not preclude any employer, including a city, county, city and county, including charter cities, charter counties, and charter cities and counties, that employs health care employees, from establishing higher wage, salary, or compensation rates for its employees or contracted or subcontracted employees.

(4) This subdivision does not preclude a city, county, city and county, including charter cities, charter counties, and charter cities and counties from establishing a minimum wage that would apply uniformly to all employees across all industries and sectors and not exclusively to employees employed by covered health care facilities.

(5) This subdivision does not preclude a city, county, city and county, including charter cities, charter counties, and charter cities and counties, from establishing or enforcing a minimum wage applicable to covered health care facility employees, as defined in this section, after January 1, 2034. Any such ordinance, regulation, or administrative action shall be evaluated under ordinary preemption principles.

(6) This subdivision does not preclude a city, county, city and county, including charter cities, charter counties, and charter cities and counties, from enacting an ordinance or regulation, or taking administrative action, limiting or otherwise relating to compensation for covered health care facility employees, as defined in this section, after January 1, 2030. Any such ordinance, regulation, or administrative action shall be evaluated under ordinary preemption principles.

(7) This subdivision shall take effect only if subdivision (c) takes effect.

(i) This section shall only take effect when a patient care minimum spending requirement applicable to skilled nursing facilities, as covered in this section, is in effect.

SEC. 29. Section 1182.16 is added to the Labor Code, to read:

1182.16. Notwithstanding subdivision (c) of Section 1182.14 and subdivision (c) of Section 1182.15, the effective dates of the minimum wage increases required by subparagraph (A) of paragraph (1) of subdivision (c), subparagraph (A) of paragraph (2) of subdivision (c), clause (i) of subparagraph (B) of paragraph (3) of subdivision (c), and subparagraph (A) of paragraph (4) of subdivision (c) of Section 1182.14 and paragraph (1) of subdivision (c) of Section 1182.15 shall be delayed until either subdivision (a) or (b) occur:

(a) (1) If, on or before October 15, 2024, the Director of Finance notifies the Joint Legislative Budget Committee that the Department of Finance has determined that agency cash receipts for the period from July 1, 2024,

through September 30, 2024, are at least 3 percent higher than the agency cash receipts projected at the time the 2024 Budget Act was enacted for the July 1, 2024, through September 30, 2024 period, based on current law as of the 2024 Budget Act, the minimum wage increases set forth in subparagraph (A) of paragraph (1) of subdivision (c), subparagraph (A) of paragraph (2) of subdivision (c), clause (i) of subparagraph (B) of paragraph (3) of subdivision (c), and subparagraph (A) of paragraph (4) of subdivision (c) of Section 1182.14 and paragraph (1) of subdivision (c) of Section 1182.15 shall be effective October 15, 2024.

(2) For purposes of this subdivision, "agency cash receipts" means the total amount of the following:

(A) Amounts received under Parts 10, 10.2, and 11 of Division 2 of the Revenue and Taxation Code, that are reported by the Franchise Tax Board to the Department of Finance as total net collections, excluding elective tax payments pursuant to Part 10.4 of Division 2 of the Revenue and Taxation Code, pursuant to law, regulation, procedure, and practice (commonly referred to as the "102 Report") in effect on the effective date of the act establishing this section.

(B) Sales and use tax net cash receipts, as reported by the California Department of Tax and Fee Administration.

(b) If the State Department of Health Care Services notifies the Joint Legislative Budget Committee that it has initiated the data retrieval required in accordance with subdivision (b) of Section 14169.59 of the Welfare and Institutions Code necessary to implement an increase to hospital quality assurance fee revenues for the program period beginning on January 1, 2025, in accordance with Article 5.230 (commencing with Section 14169.50) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, which would fund increases to supplemental Medi-Cal program payments to hospitals that will provide significant new revenues to hospitals and could support hospitals in complying with, and partially mitigate Medi-Cal program costs of, Sections 1182.14 and 1182.15, the minimum wage increases set forth in subparagraph (A) of paragraph (1) of subdivision (c), subparagraph (A) of paragraph (2) of subdivision (c), clause (i) of subparagraph (B) of paragraph (3) of subdivision (c), and subparagraph (A) of paragraph (4) of subdivision (c) of Section 1182.14 and paragraph (1) of subdivision (c) of Section 1182.15 shall be effective the earlier of January 1, 2025, or 15 days after the date of the State Department of Health Care Service's notification to the Joint Legislative Budget Committee.

SEC. 30. Section 1001.36 of the Penal Code, as added by Section 1.2 of Chapter 687 of the Statutes of 2023, is amended to read:

1001.36. (a) On an accusatory pleading alleging the commission of a misdemeanor or felony offense not set forth in subdivision (d), the court may, in its discretion, and after considering the positions of the defense and prosecution, grant pretrial diversion to a defendant pursuant to this section if the defendant satisfies the eligibility requirements for pretrial diversion set forth in subdivision (b) and the court determines that the defendant is suitable for that diversion under the factors set forth in subdivision (c).

(b) A defendant is eligible for pretrial diversion pursuant to this section if both of the following criteria are met:

(1) The defendant has been diagnosed with a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including, but not limited to, bipolar disorder, schizophrenia, schizoaffective disorder, or post-traumatic stress disorder, but excluding antisocial personality disorder and pedophilia. Evidence of the defendant's mental disorder shall be provided by the defense and shall include a diagnosis or treatment for a diagnosed mental disorder within the last five years by a qualified mental health expert. In opining that a defendant suffers from a qualifying disorder, the qualified mental health expert may rely on an examination of the defendant, the defendant's medical records, arrest reports, or any other relevant evidence.

(2) The defendant's mental disorder was a significant factor in the commission of the charged offense. If the defendant has been diagnosed with a mental disorder, the court shall find that the defendant's mental disorder was a significant factor in the commission of the offense unless there is clear and convincing evidence that it was not a motivating factor, causal factor, or contributing factor to the defendant's involvement in the alleged offense. A court may consider any relevant and credible evidence, including, but not limited to, police reports, preliminary hearing transcripts, witness statements, statements by the defendant's mental health treatment provider, medical records, records or reports by qualified medical experts, or evidence that the defendant displayed symptoms consistent with the relevant mental disorder at or near the time of the offense.

(c) For any defendant who satisfies the eligibility requirements in subdivision (b), the court must consider whether the defendant is suitable for pretrial diversion. A defendant is suitable for pretrial diversion if all of the following criteria are met:

(1) In the opinion of a qualified mental health expert, the defendant's symptoms of the mental disorder causing, contributing to, or motivating the criminal behavior would respond to mental health treatment.

(2) The defendant consents to diversion and waives the defendant's right to a speedy trial, unless a defendant has been found to be an appropriate candidate for diversion in lieu of commitment pursuant to clause (v) of subparagraph (B) of paragraph (1) of subdivision (a) of Section 1370 and, as a result of the defendant's mental incompetence, cannot consent to diversion or give a knowing and intelligent waiver of the defendant's right to a speedy trial.

(3) The defendant agrees to comply with treatment as a condition of diversion, unless the defendant has been found to be an appropriate candidate for diversion in lieu of commitment for restoration of competency treatment pursuant to clause (v) of subparagraph (B) of paragraph (1) of subdivision (a) of Section 1370 and, as a result of the defendant's mental incompetence, cannot agree to comply with treatment.

(4) The defendant will not pose an unreasonable risk of danger to public safety, as defined in Section 1170.18, if treated in the community. The court

may consider the opinions of the district attorney, the defense, or a qualified mental health expert, and may consider the defendant's treatment plan, the defendant's violence and criminal history, the current charged offense, and any other factors that the court deems appropriate.

(d) A defendant may not be placed into a diversion program, pursuant to this section, for the following current charged offenses:

(1) Murder or voluntary manslaughter.

(2) An offense for which a person, if convicted, would be required to register pursuant to Section 290, except for a violation of Section 314.

(3) Rape.

(4) Lewd or lascivious act on a child under 14 years of age.

(5) Assault with intent to commit rape, sodomy, or oral copulation, in violation of Section 220.

(6) Commission of rape or sexual penetration in concert with another person, in violation of Section 264.1.

(7) Continuous sexual abuse of a child, in violation of Section 288.5.

(8) A violation of subdivision (b) or (c) of Section 11418.

(e) At any stage of the proceedings, the court may require the defendant to make a prima facie showing that the defendant will meet the minimum requirements of eligibility for diversion and that the defendant and the offense are suitable for diversion. The hearing on the prima facie showing shall be informal and may proceed on offers of proof, reliable hearsay, and argument of counsel. If a prima facie showing is not made, the court may summarily deny the request for diversion or grant any other relief as may be deemed appropriate.

(f) As used in this chapter, the following terms have the following meanings:

(1) "Pretrial diversion" means the postponement of prosecution, either temporarily or permanently, at any point in the judicial process from the point at which the accused is charged until adjudication, to allow the defendant to undergo mental health treatment, subject to all of the following:

(A) (i) The court is satisfied that the recommended inpatient or outpatient program of mental health treatment will meet the specialized mental health treatment needs of the defendant.

(ii) The defendant may be referred to a program of mental health treatment utilizing existing inpatient or outpatient mental health resources. Before approving a proposed treatment program, the court shall consider the request of the defense, the request of the prosecution, the needs of the defendant, and the interests of the community. The treatment may be procured using private or public funds, and a referral may be made to a county mental health agency, existing collaborative courts, or assisted outpatient treatment only if that entity has agreed to accept responsibility for the treatment of the defendant, and mental health services are provided only to the extent that resources are available and the defendant is eligible for those services.

(iii) If the court refers the defendant to a county mental health agency pursuant to this section and the agency determines that it is unable to provide services to the defendant, the court shall accept a written declaration to that

effect from the agency in lieu of requiring live testimony. That declaration shall serve only to establish that the program is unable to provide services to the defendant at that time and does not constitute evidence that the defendant is unqualified or unsuitable for diversion under this section.

(B) The provider of the mental health treatment program in which the defendant has been placed shall provide regular reports to the court, the defense, and the prosecutor on the defendant's progress in treatment.

(C) The period during which criminal proceedings against the defendant may be diverted is limited as follows:

(i) If the defendant is charged with a felony, the period shall be no longer than two years.

(ii) If the defendant is charged with a misdemeanor, the period shall be no longer than one year.

(D) Upon request, the court shall conduct a hearing to determine whether restitution, as defined in subdivision (f) of Section 1202.4, is owed to any victim as a result of the diverted offense and, if owed, order its payment during the period of diversion. However, a defendant's inability to pay restitution due to indigence or mental disorder shall not be grounds for denial of diversion or a finding that the defendant has failed to comply with the terms of diversion.

(2) "Qualified mental health expert" includes, but is not limited to, a psychiatrist, psychologist, a person described in Section 5751.2 of the Welfare and Institutions Code, or a person whose knowledge, skill, experience, training, or education qualifies them as an expert.

(g) If any of the following circumstances exists, the court shall, after notice to the defendant, defense counsel, and the prosecution, hold a hearing to determine whether the criminal proceedings should be reinstated, whether the treatment should be modified, or whether the defendant should be conserved and referred to the conservatorship investigator of the county of commitment to initiate conservatorship proceedings for the defendant pursuant to Chapter 3 (commencing with Section 5350) of Part 1 of Division 5 of the Welfare and Institutions Code:

(1) The defendant is charged with an additional misdemeanor allegedly committed during the pretrial diversion and that reflects the defendant's propensity for violence.

(2) The defendant is charged with an additional felony allegedly committed during the pretrial diversion.

(3) The defendant is engaged in criminal conduct rendering the defendant unsuitable for diversion.

(4) Based on the opinion of a qualified mental health expert whom the court may deem appropriate, either of the following circumstances exists:

(A) The defendant is performing unsatisfactorily in the assigned program.

(B) The defendant is gravely disabled, as defined in subparagraph (B) of paragraph (1) of subdivision (h) of Section 5008 of the Welfare and Institutions Code. A defendant shall only be conserved and referred to the conservatorship investigator pursuant to this finding.

(h) If the defendant has performed satisfactorily in diversion, at the end of the period of diversion, the court shall dismiss the defendant's criminal charges that were the subject of the criminal proceedings at the time of the initial diversion. A court may conclude that the defendant has performed satisfactorily if the defendant has substantially complied with the requirements of diversion, has avoided significant new violations of law unrelated to the defendant's mental health condition, and has a plan in place for long-term mental health care. If the court dismisses the charges, the clerk of the court shall file a record with the Department of Justice indicating the disposition of the case diverted pursuant to this section. Upon successful completion of diversion, if the court dismisses the charges, the arrest upon which the diversion was based shall be deemed never to have occurred, and the court shall order access to the record of the arrest restricted in accordance with Section 1001.9, except as specified in subdivisions (j) and (k). The defendant who successfully completes diversion may indicate in response to any question concerning the defendant's prior criminal record that the defendant was not arrested or diverted for the offense, except as specified in subdivision (j).

(i) A record pertaining to an arrest resulting in successful completion of diversion, or any record generated as a result of the defendant's application for or participation in diversion, shall not, without the defendant's consent, be used in any way that could result in the denial of any employment, benefit, license, or certificate.

(j) The defendant shall be advised that, regardless of the defendant's completion of diversion, both of the following apply:

(1) The arrest upon which the diversion was based may be disclosed by the Department of Justice to any peace officer application request and that, notwithstanding subdivision (i), this section does not relieve the defendant of the obligation to disclose the arrest in response to any direct question contained in any questionnaire or application for a position as a peace officer, as defined in Section 830.

(2) An order to seal records pertaining to an arrest made pursuant to this section has no effect on a criminal justice agency's ability to access and use those sealed records and information regarding sealed arrests, as described in Section 851.92.

(k) A finding that the defendant suffers from a mental disorder, any progress reports concerning the defendant's treatment, including, but not limited to, any finding that the defendant be prohibited from owning or controlling a firearm because they are a danger to themselves or others pursuant to subdivision (m), or any other records related to a mental disorder that were created as a result of participation in, or completion of, diversion pursuant to this section or for use at a hearing on the defendant's eligibility for diversion under this section may not be used in any other proceeding without the defendant's consent, unless that information is relevant evidence that is admissible under the standards described in paragraph (2) of subdivision (f) of Section 28 of Article I of the California Constitution. However, when determining whether to exercise its discretion to grant

diversion under this section, a court may consider previous records of participation in diversion under this section.

(*l*) The county agency administering the diversion, the defendant's mental health treatment providers, the public guardian or conservator, and the court shall, to the extent not prohibited by federal law, have access to the defendant's medical and psychological records, including progress reports, during the defendant's time in diversion, as needed, for the purpose of providing care and treatment and monitoring treatment for diversion or conservatorship.

(m) (1) The prosecution may request an order from the court that the defendant be prohibited from owning or possessing a firearm until they successfully complete diversion because they are a danger to themselves or others pursuant to subdivision (i) of Section 8103 of the Welfare and Institutions Code.

(2) The prosecution shall bear the burden of proving, by clear and convincing evidence, both of the following are true:

(A) The defendant poses a significant danger of causing personal injury to themselves or another by having in their custody or control, owning, purchasing, possessing, or receiving a firearm.

(B) The prohibition is necessary to prevent personal injury to the defendant or any other person because less restrictive alternatives either have been tried and found to be ineffective or are inadequate or inappropriate for the circumstances of the defendant.

(3) (A) If the court finds that the prosecution has not met that burden, the court shall not order that the person is prohibited from having, owning, purchasing, possessing, or receiving a firearm.

(B) If the court finds that the prosecution has met the burden, the court shall order that the person is prohibited, and shall inform the person that they are prohibited, from owning or controlling a firearm until they successfully complete diversion because they are a danger to themselves or others.

(4) An order imposed pursuant to this subdivision shall be in effect until the defendant has successfully completed diversion or until their firearm rights are restored pursuant to paragraph (4) of subdivision (g) of Section 8103 of the Welfare and Institutions Code.

(n) This section shall become operative on July 1, 2024.

SEC. 31. Section 1370 of the Penal Code is amended to read:

1370. (a) (1) (A) If the defendant is found mentally competent, the criminal process shall resume, the trial on the offense charged or hearing on the alleged violation shall proceed, and judgment may be pronounced.

(B) If the defendant is found mentally incompetent, the trial, the hearing on the alleged violation, or the judgment shall be suspended until the person becomes mentally competent.

(i) The court shall order that the mentally incompetent defendant be delivered by the sheriff to a State Department of State Hospitals facility, as defined in Section 4100 of the Welfare and Institutions Code, as directed by the State Department of State Hospitals, or to any other available public

or private treatment facility, including a community-based residential treatment system approved by the community program director, or their designee, that will promote the defendant's speedy restoration to mental competence, or placed on outpatient status as specified in Section 1600.

(ii) (I) If a defendant has been found mentally incompetent, and the court has ordered commitment to a State Department of State Hospitals facility as described in Section 4100 of the Welfare and Institutions Code, and is not in the custody of the local sheriff, the department shall inform the sheriff when a placement in a facility becomes available and make reasonable efforts to coordinate a delivery by the sheriff to transport the defendant to the facility. If the department has made reasonable attempts for 90 days, starting with the date of commitment, and the defendant has not been transported, as originally ordered under clause (i), the department shall inform the court and sheriff in writing.

(II) If the sheriff has not delivered the defendant to a State Department of State Hospitals facility within 90 days after the department's written notice, the commitment to the State Department of State Hospitals shall be automatically stayed and the department may remove the defendant from the pending placement list until the court notifies the department in writing that the defendant is available for transport and the defendant shall regain their place on the pending placement list.

(iii) However, if the action against the defendant who has been found mentally incompetent is on a complaint charging a felony offense specified in Section 290, the prosecutor shall determine whether the defendant previously has been found mentally incompetent to stand trial pursuant to this chapter on a charge of a Section 290 offense, or whether the defendant is currently the subject of a pending Section 1368 proceeding arising out of a charge of a Section 290 offense. If either determination is made, the prosecutor shall notify the court and defendant in writing. After this notification, and opportunity for hearing, the court shall order that the defendant be delivered by the sheriff to a State Department of State Hospitals facility, as directed by the State Department of State Hospitals, or other secure treatment facility for the care and treatment of persons with a mental health disorder, unless the court makes specific findings on the record that an alternative placement would provide more appropriate treatment for the defendant and would not pose a danger to the health and safety of others.

(iv) If the action against the defendant who has been found mentally incompetent is on a complaint charging a felony offense specified in Section 290 and the defendant has been denied bail pursuant to subdivision (b) of Section 12 of Article I of the California Constitution because the court has found, based upon clear and convincing evidence, a substantial likelihood that the person's release would result in great bodily harm to others, the court shall order that the defendant be delivered by the sheriff to a State Department of State Hospitals facility, as directed by the State Department of State Hospitals, unless the court makes specific findings on the record that an alternative placement would provide more appropriate treatment for the defendant and would not pose a danger to the health and safety of others.

(v) (I) If, at any time after the court finds that the defendant is mentally incompetent and before the defendant is transported to a facility pursuant to this section, the court is provided with any information that the defendant may benefit from diversion pursuant to Chapter 2.8A (commencing with Section 1001.35) of Title 6, the court may make a finding that the defendant is an appropriate candidate for diversion.

(II) Notwithstanding subclause (I), if a defendant is found mentally incompetent and is transferred to a facility described in Section 4361.6 of the Welfare and Institutions Code, the court may, at any time upon receiving any information that the defendant may benefit from diversion pursuant to Chapter 2.8A (commencing with Section 1001.35) of Title 6, make a finding that the defendant is an appropriate candidate for diversion.

(vi) If a defendant is found by the court to be an appropriate candidate for diversion pursuant to clause (v), the defendant's eligibility shall be determined pursuant to Section 1001.36. A defendant granted diversion may participate for the lesser of the period specified in paragraph (1) of subdivision (c) or the applicable period described in subparagraph (C) of paragraph (1) of subdivision (f) of Section 1001.36. If, during that period, the court determines that criminal proceedings should be reinstated pursuant to subdivision (g) of Section 1001.36, the court shall, pursuant to Section 1369, appoint a psychiatrist, licensed psychologist, or any other expert the court may deem appropriate, to determine the defendant's competence to stand trial.

(vii) Upon the dismissal of charges at the conclusion of the period of diversion, pursuant to subdivision (h) of Section 1001.36, a defendant shall no longer be deemed incompetent to stand trial pursuant to this section.

(viii) The clerk of the court shall notify the Department of Justice, in writing, of a finding of mental incompetence with respect to a defendant who is subject to clause (iii) or (iv) for inclusion in the defendant's state summary criminal history information.

(C) Upon the filing of a certificate of restoration to competence, the court shall order that the defendant be returned to court in accordance with Section 1372. The court shall transmit a copy of its order to the community program director or a designee.

(D) A defendant charged with a violent felony may not be delivered to a State Department of State Hospitals facility or treatment facility pursuant to this subdivision unless the State Department of State Hospitals facility or treatment facility has a secured perimeter or a locked and controlled treatment facility, and the judge determines that the public safety will be protected.

(E) For purposes of this paragraph, "violent felony" means an offense specified in subdivision (c) of Section 667.5.

(F) A defendant charged with a violent felony may be placed on outpatient status, as specified in Section 1600, only if the court finds that the placement will not pose a danger to the health or safety of others. If the court places a defendant charged with a violent felony on outpatient status, as specified in Section 1600, the court shall serve copies of the placement order on

defense counsel, the sheriff in the county where the defendant will be placed, and the district attorney for the county in which the violent felony charges are pending against the defendant.

(G) If, at any time after the court has declared a defendant incompetent to stand trial pursuant to this section, counsel for the defendant or a jail medical or mental health staff provider provides the court with substantial evidence that the defendant's psychiatric symptoms have changed to such a degree as to create a doubt in the mind of the judge as to the defendant's current mental incompetence, the court may appoint a psychiatrist or a licensed psychologist to opine as to whether the defendant has regained competence. If, in the opinion of that expert, the defendant has regained competence, the court shall proceed as if a certificate of restoration of competence has been returned pursuant to paragraph (1) of subdivision (a) of Section 1372.

(H) (i) The State Department of State Hospitals may, pursuant to Section 4335.2 of the Welfare and Institutions Code, conduct an evaluation of the defendant in county custody to determine any of the following:

(I) The defendant has regained competence.

(II) There is no substantial likelihood that the defendant will regain competence in the foreseeable future.

(III) The defendant should be referred to the county for further evaluation for potential participation in a county diversion program, if one exists, or to another outpatient treatment program.

(ii) If, in the opinion of the department's expert, the defendant has regained competence, the court shall proceed as if a certificate of restoration of competence has been returned pursuant to paragraph (1) of subdivision (a) of Section 1372.

(iii) If, in the opinion of the department's expert, there is no substantial likelihood that the defendant will regain mental competence in the foreseeable future, the committing court shall proceed pursuant to paragraph (2) of subdivision (c) no later than 10 days following receipt of the report.

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

(A) (i) The court shall order the community program director or a designee to evaluate the defendant and to submit to the court within 15 judicial days of the order a written recommendation as to whether the defendant should be required to undergo outpatient treatment, or be committed to the State Department of State Hospitals or to any other treatment facility. A person shall not be admitted to a State Department of State Hospitals facility or other treatment facility or placed on outpatient status under this section without having been evaluated by the community program director or a designee. The community program director or designee shall evaluate the appropriate placement for the defendant between a State Department of State Hospitals facility or the community-based residential treatment system based upon guidelines provided by the State Department of State Hospitals.

(ii) A defendant shall first be considered for placement in an outpatient treatment program, a community treatment program, or a diversion program, if any such program is available, unless a court, based upon the recommendation of the community program director or their designee, finds that either the clinical needs of the defendant or the risk to community safety, warrant placement in a State Department of State Hospitals facility.

(B) The court shall hear and determine whether the defendant lacks capacity to make decisions regarding the administration of antipsychotic medication. The court shall consider opinions in the reports prepared pursuant to subdivision (a) of Section 1369, as applicable to the issue of whether the defendant lacks capacity to make decisions regarding the administration of antipsychotic medication, and shall proceed as follows:

(i) The court shall hear and determine whether any of the following is true:

(I) Based upon the opinion of the psychiatrist or licensed psychologist offered to the court pursuant to subparagraph (A) of paragraph (2) of subdivision (a) of Section 1369, the defendant lacks capacity to make decisions regarding antipsychotic medication, the defendant's mental disorder requires medical treatment with antipsychotic medication, and, if the defendant's mental disorder is not treated with antipsychotic medication, it is probable that serious harm to the physical or mental health of the defendant will result. Probability of serious harm to the physical or mental health of the defendant requires evidence that the defendant is presently suffering adverse effects to their physical or mental health, or the defendant has previously suffered these effects as a result of a mental disorder and their condition is substantially deteriorating. The fact that a defendant has a diagnosis of a mental disorder does not alone establish probability of serious harm to the physical or mental health of the defendant.

(II) Based upon the opinion of the psychiatrist or licensed psychologist offered to the court pursuant to subparagraph (A) of paragraph (2) of subdivision (a) of Section 1369, the defendant is a danger to others, in that the defendant has inflicted, attempted to inflict, or made a serious threat of inflicting substantial physical harm on another while in custody, or the defendant had inflicted, attempted to inflict, or made a serious threat of inflicting substantial physical harm on another that resulted in the defendant being taken into custody, and the defendant presents, as a result of mental disorder or mental defect, a demonstrated danger of inflicting substantial physical harm on others. Demonstrated danger may be based on an assessment of the defendant's present mental condition, including a consideration of past behavior of the defendant within six years prior to the time the defendant last attempted to inflict, inflicted, or threatened to inflict substantial physical harm on another, and other relevant evidence.

(III) The people have charged the defendant with a serious crime against the person or property, and based upon the opinion of the psychiatrist offered to the court pursuant to subparagraph (C) of paragraph (2) of subdivision (a) of Section 1369, the involuntary administration of antipsychotic medication is substantially likely to render the defendant competent to stand

trial, the medication is unlikely to have side effects that interfere with the defendant's ability to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a reasonable manner, less intrusive treatments are unlikely to have substantially the same results, and antipsychotic medication is medically necessary and appropriate in light of their medical condition.

(ii) (I) If the court finds the conditions described in subclause (I) or (II) of clause (i) to be true, and if pursuant to the opinion offered to the court pursuant to paragraph (2) of subdivision (a) of Section 1369, a psychiatrist has opined that treatment with antipsychotic medications is appropriate for the defendant, the court shall issue an order authorizing the administration of antipsychotic medication as needed, including on an involuntary basis, to be administered under the direction and supervision of a licensed psychiatrist.

(II) If the court finds the conditions described in subclause (I) or (II) of clause (i) to be true, and if pursuant to the opinion offered to the court pursuant to paragraph (2) of subdivision (a) of Section 1369, a licensed psychologist has opined that treatment with antipsychotic medication may be appropriate for the defendant, the court shall issue an order authorizing treatment by a licensed psychiatrist on an involuntary basis. That treatment may include the administration of antipsychotic medication as needed, to be administered under the direction and supervision of a licensed psychiatrist.

(III) If the court finds the conditions described in subclause (III) of clause (i) to be true, and if pursuant to the opinion offered to the court pursuant to paragraph (2) of subdivision (a) of Section 1369, a psychiatrist has opined that it is appropriate to treat the defendant with antipsychotic medication, the court shall issue an order authorizing the administration of antipsychotic medication as needed, including on an involuntary basis, to be administered under the direction and supervision of a licensed psychiatrist.

(iii) An order authorizing involuntary administration of antipsychotic medication to the defendant when and as prescribed by the defendant's treating psychiatrist at any facility housing the defendant for purposes of this chapter, including a county jail, shall remain in effect when the defendant returns to county custody pursuant to subparagraph (A) of paragraph (1) of subdivision (b) or paragraph (1) of subdivision (c), or pursuant to subparagraph (C) of paragraph (3) of subdivision (a) of Section 1372, but shall be valid for no more than one year, pursuant to subparagraph (A) of paragraph (7). The court shall not order involuntary administration of psychotropic medication under subclause (III) of clause (i) unless the court has first found that the defendant does not meet the criteria for involuntary administration of psychotropic medication under subclause (I) of clause (i) and does not meet the criteria under subclause (II) of clause (i).

(iv) In all cases, the treating hospital, county jail, facility, or program may administer medically appropriate antipsychotic medication prescribed by a psychiatrist in an emergency as described in subdivision (m) of Section 5008 of the Welfare and Institutions Code.

(v) If the court has determined that the defendant has the capacity to make decisions regarding antipsychotic medication, and if the defendant, with advice of their counsel, consents, the court order of commitment shall include confirmation that antipsychotic medication may be given to the defendant as prescribed by a treating psychiatrist pursuant to the defendant's consent. The commitment order shall also indicate that, if the defendant withdraws consent for antipsychotic medication, after the treating psychiatrist complies with the provisions of subparagraph (C), the defendant shall be returned to court for a hearing in accordance with subparagraphs (C) and (D) regarding whether antipsychotic medication shall be administered involuntarily.

(vi) If the court has determined that the defendant has the capacity to make decisions regarding antipsychotic medication and if the defendant, with advice from their counsel, does not consent, the court order for commitment shall indicate that, after the treating psychiatrist complies with the provisions of subparagraph (C), the defendant shall be returned to court for a hearing in accordance with subparagraphs (C) and (D) regarding whether antipsychotic medication shall be administered involuntarily.

(vii) A report made pursuant to paragraph (1) of subdivision (b) shall include a description of antipsychotic medication administered to the defendant and its effects and side effects, including effects on the defendant's appearance or behavior that would affect the defendant's ability to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a reasonable manner. During the time the defendant is confined in a State Department of State Hospitals facility or other treatment facility or placed on outpatient status, either the defendant or the people may request that the court review any order made pursuant to this subdivision. The defendant, to the same extent enjoyed by other patients in the State Department of State Hospitals facility or other treatment facility, shall have the right to contact the patients' rights advocate regarding the defendant's rights under this section.

(C) If the defendant consented to antipsychotic medication as described in clause (iv) of subparagraph (B), but subsequently withdraws their consent, or, if involuntary antipsychotic medication was not ordered pursuant to clause (v) of subparagraph (B), and the treating psychiatrist determines that antipsychotic medication has become medically necessary and appropriate, the treating psychiatrist shall make efforts to obtain informed consent from the defendant for antipsychotic medication. If informed consent is not obtained from the defendant, and the treating psychiatrist is of the opinion that the defendant lacks capacity to make decisions regarding antipsychotic medication based on the conditions described in subclause (I) or (II) of clause (i) of subparagraph (B), the treating psychiatrist shall certify whether the lack of capacity and any applicable conditions described above exist. That certification shall contain an assessment of the current mental status of the defendant and the opinion of the treating psychiatrist that involuntary antipsychotic medication has become medically necessary and appropriate.

(D) (i) If the treating psychiatrist certifies that antipsychotic medication has become medically necessary and appropriate pursuant to subparagraph (C), antipsychotic medication may be administered to the defendant for not more than 21 days, provided, however, that, within 72 hours of the certification, the defendant is provided a medication review hearing before an administrative law judge to be conducted at the facility where the defendant is receiving treatment. The treating psychiatrist shall present the case for the certification for involuntary treatment and the defendant shall be represented by an attorney or a patients' rights advocate. The attorney or patients' rights advocate shall be appointed to meet with the defendant no later than one day prior to the medication review hearing to review the defendant's rights at the medication review hearing, discuss the process, answer questions or concerns regarding involuntary medication or the hearing, assist the defendant in preparing for the hearing and advocating for the defendant's interests at the hearing, review the panel's final determination following the hearing, advise the defendant of their right to judicial review of the panel's decision, and provide the defendant with referral information for legal advice on the subject. The defendant shall also have the following rights with respect to the medication review hearing:

(I) To be given timely access to the defendant's records.

(II) To be present at the hearing, unless the defendant waives that right.

(III) To present evidence at the hearing.

(IV) To question persons presenting evidence supporting involuntary medication.

(V) To make reasonable requests for attendance of witnesses on the defendant's behalf.

(VI) To a hearing conducted in an impartial and informal manner.

(ii) If the administrative law judge determines that the defendant either meets the criteria specified in subclause (I) of clause (i) of subparagraph (B), or meets the criteria specified in subclause (II) of clause (i) of subparagraph (B), antipsychotic medication may continue to be administered to the defendant for the 21-day certification period. Concurrently with the treating psychiatrist's certification, the treating psychiatrist shall file a copy of the certification and a petition with the court for issuance of an order to administer antipsychotic medication beyond the 21-day certification period. For purposes of this subparagraph, the treating psychiatrist shall not be required to pay or deposit any fee for the filing of the petition or other document or paper related to the petition.

(iii) If the administrative law judge disagrees with the certification, medication may not be administered involuntarily until the court determines that antipsychotic medication should be administered pursuant to this section.

(iv) The court shall provide notice to the prosecuting attorney and to the attorney representing the defendant, and shall hold a hearing, no later than 18 days from the date of the certification, to determine whether antipsychotic medication should be ordered beyond the certification period.

(v) If, as a result of the hearing, the court determines that antipsychotic medication should be administered beyond the certification period, the court shall issue an order authorizing the administration of that medication.

(vi) The court shall render its decision on the petition and issue its order no later than three calendar days after the hearing and, in any event, no later than the expiration of the 21-day certification period.

(vii) If the administrative law judge upholds the certification pursuant to clause (ii), the court may, for a period not to exceed 14 days, extend the certification and continue the hearing pursuant to stipulation between the parties or upon a finding of good cause. In determining good cause, the court may review the petition filed with the court, the administrative law judge's order, and any additional testimony needed by the court to determine if it is appropriate to continue medication beyond the 21-day certification and for a period of up to 14 days.

(viii) The district attorney, county counsel, or representative of a facility where a defendant found incompetent to stand trial is committed may petition the court for an order to administer involuntary medication pursuant to the criteria set forth in subclauses (II) and (III) of clause (i) of subparagraph (B). The order is reviewable as provided in paragraph (7).

(3) (A) When the court orders that the defendant be committed to a State Department of State Hospitals facility or other public or private treatment facility, the court shall provide copies of the following documents prior to the admission of the defendant to the State Department of State Hospitals or other treatment facility where the defendant is to be committed:

(i) The commitment order, which shall include a specification of the charges, an assessment of whether involuntary treatment with antipsychotic medications is warranted, and any orders by the court, pursuant to subparagraph (B) of paragraph (2), authorizing involuntary treatment with antipsychotic medications.

(ii) A computation or statement setting forth the maximum term of commitment in accordance with subdivision (c).

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

(II) If a certificate of restoration of competency was filed with the court pursuant to Section 1372 and the court subsequently rejected the certification, a copy of the court order or minute order rejecting the certification shall be provided. The court order shall include a new computation or statement setting forth the amount of credit for time served, if any, to be deducted from the defendant's maximum term of commitment based on the court's rejection of the certification.

(iv) State summary criminal history information.

(v) Jail classification records for the defendant's current incarceration.

(vi) Arrest reports prepared by the police department or other law enforcement agency.

(vii) Court-ordered psychiatric examination or evaluation reports.

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

(ix) Records of a finding of mental incompetence pursuant to this chapter arising out of a complaint charging a felony offense specified in Section 290 or a pending Section 1368 proceeding arising out of a charge of a Section 290 offense.

(x) Medical records, including jail mental health records.

(B) If a defendant is committed to a State Department of State Hospitals facility, and the department determines that additional medical or mental health treatment records are needed for continuity of care, any private or public entity holding medical or mental health treatment records of that defendant shall release those records upon receiving a written request from the State Department of State Hospitals within 10 calendar days after the request. The private or public entity holding the medical or mental health treatment records shall comply with all applicable federal and state privacy laws prior to disclosure. The State Department of State Hospitals shall not release records obtained during the admission process under this subdivision, pursuant to Section 1798.68 of the Civil Code, or subdivision (b) of Section 5328 of the Welfare and Institutions Code.

(4) When the defendant is committed to a treatment facility pursuant to clause (i) of subparagraph (B) of paragraph (1) or the court makes the findings specified in clause (iii) or (iv) of subparagraph (B) of paragraph (1) to assign the defendant to a treatment facility other than a State Department of State Hospitals facility or other secure treatment facility, the court shall order that notice be given to the appropriate law enforcement agency or agencies having local jurisdiction at the placement facility of a finding of mental incompetence pursuant to this chapter arising out of a charge of a Section 290 offense.

(5) When directing that the defendant be confined in a State Department of State Hospitals facility pursuant to this subdivision, the court shall commit the defendant to the State Department of State Hospitals.

(6) (A) If the defendant is committed or transferred to the State Department of State Hospitals pursuant to this section, the court may, upon receiving the written recommendation of the medical director of the State Department of State Hospitals facility and the community program director that the defendant be transferred to a public or private treatment facility approved by the community program director, order the defendant transferred to that facility. If the defendant is committed or transferred to a public or private treatment facility approved by the community program director, the court may, upon receiving the written recommendation of the community program director, transfer the defendant to the State Department of State Hospitals or to another public or private treatment facility approved by the community program director. In the event of dismissal of the criminal charges before the defendant recovers competence, the person shall be subject to the applicable provisions of the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code). If either the defendant or the prosecutor chooses to contest

either kind of order of transfer, a petition may be filed in the court for a hearing, which shall be held if the court determines that sufficient grounds exist. At the hearing, the prosecuting attorney or the defendant may present evidence bearing on the order of transfer. The court shall use the same standards as are used in conducting probation revocation hearings pursuant to Section 1203.2.

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

(B) If the defendant is initially committed to a State Department of State Hospitals facility or secure treatment facility pursuant to clause (iii) or (iv) of subparagraph (B) of paragraph (1) and is subsequently transferred to any other facility, copies of the documents specified in paragraph (3) shall be electronically transferred or taken with the defendant to each subsequent facility to which the defendant is transferred. The transferring facility shall also notify the appropriate law enforcement agency or agencies having local jurisdiction at the site of the new facility that the defendant is a person subject to clause (iii) or (iv) of subparagraph (B) of paragraph (1).

(7) (A) An order by the court authorizing involuntary medication of the defendant shall be valid for no more than one year. The court shall review the order at the time of the review of the initial report and the six-month progress reports pursuant to paragraph (1) of subdivision (b) to determine if the grounds for the authorization remain. In the review, the court shall consider the reports of the treating psychiatrist or psychiatrists and the defendant's patients' rights advocate or attorney. The court may require testimony from the treating psychiatrist and the patients' rights advocate or attorney, if necessary. The court may continue the order authorizing involuntary medication for up to another six months, or vacate the order, or make any other appropriate order.

(B) Within 60 days before the expiration of the one-year involuntary medication order, the district attorney, county counsel, or representative of any facility where a defendant found incompetent to stand trial is committed may petition the committing court for a renewal, subject to the same conditions and requirements as in subparagraph (A). The petition shall include the basis for involuntary medication set forth in clause (i) of subparagraph (B) of paragraph (2). Notice of the petition shall be provided to the defendant, the defendant's attorney, and the district attorney. The court shall hear and determine whether the defendant continues to meet the criteria set forth in clause (i) of subparagraph (B) of paragraph (2). The hearing on a petition to renew an order for involuntary medication shall be conducted prior to the expiration of the current order.

(8) For purposes of subparagraph (D) of paragraph (2) and paragraph (7), if the treating psychiatrist determines that there is a need, based on preserving their rapport with the defendant or preventing harm, the treating psychiatrist may request that the facility medical director designate another psychiatrist to act in the place of the treating psychiatrist. If the medical director of the facility designates another psychiatrist to act pursuant to this

paragraph, the treating psychiatrist shall brief the acting psychiatrist of the relevant facts of the case and the acting psychiatrist shall examine the defendant prior to the hearing.

(b) (1) Within 90 days after a commitment made pursuant to subdivision (a), the medical director of the State Department of State Hospitals facility or other treatment facility to which the defendant is confined shall make a written report to the court and the community program director for the county or region of commitment, or a designee, concerning the defendant's progress toward recovery of mental competence and whether the administration of antipsychotic medication remains necessary.

If the defendant is in county custody, the county jail shall provide access to the defendant for purposes of the State Department of State Hospitals conducting an evaluation of the defendant pursuant to Section 4335.2 of the Welfare and Institutions Code. Based upon this evaluation, the State Department of State Hospitals may make a written report to the court within 90 days of a commitment made pursuant to subdivision (a) concerning the defendant's progress toward recovery of mental incompetence and whether the administration of antipsychotic medication is necessary. If the defendant remains in county custody after the initial 90-day report, the State Department of State Hospitals may conduct an evaluation of the defendant pursuant to Section 4335.2 of the Welfare and Institutions Code and make a written report to the court concerning the defendant's progress toward recovery of mental incompetence and whether the administration of antipsychotic medication is necessary.

If the defendant is on outpatient status, the outpatient treatment staff shall make a written report to the community program director concerning the defendant's progress toward recovery of mental competence. Within 90 days of placement on outpatient status, the community program director shall report to the court on this matter. If the defendant has not recovered mental competence, but the report discloses a substantial likelihood that the defendant will regain mental competence in the foreseeable future, the defendant shall remain in the State Department of State Hospitals facility or other treatment facility or on outpatient status. Thereafter, at six-month intervals or until the defendant becomes mentally competent, if the defendant is confined in a treatment facility, the medical director of the State Department of State Hospitals facility or person in charge of the facility shall report, in writing, to the court and the community program director or a designee regarding the defendant's progress toward recovery of mental competence and whether the administration of antipsychotic medication remains necessary. If the defendant is on outpatient status, after the initial 90-day report, the outpatient treatment staff shall report to the community program director on the defendant's progress toward recovery, and the community program director shall report to the court on this matter at six-month intervals. A copy of these reports shall be provided to the prosecutor and defense counsel by the court.

(A) If the report indicates that there is no substantial likelihood that the defendant will regain mental competence in the foreseeable future, custody

of the defendant shall be transferred without delay to the committing county and shall remain with the county until further order of the court. The defendant shall be returned to the court for proceedings pursuant to paragraph (2) of subdivision (c) no later than 10 days following receipt of the report. The court shall not order the defendant returned to the custody of the State Department of State Hospitals under the same commitment. The court shall transmit a copy of its order to the community program director or a designee.

(B) If the report indicates that there is no substantial likelihood that the defendant will regain mental competence in the foreseeable future, the medical director of the State Department of State Hospitals facility or other treatment facility to which the defendant is confined shall do both of the following:

(i) Promptly notify and provide a copy of the report to the defense counsel and the district attorney.

(ii) Provide a separate notification, in compliance with applicable privacy laws, to the committing county's sheriff that immediate transportation will be needed for the defendant pursuant to subparagraph (A).

(C) If a county does not take custody of a defendant committed to the State Department of State Hospitals within 10 calendar days following notification made pursuant to clause (ii) of subparagraph (B), the county shall be charged the daily rate for a state hospital bed, as established by the State Department of State Hospitals.

(2) The reports made pursuant to paragraph (1) concerning the defendant's progress toward regaining competency shall also consider the issue of involuntary medication. Each report shall include, but not be limited to, all of the following:

(A) Whether or not the defendant has the capacity to make decisions concerning antipsychotic medication.

(B) If the defendant lacks capacity to make decisions concerning antipsychotic medication, whether the defendant risks serious harm to their physical or mental health if not treated with antipsychotic medication.

(C) Whether or not the defendant presents a danger to others if the defendant is not treated with antipsychotic medication.

(D) Whether the defendant has a mental disorder for which medications are the only effective treatment.

(E) Whether there are any side effects from the medication currently being experienced by the defendant that would interfere with the defendant's ability to collaborate with counsel.

(F) Whether there are any effective alternatives to medication.

(G) How quickly the medication is likely to bring the defendant to competency.

(H) Whether the treatment plan includes methods other than medication to restore the defendant to competency.

(I) A statement, if applicable, that no medication is likely to restore the defendant to competency.

(3) After reviewing the reports, the court shall determine if grounds for the involuntary administration of antipsychotic medication exist, whether

or not an order was issued at the time of commitment, and shall do one of the following:

(A) If the original grounds for involuntary medication still exist, any order authorizing the treating facility to involuntarily administer antipsychotic medication to the defendant shall remain in effect.

(B) If the original grounds for involuntary medication no longer exist, and there is no other basis for involuntary administration of antipsychotic medication, any order for the involuntary administration of antipsychotic medication shall be vacated.

(C) If the original grounds for involuntary medication no longer exist, and the report states that there is another basis for involuntary administration of antipsychotic medication, the court shall determine whether to vacate the order or issue a new order for the involuntary administration of antipsychotic medication. The court shall consider the opinions in reports submitted pursuant to paragraph (1) of subdivision (b), including any opinions rendered pursuant to Section 4335.2 of the Welfare and Institutions Code. The court may, upon a showing of good cause, set a hearing within 21 days to determine whether the order for the involuntary administration of antipsychotic medication shall be vacated or whether a new order for the involuntary administration of antipsychotic medication shall be issued. The hearing shall proceed as set forth in subparagraph (B) of paragraph (2) of subdivision (a). The court shall require witness testimony to occur remotely, including clinical testimony pursuant to subdivision (d) of Section 4335.2 of the Welfare and Institutions Code. In-person witness testimony shall only be allowed upon a court's finding of good cause.

(D) If the report states a basis for involuntary administration of antipsychotic medication and the court did not issue such order at the time of commitment, the court shall determine whether to issue an order for the involuntary administration of antipsychotic medication. The court shall consider the opinions in reports submitted pursuant to paragraph (1) of subdivision (b), including any opinions rendered pursuant to Section 4335.2 of the Welfare and Institutions Code. The court may, upon a finding of good cause, set a hearing within 21 days to determine whether an order for the involuntary administration of antipsychotic medication shall be issued. The hearing shall proceed as set forth in subparagraph (B) of paragraph (2) of subdivision (a). The court shall require witness testimony to occur remotely, including clinical testimony pursuant to subdivision (d) of Section 4335.2 of the Welfare and Institutions Code. In-person witness testimony shall only be allowed upon a court's finding of good cause.

(E) This paragraph also applies to recommendations submitted pursuant to subdivision (e) of Section 1372, when a recommendation is included as to whether an order for the involuntary administration of antipsychotic medications should be extended or issued.

(4) If it is determined by the court that treatment for the defendant's mental impairment is not being conducted, the defendant shall be returned to the committing court, and, if the defendant is not in county custody,

returned to the custody of the county. The court shall transmit a copy of its order to the community program director or a designee.

(5) At each review by the court specified in this subdivision, the court shall determine if the security level of housing and treatment is appropriate and may make an order in accordance with its determination. If the court determines that the defendant shall continue to be treated in the State Department of State Hospitals facility or on an outpatient basis, the court shall determine issues concerning administration of antipsychotic medication, as set forth in subparagraph (B) of paragraph (2) of subdivision (a).

(c) (1) At the end of two years from the date of commitment or a period of commitment equal to the maximum term of imprisonment provided by law for the most serious offense charged in the information, indictment, or complaint, or the maximum term of imprisonment provided by law for a violation of probation or mandatory supervision, whichever is shorter, but no later than 90 days prior to the expiration of the defendant's term of commitment, a defendant who has not recovered mental competence shall be returned to the committing court, and custody of the defendant shall be transferred without delay to the committing county and shall remain with the county until further order of the court. The court shall not order the defendant returned to the custody of the State Department of State Hospitals under the same commitment. The court shall notify the community program director or a designee of the return and of any resulting court orders.

(2) (A) The medical director of the State Department of State Hospitals facility or other treatment facility to which the defendant is confined shall provide notification, in compliance with applicable privacy laws, to the committing county's sheriff that immediate transportation will be needed for the defendant pursuant to paragraph (1).

(B) If a county does not take custody of a defendant committed to the State Department of State Hospitals within 10 calendar days following notification pursuant to subparagraph (A), the county shall be charged the daily rate for a state hospital bed, as established by the State Department of State Hospitals.

(3) Whenever a defendant is returned to the court pursuant to paragraph (1) or (4) of subdivision (b) or paragraph (1) of this subdivision and it appears to the court that the defendant is gravely disabled, as defined in subparagraph (A) or (B) of paragraph (1) of subdivision (h) of Section 5008 of the Welfare and Institutions Code, the court shall order the conservatorship investigator of the county of commitment of the defendant to initiate conservatorship proceedings for the defendant pursuant to Chapter 3 (commencing with Section 5350) of Part 1 of Division 5 of the Welfare and Institutions Code. Hearings required in the conservatorship proceedings shall be held in the superior court in the county that ordered the commitment. The court shall transmit a copy of the order directing initiation of conservatorship proceedings to the community program director or a designee, the sheriff and the district attorney of the county in which criminal charges are pending, and the defendant's counsel of record. The court shall notify the community program director or a designee, the sheriff and district

attorney of the county in which criminal charges are pending, and the defendant's counsel of record of the outcome of the conservatorship proceedings.

(4) If a change in placement is proposed for a defendant who is committed pursuant to subparagraph (A) or (B) of paragraph (1) of subdivision (h) of Section 5008 of the Welfare and Institutions Code, the court shall provide notice and an opportunity to be heard with respect to the proposed placement of the defendant to the sheriff and the district attorney of the county in which the criminal charges or revocation proceedings are pending.

(5) If the defendant is confined in a treatment facility, a copy of any report to the committing court regarding the defendant's progress toward recovery of mental competence shall be provided by the committing court to the prosecutor and to the defense counsel.

(d) With the exception of proceedings alleging a violation of mandatory supervision, the criminal action remains subject to dismissal pursuant to Section 1385. If the criminal action is dismissed, the court shall transmit a copy of the order of dismissal to the community program director or a designee. In a proceeding alleging a violation of mandatory supervision, if the person is not placed under a conservatorship as described in paragraph (3) of subdivision (c), or if a conservatorship is terminated, the court shall reinstate mandatory supervision and may modify the terms and conditions of supervision to include appropriate mental health treatment or refer the matter to a local mental health court, reentry court, or other collaborative justice court available for improving the mental health of the defendant.

(e) If the criminal action against the defendant is dismissed, the defendant shall be released from commitment ordered under this section, but without prejudice to the initiation of proceedings that may be appropriate under the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code).

(f) As used in this chapter, "community program director" means the person, agency, or entity designated by the State Department of State Hospitals pursuant to Section 1605 of this code and Section 4360 of the Welfare and Institutions Code.

(g) For the purpose of this section, "secure treatment facility" does not include, except for State Department of State Hospitals facilities, state developmental centers, and correctional treatment facilities, any facility licensed pursuant to Chapter 2 (commencing with Section 1250) of, Chapter 3 (commencing with Section 1500) of, or Chapter 3.2 (commencing with Section 1569) of, Division 2 of the Health and Safety Code, or any community board and care facility.

(h) This section does not preclude a defendant from filing a petition for habeas corpus to challenge the continuing validity of an order authorizing a treatment facility or outpatient program to involuntarily administer antipsychotic medication to a person being treated as incompetent to stand trial.

SEC. 32. Section 1372 of the Penal Code is amended to read:

1372. (a) (1) If the medical director of a state hospital, a person designated by the State Department of State Hospitals at an entity contracted by the department to provide services to a defendant prior to placement in a treatment program or other facility to which the defendant is committed, or the community program director, county mental health director, or regional center director providing outpatient services, determines that the defendant has regained mental competence, the director or designee shall immediately certify that fact to the court by filing a certificate of restoration with the court by certified mail, return receipt requested, or by confidential electronic transmission. This shall include any certificate of restoration filed by the State Department of State Hospitals based on an evaluation conducted pursuant to Section 4335.2 of the Welfare and Institutions Code. For purposes of this section, the date of filing shall be the date on the return receipt.

(2) The court's order committing an individual to a State Department of State Hospitals facility or other treatment facility pursuant to Section 1370 shall include direction that the sheriff shall redeliver the patient to the court without any further order from the court upon receiving from the state hospital or treatment facility a copy of the certificate of restoration.

(3) The defendant shall be returned to the committing court in the following manner, except that a defendant in county custody that the State Department of State Hospitals has evaluated pursuant to Section 4335.2 of the Welfare and Institutions Code and filed a certificate of restoration with the court shall remain in county custody:

(A) A patient who remains confined in a state hospital or other treatment facility shall be redelivered to the sheriff of the county from which the patient was committed. The sheriff shall immediately return the person from the state hospital or other treatment facility to the court for further proceedings.

(B) The patient who is on outpatient status shall be returned by the sheriff to court through arrangements made by the outpatient treatment supervisor.

(C) In all cases, the patient shall be returned to the committing court no later than 10 days following the filing of a certificate of restoration. The state shall only pay for 10 calendar days for patients who remain in a facility described in Section 4100 of the Welfare and Institutions Code following the filing of a certificate of restoration of competency. The State Department of State Hospitals shall report to the fiscal and appropriate policy committees of the Legislature on an annual basis in February, on the number of days that exceed the 10-day limit prescribed in this subparagraph. This report shall include, but not be limited to, a data sheet that itemizes by county the number of days that exceed this 10-day limit during the preceding year.

(b) If the defendant becomes mentally competent after a conservatorship has been established pursuant to the applicable provisions of the Lanterman-Petris-Short Act, Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code, and Section 1370, the conservator shall certify that fact to the sheriff and district attorney of the

county in which the defendant's case is pending, defendant's attorney of record, and the committing court.

(c) (1) When a defendant is returned to court with a certification that competence has been regained, including a certification of restoration provided pursuant to Section 4335.2 of the Welfare and Institutions Code, the court shall notify either the community program director, the county mental health director, the State Department of State Hospitals, or the regional center director and the Director of Developmental Services, as appropriate, of the date of any hearing on the defendant's competence and whether or not the defendant was found by the court to have recovered competence.

(2) If the court rejects a certificate of restoration, the court shall base its rejection on a written report of an evaluation, conducted by a licensed psychologist or psychiatrist, that the defendant is not competent. The evaluation shall be conducted after the certificate of restoration is filed with the committing court and in compliance with Section 1369. A copy of the written report shall be provided to the department pursuant to paragraph (3) of subdivision (a) of Section 1370. The court shall also provide a copy of the court order or minute order rejecting the certification of restoration to the department, pursuant to clause (ii) of subparagraph (C) of paragraph (3) of subdivision (a) of Section 1370, including any minute orders continuing the hearing for the court's determination.

(d) If the committing court approves the certificate of restoration to competence as to a person in custody, the court shall notify the State Department of State Hospitals by providing the State Department of State Hospitals with a copy of the court order or minute order approving the certificate of restoration to competence. The court shall hold a hearing to determine whether the person is entitled to be admitted to bail or released on own recognizance status pending conclusion of the proceedings. If the superior court approves the certificate of restoration to competence regarding a person on outpatient status, unless it appears that the person has refused to come to court, that person shall remain released either on own recognizance status, or, in the case of a developmentally disabled person, either on the defendant's promise or on the promise of a responsible adult to secure the person's appearance in court for further proceedings. If the person has refused to come to court, the court shall set bail and may place the person in custody until bail is posted.

(e) (1) A defendant subject to either subdivision (a) or (b) who is not admitted to bail or released under subdivision (d) may, at the discretion of the court, and only upon the recommendation of the person or entity that issued the certification of restoration to competence, be returned to the hospital or facility of their original commitment or other appropriate secure facility approved by the community program director, the county mental health director, or the regional center director. If the recommendation was submitted by the State Department of State Hospitals, the defendant shall be placed at a facility described in Section 4100 of the Welfare and Institutions Code at the discretion of, and as directed by, the department.

The recommendation submitted to the court shall be based on the opinion that the person will need continued treatment in a hospital or treatment facility in order to maintain competence to stand trial or that placing the person in a jail environment would create a substantial risk that the person would again become incompetent to stand trial before criminal proceedings could be resumed or completed.

(2) Any return to treatment pursuant to this subdivision shall be subject to the following procedures:

(A) The recommendation described in paragraph (1) shall include a recommendation as to whether an order for the involuntary administration of antipsychotic medications should be extended or issued. The court shall review the recommendation in accordance with the procedure outlined in paragraph (3) of subdivision (b) of Section 1370, and determine if the grounds for authorization apply. If an order authorizing the involuntary administration of antipsychotic medication already exists, the court may continue the order for no more than one year or may vacate the order. If an order does not exist, the court may issue an order for no more than one year. The court shall provide copies of the reports of the treating psychiatrist or psychiatrists and the defendant's patients' rights advocate or attorney, as applicable, to both the prosecutor and defense counsel.

(B) If an order for the involuntary administration of antipsychotic medication is not authorized by the court pursuant to subparagraph (A), the defendant's treating psychiatrist, or medical director designee, may pursue an order in the manner outlined in subparagraphs (C) and (D) of paragraph (2) of subdivision (a) of Section 1370.

(C) If an order for the involuntary administration of antipsychotic medication is not renewed by the court pursuant to subparagraph (A), the district attorney, county counsel, or representative of any facility where a defendant is placed pursuant to paragraph (1) may petition the committing court for a renewal within 60 days before the expiration of the one-year involuntary medication order. The petition shall include the basis for involuntary medication set forth in clause (i) of subparagraph (B) of paragraph (2) of subdivision (a) of Section 1370. Notice of the petition shall be provided to the defendant, the defendant's attorney, and the district attorney. The court shall hear and determine whether the defendant continues to meet the criteria set forth in clause (i) of subparagraph (B) of paragraph (2) of subdivision (a) of Section 1370. The court may renew the order for no more than one year. The court may review the petition and renew the order based on the petition. If the court has a hearing on the petition to renew an order for involuntary medication, the hearing shall be conducted prior to the expiration of the current order. The court may, for a period not to exceed 14 days, extend the involuntary medication order and continue the hearing pursuant to stipulation between the parties or upon a finding of good cause. In determining good cause, the court may review the petition filed with the court, and any additional testimony needed by the court, to determine if it is appropriate to continue medication beyond the expiration date and for a period of up to 14 days.

(D) Upon the determination by the medical director or designee of the State Department of State Hospitals facility or other treatment facility to which the defendant is confined that the defendant no longer satisfies the criteria for continued treatment under this subdivision, the medical director or designee shall immediately certify that fact to the court by filing a written report containing those findings. The filing of the report shall automatically trigger the return of the defendant to county custody in the manner described in paragraph (3) of subdivision (a).

(f) Notwithstanding subdivision (e), if a defendant is returned by the court to a hospital or other facility for the purpose of maintaining competency to stand trial and that defendant is already under civil commitment to that hospital or facility from another county pursuant to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code) or as a developmentally disabled person committed pursuant to Article 2 (commencing with Section 6500) of Chapter 2 of Part 2 of Division 6 of the Welfare and Institutions Code, the costs of housing and treating the defendant in that facility following return pursuant to subdivision (e) shall be the responsibility of the original county of civil commitment.

SEC. 33. Section 30130.59 of the Revenue and Taxation Code is repealed.

SEC. 34. Section 14902 of the Vehicle Code is amended to read:

14902. (a) Except as otherwise provided in subdivisions (b), (c), (d), (g), and (h) of this section, subdivision (c) of Section 13002, and subdivision (c) of Section 14900, upon an application for an identification card a fee of twenty-six dollars ($26) shall be paid to the department.

(b) An original or replacement senior citizen identification card issued pursuant to subdivision (b) of Section 13000 shall be issued free of charge.

(c) The fee for an original or replacement identification card issued to a person who has been determined to have a current income level that meets the eligibility requirements for assistance programs under Chapter 2 (commencing with Section 11200) or Chapter 3 (commencing with Section 12000) of Part 3 of, or Part 5 (commencing with Section 17000) of, or Article 9 (commencing with Section 18900) of Chapter 10 of Part 6 of, or Chapter 10.1 (commencing with Section 18930) or Chapter 10.3 (commencing with Section 18937) of Part 6 of, Division 9 of the Welfare and Institutions Code shall be six dollars ($6). The determination of eligibility under this subdivision shall be made by a governmental or nonprofit entity, which shall be subject to regulations adopted by the department.

(d) A fee shall not be charged for an original or replacement identification card issued to any person who can verify their status as a homeless person or homeless child or youth. A homeless services provider that has knowledge of the person’s housing status may verify the person’s status for purposes of this subdivision. A determination of eligibility pursuant to this subdivision shall be subject to regulations adopted by the department. A person applying

for an identification card under this subdivision shall not be charged a fee for verification of their eligibility.

(e) All fees received pursuant to this section shall be deposited in the Motor Vehicle Account.

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

(1) A "homeless child or youth" has the same meaning as the definition of "homeless children and youths" as set forth in the federal McKinney-Vento Homeless Assistance Act (42 U.S.C. Sec. 11301 et seq.).

(2) A "homeless person" has the same meaning as the definition set forth in the federal McKinney-Vento Homeless Assistance Act (42 U.S.C. Sec. 11301 et seq.).

(3) A "homeless services provider" includes:

(A) A governmental or nonprofit agency receiving federal, state, or county or municipal funding to provide services to a "homeless person" or "homeless child or youth," or that is otherwise sanctioned to provide those services by a local homeless continuum of care organization.

(B) An attorney licensed to practice law in this state.

(C) A local educational agency liaison for homeless children and youth designated as such pursuant to Section 11432 (g)(1)(J)(ii) of Title 42 of the United States Code, or a school social worker.

(D) A human services provider or public social services provider funded by the State of California to provide homeless children or youth services, health services, mental or behavioral health services, substance use disorder services, or public assistance or employment services.

(E) A law enforcement officer designated as a liaison to the homeless population by a local police department or sheriff's department within the state.

(F) Any other homeless services provider that is qualified to verify an individual's housing status, as determined by the department.

(g) The fee for a replacement identification card issued to an eligible inmate upon release from a federal correctional facility or a county jail facility is eight dollars ($8). For purposes of this subdivision, "eligible inmate" means an inmate who meets all of the following requirements:

(1) The inmate previously held a California driver's license or identification card.

(2) The inmate has a usable photo on file with the department that is not more than 10 years old.

(3) The inmate has no outstanding fees due for a prior California identification card.

(4) The inmate has provided, and the department has verified, their true full name, date of birth, social security number, and legal presence in the United States, or, upon implementation of paragraph (2) of subdivision (a) of Section 12801.9, if the inmate is unable to submit satisfactory proof that their presence in the United States is authorized under federal law, the inmate has provided proof of their identity pursuant to Section 12801.9.

(5) The inmate currently resides in a federal correctional facility or a county jail facility.

(6) The inmate has provided the department, upon application, a verification of their eligibility under this subdivision that meets all of the following requirements:

(A) Be on federal correctional facility letterhead or county sheriff letterhead.

(B) Be typed or computer generated.

(C) Contain the inmate's name.

(D) Contain the inmate's date of birth.

(E) Contain the original signature of an official from the federal correctional facility or county sheriff's office.

(F) Be dated within 90 days of the date of application.

(h) The fee for an original or replacement identification card issued to an eligible inmate upon release from a state correctional facility is eight dollars ($8). For purposes of this subdivision, "eligible inmate" has the same meaning as that term is defined under subdivision (b) of Section 3007.05 of the Penal Code, and meets both of the following requirements:

(1) The inmate currently resides in a facility housing inmates under the control of the Department of Corrections and Rehabilitation.

(2) The inmate has provided the department, upon application, a verification of their eligibility under this subdivision that meets the requirements described under subparagraphs (A) to (D), inclusive, and (F) of paragraph (6) of subdivision (g) and contains the signature of an official from the state facility.

(i) (1) The fee for an original or replacement identification card issued to an eligible patient treated in a facility of the State Department of State Hospitals is eight dollars ($8). For purposes of this subdivision, "eligible patient" means a patient who is currently housed in a facility described in Section 4100 of the Welfare and Institutions Code, is preparing to be discharged unconditionally or through a conditional release program, and who meets either of the following sets of requirements:

(A) The patient has previously held a California driver's license or identification card and all of the following requirements are met:

(i) The patient has a usable photo on file with the department that is not more than 10 years old or has a new usable photo taken.

(ii) The patient has provided, and the department has verified, their true full name, date of birth, social security number, California residence, and legal presence in the United States, or, upon implementation of paragraph (2) of subdivision (a) of Section 12801.9, if the patient is unable to submit satisfactory proof that their presence in the United States is authorized under federal law, the patient has provided proof of their identity pursuant to Section 12801.9.

(iii) The patient has provided the department, upon application, a verification of their eligibility under this subdivision that meets all of the following requirements:

(I) Be on State Department of State Hospitals letterhead.

(II) Be typed or computer generated.

(III) Contain the patient's name.

(IV) Contain the patient's date of birth.

(V) Contain the original signature of an official from the State Department of State Hospitals.

(VI) Be dated within 90 days of the date of application.

(B) The patient has not previously held a California driver's license or identification card and all of the following requirements are met:

(i) The patient has verified and signed under penalty of perjury a completed application for an identification card.

(ii) The patient has a usable photo taken.

(iii) The patient provides a legible print of the thumb or finger.

(iv) The patient has provided acceptable proof of the information described in clause (ii) of subparagraph (A), subject to verification by the department.

(v) The patient has provided verification of eligibility as described in clause (iii) of subparagraph (A).

(2) The State Department of State Hospitals shall reimburse the Department of Motor Vehicles for any actual costs incurred in providing assistance pursuant to this paragraph.

SEC. 35. Section 4361 of the Welfare and Institutions Code is amended to read:

4361. (a) As used in this section, "department" means the State Department of State Hospitals.

(b) The purpose of this chapter is to, subject to appropriation by the Legislature, promote the diversion of individuals with serious mental disorders as prescribed in Chapter 2.8A (commencing with Section 1001.35) of Title 6 of Part 2 of the Penal Code, and to assist counties in providing diversion for individuals with serious mental illnesses who have been found incompetent to stand trial and committed to the department for restoration of competency. In implementing this chapter, the department shall consider local discretion and flexibility in diversion activities that meet the community's needs and provide for the safe and effective treatment of individuals with serious mental disorders across a continuum of care.

(c) (1) Subject to appropriation by the Legislature, the department may solicit proposals from, and may contract with, a county to help fund the development or expansion of pretrial diversion described in Chapter 2.8A (commencing with Section 1001.35) of Title 6 of Part 2 of the Penal Code, for the population described in subdivision (b) and that meets all of the following criteria:

(A) Participants are individuals diagnosed with a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including, but not limited to, bipolar disorder, schizophrenia, and schizoaffective disorder, but excluding a primary diagnosis of antisocial personality disorder, borderline personality disorder, and pedophilia, and who are presenting non-substance-induced psychotic symptoms, who have been found incompetent to stand trial pursuant to clause (iv) of subparagraph (B) of paragraph (1) of subdivision (a) of Section 1370 of the Penal Code.

(B) There is a significant relationship between the individual's serious mental disorder and the charged offense, or between the individual's conditions of homelessness and the charged offense.

(C) The individual does not pose an unreasonable risk of danger to public safety, as defined in Section 1170.18 of the Penal Code, if treated in the community.

(2) A county submitting a proposal for funding under this chapter shall designate a lead entity to apply for the funds. This lead entity shall show in its proposal that it has support from other county entities or other relevant entities, including courts, that are necessary to provide successful diversion of individuals under the contract.

(d) When evaluating proposals from the county, the department, in consultation with the Council on Criminal Justice and Behavioral Health within the Department of Corrections and Rehabilitation, shall prioritize proposals that demonstrate all of the following:

(1) Provision of clinically appropriate or evidence-based mental health treatment and wraparound services across a continuum of care, as appropriate, to meet the individual needs of the diversion participant. For purposes of this section, "wraparound services" means services provided in addition to the mental health treatment necessary to meet the individual's needs for successfully managing the individual's mental health symptoms and to successfully live in the community. Wraparound services provided by the diversion program shall include appropriate housing, intensive case management, and substance use disorder treatment, and may include, without limitation, forensic assertive community treatment teams, crisis residential services, criminal justice coordination, peer support, and vocational support.

(2) Collaboration between community stakeholders and other partner government agencies in the diversion of individuals with serious mental disorders.

(3) Connection of individuals to services in the community after they have completed diversion as provided in this chapter.

(e) The department may also provide funding in the contract with the county, subject to appropriation by the Legislature, to cover the cost of providing postbooking assessment of defendants who are likely to be found incompetent to stand trial on felony charges to determine whether the defendant would benefit from diversion as included in the contract.

(f) The department may also provide funding in the contract with the county, subject to appropriation by the Legislature, to cover the cost of in-jail treatment prior to the placement in the community for up to an average of 15 days for defendants who have been approved by the court for diversion as included in the contract.

(g) A county contracted pursuant to this chapter shall report data and outcomes to the department, within 30 days after the end of each month, regarding those individuals targeted by the contract and in the program. This subdivision does not preclude the department from specifying reporting formats or from modifying, reducing, or adding data elements or outcome measures from a contracting county, as needed to provide for reporting of

effective data and outcome measures. Notwithstanding any other law, but only to the extent not prohibited by federal law, the county shall provide specific patient information to the department for reporting purposes. The patient information is confidential and is not open to public inspection. A contracting county shall, at a minimum, report all of the following:

(1) The number of individuals that the court ordered to postbooking diversion and the length of time for which the defendant has been ordered to diversion.

(2) The number of individuals participating in diversion.

(3) The name, social security number, criminal identification and information (CII) number, date of birth, and demographics of each individual participating in the program. This information is confidential and is not open to public inspection.

(4) The length of time in diversion for each participating individual. This information is confidential and is not open to public inspection.

(5) The types of services and supports provided to each individual participating in diversion. This information is confidential and is not open to public inspection.

(6) The number of days each individual was in jail prior to placement in diversion. This information is confidential and is not open to public inspection.

(7) The number of days that each individual spent in each level of care facility. This information is confidential and is not open to public inspection.

(8) The diagnoses of each individual participating in diversion. This information is confidential and is not open to public inspection.

(9) The nature and felony or misdemeanor classification of the charges for each individual participating in diversion. This information is confidential and is not open to public inspection.

(10) The number of individuals who completed diversion.

(11) The name, social security number, CII number, and birth date of each individual who did not complete diversion and the reasons for not completing. This information is confidential and is not open to public inspection.

(h) Contracts awarded pursuant to this chapter are exempt from the requirements contained in the Public Contract Code and the State Administrative Manual and are not subject to approval by the Department of General Services.

(i) The funds shall not be used to supplant existing services or services reimbursable from an available source but rather to expand upon them or support new services for which existing reimbursement may be limited.

(j) (1) Beginning July 1, 2021, subject to appropriation by the Legislature, the department may amend contracts with a county to fund the expansion of an existing department-funded pretrial diversion as described in Chapter 2.8A (commencing with Section 1001.35) of Title 6 of Part 2 of the Penal Code, for the population described in subdivision (b) and that meets both of the following criteria:

(A) All participants identified for potential diversion are found incompetent to stand trial on a felony charge.

(B) Participants diverted through a program expansion suffer from a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, excluding antisocial personality disorder, borderline personality disorder, and pedophilia.

(2) Counties expanding their programs under this section will not be required to meet any additional match funding requirements.

(k) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the state hospitals and the department may implement, interpret, or make specific this section by means of a departmental letter or other similar instruction, as necessary.

(*l*) The department shall have access to the arrest records and state summary of criminal history of defendants who are participating or have participated in the diversion program. The information may be used solely for the purpose of looking at the recidivism rate for those patients.

(m) If the defendant is committed directly to a county program in lieu of commitment to the department, counties shall provide the minute order from the court documenting the incompetent to stand trial finding on a felony charge and the original alienist evaluation associated with that finding.

(n) For department-funded diversion programs funded through appropriations made by the Budget Act of 2018 or new county programs funded through the Budget Act of 2021, participants in those county programs may include individuals diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder, who are likely to be found incompetent to stand trial for felony charges, pursuant to Section 1368 of the Penal Code, or who have been found incompetent to stand trial pursuant to clause (iv) of subparagraph (B) of paragraph (1) of subdivision (a) of Section 1370 of the Penal Code, until new funds are dispersed to the county. Counties shall continue to comply with all terms of the contract signed with the department, including matching fund and data reporting requirements.

SEC. 36. Section 5014 of the Welfare and Institutions Code is amended to read:

5014. (a) To the extent otherwise permitted under state and federal law and consistent with the Mental Health Services Act, both of the following apply for purposes of Article 1 (commencing with Section 5150) and Article 4 (commencing with Section 5250) of Chapter 2 and Chapter 3 (commencing with Section 5350):

(1) Counties may pay for the provision of services using funds distributed to the counties from the Mental Health Subaccount, the Mental Health Equity Subaccount, and the Vehicle License Collection Account of the Local Revenue Fund, funds from the Mental Health Account and the Behavioral Health Subaccount within the Support Services Account of the Local Revenue Fund 2011, funds from the Behavioral Health Services Fund when included in county plans pursuant to Section 5847, and any other funds from which the Controller makes distributions to the counties for those purposes.

(2) A person shall not be denied access to services funded by the Behavioral Health Services Fund based solely on the person's voluntary or involuntary legal status.

(b) 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. 37. Section 5349 of the Welfare and Institutions Code is amended to read:

5349. (a) A county or group of counties that does not wish to implement this article may opt out of the requirements of this article by a resolution passed by the governing body that state the reasons for opting out and any facts or circumstances relied on in making that decision. To the extent otherwise permitted under state and federal law, counties that implement this article may pay for the provision of services under Sections 5347 and 5348 using funds distributed to the counties from the Mental Health Subaccount, the Mental Health Equity Subaccount, and the Vehicle License Collection Account of the Local Revenue Fund, funds from the Mental Health Account and the Behavioral Health Subaccount within the Support Services Account of the Local Revenue Fund 2011, funds from the Behavioral Health Services Fund when included in county plans pursuant to Section 5847, and any other funds from which the Controller makes distributions to the counties for those purposes. Compliance with this section shall be monitored by the State Department of Health Care Services as part of the review and approval of city, county, or group of county performance contracts.

(b) In lieu of the resolution to opt out pursuant to subdivision (a), a county may elect to implement this article in combination with one or more counties pursuant to the implementation provisions of subdivision (d).

(c) A county or group of counties implementing this article shall not reduce existing voluntary mental health programs serving adults or children's mental health programs as a result of implementation.

(d) If multiple counties choose to provide services pursuant to Section 5348, those counties shall execute a memorandum of understanding (MOU) that shall include, but not be limited to, a process for designating the lead county for an individual receiving services pursuant to the MOU for the following purposes:

(1) Making the finding set forth in subdivision (d) of Section 5346.

(2) Ensuring that services are provided and determining where they are provided.

(3) Determining the county incurring financial responsibility, as applicable, for an individual receiving services.

(4) Ensuring that appropriate followup care is in place upon an individual's release from the treatment program.

(e) This section shall become operative on July 1, 2021.

SEC. 38. Section 5813.5 of the Welfare and Institutions Code, as amended by Section 39 of Chapter 790 of the Statutes of 2023, is amended to read:

5813.5. Subject to the availability of funds from the Behavioral Health Services Fund, the state shall distribute funds for the provision of services under Sections 5801, 5802, and 5806 to county mental health programs. Services shall be available to adults and seniors with severe illnesses who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3. For purposes of this act, "seniors" means older adult persons identified in Part 3 (commencing with Section 5800) of this division.

(a) Funding shall be provided at sufficient levels to ensure that counties can provide each adult and senior served pursuant to this part with the medically necessary mental health services, medications, and supportive services set forth in the applicable treatment plan.

(b) The funding shall only cover the portions of those costs of services that cannot be paid for with other funds, including other mental health funds, public and private insurance, and other local, state, and federal funds.

(c) Each county mental health program's plan shall provide for services in accordance with the system of care for adults and seniors who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3.

(d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

(1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

(2) To promote consumer-operated services as a way to support recovery.

(3) To reflect the cultural, ethnic, and racial diversity of mental health consumers.

(4) To plan for each consumer's individual needs.

(e) The plan for each county mental health program shall indicate, subject to the availability of funds as determined by Part 4.5 (commencing with Section 5890) of this division, and other funds available for mental health services, adults and seniors with a severe mental illness being served by this program are either receiving services from this program or have a mental illness that is not sufficiently severe to require the level of services required of this program.

(f) Each county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state prison. Funds may be used to provide services to persons who are participating in a presentencing or postsentencing diversion program or who are on parole, probation, postrelease community supervision, or mandatory supervision. When included in county plans pursuant to Section 5847, funds may be used for the provision of mental health services under Sections 5347 and 5348 in counties that elect to participate in the Assisted Outpatient Treatment Demonstration Project Act of 2002 (Article 9 (commencing with Section

5345) of Chapter 2 of Part 1), and for the provision of services to clients pursuant to Part 8 (commencing with Section 5970).

(g) The department shall contract for services with county mental health programs pursuant to Section 5897. After November 2, 2004, the term "grants," as used in Sections 5814 and 5814.5, shall refer to those contracts.

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

SEC. 39. Section 5840 of the Welfare and Institutions Code, as added by Section 50 of Chapter 790 of the Statutes of 2023, is amended to read:

5840. (a) (1) Each county shall establish and administer an early intervention program that is designed to prevent mental illnesses and substance use disorders from becoming severe and disabling and to reduce disparities in behavioral health.

(2) Early intervention programs shall be funded pursuant to clause (ii) of subparagraph (A) of paragraph (3) of subdivision (a) of Section 5892.

(b) An early intervention program shall include the following components:

(1) Outreach to families, employers, primary care health care providers, behavioral health urgent care, hospitals, inclusive of emergency departments, education, including early care and learning, T-12, and higher education, and others to recognize the early signs of potentially severe and disabling mental health illnesses and substance use disorders.

(2) (A) Access and linkage to medically necessary care provided by county behavioral health programs as early in the onset of these conditions as practicable.

(B) Access and linkage to care includes the scaling of, and referral to, the Early Psychosis Intervention (EPI) Plus Program, pursuant to Part 3.4 (commencing with Section 5835), Coordinated Specialty Care, or other similar evidence-based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs.

(3) (A) Mental health and substance use disorder treatment services, evidence-based practices and community-defined evidence practices for similar to those provided under other programs that are effective in preventing mental health illnesses and substance use disorders from becoming severe, and components similar to programs that have been successful in reducing the duration of untreated serious mental health illnesses and substance use disorders and assisting people in quickly regaining productive lives.

(B) Mental health treatment services may include services to address first episode psychosis.

(C) Mental health and substance use disorder services shall include services that are demonstrated to be effective at meeting the cultural and linguistic needs of diverse communities.

(D) Mental health and substance use disorder services may be provided to the following eligible children and youth:

(i) Individual children and youth at high risk for a behavioral health disorder due to experiencing trauma, as evidenced by scoring in the high-risk range under a trauma screening tool such as an adverse childhood experiences (ACEs) screening tool, involvement in the child welfare system or juvenile justice system, or experiencing homelessness.

(ii) Individual children and youth in populations with identified disparities in behavioral health outcomes.

(E) Mental health and substance use services may include services that prevent, respond to, or treat a behavioral health crisis.

(4) Additional components developed by the State Department of Health Care Services.

(c) (1) The State Department of Health Care Services, in consultation with the Behavioral Health Services Oversight and Accountability Commission, counties, and stakeholders, shall establish a biennial list of evidence-based practices and community-defined evidence practices that may include practices identified pursuant to the Children and Youth Behavioral Health Initiative Act set forth in Chapter 2 (commencing with Section 5961) of Part 7.

(2) Evidence-based practices and community-defined evidence practices may focus on addressing the needs of those who decompensate into severe behavioral health conditions.

(3) Local programs utilizing evidence-based practices and community-defined evidence practices may focus on addressing the needs of underserved communities, such as BIPOC and LGBTQ+.

(4) Counties shall utilize the list to determine which evidence-based practices and community-defined evidence practices to implement locally.

(5) The State Department of Health Care Services may require a county to implement specific evidence-based and community-defined evidence practices.

(d) The early intervention program shall emphasize the reduction of the likelihood of:

(1) Suicide and self-harm.

(2) Incarcerations.

(3) School, including early childhood 0 to 5 years of age, inclusive, TK-12, and higher education, suspension, expulsion, referral to an alternative or community school, or failure to complete.

(4) Unemployment.

(5) Prolonged suffering.

(6) Homelessness.

(7) Removal of children from their homes.

(8) Overdose.

(9) Mental illness in children and youth from social, emotional, developmental, and behavioral needs in early childhood.

(e) For purposes of this section, “substance use disorder” shall have the meaning as defined in subdivision (c) of Section 5891.5.

(f) For purposes of this section, “community-defined evidence practices” is defined as an alternative or complement to evidence-based practices, that

offers culturally anchored interventions that reflect the values, practices, histories, and lived-experiences of the communities they serve. These practices come from the community and the organizations that serve them and are found to yield positive results as determined by community consensus over time.

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

SEC. 40. Section 5840.6 of the Welfare and Institutions Code, as amended by Section 52 of Chapter 790 of the Statutes of 2023, is amended to read:

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

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

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

(c) "Prevention and early intervention funds" means funds from the Behavioral Health Services Fund allocated for prevention and early intervention programs pursuant to paragraph (3) of subdivision (a) of Section 5892.

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

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

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

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

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

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

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

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

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

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

(f) "Youth outreach and engagement" means strategies that target secondary school and transition age youth, with a priority on partnerships with college mental health programs that educate and engage students and provide either on-campus, off-campus, or linkages to mental health services not provided through the campus to students who are attending colleges and universities, including, but not limited to, public community colleges. Outreach and engagement may include, but is not limited to, all of the following:

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

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

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

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

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

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

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

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

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

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

(11) Integrated youth mental health programming.

(12) Suicide prevention programming.

(g) "Culturally competent and linguistically appropriate prevention and intervention" refers to a program that creates critical linkages with community-based organizations, including, but not limited to, clinics licensed or operated under subdivision (a) of Section 1204 of the Health and Safety Code, or clinics exempt from clinic licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code.

(1) "Culturally competent and linguistically appropriate" means the ability to reach underserved cultural populations and address specific barriers

related to racial, ethnic, cultural, language, gender, age, economic, or other disparities in mental health services access, quality, and outcomes.

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

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

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

(2) Suicide prevention programming.

(3) Outreach to older adults who are isolated.

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

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

SEC. 41. Section 5845 of the Welfare and Institutions Code, as added by Section 58 of Chapter 790 of the Statutes of 2023, is amended to read:

5845. (a) The Behavioral Health Services Oversight and Accountability Commission is hereby established to promote transformational change in California's behavioral health system through research, evaluation and tracking outcomes, and other strategies to assess and report progress. The commission shall use this information and analyses to inform the commission's grant making, identify key policy issues and emerging best practices, provide technical assistance and training, promote high-quality programs implemented, and advise the Governor and the Legislature, pursuant to the Behavioral Health Services Act and related components of California's behavioral health system. For this purpose, the commission shall collaborate with the California Health and Human Services Agency, its departments and other state entities.

(b) (1) The commission shall replace the advisory committee established pursuant to Section 5814.

(2) The commission shall consist of 27 voting members as follows:

(A) The Attorney General or the Attorney General's designee.

(B) The Superintendent of Public Instruction or the Superintendent's designee.

(C) The Chairperson of the Senate Committee on Health, the Chairperson of the Senate Committee on Human Services, or another member of the Senate selected by the President pro Tempore of the Senate, or their designee.

(D) The Chairperson of the Assembly Committee on Health, the Chairperson of the Assembly Committee on Human Services, or another Member of the Assembly selected by the Speaker of the Assembly, or their designee.

(E) (i) The following individuals, all appointed by the Governor:

(I) Two persons who have or have had a mental health disorder.

(II) Two persons who have or have had a substance use disorder.

(III) A family member of an adult or older adult who has or has had a mental health disorder.

(IV) One person who is 25 years of age or younger and has or has had a mental health disorder, substance use disorder, or cooccurring disorder.

(V) A family member of an adult or older adult who has or has had a substance use disorder.

(VI) A family member of a child or youth who has or has had a mental health disorder.

(VII) A family member of a child or youth who has or has had a substance use disorder.

(VIII) A current or former county behavioral health director.

(IX) A physician specializing in substance use disorder treatment, including the provision of medications for addiction treatment.

(X) A mental health professional.

(XI) A professional with expertise in housing and homelessness.

(XII) A county sheriff.

(XIII) A superintendent of a school district.

(XIV) A representative of a labor organization.

(XV) A representative of an employer with less than 500 employees.

(XVI) A representative of an employer with more than 500 employees.

(XVII) A representative of a health care service plan or insurer.

(XVIII) A representative of an aging or disability organization.

(XIX) A person with knowledge and experience in community-defined evidence practices and reducing behavioral health disparities.

(XX) A representative of a children and youth organization.

(XXI) A veteran or a representative of a veterans organization.

(ii) In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness or substance use disorder.

(c) Members shall serve without compensation but shall be reimbursed for all actual and necessary expenses incurred in the performance of their duties.

(d) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(e) (1) The commission shall have an Executive Director.

(2) The Executive Director will be responsible for management over the administrative, fiscal, and program performance of the commission.

(3) The Executive Director shall be selected by the commission.

(4) The commission may delegate to the Executive Director any power, duty, purpose, function, or jurisdiction that the commission may lawfully delegate, including the authority to enter into and sign contracts on behalf of the commission. The Executive Director may redelegate any of those powers, duties, purposes, functions, or jurisdictions to the Executive Director’s designee, unless by statute, or rule or regulation, the Executive Director is expressly required to act personally.

(f) In carrying out its duties and responsibilities, the commission may do all of the following:

(1) (A) Meet at least once each quarter at a time and location convenient to the public as it may deem appropriate.

(B) All meetings of the commission shall be open to the public.

(2) Within the limit of funds allocated for these purposes, pursuant to the laws and regulations governing state civil service, employ staff, including clerical, legal, and technical assistance, as necessary.

(3) The commission shall administer its operations separate and apart from the State Department of Health Care Services and the California Health and Human Services Agency.

(4) Establish technical advisory committees, such as a committee of consumers and family members, and a reducing disparities committee focusing on demographic, geographic, and other communities. The commission may provide pertinent information gained from those committees to relevant state agencies and departments, including, but not limited to, the California Health and Humans Services Agency and its departments.

(5) Employ all other appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted, notwithstanding authority expressly granted to an officer or employee of state government.

(6) Enter into contracts.

(7) Make reasonable requests for data and information to the State Department of Health Care Services, the Department of Health Care Access and Information, the State Department of Public Health, or other state and local entities that receive Behavioral Health Services Act funds. These entities shall respond in a timely manner and provide information and data in their possession that the commission deems necessary for the purposes of carrying out its responsibilities.

(8) Participate in the joint state-county decisionmaking process, as described in Section 4061, for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system.

(9) Identify best practices to overcome stigma and discrimination, in consultation with the State Department of Public Health.

(10) At any time, advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness or substance use disorder.

(11) If the commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the State Department of Health Care Services pursuant to Section 5655 or 5963.04.

(12) Provide technical assistance to counties on implementation planning, training, and capacity building investments as defined by the State Department of Health Care Services and in consultation with the County Behavioral Health Directors Association of California. Technical assistance may also include innovative behavioral health models of care and innovative promising practices pursuant to subparagraph (A) of paragraph (4) of

subdivision (a) of Section 5892. Technical assistance may also include compiling and publishing a list of innovative behavioral health models of care programs and promising practices for each of the programs set forth in subparagraphs (1), (2), and (3) of subdivision (a) of Section 5892.

(13) Work in collaboration with the State Department of Health Care Services to define the parameters of a report that includes recommendations for improving and standardizing promising practices across the state based on the technical assistance provided to counties as specified in paragraph (12). The commission shall prepare and publish the report on its internet website. In formulating this report, the commission shall prioritize the perspectives of the California behavioral health community through a robust public engagement process with a focus on priority populations and diverse communities.

(14) Establish a framework and voluntary standard for mental health in the workplace that serves to reduce mental health stigma, increase public, employee, and employer awareness of the recovery goals of the Mental Health Services Act, and provide guidance to California's employer community to put in place strategies and programs, as determined by the commission, to support the mental health and wellness of employees. The commission shall consult with the Labor and Workforce Development Agency or its designee to develop the standard.

(g) (1) The commission shall work in collaboration with the State Department of Health Care Services and the California Behavioral Health Planning Council, and in consultation with the County Behavioral Health Directors Association of California, to write a report that includes recommendations for improving and standardizing promising practices for Behavioral Health Services Act programs.

(2) The commission shall complete the report and provide a written report on its internet website no later than January 1, 2030, and every three years thereafter.

(h) For purposes of this section, "substance use disorder" shall have the meaning as defined in subdivision (c) of Section 5891.5.

(i) 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. 42. Section 5845.1 of the Welfare and Institutions Code is amended to read:

5845.1. (a) (1) The Behavioral Health Services Act Innovation Partnership Fund is hereby created in the State Treasury.

(2) The fund shall be administered by the state for the purposes of funding a grant program administered by the Behavioral Health Services Oversight and Accountability Commission pursuant to this section and subdivision (f) of Section 5892.

(b) All of the following may be paid into the fund:

(1) Any private donation or grant.

(2) Any other federal or state grant.

(3) Any interest that accrues on amounts in the fund and any moneys previously allocated from private donations or grants received by the fund that are subsequently returned to the fund.

(c) (1) The Behavioral Health Services Oversight and Accountability Commission shall award grants to private, public, and nonprofit partners to promote development of innovative mental health and substance use disorder programs and practices.

(2) The innovative mental health and substance use disorder programs and practices shall be designed for the following purposes:

(A) Improving Behavioral Health Services Act programs and practices funded pursuant to subdivision (a) of Section 5892 for the following groups:

(i) Underserved populations.

(ii) Low-income populations.

(iii) Communities impacted by other behavioral health disparities.

(iv) Other populations, as determined by the Behavioral Health Services Oversight and Accountability Commission.

(B) Meeting statewide Behavioral Health Services Act goals and objectives.

(3) The Behavioral Health Services Oversight and Accountability Commission, in determining the allowable uses of the funds, shall consult with the California Health and Human Services Agency and the State Department of Health Care Services. If the Behavioral Health Services Oversight and Accountability Commission utilizes funding for population-based prevention or workforce innovation grants, the commission shall consult with the State Department of Public Health for population-based prevention innovations and the Department of Health Care Access and Information for workforce innovations.

(d) (1) The Behavioral Health Services Oversight and Accountability Commission shall submit a report to the Legislature by January 1, 2030, and every three years thereafter. The report shall cover the three-fiscal-year period immediately preceding the date of submission.

(2) The report shall include the practices funded pursuant to this section and the extent to which they accomplished the purposes specified in paragraphs (1), (2), and (3) of subdivision (b).

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

SEC. 43. Section 5847 of the Welfare and Institutions Code, as amended by Section 63 of Chapter 790 of the Statutes of 2023, is amended to read:

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

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

(b) The three-year program and expenditure plan shall be based on available unspent funds and estimated revenue allocations provided by the

state and in accordance with established stakeholder engagement and planning requirements, as required in Section 5848. The three-year program and expenditure plan and annual updates shall include all of the following:

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

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

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

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

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

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

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

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

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

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

county mental health programs shall consider the needs of transition age foster youth.

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

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

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

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

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

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

(i) Notwithstanding paragraph (7) of subdivision (b) and subdivision (f), a county may, during the 2020–21 and 2021–22 fiscal years, use funds from its prudent reserve for prevention and early intervention programs created in accordance with Part 3.6 (commencing with Section 5840) and for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850) for the children's system of care and Part 3 (commencing

with Section 5800) for the adult and older adult system of care. These services may include housing assistance, as defined in Section 5892.5, to the target population specified in Section 5600.3.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, may implement, interpret, or make specific subdivisions (h) and (i) of this section and subdivision (i) of Section 5892 by means of all-county letters or other similar instructions.

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

SEC. 44. Section 5849.35 of the Welfare and Institutions Code is amended to read:

5849.35. (a) The authority may do all of the following:

(1) Consult with the commission and the State Department of Health Care Services concerning the implementation of the No Place Like Home Program, including the review of annual reports provided to the authority by the department pursuant to Section 5849.11.

(2) Enter into one or more single-year or multiyear contracts with the department for the department to provide, and the authority to pay the department for providing, services described in Sections 5849.7, 5849.8, and 5849.9, related to permanent supportive housing for the target population and to provide for payments to the department from amounts on deposit in the Supportive Housing Program Subaccount created within the Behavioral Health Services Fund pursuant to paragraph (1) of subdivision (f) of Section 5890. Before entering into any contract pursuant to this paragraph, the executive director of the authority shall transmit to the commission a copy of the contract in substantially final form. The contract shall be deemed approved by the commission unless it acts within 10 days to disapprove the contract.

(3) On or before June 15 and December 15 of each year, the authority shall certify to the Controller the amounts the authority is required to pay as provided in Section 5890 for the following six-month period to the department pursuant to any service contract entered into pursuant to paragraph (2).

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

(1) Enter into one or more single-year or multiyear contracts with the authority to provide services described in Sections 5849.7, 5849.8, and 5849.9, related to permanent supportive housing for the target population and to receive payments from amounts on deposit in the Supportive Housing Program Subaccount pursuant to paragraph (1) of subdivision (f) of Section 5890. Payments received by the department under any service contract authorized by this paragraph shall be used, before any other allocation or distribution, to repay loans from the authority pursuant to Section 15463 of the Government Code.

(2) Enter into one or more loan agreements with the authority as security for the repayment of the revenue bonds issued by the authority pursuant to Section 15463 of the Government Code. The department shall deposit the proceeds of these loans, excluding any refinancing loans to redeem, refund, or retire bonds, into the fund. The department's obligations to make payments under these loan agreements shall be limited obligations payable solely from amounts received pursuant to its service contracts with the authority.

(3) The department may pledge and assign its right to receive all or a portion of the payments under the service contracts entered into pursuant to paragraph (1) directly to the authority or its bond trustee for the payment of principal, premiums, if any, and interest under any loan agreement authorized by paragraph (2).

(c) The Legislature hereby finds and declares both of the following:

(1) The consideration to be paid by the authority to the department for the services provided pursuant to the contracts authorized by paragraph (2) of subdivision (a) and paragraph (1) of subdivision (b) is fair and reasonable and in the public interest.

(2) The service contracts and payments made by the authority to the department pursuant to a service contract authorized by paragraph (2) of subdivision (a) and paragraph (1) of subdivision (b) and the loan agreements and loan repayments made by the department to the authority pursuant to a loan agreement authorized by paragraph (2) of subdivision (b) shall not constitute a debt or liability, or a pledge of the faith and credit, of the state or any political subdivision, except as approved by the voters at the November 6, 2018, statewide general election.

(d) The state hereby covenants with the holders from time to time of any bonds issued by the authority pursuant to Section 15463 of the Government Code that it will not alter, amend, or restrict the provisions of this section, paragraph (1) of subdivision (f) of Section 5890, subdivision (b) of Section 5891, Section 19602.5 of the Revenue and Taxation Code, or any other provision requiring the deposit of the revenues derived from the additional tax imposed under Section 17043 of the Revenue and Taxation Code into the Behavioral Health Services Fund in any manner adverse to the interests of those bondholders so long as any of those bonds remain outstanding. The authority may include this covenant in the resolution, indenture, or other documents governing the bonds.

(e) Agreements under this section are not subject to, and need not comply with, the requirements of any other law applicable to the execution of those agreements, including, but not limited to, the California Environmental Quality Act (Division 13 (commencing with Section 21000) of the Public Resources Code).

(f) Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code shall not apply to any contract entered into between the authority and the department under this section.

SEC. 45. Section 5886 of the Welfare and Institutions Code, as added by Section 85 of Chapter 790 of the Statutes of 2023, is amended to read:

5886. (a) The Behavioral Health Student Services Act is hereby established as a mental health partnership grant program for the purpose of establishing mental health partnerships between a county's mental health or behavioral health departments and school districts, charter schools, and the county office of education within the county.

(b) The Behavioral Health Services Oversight and Accountability Commission shall award grants to county mental health or behavioral health departments to fund partnerships between educational and county mental health entities. Subject to an appropriation for this purpose, commencing with the 2021–22 fiscal year, the commission shall award a grant under this section to a county mental health or behavioral health department, or another lead agency, as identified by the partnership within each county that meets the requirements of this section.

(1) County, city, or multicounty mental health or behavioral health departments, or a consortium of those entities, including multicounty partnerships, may, in partnership with one or more school districts and at least one of the following educational entities located within the county, apply for a grant to fund activities of the partnership:

(A) The county office of education.

(B) A charter school.

(2) (A) An educational entity may be designated as the lead agency at the request of the county, city, or multicounty department, or consortium, and authorized to submit the application.

(B) The county, city, or multicounty department, or consortium, shall be the grantee and receive grant funds awarded pursuant to this section, even if an educational entity is designated as the lead agency and submits the application pursuant to this paragraph.

(c) The commission shall establish criteria for awarding funds under the grant program, including the allocation of grant funds pursuant to this section, and shall require that applicants comply with, at a minimum, all of the following requirements:

(1) That all school districts, charter schools, and the county office of education have been invited to participate in the partnership, to the extent possible.

(2) That applicants include with their application a plan developed and approved in collaboration with participating educational entity partners and that include a letter of intent, a memorandum of understanding, or other evidence of support or approval by the governing boards of all partners.

(3) That plans address all of the following goals:

(A) Preventing mental illnesses from becoming severe and disabling.

(B) Improving timely access to services for underserved populations.

(C) Providing outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.

(D) Reducing the stigma associated with the diagnosis of a mental illness or seeking mental health services.

(E) Reducing discrimination against people with mental illness.

(F) Preventing negative outcomes in the targeted population, including, but not limited to, all of the following:

(i) Suicide and attempted suicide.

(ii) Incarceration.

(iii) School failure or dropout.

(iv) Unemployment.

(v) Prolonged suffering.

(vi) Homelessness.

(vii) Removal of children and youth from their homes.

(viii) Involuntary mental health detentions.

(4) That plans include a description of the following:

(A) The need for mental health services for children and youth, including campus-based mental health services and potential gaps in local service connections.

(B) The proposed use of funds, which shall include, at a minimum, that funds will be used to provide personnel or peer support.

(C) How the funds will be used to facilitate linkage and access to ongoing and sustained services, including, but not limited to, objectives and anticipated outcomes.

(D) How the partnership will collaborate with preschool and childcare providers, or other early childhood service organizations, to ensure the mental health needs of children are met before and after they transition to a school setting.

(E) The partnership's ability to do all of the following:

(i) Obtain federal Medicaid or other reimbursement, including Early and Periodic Screening, Diagnostic, and Treatment funds, when applicable, or to leverage other funds, when feasible.

(ii) Collect information on the health insurance carrier for each child or youth, with the permission of the child or youth's parent, to allow the partnership to seek reimbursement for mental health services provided to children and youth, where applicable.

(iii) Engage a health care service plan or a health insurer in the mental health partnership, when applicable, and to the extent mutually agreed to by the partnership and the plan or insurer.

(iv) Administer an effective service program and the degree to which mental health providers and educational entities will support and collaborate to accomplish the goals of the effort.

(v) Connect children and youth to a source of ongoing mental health services, including, but not limited to, through Medi-Cal, specialty mental health plans, county mental health programs, or private health coverage.

(vi) Continue to provide services and activities under this program after grant funding has been expended.

(d) Grants awarded pursuant to this section shall be used to provide support services that include, at a minimum, all of the following:

(1) Services provided on school campuses, to the extent practicable.

(2) Suicide prevention services.

(3) Drop-out prevention services.

(4) Outreach to high-risk youth and young adults, including, but not limited to, foster youth, youth who identify as LGBTQ+, victims of domestic violence and sexual abuse, and youth who have been expelled or suspended from school.

(5) Placement assistance and development of a service plan that can be sustained over time for students in need of ongoing services.

(e) Funding may also be used to provide other prevention, early intervention, and direct services, including, but not limited to, hiring qualified mental health personnel, professional development for school staff on trauma-informed and evidence-based mental health practices, and other strategies that respond to the mental health needs of children and youth, as determined by the commission.

(f) (1) The commission shall determine the amount of grants and shall take into consideration the level of need and the number of schoolage youth in participating educational entities when determining grant amounts.

(2) In determining the distribution of funds appropriated in the 2021–22 fiscal year, the commission shall take into consideration previous funding the grantee received under this section.

(g) The commission may establish incentives to provide matching funds by awarding additional grant funds to partnerships that do so.

(h) If the commission is unable to provide a grant to a partnership in a county because of a lack of applicants or because no applicants met the minimum requirements within the timeframes established by the commission, the commission may redistribute those funds to other eligible grantees.

(i) Partnerships currently receiving grants from the Investment in Mental Health Wellness Act of 2013 (Part 3.8 (commencing with Section 5848.5)) are eligible to receive a grant under this section for the expansion of services funded by that grant or for the inclusion of additional educational entity partners within the mental health partnership.

(j) Grants awarded pursuant to this section may be used to supplement, but not supplant, existing financial and resource commitments of the county, city, or multicounty mental health or behavioral health departments, or a consortium of those entities, or educational entities that receive a grant.

(k) (1) The commission shall develop metrics and a system to measure and publicly report on the performance outcomes of services provided using the grants.

(2) (A) The commission shall provide a status report to the fiscal and policy committees of the Legislature on the progress of implementation of this section no later than March 1, 2022, and provide an updated report no later than March 1, 2024. The reports shall address, at a minimum, all of the following:

(i) Successful strategies.

(ii) Identified needs for additional services.

(iii) Lessons learned.

(iv) Numbers of, and demographic information for, the schoolage children and youth served.

(v) Available data on outcomes, including, but not limited to, linkages to ongoing services and success in meeting the goals identified in paragraph (3) of subdivision (c).

(B) The reports to be submitted pursuant to this paragraph shall be submitted in compliance with Section 9795 of the Government Code.

(*l*) This section does not require the use of funds allocated for the purpose of satisfying the minimum funding obligation under Section 8 of Article XVI of the California Constitution for the partnerships established by this section.

(m) The commission may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis to implement this section. Contracts entered into or amended pursuant to this subdivision are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, 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.

(n) This section shall be implemented only to the extent moneys are appropriated in the annual Budget Act or another statute for purposes of this section.

(o) 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. 46. Section 5890 of the Welfare and Institutions Code, as amended by Section 87 of Chapter 790 of the Statutes of 2023, is amended to read:

5890. (a) The Behavioral Health Services Fund is hereby created in the State Treasury. The fund shall be administered by the state. Notwithstanding Section 13340 of the Government Code, all moneys in the fund are, except as provided in subdivision (d) of Section 5892, continuously appropriated, without regard to fiscal years, for the purpose of funding the following programs and other related activities as designated by other provisions of this division:

(1) Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act.

(2) Part 3.2 (commencing with Section 5830), Innovative Programs.

(3) Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs.

(4) Part 3.9 (commencing with Section 5849.1), No Place Like Home Program.

(5) Part 4 (commencing with Section 5850), the Children's Mental Health Services Act.

(b) The establishment of this fund and any other provisions of the act establishing it or the programs funded shall not be construed to modify the obligation of health care service plans and disability insurance policies to provide coverage for mental health services, including those services required under Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code, related to mental health parity. This act shall not be

construed to modify the oversight duties of the Department of Managed Health Care or the duties of the Department of Insurance with respect to enforcing these obligations of plans and insurance policies.

(c) This act shall not be construed to modify or reduce the existing authority or responsibility of the State Department of Health Care Services.

(d) The State Department of Health Care Services shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults, and seniors for medically necessary care.

(e) Share of costs for services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) of this division, shall be determined in accordance with the Uniform Method of Determining Ability to Pay applicable to other publicly funded mental health services, unless this Uniform Method is replaced by another method of determining copayments, in which case the new method applicable to other mental health services shall be applicable to services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) of this division.

(f) (1) The Supportive Housing Program Subaccount is hereby created in the Behavioral Health Services Fund. Notwithstanding Section 13340 of the Government Code, all moneys in the subaccount are reserved and continuously appropriated, without regard to fiscal years, to the California Health Facilities Financing Authority to provide funds to meet its financial obligations pursuant to any service contracts entered into pursuant to Section 5849.35. Notwithstanding any other law, including any other provision of this section, no later than the last day of each month, the Controller shall, before any transfer or expenditure from the fund for any other purpose for the following month, transfer from the Behavioral Health Services Fund to the Supportive Housing Program Subaccount an amount that has been certified by the California Health Facilities Financing Authority pursuant to paragraph (3) of subdivision (a) of Section 5849.35, but not to exceed an aggregate amount of one hundred forty million dollars ($140,000,000) per year. If, in any month, the amounts in the Behavioral Health Services Fund are insufficient to fully transfer to the subaccount or the amounts in the subaccount are insufficient to fully pay the amount certified by the California Health Facilities Financing Authority, the shortfall shall be carried over to the next month, to be transferred by the Controller with any transfer required by the preceding sentence. Moneys in the Supportive Housing Program Subaccount shall not be loaned to the General Fund pursuant to Section 16310 or 16381 of the Government Code.

(2) Prior to the issuance of any bonds pursuant to Section 15463 of the Government Code, the Legislature may appropriate for transfer funds in the Behavioral Health Services Fund to the Supportive Housing Program Subaccount in an amount up to one hundred forty million dollars ($140,000,000) per year. Any amount appropriated for transfer pursuant to this paragraph and deposited in the No Place Like Home Fund shall reduce the authorized but unissued amount of bonds that the California Health Facilities Financing Authority may issue pursuant to Section 15463 of the

Government Code by a corresponding amount. Notwithstanding Section 13340 of the Government Code, all moneys in the subaccount transferred pursuant to this paragraph are reserved and continuously appropriated, without regard to fiscal years, for transfer to the No Place Like Home Fund, to be used for purposes of Part 3.9 (commencing with Section 5849.1). The Controller shall, before any transfer or expenditure from the fund for any other purpose for the following month but after any transfer from the fund for purposes of paragraph (1), transfer moneys appropriated from the Behavioral Health Services Fund to the subaccount pursuant to this paragraph in equal amounts over the following 12-month period, beginning no later than 90 days after the effective date of the appropriation by the Legislature. If, in any month, the amounts in the Behavioral Health Services Fund are insufficient to fully transfer to the subaccount or the amounts in the subaccount are insufficient to fully pay the amount appropriated for transfer pursuant to this paragraph, the shortfall shall be carried over to the next month.

(3) The sum of any transfers described in paragraphs (1) and (2) shall not exceed an aggregate of one hundred forty million dollars ($140,000,000) per year.

(4) Paragraph (2) shall become inoperative once any bonds authorized pursuant to Section 15463 of the Government Code are issued.

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

SEC. 47. Section 5891 of the Welfare and Institutions Code, as amended by Section 89 of Chapter 790 of the Statutes of 2023, is amended to read:

5891. (a) (1) (A) The funding established pursuant to this act shall be utilized to expand mental health services.

(B) Except as provided in subdivision (j) of Section 5892 due to the state's fiscal crisis, these funds shall not be used to supplant existing state or county funds utilized to provide mental health services.

(C) The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund or from the Local Revenue Fund 2011 in the State Treasury, and formula distributions of dedicated funds as provided in the last fiscal year which ended prior to the effective date of this act.

(D) The state shall not make any change to the structure of financing mental health services, which increases a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk.

(E) These funds shall only be used to pay for the programs authorized in Sections 5890 and 5892. These funds may not be used to pay for any other program.

(F) These funds may not be loaned to the General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by Sections 5890 and 5892.

(2) To maximize federal financial participation in furtherance of subdivision (d) of Section 5890, a county shall submit claims for reimbursement to the State Department of Health Care Services in accordance with applicable Medi-Cal rules and procedures for a behavioral health service or supportive service eligible for reimbursement pursuant to Title XIX or XXI of the federal Social Security Act (42 U.S.C. Sec. 1396, et seq. and 1397aa, et seq.) when such service is paid, in whole or in part, using the funding established pursuant to this act.

(3) (A) To maximize funding from other sources, a county shall seek reimbursement for a behavioral health service, supportive service, housing intervention, or other related activity provided, pursuant to subdivision (a) of Section 5892, that is covered by or can be paid from another available funding source, including other mental health funds, substance use disorder funds, public and private insurance, and other local, state, and federal funds. This paragraph does not require counties to exhaust other funding sources before using Behavioral Health Service Fund moneys to pay for a service-related activity.

(B) A county shall make a good faith effort to enter into contracts, single case agreements, or other agreements to obtain reimbursement with health care service plans and disability insurance plans, pursuant to Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code.

(C) A county shall also submit requests for prior authorization for services, request letters of agreement for payment as an out-of-network provider, and pursue other means to obtain reimbursement in accordance with state and federal laws.

(b) (1) Notwithstanding subdivision (a), and except as provided in paragraph (2), the Controller may use the funds created pursuant to this part for loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code. Any such loan shall be repaid from the General Fund with interest computed at 110 percent of the Pooled Money Investment Account rate, with interest commencing to accrue on the date the loan is made from the fund. This subdivision does not authorize any transfer that would interfere with the carrying out of the object for which these funds were created.

(2) This subdivision does not apply to the Supportive Housing Program Subaccount created by subdivision (f) of Section 5890 or any moneys paid by the California Health Facilities Financing Authority to the Department of Housing and Community Development as a service fee pursuant to a service contract authorized by Section 5849.35.

(c) Commencing July 1, 2012, on or before the 15th day of each month, pursuant to a methodology provided by the State Department of Health Care Services, the Controller shall distribute to each Local Mental Health Service Fund established by counties pursuant to subdivision (f) of Section 5892, all unexpended and unreserved funds on deposit as of the last day of the prior month in the Behavioral Health Services Fund, established pursuant to Section 5890, for the provision of programs and other related activities set forth in Part 3 (commencing with Section 5800), Part 3.2 (commencing

with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.9 (commencing with Section 5849.1), and Part 4 (commencing with Section 5850).

(d) (1) Counties shall base their expenditures on the county mental health program's three-year program and expenditure plan or annual update, as required by Section 5847.

(2) This subdivision does not affect subdivision (a) or (b).

(e) This act shall not be construed to modify or reduce a health plan's obligations under the Knox-Keene Health Care Service Plan Act of 1975.

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

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

SEC. 48. Section 5892 of the Welfare and Institutions Code, as added by Section 94 of Chapter 790 of the Statutes of 2023, is amended to read:

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

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

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

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

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

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

exceed 20 percent of the average amount of funds allocated to that county for the previous five fiscal years pursuant to this section.

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

(3) A county with a population of less than 200,000 shall calculate a maximum amount it establishes as the prudent reserve for its Local Behavioral Health Services Fund, not to exceed 25 percent of the average of the total funds distributed to the county pursuant to subdivision (c) of Section 5891 in the preceding five years.

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

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

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

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

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

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

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

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

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

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

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

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

(h) (1) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county that have not been spent for their authorized purpose within three years, and the interest accruing on those funds, shall revert to the state to be deposited into the Reversion Account, hereby established in the fund, and available for other counties in future years, provided, however, that funds, including interest accrued on those funds, for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the Reversion Account.

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

(B) Subparagraph (A) applies to all plans for innovative programs that have received commission approval and are in the process at the time of

enactment of the act that added this subparagraph, and to all plans that receive commission approval thereafter.

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

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

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

(i) Notwithstanding subdivision (h) and Section 5892.1, unspent funds allocated to a county, and interest accruing on those funds, which are subject to reversion as of July 1, 2019, and July 1, 2020, shall be subject to reversion on July 1, 2021.

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

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

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

SEC. 49. Section 5892.5 of the Welfare and Institutions Code, as amended by Section 99 of Chapter 790 of the Statutes of 2023, is amended to read:

5892.5. (a) (1) The California Housing Finance Agency, with the concurrence of the State Department of Health Care Services, shall release unencumbered Behavioral Health Services Fund moneys dedicated to the Mental Health Services Act housing program upon the written request of the respective county. The county shall use these Behavioral Health Services Fund moneys released by the agency to provide housing assistance to the target populations who are identified in Section 5600.3.

(2) For purposes of this section, "housing assistance" means each of the following:

(A) Rental assistance or capitalized operating subsidies.

(B) Security deposits, utility deposits, or other move-in cost assistance.

(C) Utility payments.

(D) Moving cost assistance.

(E) Capital funding to build or rehabilitate housing for homeless, mentally ill persons or mentally ill persons who are at risk of being homeless.

(b) For purposes of administering those funds released to a respective county pursuant to subdivision (a), the county shall comply with all of the requirements described in the Mental Health Services Act, including, but not limited to, Sections 5664, 5847, subdivision (h) of Section 5892, and 5899.

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

SEC. 50. Section 5893 of the Welfare and Institutions Code, as amended by Section 101 of Chapter 790 of the Statutes of 2023, is amended to read:

5893. (a) In any year in which the funds available exceed the amount allocated to counties, such funds shall be carried forward to the next fiscal year to be available for distribution to counties in accordance with Section 5892 in that fiscal year.

(b) All funds deposited into the Behavioral Health Services Fund shall be invested in the same manner in which other state funds are invested. The fund shall be increased by its share of the amount earned on investments.

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

SEC. 51. Section 5895 of the Welfare and Institutions Code, as amended by Section 103 of Chapter 790 of the Statutes of 2023, is amended to read:

5895. (a) If any provisions of Part 3 (commencing with Section 5800) or Part 4 (commencing with Section 5850) are repealed or modified so the purposes of this act cannot be accomplished, the funds in the Behavioral Health Services Fund shall be administered in accordance with those sections as they read on January 1, 2004.

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

SEC. 52. Section 5899 of the Welfare and Institutions Code, as amended by Section 108 of Chapter 790 of the Statutes of 2023, is amended to read:

5899. (a) (1) The State Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission and the County Behavioral Health Directors Association of

California, shall develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report.

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

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

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

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

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

(b) The department, in consultation with the commission and the County Behavioral Health Directors Association of California, shall revise the instructions described in subdivision (a) by July 1, 2017, and as needed thereafter, to improve the timely and accurate submission of county revenue and expenditure data.

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

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

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

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

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

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

(1) Children's systems of care.

(2) Prevention and early intervention strategies.

(3) Innovative projects.

(4) Workforce education and training.

(5) Adults and older adults systems of care.

(6) Capital facilities and technology needs.

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

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

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

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

SEC. 53. Section 5961.4 of the Welfare and Institutions Code is amended to read:

5961.4. (a) As a component of the initiative, the State Department of Health Care Services shall develop and maintain a school-linked statewide fee schedule for outpatient mental health or substance use disorder treatment provided to a student 25 years of age or younger at a schoolsite.

(b) The department shall develop and maintain a school-linked statewide provider network of schoolsite behavioral health counselors.

(c) (1) Commencing January 1, 2024, and subject to subdivision (h), each Medi-Cal managed care plan and Medi-Cal behavioral health delivery system, as applicable, shall reimburse providers of medically necessary outpatient mental health or substance use disorder treatment provided at a schoolsite to a student 25 years of age or younger who is an enrollee of the plan or delivery system, in accordance with paragraph (2), but only to the extent the Medi-Cal managed care plan or Medi-Cal behavioral delivery system is financially responsible for those schoolsite services under its approved managed care contract with the department.

(2) Providers of medically necessary schoolsite services described in this section shall be reimbursed, at a minimum, at the fee schedule rate or rates developed pursuant to subdivision (a), regardless of network provider status.

(d) (1) The department may contract with an entity to administer the school-linked statewide behavioral health provider network in accordance with this subdivision.

(2) The entity that administers the school-linked statewide behavioral health provider network shall do all of the following:

(A) Create and administer a process for enrolling and credentialing all eligible practitioners and providers seeking to provide medically necessary schoolsite services described in this section.

(B) Create and administer a process for the submission and reimbursement of claims eligible to be reimbursed pursuant to this section, which may include resolving disputes related to the school-linked statewide all-payer fee schedule and administering fee collection pursuant to subdivision (g).

(C) Create and administer a mechanism for the sharing of data between the entity contracted pursuant to this subdivision and a health care service plan, insurer, or Medi-Cal managed care plan that covers medically necessary schoolsite services subject to the school-linked statewide all-payer fee schedule that is necessary to facilitate timely claims processing, payment, and reporting, avoid duplication of claims, allow for tracking of grievance

remediation, and to facilitate coordination of care and continuity of care for enrollees.

(e) A provider or practitioner of medically necessary schoolsite services participating in the school-linked statewide behavioral health provider network described in this section shall do all of the following:

(1) Comply with all administrative requirements necessary to be enrolled and credentialed, as applicable, by the entity that administers the school-linked statewide behavioral health provider network.

(2) Submit all claims for reimbursement for services billed under the school-linked statewide all-payer fee schedule through the entity that administers the school-linked statewide behavioral health provider network.

(3) If a provider or practitioner of medically necessary schoolsite services has, or enters into, a direct agreement established with a health care service plan, insurer, or Medi-Cal managed care plan that covers medically necessary schoolsite services outside of the school-linked statewide all-payer fee schedule, they shall be allowed to bill for services provided directly under the terms of the established agreement.

(f) (1) A health care service plan, insurer, or Medi-Cal managed care plan that covers medically necessary schoolsite services subject to the school-linked statewide all-payer fee schedule, pursuant to Section 1374.722 of the Health and Safety Code, Section 10144.53 of the Insurance Code, and this section, shall comply with all administrative requirements necessary to cover and reimburse those services set forth by the entity that administers the school-linked statewide behavioral health provider network.

(2) If an agreement exists between a health care service plan, insurer, or Medi-Cal managed care plan and a provider or practitioner of medically necessary schoolsite services outside of the school-linked statewide all-payer fee schedule, the health care service plan, insurer, or Medi-Cal managed care plan shall do all of the following:

(A) At minimum, reimburse the contracted provider or practitioner at the school-linked statewide all-payer fee schedule rates.

(B) Provide to the department data deemed necessary and appropriate for program reporting and compliance purposes.

(C) Comply with all administrative requirements necessary to cover and reimburse medically necessary schoolsite services subject to the school-linked statewide all-payer fee schedule, as determined by the department.

(g) (1) The department shall establish and charge a fee to participating health care service plans, insurers, or Medi-Cal managed care plans to cover the reasonable cost of administering the school-linked statewide behavioral health provider network.

(2) The department shall set the fees in an amount that it projects is sufficient to cover all administrative costs incurred by the state associated with implementing this section and consider the assessed volume of claims and providers or practitioners of medically necessary schoolsite services that are credentialed and enrolled by the entity contracted pursuant to subdivision (d).

(3) The department shall not assess the fee authorized by this subdivision until the time that the contract between the department and the entity contracted pursuant to subdivision (d) commences.

(4) (A) The department may periodically update the amount and structure of the fees, as necessary, to provide sufficient funding for the purpose specified in this subdivision.

(B) The fees authorized in this paragraph shall be evaluated annually and based on the state's projected costs for the forthcoming fiscal year.

(C) If the department proposes to increase the fees, it shall notify the Legislature of the proposed increase through the submission of the semiannual Medi-Cal estimate provided to the Legislature.

(5) (A) (i) The Behavioral Health Schoolsite Fee Schedule Administration Fund is hereby established in the State Treasury.

(ii) The department shall administer the Behavioral Health Schoolsite Fee Schedule Administration Fund consistent with this subdivision.

(B) All revenues, less refunds, derived from the fees authorized in this subdivision shall be deposited in the Behavioral Health Schoolsite Fee Schedule Administration Fund.

(C) The moneys in the Behavioral Health Schoolsite Fee Schedule Administration Fund shall be available upon appropriation by the Legislature and shall be used only for purposes of this subdivision.

(D) Notwithstanding Section 16305.7 of the Government Code, interest and dividends earned on moneys in the Behavioral Health Schoolsite Fee Schedule Administration Fund shall be retained in the fund and used solely for the purposes specified in this section.

(E) Notwithstanding any other provision of law, the Controller may use moneys in the Behavioral Health Schoolsite Fee Schedule Administration Fund for cashflow loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code.

(F) Funds remaining in the Behavioral Health Schoolsite Fee Schedule Administration Fund at the end of a fiscal year shall be available for use in the following fiscal year and taken into consideration in establishment of fees for the subsequent fiscal year.

(h) This section shall be implemented only to the extent that the department obtains any necessary federal approvals, and federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.

(i) This section does not relieve a local educational agency or institution of higher education from requirements to accommodate or provide services to students with disabilities pursuant to any applicable state and federal law, including, but not limited to, the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.), Part 30 (commencing with Section 56000) of Division 4 of Title 2 of the Education Code, Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code, and Chapter 3 (commencing with Section 3000) of Division 1 of Title 5 of the California Code of Regulations.

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

(3) 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.

(4) "Medi-Cal behavioral health delivery system" has the meaning described in subdivision (i) of Section 14184.101.

(5) "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 beneficiaries pursuant to any provision of Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9.

(6) "Schoolsite" has the meaning described in paragraph (6) of subdivision (b) of Section 1374.722 of the Health and Safety Code.

SEC. 54. Section 7296 is added to the Welfare and Institutions Code, to read:

7296. (a) To the extent administratively feasible and within available resources, the State Department of State Hospitals shall do all of the following:

(1) Provide any eligible patient with assistance in obtaining an original or replacement identification card pursuant to subdivision (i) of Section 14902 of the Vehicle Code.

(2) Facilitate the process between a patient and those entities holding documentation, such as a birth certificate or social security card, required for a patient to obtain an identification card. This assistance shall include, without limitation, the provision of any necessary notary services, assistance with obtaining forms, and any required correspondence.

(3) Provide an eligible patient with the verification of eligibility described in clause (iii) of subparagraph (A) of paragraph (1) of subdivision (i) of Section 14902 of the Vehicle Code.

(b) For purposes of this section, "eligible patient" means a patient who is currently housed in a facility described in Section 4100, is preparing to be discharged unconditionally or through a conditional release program, and who qualifies to obtain an original or replacement identification pursuant to subdivision (i) of Section 14902 of the Vehicle Code.

SEC. 55. Section 14105.192 of the Welfare and Institutions Code is amended to read:

14105.192. (a) The Legislature finds and declares all of the following:

(1) Costs within the Medi-Cal program continue to grow due to the rising cost of providing health care throughout the state and also due to increases in enrollment, which are more pronounced during difficult economic times.

(2) In order to minimize the need for drastically cutting enrollment standards or benefits during times of economic crisis, it is crucial to find areas within the Medi-Cal program that have reimbursement levels higher

than required under the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and may be reduced in accordance with federal law.

(3) The Medi-Cal program delivers its services and benefits to Medi-Cal beneficiaries through a wide variety of health care providers, some of which deliver care via managed care or other contract models while others do so through fee-for-service arrangements.

(4) The setting of rates within the Medi-Cal program is complex and subject to close supervision by the United States Department of Health and Human Services.

(5) As the single state agency for the Medicaid program in California, the department has unique expertise that can inform decisions that set or adjust reimbursement methodologies and levels consistent with the requirements of federal law.

(b) Therefore, it is the intent of the Legislature for the department to analyze and identify where reimbursement levels can be reduced consistent with the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and consistent with federal and state law and policies, including exemptions contained in the act that added this section, provided that the reductions in reimbursement shall not exceed 10 percent on an aggregate basis for all providers, services, and products.

(c) Notwithstanding any other law, the director shall adjust provider payments, as specified in this section.

(d) (1) Except as otherwise provided in this section, payments shall be reduced by 10 percent for Medi-Cal fee-for-service benefits for dates of service on and after June 1, 2011.

(2) For managed health care plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), except contracts with Senior Care Action Network and AIDS Healthcare Foundation, payments shall be reduced by the actuarial equivalent amount of the payment reductions specified in this section pursuant to contract amendments or change orders effective on July 1, 2011, or thereafter.

(3) Payments shall be reduced by 10 percent for non-Medi-Cal programs described in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after June 1, 2011. This paragraph shall not apply to inpatient hospital services provided in a hospital that is paid under contract pursuant to Article 2.6 (commencing with Section 14081).

(4) (A) Notwithstanding any other law, the director may adjust the payments specified in paragraphs (1) and (3) with respect to one or more categories of Medi-Cal providers, or for one or more products or services rendered, or any combination thereof, if the resulting reductions to any category of Medi-Cal providers, in the aggregate, total no more than 10 percent.

(B) The adjustments authorized in subparagraph (A) shall be implemented only if the director determines that, for each affected product, service, or

provider category, the payments resulting from the adjustment comply with subdivision (m).

(e) Notwithstanding this section, payments to hospitals that are not under contract with the department pursuant to Article 2.6 (commencing with Section 14081) for inpatient hospital services provided to Medi-Cal beneficiaries and that are subject to former Section 14166.245 shall be governed by that section.

(f) Notwithstanding this section, both of the following apply:

(1) Payments to providers that are paid pursuant to Article 3.8 (commencing with Section 14126) shall be governed by that article.

(2) (A) Subject to subparagraph (B), for dates of service on and after June 1, 2011, Medi-Cal reimbursement rates for intermediate care facilities for the developmentally disabled licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20, as determined by the applicable methodology for setting reimbursement rates for these facilities, shall not exceed the reimbursement rates that were applicable to providers in the 2008–09 rate year.

(B) (i) If Section 14105.07 is added to the Welfare and Institutions Code during the 2011–12 Regular Session of the Legislature, subparagraph (A) shall become inoperative.

(ii) If Section 14105.07 is added to the Welfare and Institutions Code during the 2011–12 Regular Session of the Legislature, then for dates of service on and after June 1, 2011, payments to intermediate care facilities for the developmentally disabled licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20, shall be governed by the applicable methodology for setting reimbursement rates for these facilities and by Section 14105.07.

(g) The department may enter into contracts with a vendor for the purposes of implementing this section on a bid or nonbid basis. In order to achieve maximum cost savings, the Legislature declares that an expedited process for contracts under this subdivision is necessary. Therefore, contracts entered into to implement this section and all contract amendments and change orders shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 Division 2 of the Public Contract Code.

(h) To the extent applicable, all of the following services, facilities, and payments shall be exempt from the payment reductions specified in subdivision (d):

(1) Acute hospital inpatient services that are paid under contracts pursuant to Article 2.6 (commencing with Section 14081).

(2) Federally qualified health center services, including those facilities deemed to have federally qualified health center status pursuant to a waiver pursuant to subsection (a) of Section 1115 of the federal Social Security Act (42 U.S.C. Sec. 1315(a)).

(3) Rural health clinic services.

(4) Payments to facilities owned or operated by the State Department of State Hospitals or the State Department of Developmental Services.

(5) Hospice services.

(6) Contract services, as designated by the director pursuant to subdivision (k).

(7) Payments to providers to the extent that the payments are funded by means of a certified public expenditure or an intergovernmental transfer pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations. This paragraph shall apply to payments described in paragraph (3) of subdivision (d) only to the extent that they are also exempt from reduction pursuant to subdivision (*l*).

(8) Services pursuant to local assistance contracts and interagency agreements to the extent the funding is not included in the funds appropriated to the department in the annual Budget Act.

(9) Breast and cervical cancer treatment provided pursuant to Section 14007.71 and as described in paragraph (3) of subdivision (a) of Section 14105.18 or Article 1.5 (commencing with Section 104160) of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code.

(10) The Family Planning, Access, Care, and Treatment (Family PACT) Program pursuant to subdivision (aa) of Section 14132.

(11) (A) Effective for dates of service on or after July 1, 2015, or the effective date of any necessary federal approvals as required by subdivisions (n) and (o), whichever is later, dental services and applicable ancillary services.

(B) For dental managed care plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), payments pursuant to contract amendments or change orders effective on or after July 1, 2015, or the effective date of any necessary federal approvals as required by subdivisions (n) and (o), whichever is later.

(12) For dates of service on and after January 1, 2022, or the effective date of any necessary federal approvals as required by subdivisions (n) and (o), whichever is later, providers of complex rehabilitation technology and complex rehabilitation technology services, as described in Section 14132.85.

(13) For dates of service on and after July 1, 2022, or the effective date of any necessary federal approvals as required by subdivisions (n) and (o), whichever is later, all of the following services and providers:

(A) Nurses, including certified nurse-midwives, nurse anesthetists, certified pediatric nurse practitioners, certified family nurse practitioners, and group certified pediatric nurse practitioners.

(B) Alternative birth centers as described in Section 14148.8.

(C) Audiologists and hearing aid dispensers as described in Section 14105.49 of this code and Section 51319 of Title 22 of the California Code of Regulations.

(D) Respiratory care providers as described in Section 51316 of Title 22 of the California Code of Regulations.

(E) Durable medical equipment, as described in Section 51160 of Title 22 of the California Code of Regulations.

(F) Chronic dialysis clinics.

(G) Emergency medical air transportation services as described in Section 76000.10 of the Government Code.

(H) Nonemergency medical transportation services as described in Section 51323 of Title 22 of the California Code of Regulations.

(I) Doula services as described in Section 14132.24.

(J) Community health worker services as described in the approved Medi-Cal State Plan.

(K) Durable medical equipment and related supplies or accessories, as described in Section 14105.48 and Section 51160 of Title 22 of the California Code of Regulations, that is a continuous glucose monitoring system or continuous glucose monitoring system supplies and accessories, as determined by the department.

(L) Health care services delivered via remote patient monitoring, authorized pursuant to subparagraph (B) of paragraph (1) of subdivision (f) of Section 14124.12.

(M) Asthma prevention services as described in the approved Medi-Cal State Plan.

(N) Dyadic services as described in Section 14132.755.

(O) Medication therapy management services as described in Section 14132.969.

(P) Clinical laboratory services, as defined in Section 51137.2 of Title 22 of the California Code of Regulations, that are 2019 Novel Coronavirus (COVID-19) diagnostic testing or specimen collection services, as determined by the department.

(Q) Blood banks, as described in Section 51052 of Title 22 of the California Code of Regulations.

(R) Occupational therapy, as described in Section 51085 of the California Code of Regulations.

(S) Orthotists, as described in Section 51101 of Title 22 of the California Code of Regulations.

(T) Psychologists, as described in Section 51099 of Title 22 of the California Code of Regulations.

(U) Medical social work or medical social services, as described in Section 51147 of Title 22 of the California Code of Regulations.

(V) Speech pathologists, as described in Section 51095 of Title 22 of the California Code of Regulations.

(W) Outpatient heroin detoxification services, as described in Section 51116 of Title 22 of the California Code of Regulations.

(X) Dispensing opticians, as described in Section 51090 of Title 22 of the California Code of Regulations.

(Y) Optometrists, including optometry groups, as described in Section 51091 of Title 22 of the California Code of Regulations.

(Z) Acupuncturists, as described in Section 51074 of Title 22 of the California Code of Regulations.

(AA) Portable imaging services, as described in Section 51193.1 of Title 22 of the California Code of Regulations.

(AB) The following primary care or specialty clinics, as determined by the department:

(i) Community clinics, as defined in Section 1204 of the Health and Safety Code.

(ii) Free clinics, as defined in Section 1204 of the Health and Safety Code.

(iii) Surgical clinics, as defined in Section 1204 of the Health and Safety Code.

(iv) Rehabilitation clinics, as defined in Section 1204 of the Health and Safety Code.

(v) Clinics exempt from licensure under Section 1206 of the Health and Safety Code, including nonhospital county-operated community clinics.

(AC) Services provided under the California Children's Services Program, established pursuant to Article 5 (commencing with Section 123845) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and under the Genetically Handicapped Persons Program, established pursuant to Article 1 (commencing with Section 125125) of Chapter 2 of Part 5 of Division 106 of the Health and Safety Code, as determined by the department.

(AD) Community-Based Adult Services (CBAS), as described in Section 14186.3 and as covered pursuant to subdivision (e) of Section 14184.201.

(14) For dates of service on and after January 1, 2023, or the effective date of any necessary federal approvals as required by subdivisions (n) and (o), whichever is later, both of the following providers:

(A) Podiatrists, as described in Section 51075 of Title 22 of the California Code of Regulations.

(B) Prosthetists, as described in Section 51103 of Title 22 of the California Code of Regulations.

(15) For dates of service on and after January 1, 2024, or the effective date of the payments implemented pursuant to subdivision (a) of Section 14105.201, whichever is later, all of the following services and providers:

(A) Primary care services, including those provided by physicians or nonphysician health professionals, as defined in Section 51170.5 of Title 22 of the California Code of Regulations.

(B) Obstetric care services and doula services as described in Section 14132.24.

(C) Outpatient mental health services that are not the financial responsibility of county mental health plans operating pursuant to Chapter 8.9 (commencing with Section 14700).

(16) (A) For dates of service on and after January 1, 2025, or the effective dates of the payments implemented pursuant to Sections 14124.163 and 14124.165, whichever is later, as applicable, all of the following services and providers:

(i) Physician and professional services subject to reimbursement pursuant to Section 14124.163.

(ii) Abortion services, as defined in subdivision (d) of Section 14124.161, subject to reimbursement pursuant to Section 14124.165.

(B) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to this part at the November 5, 2024, statewide general election, this paragraph shall be inoperative as of January 1, 2025.

(i) Subject to the exception for services listed in subdivision (h), the payment reductions required by subdivision (d) shall apply to the benefits rendered by any provider who may be authorized to bill for the service, including, but not limited to, physicians, podiatrists, nurse practitioners, certified nurse-midwives, nurse anesthetists, and organized outpatient clinics.

(j) Notwithstanding any other law, for dates of service on and after June 1, 2011, Medi-Cal reimbursement rates applicable to the following classes of providers shall not exceed the reimbursement rates that were applicable to those classes of providers in the 2008–09 rate year, as described in subdivision (f) of Section 14105.191, reduced by 10 percent:

(1) Intermediate care facilities, excluding those facilities identified in paragraph (2) of subdivision (f). For purposes of this section, "intermediate care facility" has the same meaning as defined in Section 51118 of Title 22 of the California Code of Regulations.

(2) Skilled nursing facilities that are distinct parts of general acute care hospitals. For purposes of this section, "distinct part" has the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

(3) Rural swing-bed facilities.

(4) Subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this paragraph, "subacute care unit" has the same meaning as defined in Section 51215.5 of Title 22 of the California Code of Regulations.

(5) Pediatric subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this paragraph, "pediatric subacute care unit" has the same meaning as defined in Section 51215.8 of Title 22 of the California Code of Regulations.

(6) Adult day health care centers.

(7) Freestanding pediatric subacute care units, as defined in Section 51215.8 of Title 22 of the California Code of Regulations.

(k) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement and administer this section by means of provider bulletins or similar instructions, without taking regulatory action.

(*l*) The reductions described in this section shall apply only to payments for services when the General Fund share of the payment is paid with funds directly appropriated to the department in the annual Budget Act and shall not apply to payments for services paid with funds appropriated to other departments or agencies.

(m) Notwithstanding this section, the payment reductions and adjustments provided for in subdivision (d) shall be implemented only if the director determines that the payments that result from the application of this section

comply with applicable federal Medicaid program requirements and that federal financial participation will be available.

(1) In determining whether federal financial participation is available, the director shall determine whether the payments comply with applicable federal Medicaid program requirements, including those set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code.

(2) To the extent that the director determines that the payments do not comply with the federal Medicaid program requirements or that federal financial participation is not available with respect to any payment that is reduced pursuant to this section, the director shall retain the discretion to not implement the particular payment reduction or adjustment and may adjust the payment as necessary to comply with federal Medicaid program requirements.

(n) The department shall seek any necessary federal approvals for the implementation of this section.

(o) (1) The payment reductions and adjustments set forth in this section shall not be implemented until federal approval is obtained.

(2) To the extent that federal approval is obtained for one or more of the payment reductions and adjustments in this section and Section 14105.07, the payment reductions and adjustments set forth in Section 14105.191 shall cease to be implemented for the same services provided by the same class of providers. If there is a conflict between this section and Section 14105.191, other than the provisions setting forth a payment reduction or adjustment, this section shall govern.

(3) When federal approval is obtained, the payments resulting from the application of this section shall be implemented retroactively to June 1, 2011, or on any other date or dates, as may be applicable.

(4) The director may clarify the application of this subdivision by means of provider bulletins or similar instructions, pursuant to subdivision (k).

(p) Adjustments to pharmacy drug product payment pursuant to this section shall no longer apply when the department determines that the average acquisition cost methodology pursuant to Section 14105.45 has been fully implemented and the department's pharmacy budget reduction targets, consistent with payment reduction levels pursuant to this section, have been met.

SEC. 56. Section 14105.200 of the Welfare and Institutions Code is amended to read:

14105.200. (a) The Medi-Cal Provider Payment Reserve Fund is hereby created in the State Treasury.

(b) Notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on moneys in the Medi-Cal Provider Payment Reserve Fund shall be retained in the fund and used solely for the purposes specified in this section.

(c) (1) Subject to an appropriation made by the Legislature, the department shall use the funds transferred to the Medi-Cal Provider Payment Reserve Fund pursuant to paragraph (3) of subdivision (d) of Section 14199.82 for purposes of funding targeted increases to Medi-Cal payments

or other investments that advance access, quality, and equity for Medi-Cal beneficiaries and promote provider participation in the Medi-Cal program.

(2) The expenditures of funds appropriated pursuant to paragraph (1) shall include, but not be limited to, all of the following:

(A) Increased costs incurred as a result of the reimbursement requirements established in Section 14105.201.

(B) Transfers authorized in paragraph (2) of subdivision (e) of Section 129385 of the Health and Safety Code.

(C) Transfers, or an appropriation in the annual Budget Act, to the Small and Rural Hospital Relief Fund, as established in Section 130077 of the Health and Safety Code, in the amount of fifty million dollars ($50,000,000) in state fiscal year 2023–24 to support the Small and Rural Hospital Relief Program for seismic assessment and construction.

(D) Effective no sooner than January 1, 2025, increased costs authorized pursuant to Article 3.1 (commencing with Section 14124.160).

(E) Transfers in the amount of forty million dollars ($40,000,000) in state fiscal year 2026–27 to support workforce investments as implemented by the Department of Health Care Access and Information.

(F) Increased costs incurred as a result of the provision of continuous eligibility to children up to five years of age pursuant to Sections 15832 and 15853 of this code and Section 12693.74 of the Insurance Code.

(G) Reimbursement of the department's administrative costs incurred in administering and implementing Article 3.1 (commencing with Section 14124.160).

(d) The department shall provide an annual report to all health plans accounting for the funds deposited in, and expended from, the Medi-Cal Provider Payment Reserve Fund, in a time and manner deemed appropriate by the director.

(e) Notwithstanding any other law, the Controller may use the funds in the Medi-Cal Provider Payment Reserve Fund for cashflow loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code.

(f) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to this part at the November 5, 2024, statewide general election, this section is repealed as of January 1, 2025.

SEC. 57. Section 14105.200 is added to the Welfare and Institutions Code, to read:

14105.200. (a) The Medi-Cal Provider Payment Reserve Fund is hereby created in the State Treasury.

(b) Notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on moneys in the Medi-Cal Provider Payment Reserve Fund shall be retained in the fund and used solely for the purposes specified in this section.

(c) (1) Subject to an appropriation made by the Legislature, the department shall use the funds transferred to the Medi-Cal Provider Payment Reserve Fund pursuant to paragraph (3) of subdivision (d) of Section 14199.82 for purposes of funding targeted increases to Medi-Cal payments

or other investments that advance access, quality, and equity for Medi-Cal beneficiaries and promote provider participation in the Medi-Cal program.

(2) The expenditures of funds appropriated pursuant to paragraph (1) shall include, but not be limited to, all of the following:

(A) Increased costs incurred as a result of the reimbursement requirements established in Section 14105.201.

(B) Transfers authorized in paragraph (2) of subdivision (e) of Section 129385 of the Health and Safety Code.

(C) Transfers, or an appropriation in the annual Budget Act, to the Small and Rural Hospital Relief Fund, as established in Section 130077 of the Health and Safety Code, in the amount of fifty million dollars ($50,000,000) in state fiscal year 2023–24 to support the Small and Rural Hospital Relief Program for seismic assessment and construction.

(d) The department shall provide an annual report to all health plans accounting for the funds deposited in, and expended from, the Medi-Cal Provider Payment Reserve Fund, in a time and manner deemed appropriate by the director.

(e) Notwithstanding any other law, the Controller may use the funds in the Medi-Cal Provider Payment Reserve Fund for cashflow loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code.

(f) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to this part at the November 5, 2024, statewide general election, this section shall become operative on January 1, 2025.

SEC. 58. Section 14105.201 of the Welfare and Institutions Code is amended to read:

14105.201. (a) (1) Notwithstanding any other law, for dates of service no sooner than January 1, 2024, or on the effective date of any necessary federal approvals as required by subdivision (e), whichever is later, the reimbursement rates for the following services, as determined in accordance with subdivision (g), shall be the greater of 87.5 percent of the lowest maximum allowance established by the federal Medicare Program for the same or similar services or the level of reimbursement, which shall account for, and be inclusive of, the exemption of these services from payment reductions pursuant to Section 14105.192, and supplemental payments or rate increases, or both, as applicable, under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56, an initiative measure approved at the November 8, 2016, statewide general election) that were implemented with funds from the Healthcare Treatment Fund, as established pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code, in effect as of December 31, 2023, as determined by the department:

(A) Primary care services, including those provided by physicians or nonphysician health professionals, as defined in Section 51170.5 of Title 22 of the California Code of Regulations.

(B) Obstetric care services, and doula services as described in Section 14132.24.

(C) Outpatient mental health services that are not the financial responsibility of county mental health plans operating pursuant to Chapter 8.9 (commencing with Section 14700).

(2) The department shall annually review and revise the reimbursement rates in accordance with paragraph (1) based on changes to the lowest maximum allowance established by the federal Medicare Program for the same or similar services. Any revisions to the reimbursement rates determined in accordance with paragraph (1) shall be considered as part of the annual budget development process and take effect beginning on January 1, 2025, and each subsequent January 1 thereafter, of the calendar year following the department's annual review.

(3) The department shall develop and implement a methodology for establishing reimbursement rates or payments for the services described in paragraph (1) where there is no specified maximum allowable rate established by the federal Medicare Program. The department shall review this methodology annually and may, in its sole discretion, modify the methodology on a prospective basis.

(b) (1) (A) For contract periods during which subdivision (a) is implemented, each Medi-Cal managed care plan shall reimburse a network provider furnishing the services subject to subdivision (a) at least the amount the network provider would be paid for those services in the Medi-Cal fee-for-service delivery system, as set forth by the department in the approved Medi-Cal State Plan and guidance issued pursuant to subdivision (f).

(B) Medi-Cal managed care plans that reimburse a network provider furnishing the services identified in subparagraphs (A) to (C), inclusive, of paragraph (1) of subdivision (a) on a capitated basis shall ensure that the network provider receives reimbursement that is equal to, or projected to be equal to, the level of reimbursement required in subparagraph (A) for the applicable services and, as applicable, shall increase reimbursement to the network provider to comply with this subparagraph.

(2) The department may require Medi-Cal managed care plans and network providers of the applicable services to submit information the department deems necessary to implement and monitor compliance with this subdivision, at the times and in the form and manner specified by the department.

(c) (1) The payments implemented pursuant to subdivisions (a) and (b) shall be supported by the managed care organization provider tax revenue, pursuant to Article 7.1 (commencing with Section 14199.80), or other state funds appropriated to the department as the state share for this purpose, including, but not limited to, funds transferred to the Medi-Cal Provider Payment Reserve Fund in accordance with Sections 14105.200 and 14199.82 and to the Healthcare Treatment Fund in accordance with subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

(2) Notwithstanding any other law, increases to fee-for-service reimbursement rates and managed care directed payments that are made pursuant to subdivisions (a) and (b) constitute increases in accordance with

subdivision (a) of Section 30130.55 of the Revenue and Taxation Code, and all other fee-for-service supplemental payments and managed care directed payments for the services identified in subparagraphs (A) to (C), inclusive, of paragraph (1) of subdivision (a) that are made pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code shall be discontinued on the date the payments implemented pursuant to subdivisions (a) and (b) are effective.

(d) (1) Effective for dates of service on or after January 1, 2025, community health workers shall be an eligible provider type for the rate increases effective pursuant to this section.

(2) In establishing the reimbursement rate for community health workers pursuant to subdivision (a), the department shall set rates equal to 100 percent of the lowest maximum allowance established by the federal Medicare Program for the same or similar services.

(3) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to this part at the November 5, 2024, statewide general election, this subdivision shall be inoperative as of January 1, 2025.

(e) In implementing this section, the department shall seek any federal approvals that it deems necessary. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

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

(g) The department shall develop the methodologies and parameters for the payments implemented pursuant to subdivisions (a), (b), and (d), and may revise the methodologies and parameters, for purposes including, but not limited to, obtaining or maintaining any necessary federal approvals as required by subdivision (e).

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

(1) "Community health workers" has the same meaning as set forth in the Medi-Cal State Plan.

(2) "Medi-Cal managed care plan" has the same meaning as that term is defined in subdivision (j) of Section 14184.101.

(3) "Network provider" has the same meaning as that term is defined in Section 438.2 of Title 42 of the Code of Federal Regulations.

(i) The Legislature finds and declares that this section, as it pertains to funding made available for expenditure pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code, is consistent and in accordance with the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56, an initiative measure approved at the November 8, 2016, statewide general election).

SEC. 59. Section 14105.202 of the Welfare and Institutions Code is repealed.

SEC. 60. Section 14105.467 of the Welfare and Institutions Code is amended to read:

14105.467. (a) The department shall establish, implement, and maintain a supplemental payment pool for nonhospital 340B community clinics, subject to an appropriation by the Legislature.

(b) Beginning January 1, 2021, and any subsequent fiscal year to the extent funds are appropriated by the Legislature for the purpose described in this section, the department shall make available fee-for-service-based supplemental payments from a fixed-amount payment pool to qualifying nonhospital 340B community clinics in accordance with this section and any terms of federal approval obtained pursuant to subdivision (f).

(c) (1) On or before July 15, 2020, the department shall establish a stakeholder process, which shall include representatives of qualifying nonhospital 340B community clinics. Representatives shall be geographically diverse and consist of qualifying nonhospital 340B community clinics with differing pharmacy arrangements, including those that operate in-house pharmacies and those with contract pharmacy arrangements. The stakeholder process shall be utilized to develop and implement the methodology for distribution of supplemental pool payments to qualifying nonhospital 340B community clinics. This shall include the eligibility criteria for receipt of supplemental payments, the aggregate amount of pool funding available in a respective fiscal year, the criteria for apportioning the pool funding among qualifying nonhospital 340B community clinics, and the timing, frequency, and amount of the resultant supplemental payments.

(2) The department shall conduct at least three meetings with stakeholders and shall finalize the methodology for distribution no later than October 1, 2020.

(d) (1) For any fiscal year that the department implements this section, the aggregate amount of supplemental payments available shall not exceed the pool amount established by the department for the respective fiscal year pursuant to subdivision (b).

(2) For any fiscal year that the department implements this section, the supplemental payment amounts received by a qualifying nonhospital 340B community clinic shall not exceed the apportioned amounts of the pool funding attributable to that individual clinic under the methodology developed pursuant to subdivision (c).

(e) To the extent permissible under federal law, supplemental payments received by qualifying nonhospital 340B community clinics pursuant to this section shall be considered separate and apart from the prospective payment system (PPS) reimbursement the clinic receives pursuant to Section 1396a(bb) of Title 42 of the United States Code and shall not be considered during annual reconciliation of the PPS rate.

(f) (1) The department may modify any methodology or other requirement specified in this section to the extent it deems necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure federal financial participation is available or not otherwise jeopardized.

(2) If the department determines that a modification is necessary pursuant to paragraph (1), the department shall consult with participants of the stakeholder process established pursuant to subdivision (c) to the extent practicable.

(3) If a modification is made, the department shall notify qualifying nonhospital 340B community clinics, the Joint Legislative Budget Committee, and the relevant policy and fiscal committees of the Legislature within 10 business days of that modification.

(g) The department shall implement this section only to the extent that any necessary federal approvals have been obtained, and federal financial participation is available and is not otherwise jeopardized.

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

(i) For purposes of this section:

(1) "340B" means the discount drug purchasing program described in Section 256b of Title 42 of the United States Code.

(2) "Qualifying nonhospital 340B community clinic" means a center or clinic that is licensed under subdivision (a) of Section 1204 of the Health and Safety Code, or a clinic operated by a city, county, city and county, or hospital authority that is exempt from licensure under subdivision (b) of Section 1206 of the Health and Safety Code, and that is a 340B covered entity pursuant to Section 256b of Title 42 of the United States Code for the duration of each applicable fiscal year for which the department implements this section.

(j) Upon implementation of Section 14105.468 and the completion of all closeout activities associated with this section, the director shall execute a declaration, which shall be retained by the director, stating that implementation of Section 14105.468 has commenced and that all closeout activities associated with this section have been completed. This section shall become inoperative one year after the date that the director executes the declaration and shall be repealed on January 1 of the year following the date upon which this section becomes inoperative.

SEC. 61. Section 14105.468 is added to the Welfare and Institutions Code, to read:

14105.468. (a) (1) Beginning for dates of service on or after January 1, 2025, the department shall establish and implement a directed payment program under which a qualifying nonhospital 340B community clinic may earn payments from contracted Medi-Cal managed care plans, subject to an appropriation by the Legislature.

(2) (A) Beginning for dates of service on or after January 1, 2026, the department shall increase the amount of directed payments pursuant to paragraph (1) with amounts allocated from the Medi-Cal Provider Payment Reserve Fund in accordance with Section 14105.200.

(B) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to this part at the November 5, 2024, statewide general election, this paragraph shall be inoperative as of January 1, 2025.

(b) The department, in consultation with affected stakeholders, and affected Medi-Cal managed care plans, as applicable, 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 a qualifying nonhospital 340B community clinic shall meet in order to receive a directed payment from a Medi-Cal managed care plan pursuant to this section. The department may implement the directed payment described in this subdivision using one or more of the models authorized by subsection (c) of Section 438.6 of Title 42 of the Code of Federal Regulations.

(c) To the extent permissible under federal law, directed payments received by qualifying nonhospital 340B community clinics pursuant to this section shall be considered separate and apart from the prospective payment system (PPS) reimbursement the clinic receives pursuant to subsection (bb) of Section 1396a of Title 42 of the United States Code and shall not be considered during annual reconciliation of the PPS rate.

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

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

(f) For any calendar year in which this section is implemented, in whole or in part, and notwithstanding any other law, neither the department nor a Medi-Cal managed care plan shall be required to make the payments specified in Section 14105.467.

(g) For purposes of this section:

(1) "340B" means the discount drug purchasing program described in Section 256b of Title 42 of the United States Code.

(2) "Qualifying nonhospital 340B community clinic" means a center or clinic that is licensed under subdivision (a) of Section 1204 of the Health and Safety Code, or a clinic operated by a city, county, city and county, or hospital authority that is exempt from licensure under subdivision (b) of Section 1206 of the Health and Safety Code, and that is a 340B covered entity pursuant to Section 256b of Title 42 of the United States Code for the duration of each applicable fiscal year for which the department implements this section.

SEC. 62. Section 14124.12 of the Welfare and Institutions Code is amended to read:

14124.12. (a) (1) Notwithstanding any other law, for the duration of the COVID-19 emergency period, the department shall implement any federal Medicaid program waiver or flexibility approved by the federal Centers for Medicare and Medicaid Services related to the COVID-19 public health emergency. This includes, but is not limited to, any waiver or flexibility approved pursuant to Sections 1315, 1320b-5, or 1396n of Title 42 of the United States Code, or the Medi-Cal state plan. Any request for a federal Medicaid program waiver or flexibility shall be subject to Department of Finance approval before the department submits that request to the federal Centers for Medicare and Medicaid Services.

(2) During the COVID-19 emergency period, and through December 31, 2022, for any extended waiver or flexibility described in subdivision (f), if there is a conflict between this chapter, Chapter 8 (commencing with Section 14200), Chapter 8.8 (commencing with Section 14600), or Chapter 8.9 (commencing with Section 14700), and any approved federal waiver or flexibility, as described in paragraph (1), the approved federal waiver or flexibility shall control over any conflict in the specified state law.

(b) (1) To the extent that federal financial participation is available, the department, subject to Department of Finance approval, shall exercise its option under Section 1396a(a)(10)(A)(ii)(XXIII) of Title 42 of the United States Code to extend the medical assistance, as described in Section 1396a(a)(10)(A)(ii)(XVIII) of Title 42 of the United States Code, to uninsured individuals, as defined in Section 1396a(ss) of Title 42 of the United States Code, for the duration of the COVID-19 emergency period.

(2) The department, subject to Department of Finance approval, may seek federal approval pursuant to Section 1315 of Title 42 of the United States Code to extend the medical assistance afforded to uninsured individuals pursuant to paragraph (1) to include COVID-19-related treatment services that are otherwise covered for full-scope Medi-Cal beneficiaries, as defined by the department. If federal financial participation is unavailable, the department, subject to Department of Finance approval, may elect to implement this paragraph on a state-only funding basis, and subject to an appropriation by the Legislature.

(c) Notwithstanding any other law, the department shall seek to maximize federal financial participation for Medi-Cal expenditures that it determines to be available for the COVID-19 public health emergency, and shall comply with any federal requirements and conditions for receipt of that federal financial participation. This includes, but is not limited to, the temporary increase in the federal medical assistance percentage made available pursuant to Section 6008 of the federal Families First Coronavirus Response Act (Public Law 116-127).

(d) Due to the impact of the COVID-19 public health emergency on the department's ongoing administration of the Medi-Cal program, the department may seek any federal approvals it deems necessary for any number of temporary extensions of all or select components of the California Medi-Cal 2020 Demonstration (No. 11-W-00193/9) pursuant to Article 5.5 (commencing with Section 14184), which is scheduled to expire on

December 31, 2020. If the department elects to seek any extension, the department shall determine the length of time for the extension sought and whether to seek an extension for the entirety of the demonstration or select components of the demonstration. In implementing this subdivision, the department, to the extent practicable, shall consult with affected stakeholder entities before seeking a temporary extension.

(e) The department, subject to Department of Finance approval, shall seek any federal approvals it deems necessary to implement this section or to maintain sufficient access to covered benefits under the Medi-Cal program during the COVID-19 emergency period. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(f) (1) (A) The department shall seek any federal approvals it deems necessary to extend the approved waiver or flexibility implemented pursuant to subdivision (a), as of July 1, 2021, that are related to the delivery and reimbursement of services via telehealth modalities in the Medi-Cal program. Subject to subdivision (e), the department shall implement those extended waivers or flexibilities for which federal approval is obtained, to commence on the first calendar day immediately following the last calendar day of the federal COVID-19 public health emergency period, and through December 31, 2022.

(B) Subject to subdivision (e), the department may authorize the use of remote patient monitoring as an allowable telehealth modality for covered health care services and provider types it deems appropriate for dates of service on or after July 1, 2021. The department may establish a fee schedule for applicable health care services delivered via remote patient monitoring.

(2) (A) For purposes of informing the 2022–23 proposed Governor's Budget, released in January 2022, the department shall convene an advisory group consisting of consultants, subject matter experts, and other affected stakeholders to provide recommendations to inform the department in establishing and adopting billing and utilization management protocols for telehealth modalities to increase access and equity and reduce disparities in the Medi-Cal program. The advisory group shall analyze the impact of telehealth in increased access for patients, changes in health quality outcomes and utilization, best practices for the appropriate mix of in-person visits and telehealth, and the benefits or liabilities of any practice or care model changes that have resulted from telephonic visits.

(B) The advisory group shall include representatives of the California Medical Association, the California Primary Care Association, the California Association of Public Hospitals, the County Behavioral Health Directors Association, Medi-Cal managed care plans, Planned Parenthood Affiliates of California, Essential Access Health, and other subject matter experts or other affected stakeholders as identified by the department.

(3) For purposes of implementing this subdivision, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this paragraph shall be exempt from Chapter 6 (commencing with Section

14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(4) Nothing in this subdivision shall be construed to limit coverage of, and reimbursement for, telehealth modalities that are the type authorized by the department prior to the COVID-19 emergency period and described in the Medi-Cal State Plan, the Medi-Cal provider manual, or other departmental guidance.

(g) (1) Notwithstanding any other law, subject to appropriation by the Legislature and Section 11.95 of the Budget Act of 2021, the department shall implement those activities and expenditures to enhance, expand, or strengthen home and community-based services (HCBS) under the Medi-Cal program that are approved by the federal Centers for Medicare and Medicaid Services pursuant to Section 9817 of the federal American Rescue Plan Act of 2021 (Public Law 117-2) and associated federal guidance.

(2) Notwithstanding any other law, the department shall comply with any federal requirements and conditions as necessary to claim the increased federal medical assistance percentage for eligible HCBS expenditures pursuant to Section 9817 of the federal American Rescue Plan Act of 2021 (Public Law 117-2) and associated federal guidance.

(3) Notwithstanding any other law, stipends or payments received by an individual from initiatives included in the approved HCBS spending plan described in this subdivision shall not be considered income or resources for purposes of determining the individual's, or any member of their household's, eligibility for benefits or assistance, or the amount or extent of benefits or assistance, under any state or local benefit or assistance program, to the extent permitted under federal law and, where applicable, to the extent any necessary federal approvals are obtained.

(4) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, the State Department of Social Services, the California Department of Aging, the State Department of Public Health, the State Department of Developmental Services, the State Department of Rehabilitation, and the Department of Health Care Access and Information, as applicable, may implement, interpret, or make specific this subdivision and any HCBS activity described in paragraph (1) by means of all-county letters, plan letters, provider bulletins, or other similar instructions, without taking any further regulatory action.

(5) For purposes of implementing this subdivision and any HCBS activity described in paragraph (1), the department, the State Department of Social Services, the California Department of Aging, the State Department of Public Health, the State Department of Developmental Services, the State Department of Rehabilitation, and the Department of Health Care Access and Information, as applicable, may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts

entered into or amended pursuant to this paragraph, and the implementation of any HCBS activity described in paragraph (1), shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Chapters 7 (commencing with Section 9530) and 7.5 (commencing with Section 9540) of Division 8.5 of this code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(6) Any funding made available to the Traumatic Brain Injury Program in the State Department of Rehabilitation pursuant to paragraph (1) shall be exempted from subdivision (b) of Section 4355, subdivision (b) of Section 4357, and subdivision (c) of Section 4357.1.

(h) Notwithstanding any other law, subject to subdivision (e), the department shall align COVID-19 vaccine administration payments to payment reimbursement structures for vaccines administered in accordance with the Medi-Cal State Plan.

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

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

(1) "COVID-19 emergency period" has the same meaning as "emergency period" as defined in Section 1320b-5(g)(1)(B) of Title 42 of the United States Code, unless otherwise defined in federal law or any federal approval obtained pursuant to this section.

(2) "COVID-19 public health emergency" means the Public Health Emergency declared by the Secretary of the United States Department of Health and Human Services on January 31, 2020, pursuant to Section 247d of Title 42 of the United States Code, and entitled "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus," including any subsequent renewal of that declaration.

SEC. 63. Article 3.1 (commencing with Section 14124.160) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 3.1. Medi-Cal Provider Payment Increases and Investments Act

14124.160. (a) This article shall be known, and may be cited, as the Medi-Cal Provider Payment Increases and Investments (PPI) Act.

(b) The implementation of the act, as set forth in this article and the PPI Terms and Conditions, shall support all of the following goals:

(1) Improve access to high-quality care for Medi-Cal members, especially in underserved areas.

(2) Promote provider participation in the Medi-Cal program.

(3) Strengthen the Medi-Cal program's foundation through reimbursement methodologies that are more competitive with other payors and, where applicable, allow for periodic adjustments to keep pace with health care cost inflation.

14124.161. For purposes of this article, and elsewhere in law where specified, the following definitions shall apply:

(a) "PPI" means the respective components of the Medi-Cal Provider Payment Increases and Investments Act authorized by this article or other sections of law amended by the act that added this subdivision, and, as applicable, approved by the federal Centers for Medicare and Medicaid Services in the PPI Terms and Conditions.

(b) "PPI Terms and Conditions" means those terms and conditions issued and approved by the federal Centers for Medicare and Medicaid Services, including any attachments, appendices, or similar documents, and subsequent amendments thereto, that govern implementation of the respective components of PPI pursuant to this article or other sections of law amended by the act that added this subdivision. PPI Terms and Conditions shall include, at a minimum, any terms and conditions specified in the following:

(1) Any Medi-Cal Demonstration approved by the federal Centers for Medicare and Medicaid Services pursuant to Section 1315 of Title 42 of the United States Code that are necessary to implement a PPI component.

(2) Any Medicaid Waivers as approved by the federal Centers for Medicare and Medicaid Services pursuant to Section 1396n of Title 42 of the United States Code that are necessary to implement a PPI component.

(3) Any associated Medi-Cal State Plan amendments approved by the federal Centers for Medicare and Medicaid Services that are necessary to implement a PPI component.

(4) Any provision of a comprehensive risk contract, nonrisk contract, or other similar managed care arrangement, including an intergovernmental agreement or directed payment authorized pursuant to Section 438.6(c) of Title 42 of the Code of Federal Regulations, approved by the federal Centers for Medicare and Medicaid Services to implement this article, or the authorities described in paragraph (1), (2), or (3).

(c) "Abortion services" has the same meaning as set forth in subdivision (a) of Section 123464 of the Health and Safety Code.

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

(e) "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 beneficiaries pursuant to any provision of this chapter or Chapter 8 (commencing with Section 14200).

(f) "Network provider" has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

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

14124.162. (a) Consistent with federal law, the department shall seek federal approval for, and implement PPI, including, but not limited to, all of the following components:

(1) Reimbursement increases for professional services described in Section 14124.163.

(2) Reimbursement increases for ground emergency medical transport services described in Section 14124.164.

(3) Reimbursement increases for abortion services described in Section 14124.165.

(4) Reimbursement increases for family planning services described in Section 14124.166.

(5) Reimbursement increases for services described in Section 14124.167.

(6) Updating the reimbursement methodology for optional hearing aid benefits, as described in Section 14131.05.

(7) Elimination of certain rate reductions as described in paragraph (16) of subdivision (h) of Section 14105.192.

(8) Implementation of increases to the amount of directed payments for qualifying nonhospital 340B community clinics pursuant to paragraph (2) of subdivision (a) of Section 14105.468.

(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, other sections of law amended by the act that added this subdivision, the PPI Terms and Conditions, or any appertaining Medi-Cal reimbursement methodologies in whole or in part, by means of all-county letters, plan letters, provider bulletins, information notices, or other similar instructions, without taking any further regulatory action.

(c) For purposes of implementing this article, other sections of law amended by the act that added this subdivision, or the PPI Terms and Conditions, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis, and may implement changes to existing information technology systems. Notwithstanding any other law, contracts entered into or amended, or changes to existing information technology systems, pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, 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.

(d) The department shall seek any federal approvals it deems necessary to implement PPI under this article and other provisions of law amended by the act that added this subdivision. This shall include, but need not be limited to, approval of any amendment, addition, or technical correction to the PPI Terms and Conditions, as the department deems necessary. Except those portions of this article related to abortion services, 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.

(e) To the extent that there is a later enacted statute that restricts the availability of the moneys in, restricts transfers of moneys into, or transfers moneys out of the Medi-Cal Provider Payment Reserve Fund, or restricts the availability or use of managed care organization provider tax revenues derived from the taxes imposed pursuant to Article 7.1 (commencing with Section 14199.80) or any subsequent continuation of the managed care organization provider tax, the department shall only implement this article or other sections of law amended by the act that added this section to the extent that the department determines the provisions of this article remain feasible with or without making modifications pursuant to subdivision (f).

(f) (1) Consistent with subdivisions (d) and (e), the director may modify any methodology or parameter specified in this article or other sections of law amended by the act that added this subdivision, to the extent necessary to do any of the following:

(A) To comply with federal law or the PPI Terms and Conditions, to obtain or maintain federal approval, or to ensure federal financial participation is available and not otherwise jeopardized.

(B) To conform with any later enacted statute that restricts the availability of the moneys in, restricts transfers of moneys into, or transfers moneys out of the Medi-Cal Provider Payment Reserve Fund, or restricts the availability or use of managed care organization provider tax revenues derived from the taxes imposed pursuant to Article 7.1 (commencing with Section 14199.80) or any subsequent continuation of the managed care organization provider tax.

(2) Any modification must be consistent with the goals set forth in this article and its individual components. Modifications may include, but are not limited to, implementing PPI components on a time-limited basis or modifying the targeted funding amounts or applicable percentages without exceeding amounts appropriated in the state budget for these purposes.

(3) Prior to proposing a modification pursuant to this subdivision, the director shall consult with affected stakeholders. Upon approval by the Department of Finance, any modification made pursuant to this subdivision shall take effect no sooner than 30 days after the director provides public notice of the proposed modification and provides notification to the chairpersons of the committees in each house of the Legislature that consider health policy, chairpersons of the committees in each house of the Legislature that consider appropriations, the chairpersons of the committees and appropriate subcommittees that consider the State Budget, and the Chairperson of the Joint Legislative Budget Committee, or not sooner than whatever lesser time the chairperson of the joint committee, or the chairperson's designee, may determine. The public notice shall include a description of the projected fiscal impact of the proposed modification on each PPI component. Submission of the semiannual Medi-Cal estimate provided to the Legislature in January and May shall be considered meeting

the notification requirement of this provision if the required information is included in the estimate.

(g) The payment methodologies, investments, and parameters developed and implemented pursuant to this article, the PPI Terms and Conditions, or other sections of law amended by the act that added this subdivision shall supersede any conflicting law or regulation, shall, as applicable, supersede and replace any other applicable payment methodology, and shall be implemented notwithstanding any other law.

(h) (1) The payments implemented pursuant to this article, other sections of law amended by the act that added this subdivision, or the PPI Terms and Conditions shall be supported by managed care organization provider tax revenue, either pursuant to Article 7.1 (commencing with Section 14199.80) or any subsequent continuation of the managed care organization provider tax, or other state funds appropriated by the Legislature to the department as the state's share for this purpose, including, but not limited to, funds transferred to the Medi-Cal Provider Payment Reserve Fund in accordance with Sections 14105.200 and 14199.82, and to the Healthcare Treatment Fund in accordance with subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

(2) Notwithstanding any other law, the Legislature finds and declares increases to fee-for-service reimbursement rates and managed care capitation payments that are made pursuant to this article, other sections of law amended by the act that added this subdivision, or the PPI Terms and Conditions constitute increases in accordance with subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

(3) Notwithstanding any other law, increases to fee-for-service reimbursement rates, managed care capitation payments, or other investments that are made pursuant to this article, other sections of law amended by the act that added this section, or the PPI Terms and Conditions constitute increased reimbursement rates in accordance with statutory requirements imposed on the use of funds generated by the managed care organization provider tax, pursuant to Article 7.1 (commencing with Section 14199.80) or any subsequent statute that continues the managed care organization provider tax.

(i) The department may require Medi-Cal providers, Medi-Cal managed care plans, and other persons or entities pertaining to the Medi-Cal delivery system to submit information the department deems necessary to implement and monitor compliance with this article, other sections of law amended by the act that added this section, or the PPI Terms and Conditions, at the times and in the form and manner specified by the department.

(j) (1) The department may direct Medi-Cal managed care plans to reimburse eligible providers furnishing the services subject to PPI in accordance with one or more directed payment methodologies pursuant to subsection (c) of Section 438.6 of Title 42 of the Code of Federal Regulations, and as set forth by other sections of law amended by the act that added this section and by the department in guidance issued pursuant to subdivision (b).

(2) Commencing with the first managed care rating period for which the department documents in the annual rate certification that the base period data submitted and attested to by Medi-Cal managed care plans that is used by the department for the development of capitation rates for the Medi-Cal managed care delivery system reflects the increased reimbursement levels for a service subject to PPI, the department may, following consultation with affected stakeholders, elect to discontinue any directed payment methodologies implemented for that service.

(k) The department, as appropriate and to the extent practicable, shall consult with interested stakeholders regarding implementation of applicable components of PPI in which they will participate.

14124.163. (a) For the purposes of this section:

(1) "Eligible providers" means physicians, physician assistants, nurse practitioners, podiatrists, certified nurse midwives, licensed midwives, doula providers, psychologists, licensed professional clinical counselors, licensed clinical social workers, licensed marriage and family therapists, optometrists, audiologists, and community health workers.

(2) "Applicable professional services" means:

(A) Evaluation and management services associated with primary care and specialist office visits, preventative care services, and care management services.

(B) Maternal care services, including obstetric care services and doula services.

(C) Outpatient behavioral health services that are not the financial responsibility of county mental health plans operating pursuant to Chapter 8.9 (commencing with Section 14700).

(D) Vaccine administration services, as specified by the department.

(E) Vision services.

(F) Community health worker services, as described in the approved Medi-Cal State Plan.

(G) Evaluation and management services associated with emergency physician services.

(H) Other services commonly provided by primary care, specialist, and hospital-based emergency physician and non-physician health professionals as determined by the department.

(I) Hearing aids and audiological services.

(3) "Applicable professional services" do not include:

(A) Abortion and family planning services.

(B) Other allied health services, clinical laboratory services, radiology, and durable medical equipment.

(C) Outpatient hospital facility services other than services described in subparagraphs (B) and (C) of paragraph (2).

(4) "Applicable percentage" means:

(A) With respect to the applicable services listed in subparagraphs (A) and (B) of paragraph (2), 95 percent.

(B) With respect to the applicable services listed in subparagraphs (C) to (E), inclusive, of paragraph (2), 87.5 percent.

(C) With respect to the applicable services listed in subparagraph (F) of paragraph (2), 100 percent.

(D) With respect to the applicable services listed in subparagraph (G) of paragraph (2), 90 percent.

(E) With respect to the applicable services listed in subparagraphs (H) and (I) of paragraph (2), 80 percent.

(b) Notwithstanding any other law, for dates of service no sooner than January 1, 2026, or on the effective date of any necessary federal approvals as required by subdivision (d) of Section 14124.162, whichever is later, the department shall establish a geographically adjusted fee schedule for applicable services rendered by eligible providers consistent with the geographic localities utilized by the federal Medicare Program.

(c) (1) (A) Notwithstanding any other law, for dates of service no sooner than January 1, 2025, or on the effective date of any necessary federal approvals as required by subdivision (d) of Section 14124.162, whichever is later, the reimbursement rates for eligible providers rendering the services described in subparagraph (G) of paragraph (2) of subdivision (a) shall be no less than the applicable percentage of the lowest maximum allowance established by the federal Medicare Program for the same or similar services in effect as of January 1 of the calendar year prior to the implementation of this subparagraph.

(B) Notwithstanding any other law, for dates of service no sooner than January 1, 2026, or on the effective date of any necessary federal approvals as required by subdivision (d) of Section 14124.162, whichever is later, the reimbursement rates for eligible providers rendering the applicable professional services shall be no less than the applicable percentage of the applicable, geographically adjusted, maximum allowance established by the federal Medicare Program for the same or similar services in effect as of January 1 of the calendar year prior to the implementation of this subdivision for each geographic locality established by the Medicare Program.

(2) The department shall develop and implement a methodology for establishing reimbursement rates or payments for services for which there is no maximum allowable rate established by the federal Medicare Program. The department shall review this methodology annually and may, in its sole discretion, modify the methodology on a prospective basis.

(3) The department shall annually review and, subject to appropriation by the Legislature, revise the reimbursement rates established in accordance with this subdivision based on changes to the applicable maximum allowable rate established by the federal Medicare Program for the same or similar services. Any revisions to the reimbursement rates shall be considered as part of the annual budget development process and subject to the provisions of subdivision (d) of Section 14124.162 and take effect beginning no sooner than January 1, 2026, and thereafter on each subsequent January 1 of the calendar year following the department's annual review.

(d) Notwithstanding subdivision (b) of Section 14105.201, the following shall apply:

(1) For contract periods during which subdivision (c) is implemented, each Medi-Cal managed care plan shall reimburse a network provider furnishing the services subject to subdivision (c) at least the amount the network provider would be paid for those services in the Medi-Cal fee-for-service delivery system, as set forth by the department in the approved Medi-Cal State Plan and guidance issued pursuant to subdivision (b) of Section 14124.162.

(2) In any instance where a Medi-Cal managed care plan and network provider furnishing the services subject to subdivision (c) mutually agree to reimbursement on a basis other than per-service reimbursement, the Medi-Cal managed care plan shall account for the reimbursement amount required pursuant to paragraph (1) in determining the negotiated level of reimbursement and disclose to the network provider the value of any reimbursement increases associated with the changes to Medi-Cal managed care program described in this section.

(3) (A) For the 2026 calendar year, the department shall require Medi-Cal managed care plans to demonstrate compliance with the requirements of paragraphs (1) and (2) in a form and manner specified by the department.

(B) Subsequent to the 2026 calendar year, and subject to paragraph (2) of subdivision (j) of Section 14124.162, the department shall require Medi-Cal managed care plans to redemonstrate compliance with the requirements of paragraphs (1) and (2), in a form and manner specified by the department, no less than once every four years, or more frequently as deemed necessary by the department.

(C) This paragraph does not limit the department's authority to audit, monitor, or oversee a Medi-Cal managed care plan's compliance with applicable contractual, statutory, or other requirements.

14124.164. (a) (1) Notwithstanding Section 51527 of Title 22 of the California Code of Regulations or any other law, for dates of service no sooner than January 1, 2025, or on the effective date of any necessary federal approvals as required by subdivision (d) of Section 14124.162, whichever is later, the department shall increase reimbursement for eligible providers rendering ground emergency medical transport services.

(2) The department may implement the reimbursement increases described in paragraph (1) solely with respect to the per-transport rate, with respect to both the per-transport and the mileage rates, or in any other manner as deemed appropriate by the department.

(3) This subdivision shall not apply to an eligible provider as defined in paragraph (1) of subdivision (a) of Section 14105.945.

(b) Notwithstanding Section 51527 of Title 22 of the California Code of Regulations or any other law, for dates of service no sooner than January 1, 2025, or on the effective date of any necessary federal approvals as required by subdivision (d) of Section 14124.162, whichever is later, the department may vary the reimbursement increases described in subdivision (a), or reimbursement rates for ground emergency medical transport services, based on complexity or the geographic localities utilized by the federal Medicare Program, may categorize localities into rural tiers, and may vary

the amount of the rural adjustment per tier from those utilized by the Medicare Program to reflect a California-specific index of localities and adjustment factors. Nothing in this subdivision shall be construed to require the department to reimburse providers rendering ground emergency medical transport services the rates utilized by the Medicare Program or to replicate the rural adjustment factors, or any other factors, utilized by the Medicare Program.

(c) Each applicable Medi-Cal managed care health plan shall satisfy its obligation under Section 438.114(c) of Title 42 of the Code of Federal Regulations for emergency medical transports and shall provide payment to noncontract emergency medical transport providers consistent with Section 1396u-2(b)(2)(D) of Title 42 of the United States Code. Effective upon implementation of this section, and for each state fiscal year thereafter for which this section is operative, the amounts a noncontract emergency medical transport provider could collect if the beneficiary received medical assistance other than through enrollment in a Medi-Cal managed care health plan pursuant to Section 1396u-2(b)(2)(D) of Title 42 of the United States Code shall be the resulting fee-for-service payment schedule amounts after the application of this section.

(d) The department shall implement the reimbursement increases specified in subdivision (a) in amounts that are designed to target increased state fund expenditures of equal to the annualized amount set forth in the state fiscal year 2024–25 budget for the first year of implementation in aggregate across both the Medi-Cal fee-for-service and managed care delivery systems. The reimbursement increases established pursuant to this methodology shall continue at these levels for each year thereafter, subject to subdivision (e).

(e) The department may annually review and revise the reimbursement increases established in accordance with subdivision (a). Any revisions shall be subject to the provisions of subdivision (d) of Section 14124.162 and take effect beginning no sooner than January 1, 2026, and thereafter on each subsequent January 1 of the calendar year following the department's annual review.

14124.165. (a) (1) Notwithstanding any other law, for dates of service no sooner than January 1, 2025, the base reimbursement rates for eligible providers rendering Medi-Cal covered abortion services identified by the department, shall be increased in the fee-for-service delivery system such that, in combination with the projected actuarially equivalent impact on the managed care delivery system expenditures, the projected cost of the base reimbursement rate increases on an annualized basis is equal, as determined by the department, to the annualized amount set forth in the state fiscal year 2024–25 budget.

(2) The reimbursement rate increases described in paragraph (1) shall account for, and be inclusive of, the exemption of these services from payment reductions pursuant to Section 14105.192, and may be geographically adjusted as deemed appropriate by the department.

(b) For contract periods during which subdivision (a) is implemented, each Medi-Cal managed care plan shall reimburse eligible providers

furnishing the services subject to subdivision (a) no less than the amounts established pursuant to subdivision (a) as directed by the department in guidance issued pursuant to subdivision (b) of Section 14124.162.

14124.166. (a) Beginning for dates of service no sooner than January 1, 2025, or on the effective date of any necessary federal approvals as required by subdivision (d) of Section 14124.162, whichever is later, the department may implement a supplemental payment program for services provided under the Family Planning, Access, Care, and Treatment program, as described in subdivision (aa) of Section 14132.

(b) The department shall develop, establish, and maintain the methodology, eligibility criteria, conditions, and payment amounts for the supplemental payments described in this section.

14124.167. (a) For the purposes of this section, the following definitions apply:

(1) Beginning for dates of service on or after January 1, 2025, "applicable services" means the following services:

(A) Emergency medical air transportation services as described in Section 76000.10 of the Government Code.

(B) Community-based adult services, as described in Section 14186.3 and as covered pursuant to subdivision (e) of Section 14184.201.

(C) Pediatric day health care, as described in Section 14132.10 and Section 1760.2 of the Health and Safety Code.

(D) Services provided in a congregate living health facility as defined in subdivision (i) of Section 1250 of the Health and Safety Code.

(2) Beginning for dates of service on or after January 1, 2026, "applicable services" means the following services:

(A) Services described in paragraph (1).

(B) Nonemergency medical transportation services as described in Section 51323 of Title 22 of the California Code of Regulations.

(C) Private duty nursing as described in Section 14105.13 and Section 1743.2 of the Health and Safety Code.

(b) Beginning for dates of service on or after January 1, 2025, or on the effective date of any necessary federal approvals as required by subdivision (d) of Section 14124.162, whichever is later, the department shall implement reimbursement increases for applicable services in the fee-for-service delivery system such that, in combination with the projected actuarially equivalent impact on the managed care delivery system expenditures, as applicable, the projected nonfederal share cost of the reimbursement increases on an annualized basis is equal, as determined by the department, to the annualized amount set forth in the state fiscal year 2024–25 budget.

14124.168. If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to this part at the November 5, 2024, statewide general election, this article shall be repealed as of January 1, 2025.

SEC. 64. Section 14131.05 of the Welfare and Institutions Code is amended to read:

14131.05. (a) Notwithstanding any other provision of this chapter or Chapter 8 (commencing with Section 14200), optional hearing aid benefits are subject to per beneficiary benefit cap amounts under the Medi-Cal program.

(b) For the purposes of this section, "benefit cap amount" means the maximum amount of Medi-Cal coverage for optional hearing aid benefits as specified in subdivision (c), for each beneficiary, for each fiscal year.

(c) (1) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to this part at the November 5, 2024, statewide general election, hearing aid benefits are subject to a benefit cap amount of one thousand five hundred ten dollars ($1,510).

(2) Notwithstanding paragraph (1), if the voters do not approve the addition of Chapter 7.5 (commencing with Section 14199.100) to this part at the November 5, 2024, statewide general election, hearing aid benefits are subject to a benefit cap amount of no less than one thousand five hundred ten dollars ($1,510). Under that circumstance, the benefit cap amount shall be set by the department and may be adjusted annually, any revisions to the benefit cap shall be subject to the provisions of Sections 14124.162 and 14124.163.

(d) Pregnancy-related benefits and benefits for the treatment of other conditions that might complicate the pregnancy are not subject to the benefit cap amount in subdivision (c).

(e) The benefit cap amount in subdivision (c) does not apply to the following:

(1) Beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment Program.

(2) Beneficiaries receiving long-term care in a nursing facility that is both of the following:

(A) A skilled nursing facility or intermediate care facility as defined in subdivisions (c), (d), (e), (g), and (h), respectively, of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the program established by Section 14132.20.

(B) A licensed nursing facility pursuant to subdivision (k) of Section 1250 of the Health and Safety Code.

(f) For managed care health plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), except for contracts with the Senior Care Action Network and AIDS Healthcare Foundation, payments for optional hearing aid benefits shall be reduced by the actuarial equivalent amount of the benefit reductions resulting from the implementation of the benefit cap amount specified in this section pursuant to contract amendments or change orders effective on July 1, 2011, or any date thereafter.

(g) This section shall be implemented only to the extent permitted by federal law.

(h) Notwithstanding 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), the department may implement the provisions of this section by means of all-county letters, provider bulletins, or similar instructions, without taking further regulatory action.

(i) This section shall be implemented on the first day of the first calendar month following 210 days after the effective date of this section, 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. If the implementation date occurs after July 1, 2011, then the benefit cap described in subdivision (c) for the first year of implementation shall be applied from the implementation date through June 30 of the state fiscal year in which implementation commences. Thereafter, the benefit cap shall apply on a state fiscal year basis.

SEC. 65. Section 14154 of the Welfare and Institutions Code is amended to read:

14154. (a) (1) The department shall establish and maintain a plan whereby costs for county administration of the determination of eligibility for benefits under this chapter will be effectively controlled within the amounts annually appropriated for that administration. The plan, to be known as the County Administrative Cost Control Plan, shall establish standards and performance criteria, including workload, productivity, and support services standards, to which counties shall adhere. The plan shall include standards for controlling eligibility determination costs that are incurred by performing eligibility determinations at county hospitals, or that are incurred due to the outstationing of any other eligibility function. Except as provided in Section 14154.15, reimbursement to a county for outstationed eligibility functions shall be based solely on productivity standards applied to that county's welfare department office.

(2) (A) The plan shall delineate both of the following:

(i) The process for determining county administration base costs, which include salaries and benefits, support costs, and staff development.

(ii) The process for determining funding for caseload changes, cost-of-living adjustments, and program and other changes.

(B) The annual county budget survey document utilized under the plan shall be constructed to enable the counties to provide sufficient detail to the department to support their budget requests.

(3) The plan shall be part of a single state plan, jointly developed by the department and the State Department of Social Services, in conjunction with the counties, for administrative cost control for the California Work Opportunity and Responsibility to Kids (CalWORKs), CalFresh, and Medical Assistance (Medi-Cal) programs. Allocations shall be made to each county and shall be limited by and determined based upon the County Administrative Cost Control Plan. In administering the plan to control county administrative costs, the department shall not allocate state funds to cover county cost overruns that result from county failure to meet requirements of the plan. The department and the State Department of Social Services

shall budget, administer, and allocate state funds for county administration in a uniform and consistent manner.

(4) The department and county welfare departments shall develop procedures to ensure the data clarity, consistency, and reliability of information contained in the county budget survey document submitted by counties to the department. These procedures shall include the format of the county budget survey document and process, data submittal and its documentation, and the use of the county budget survey documents for the development of determining county administration costs. Communication between the department and the county welfare departments shall be ongoing as needed regarding the content of the county budget surveys and any potential issues to ensure the information is complete and well understood by involved parties. Any changes developed pursuant to this section shall be incorporated within the state's annual budget process by no later than the 2011–12 fiscal year.

(5) The department shall provide a clear narrative description along with fiscal detail in the Medi-Cal estimate package, submitted to the Legislature in January and May of each year, of each component of the county administrative funding for the Medi-Cal program. This shall describe how the information obtained from the county budget survey documents was utilized and, if applicable, modified and the rationale for the changes.

(6) Notwithstanding any other law, the department shall develop and implement, in consultation with county program and fiscal representatives, a new budgeting methodology for Medi-Cal county administrative costs that reflects the impact of PPACA implementation on county administrative work. The new budgeting methodology shall be used to reimburse counties for eligibility processing and case maintenance for applicants and beneficiaries.

(A) The budgeting methodology may include, but is not limited to, identification of the costs of eligibility determinations for applicants, and the costs of eligibility redeterminations and case maintenance activities for recipients, for different groupings of cases, based on variations in time and resources needed to conduct eligibility determinations. The calculation of time and resources shall be based on the following factors: complexity of eligibility rules, ongoing eligibility requirements, and other factors as determined appropriate by the department. The development of the new budgeting methodology may include, but is not limited to, county survey of costs, time and motion studies, in-person observations by department staff, data reporting, and other factors deemed appropriate by the department.

(B) The new budgeting methodology shall be clearly described, state the necessary data elements to be collected from the counties, and establish the timeframes for counties to provide the data to the state.

(C) The new budgeting methodology developed pursuant to this paragraph shall be implemented no sooner than the 2015–16 fiscal year. The department may develop a process for counties to phase in the requirements of the new budgeting methodology.

(D) The department shall provide the new budgeting methodology to the legislative fiscal committees by March 1 of the fiscal year immediately preceding the first fiscal year of implementation of the new budgeting methodology.

(E) To the extent that the funding for the county budgets developed pursuant to the new budget methodology is not fully appropriated in any given fiscal year, the department, with input from the counties, shall identify and consider options to align funding and workload responsibilities.

(F) For purposes of this paragraph, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

(G) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this paragraph by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 1, 2017, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the implementation of the new budgeting methodology pursuant to this paragraph, 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.

(b) Nothing in this section, Section 15204.5, or Section 18906 shall be construed to limit the administrative or budgetary responsibilities of the department in a manner that would violate Section 14100.1, and thereby jeopardize federal financial participation under the Medi-Cal program.

(c) (1) The Legislature finds and declares that in order for counties to do the work that is expected of them, it is necessary that they receive adequate funding, including adjustments for reasonable annual cost-of-doing-business increases. The Legislature further finds and declares that linking appropriate funding for county Medi-Cal administrative operations, including annual cost-of-doing-business adjustments, with performance standards will give counties the incentive to meet the performance standards and enable them to continue to do the work they do on behalf of the state. It is therefore the Legislature's intent, upon an appropriation by the Legislature for this purpose, to provide appropriate funding to the counties for the effective administration of the Medi-Cal program at the local level to ensure that counties can reasonably meet the purposes of the performance measures as contained in this section.

(2) It is the intent of the Legislature to not appropriate funds for the cost-of-doing-business adjustment for the 2008–09, 2009–10, 2010–11, 2011–12, 2012–13, 2014–15, 2015–16, 2016–17, and 2017–18 fiscal years and the 2024–25 to 2027–28, inclusive, fiscal years.

(d) The department is responsible for the Medi-Cal program in accordance with state and federal law. A county shall determine Medi-Cal eligibility in accordance with state and federal law. If in the course of its duties the department becomes aware of accuracy problems in any county, the department shall, within available resources, provide training and technical assistance as appropriate. This section shall not be interpreted to eliminate any remedy otherwise available to the department to enforce accurate county administration of the program. In administering the Medi-Cal eligibility process, each county shall meet the following performance standards each fiscal year:

(1) Complete eligibility determinations as follows:

(A) Ninety percent of the general applications without applicant errors and are complete shall be completed within 45 days.

(B) Ninety percent of the applications for Medi-Cal based on disability shall be completed within 90 days, excluding delays by the state.

(2) (A) The department shall establish best-practice guidelines for expedited enrollment of newborns into the Medi-Cal program, preferably with the goal of enrolling newborns within 10 days after the county is informed of the birth. The department, in consultation with counties and other stakeholders, shall work to develop a process for expediting enrollment for all newborns, including those born to mothers receiving CalWORKs assistance.

(B) Upon the development and implementation of the best-practice guidelines and expedited processes, the department and the counties may develop an expedited enrollment timeframe for newborns that is separate from the standards for all other applications, to the extent that the timeframe is consistent with these guidelines and processes.

(3) Perform timely annual redeterminations, as follows:

(A) Ninety percent of the annual redetermination forms shall be mailed to the recipient by the anniversary date.

(B) Ninety percent of the annual redeterminations shall be completed within 60 days of the recipient's annual redetermination date for those redeterminations based on forms that are complete and have been returned to the county by the recipient in a timely manner.

(C) Ninety percent of those annual redeterminations where the redetermination form has not been returned to the county by the recipient shall be completed by sending a notice of action to the recipient within 45 days after the date the form was due to the county.

(e) The department shall develop procedures in collaboration with the counties and stakeholder groups for determining county review cycles, sampling methodology and procedures, and data reporting.

(f) On January 1 of each year, each applicable county, as determined by the department, shall report to the department on the county's results in meeting the performance standards specified in this section. The report shall be subject to verification by the department. County reports shall be provided to the public upon written request.

(g) If the department finds that a county is not in compliance with one or more of the standards set forth in this section, the county shall, within 60 days, submit a corrective action plan to the department for approval. The corrective action plan shall, at a minimum, include steps that the county shall take to improve its performance on the standard or standards with which the county is out of compliance. The plan shall establish interim benchmarks for improvement that shall be expected to be met by the county in order to avoid a sanction.

(h) (1) If a county does not meet the performance standards for completing eligibility determinations and redeterminations as specified in this section, the department may, at its sole discretion, reduce the allocation of funds to that county in the following year by 2 percent. Any funds so reduced may be restored by the department if, in the determination of the department, sufficient improvement has been made by the county in meeting the performance standards during the year for which the funds were reduced. If the county continues not to meet the performance standards, the department may reduce the allocation by an additional 2 percent for each year thereafter in which sufficient improvement has not been made to meet the performance standards.

(2) No reduction of the allocation of funds to a county shall be imposed pursuant to this subdivision for failure to meet performance standards during any period of time in which the cost-of-doing-business increase is suspended.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and except as provided in subparagraph (G) of paragraph (6) of subdivision (a), the department shall, without taking any further regulatory action, implement, interpret, or make specific this section and any applicable federal waivers and state plan amendments by means of all-county letters or similar instructions.

SEC. 66. Section 14165.58 of the Welfare and Institutions Code is repealed.

SEC. 67. Section 14184.10 of the Welfare and Institutions Code is amended to read:

14184.10. For purposes of this article, the following definitions shall apply:

(a) “Demonstration project” means the California Medi-Cal 2020 Demonstration Project, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services, effective for the period from December 30, 2015, to December 31, 2020, inclusive, and any applicable extension period.

(b) “Demonstration term” means the entire period during which the demonstration project is in effect, as approved by the federal Centers for Medicare and Medicaid Services, including any applicable extension period.

(c) “Demonstration year” means the demonstration year as identified in the Special Terms and Conditions that corresponds to a specific period of time as set forth in paragraphs (1) to (6), inclusive. Individual programs under the demonstration project may be operated on program years that

differ from the demonstration years identified in paragraphs (1) to (6), inclusive.

(1) Demonstration year 11 corresponds to the period of January 1, 2016, to June 30, 2016, inclusive.

(2) Demonstration year 12 corresponds to the period of July 1, 2016, to June 30, 2017, inclusive.

(3) Demonstration year 13 corresponds to the period of July 1, 2017, to June 30, 2018, inclusive.

(4) Demonstration year 14 corresponds to the period of July 1, 2018, to June 30, 2019, inclusive.

(5) Demonstration year 15 corresponds to the period of July 1, 2019, to June 30, 2020, inclusive.

(6) Demonstration year 16 corresponds to the period of July 1, 2020, to December 31, 2020, inclusive.

(d) "Dental Transformation Initiative" or "DTI" means the waiver program intended to improve oral health services for children, as authorized under the Special Terms and Conditions and described in Section 14184.70.

(e) "Designated state health program" has the same meaning as set forth in the Special Terms and Conditions.

(f) (1) "Designated public hospital" means any one of the following hospitals, and any successor, including any restructured, reorganized, or differently named hospital, which is operated by a county, a city and county, the University of California, or a special hospital authority described in Chapter 5 (commencing with Section 101850) or Chapter 5.5 (commencing with Section 101852) of Part 4 of Division 101 of the Health and Safety Code, or any additional public hospital to the extent identified as a "designated public hospital" in the Special Terms and Conditions or, effective July 1, 2021, the CalAIM Terms and Conditions as defined in Section 14184.101. Unless otherwise provided for in law, in the California Medicaid State Plan, or in the Special Terms and Conditions, all references in law to a designated public hospital as defined in subdivision (d) of Section 14166.1 shall be deemed to refer to a hospital described in this section effective as of January 1, 2016, except as provided in paragraph (2) or, for a hospital not otherwise listed in subparagraphs (A) through (T), inclusive, as of the date specified in the applicable Terms and Conditions or State Plan amendment:

(A) UC Davis Medical Center.

(B) UC Irvine Medical Center.

(C) UC San Diego Medical Center, including, effective no sooner than January 1, 2024, the East Campus Medical Center formerly known as Alvarado Hospital Medical Center.

(D) UC San Francisco Medical Center.

(E) UCLA Medical Center.

(F) Santa Monica/UCLA Medical Center, also known as the Santa Monica-UCLA Medical Center and Orthopaedic Hospital.

(G) LA County Health System Hospitals:

(i) LA County Harbor/UCLA Medical Center.

(ii) LA County Olive View UCLA Medical Center.
(iii) LA County Rancho Los Amigos National Rehabilitation Center.
(iv) LA General Medical Center.
(H) Alameda Health System Hospitals, including the following:
(i) Highland Hospital, including the Fairmont and John George Psychiatric facilities.
(ii) Alameda Hospital.
(iii) San Leandro Hospital.
(I) Arrowhead Regional Medical Center.
(J) Contra Costa Regional Medical Center.
(K) Kern Medical Center.
(L) Natividad Medical Center.
(M) Riverside University Health System-Medical Center.
(N) San Francisco General Hospital.
(O) San Joaquin General Hospital.
(P) San Mateo Medical Center.
(Q) Santa Clara Valley Medical Center.
(R) Ventura County Medical Center.
(S) The following hospitals, effective no sooner than April 1, 2024:
(i) UCLA West Valley Medical Center (formerly West Hills Hospital and Medical Center).
(ii) UCI Health – Fountain Valley.
(iii) UCI Health – Lakewood.
(iv) UCI Health – Placentia Linda.
(v) UCI Health – Los Alamitos.
(T) The following hospitals, effective no sooner than the later of July 1, 2024, or the first day of the quarter following the closing of the applicable affiliation transaction with the University of California, San Francisco:
(i) UCSF Health – St. Mary's (formerly St. Mary's Medical Center).
(ii) UCSF Health – Saint Francis (formerly Saint Francis Memorial Hospital).
(2) For purposes of the following reimbursement methodologies, the hospitals identified in clauses (ii) and (iii) of subparagraph (H) of paragraph (1) shall be deemed to be a designated public hospital as of the following effective dates:
(A) For purposes of the fee-for-service payment methodologies established and implemented under Section 14166.4, the effective date shall be the date described in paragraph (3) of subdivision (a) of Section 14184.30.
(B) For purposes of Article 5.230 (commencing with Section 14169.50), the effective date shall be January 1, 2017.
(g) "Disproportionate share hospital provisions of the Medi-Cal State Plan" means those applicable provisions contained in Attachment 4.19-A of the California Medicaid state plan, approved by the federal Centers for Medicare and Medicaid Services, that implement the payment adjustment program for disproportionate share hospitals.

(h) "Federal disproportionate share hospital allotment" means the amount specified for California under Section 1396r-4(f) of Title 42 of the United States Code for a federal fiscal year.

(i) "Federal medical assistance percentage" means the federal medical assistance percentage applicable for federal financial participation purposes for medical services under the Medi-Cal State Plan pursuant to Section 1396b(a)(1) of Title 42 of the United States Code.

(j) "Global Payment Program" or "GPP" means the payment program authorized under the demonstration project and described in Section 14184.40 that assists participating public health care systems that provide health care for the uninsured and that promotes the delivery of more cost-effective, higher-value health care services and activities.

(k) "Nondesignated public hospital" means a public hospital as that term is defined in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(*l*) "Nonfederal share percentage" means the difference between 100 percent and the federal medical assistance percentage.

(m) "PRIME" means the Public Hospital Redesign and Incentives in Medi-Cal program authorized under the demonstration project and described in Section 14184.50.

(n) "Total computable disproportionate share hospital allotment" means the federal disproportionate share hospital allotment for a federal fiscal year, divided by the applicable federal medical assistance percentage with respect to that same federal fiscal year.

(o) "Special Terms and Conditions" means those terms and conditions issued by the federal Centers for Medicare and Medicaid Services, including all attachments to those terms and conditions and any subsequent amendments approved by the federal Centers for Medicare and Medicaid Services, that apply to the demonstration project.

(p) "Uninsured" means an individual for whom there is no source of third-party coverage for the health care services the individual receives, as determined pursuant to the Special Terms and Conditions.

(q) "Whole Person Care pilot program" means a local collaboration among local governmental agencies, Medi-Cal managed care plans, health care and behavioral health providers, or other community organizations, as applicable, that are approved by the department to implement strategies to serve one or more identified target populations, pursuant to Section 14184.60 and the Special Terms and Conditions.

SEC. 68. Section 14197.4 of the Welfare and Institutions Code is amended to read:

14197.4. (a) The Legislature finds and declares all of the following:

(1) Designated public hospital systems play an essential role in the Medi-Cal program, providing high-quality care to a disproportionate number of low-income Medi-Cal and uninsured populations in the state. Because Medi-Cal covers approximately one-third of the state's population, the strength of these essential public health care systems is of critical importance to the health and welfare of the people of California.

(2) Designated public hospital systems provide comprehensive health care services to low-income patients and lifesaving trauma, burn, and disaster-response services for entire communities, and train the next generation of doctors and other health care professionals, such as nurses and paramedical professionals, who are critical to new team-based care models that achieve more efficient and patient-centered care.

(3) The Legislature intends to continue to provide levels of support for designated public hospital systems in light of their reliance on Medi-Cal funding to provide quality care to everyone, regardless of insurance status, ability to pay, or other circumstance, the significant proportion of Medi-Cal services provided under managed care by these public hospital systems, and federal requirements related to Medicaid managed care.

(4) It is the intent of the Legislature that Medi-Cal managed care plans and designated public hospital systems that may enter into contracts to provide services for Medi-Cal beneficiaries shall in good faith negotiate for, and implement, contract rates, the provision and arrangement of services and member assignment that are sufficient to ensure continued participation by Medi-Cal managed care plans and designated public hospital systems and to maintain access to services for Medi-Cal managed care beneficiaries and other low-income patients.

(5) It is the intent of the Legislature that, in order to ensure both the financial viability of Medi-Cal managed care plans and support the participation of designated public hospital systems in Medi-Cal managed care, the department shall provide Medi-Cal managed care plans actuarially sound rates reflecting the directed contract services payments implemented to comply with federal requirements relating to Medicaid managed care.

(b) Commencing with the 2017–18 state fiscal year for designated public hospital systems, and commencing with the 2023 calendar year for district and municipal public hospitals, and for each state fiscal year or rate year, as applicable, thereafter, and notwithstanding any other law, the department shall require each Medi-Cal managed care plan to increase contract services payments to the designated public hospital systems and to district and municipal public hospitals by amounts determined under a directed payment methodology that meets federal requirements and as described in this subdivision. The directed payments may be determined and applied as distributions from directed payment pools, as uniform dollar or percentage increases, or on other bases, and may incorporate acuity adjustments or other factors.

(1) The directed payments may separately account for inpatient hospital services and noninpatient hospital services. The directed payments shall be developed and applied separately for classes of designated public hospital systems and district and municipal public hospitals. The department, in consultation with the designated public hospital systems and district and municipal public hospitals, as applicable, shall establish the classes of designated public hospital systems and district and municipal public hospitals, as applicable, consistent with the objectives set forth in subdivisions (a) and (d) and that take into account differences in services

provided, service delivery systems, and the level of risk assumed from Medi-Cal managed care plans. For designated public hospital systems, the factors to be considered shall include, but are not limited to, operation by the University of California, designated public hospital systems comprised of multiple acute care hospitals, level 1 or level 2 trauma designation, and the assumption of risk for the provision of inpatient hospital services.

(2) To the extent permitted by federal law and to meet the objectives identified in subdivisions (a) and (d), the department shall develop and implement the directed payment program in consultation with designated public hospital systems and district and municipal public hospitals or Medi-Cal managed care plans, or all, as follows:

(A) The department, in consultation with the designated public hospital systems and district and municipal public hospitals, as applicable, shall annually determine on a prospective basis the aggregate amount of payments that will be directed to each class of designated public hospital systems and district and municipal public hospitals pursuant to this subdivision and the classification of each designated public hospital system and district and municipal public hospital. Once the department determines the classification for each designated public hospital system and district and municipal public hospital for a particular state fiscal year or rate year, that classification shall not be eligible to change until no sooner than the subsequent year. For state fiscal years or rate years following the 2017–18 state fiscal year, the aggregate amounts of payments to a class of designated public hospital systems shall account for trend adjustments to the aggregate amounts available during the prior year, subject to any modifications to account for changes in the classification of designated public hospital systems, changes required by federal law, changes to account for the size of the payments made pursuant to subdivision (c), or other material changes.

(B) The department, in consultation with the designated public hospital systems and district and municipal public hospitals, as applicable, shall develop the methodologies for determining the required directed payments for each designated public hospital system and district and municipal public hospital.

(C) To the extent necessary to meet the objectives identified in subdivisions (a) and (d) or to comply with federal requirements, the department may, in consultation with the designated public hospital systems and district and municipal public hospitals, as applicable, adjust or modify the amounts of the aggregate directed payments for any class of designated public hospital systems and district and municipal public hospitals, the method for determining the distribution of the directed payment amounts within any class of designated public hospital systems and district and municipal public hospitals, and may modify, consolidate, or subdivide the classes of designated public hospital systems and district and municipal public hospitals established pursuant to paragraph (1).

(D) After the aggregate amounts and the distribution methodology of directed payments for each designated public hospital system and district and municipal public hospital class have been established, the department

shall consult with the designated public hospital systems, district and municipal public hospitals, and each affected Medi-Cal managed care plan with regard to the impact on the Medi-Cal managed care plan capitation ratesetting process and implementation of the directed payment requirements, including applicable interim and final payment processes, to ensure that 100 percent of the aggregate amounts are paid to the applicable designated public hospital system and district and municipal public hospital.

(3) The required directed payment amounts shall be paid by the Medi-Cal managed care plans as adjustments, in a form and manner specified by the department, to the total amounts of contract services payments otherwise paid to the designated public hospital systems and district and municipal public hospitals.

(4) The directed payments required under this subdivision shall be implemented and documented by each Medi-Cal managed care plan, designated public hospital system, and district and municipal public hospital, as applicable, in accordance with all of the following parameters and any guidance issued by the department:

(A) A Medi-Cal managed care plan and the designated public hospital systems and district and municipal public hospitals shall determine the manner, timing, and amount of payment for contract services, including through fee-for-service, capitation, or other permissible manner. The rates of payment for contract services agreed upon by the Medi-Cal managed care plan and the designated public hospital system and district and municipal public hospital, as applicable, shall be established and documented without regard to the directed payments and quality incentive payments required by this section.

(B) The required directed payment enhancements provided pursuant to this subdivision shall not supplant amounts that would otherwise be payable by a Medi-Cal managed care plan to a designated public hospital system or district and municipal public hospital for an applicable state fiscal year or rate year, and the Medi-Cal managed care plan shall not impose a fee or retention amount that would result in a direct or indirect reduction to the amounts required under this subdivision.

(C) A contract between a Medi-Cal managed care plan and a designated public hospital system or district and municipal public hospital shall not be terminated by either party for the specific purpose of circumventing or otherwise impacting the payment obligations implemented pursuant to this subdivision.

(D) If a Medi-Cal managed care plan subcontracts or delegates responsibility to a separate entity for either or both the arrangement or payment of services, the Medi-Cal managed care plan shall be responsible for paying the designated public hospital system and district and municipal public hospital, as applicable, the directed payment described in this subdivision with respect to the services it provides that are covered by that arrangement. The designated public hospital system or district and municipal public hospital, as applicable, and the applicable subcontractor or delegated entity shall work together with the Medi-Cal managed care plan to provide

the information necessary to facilitate the Medi-Cal managed care plan's compliance with the payment requirements under this subdivision.

(5) Each state fiscal year, a Medi-Cal managed care plan shall provide to the department, at the times and in the form and manner specified by the department, an accounting of amounts paid or payable to the designated public hospital systems and district and municipal public hospitals with which it contracts, including both contract rates and the directed payments, to demonstrate compliance with this subdivision. To the extent that the department determines that a Medi-Cal managed care plan is not in compliance with the requirements of this subdivision, or is otherwise circumventing the purposes thereof, to the material detriment of an applicable designated public hospital system, the department may, after providing notice of its determination to the affected Medi-Cal managed care plan and allowing a reasonable period for the Medi-Cal managed care plan to cure the specified deficiencies, reduce the default assignment into the Medi-Cal managed care plan with respect to all Medi-Cal managed care beneficiaries by up to 25 percent in the applicable county, so long as the other Medi-Cal managed care plan or Medi-Cal managed care plans in the applicable county have the capacity to receive the additional default membership. The department's determination whether to exercise discretion under this paragraph shall not be subject to judicial review, except that a Medi-Cal managed care plan that has its default assignment reduced pursuant to this paragraph may bring a writ of mandate under Section 1085 of the Code of Civil Procedure to rectify an abuse of discretion by the department under this paragraph. Nothing in this paragraph shall be construed to preclude or otherwise limit the right of any Medi-Cal managed care plan or designated public hospital system to pursue a breach of contract action, or any other available remedy as appropriate, in connection with the requirements of this subdivision.

(6) Capitation rates paid by the department to a Medi-Cal managed care plan shall be actuarially sound and account for the Medi-Cal managed care plan's obligation to pay the directed payments to designated public hospital systems and district and municipal public hospitals in accordance with this subdivision. The department may require Medi-Cal managed care plans and the designated public hospital systems and district and municipal public hospitals to submit information regarding contract rates and expected or actual utilization of services, at the times and in the form and manner specified by the department. To the extent consistent with federal law and actuarial standards of practice, the department shall utilize the most recently available data and reasonable projections, as determined by the department, when accounting for the directed payments required under this subdivision, and shall account for additional clinics, practices, or other health care providers added to a designated public hospital system or district and municipal public hospital. In implementing the requirements of this section, including the Medi-Cal managed care plan ratesetting process, the department may additionally account for material adjustments, as appropriate under federal law and actuarial standards, as described above, and as

determined by the department, to contracts entered into between a Medi-Cal managed care plan or applicable subcontracted or delegated entity and a designated public hospital system or district and municipal public hospital, as applicable.

(c) Commencing with the 2017–18 state fiscal year for designated public hospital systems, and commencing with the 2020–21 state fiscal year for district and municipal public hospitals, and for each state fiscal year or rate year, as applicable, thereafter, the department, in consultation with the designated public hospital systems, district and municipal public hospitals, and applicable Medi-Cal managed care plans, as applicable, shall establish and implement a program or programs under which a designated public hospital system or a district and municipal public hospital may earn performance-based quality incentive payments from the Medi-Cal managed care plan with which they contract in accordance with this subdivision.

(1) Payments shall be earned by each designated public hospital system based on its performance in achieving identified targets for quality of care.

(A) The department, in consultation with the designated public hospital systems and applicable Medi-Cal managed care plans, shall establish and provide a method for updating uniform performance measures for the performance-based quality incentive payment program and parameters for the designated public hospital systems to select the applicable measures. The performance measures shall advance at least one goal identified in the state's Medicaid quality strategy. Through and until June 30, 2020, performance measures pursuant to this subdivision shall not duplicate measures utilized in the PRIME program established pursuant to Section 14184.50.

(B) Each designated public hospital system shall submit reports to the department containing information required to evaluate its performance on all applicable performance measures, at the times and in the form and manner specified by the department. A Medi-Cal managed care plan shall assist a designated public hospital system in collecting and distributing information necessary for these reports.

(2) The department, in consultation with each designated public hospital system, shall determine a maximum amount that each class established pursuant to paragraph (1) of subdivision (b) may earn in quality incentive payments for the state fiscal year or rate year.

(3) The department shall calculate the amount earned by each designated public hospital system based on its performance score established pursuant to paragraph (1).

(A) This amount shall be paid to the designated public hospital system by each of its contracted Medi-Cal managed care plans. If a designated public hospital system contracts with multiple Medi-Cal managed care plans, the department shall identify each Medi-Cal managed care plan's proportionate amount of the designated public hospital system's payment. The timing and amount of the distributions and any related reporting requirements for interim payments shall be established and agreed to by the

designated public hospital system and each of the applicable Medi-Cal managed care plans.

(B) A contract between a Medi-Cal managed care plan and designated public hospital system shall not be terminated by either party for the specific purpose of circumventing or otherwise impacting the payment obligations implemented pursuant to this subdivision.

(C) Each Medi-Cal managed care plan shall be responsible for payment of the quality incentive payments described in this subdivision, subject to funding by the department pursuant to paragraph (5).

(4) Commencing with the 2020–21 state fiscal year, payments under this paragraph shall be earned by a district and municipal public hospital based on its performance in achieving identified targets for quality of care.

(A) The department, in consultation with district and municipal public hospitals, shall establish a class of district and municipal public hospitals, or multiple classes to the extent federal approval is available, for purposes of payments under this paragraph.

(B) The department, in consultation with district and municipal public hospitals, shall determine a maximum amount that the class, or classes, of district and municipal public hospitals established pursuant to subparagraph (A) may earn in quality incentive payments for an applicable state fiscal year or rate year.

(C) The department, in consultation with district and municipal public hospitals and applicable Medi-Cal managed care plans, shall establish and provide a method for updating uniform performance measures for the performance-based quality incentive payments and parameters for district and municipal public hospitals to select the applicable measures. The performance measures shall advance at least one goal identified in the state's Medicaid quality strategy.

(D) Each district and municipal public hospital shall submit reports to the department containing information required to evaluate its performance on all applicable performance measures, at the time and in the form and manner specified by the department. Medi-Cal managed care plans shall assist a district and municipal public hospital in collecting and distributing information necessary for these reports.

(E) The department shall calculate the amount earned by each district and municipal public hospital based on its performance score established pursuant to subparagraphs (C) and (D). This amount shall be paid to the district and municipal public hospital by each of its contracted Medi-Cal managed care plans. If a district and municipal public hospital contracts with multiple Medi-Cal managed care plans, the department shall identify each Medi-Cal managed care plan's proportionate amount of the district and municipal public hospital's payment. The timing and amount of the distributions and any related reporting requirements for interim payments shall be established and agreed to by the district and municipal public hospital and each of the applicable Medi-Cal managed care plans.

(F) A contract between a Medi-Cal managed care plan and district and municipal public hospital shall not be terminated by either party for the

specific purpose of circumventing or otherwise impacting the payment obligations implemented pursuant to this paragraph.

(G) Each Medi-Cal managed care plan shall be responsible for payment of the quality incentive payments described in this paragraph, subject to funding by the department pursuant to paragraph (5).

(5) The department shall provide appropriate funding to each Medi-Cal managed care plan, to account for and to enable them to make the quality incentive payments described in this subdivision, through the incorporation into actuarially sound capitation rates or any other federally permissible method. The amounts designated by the department for the quality incentive payments made pursuant to this subdivision shall be reserved for the purposes of the performance-based quality incentive payment program.

(d) (1) In determining the amount of the required directed payments described in paragraph (2) of subdivision (b), and the aggregate size of the quality incentive payment program described in paragraph (2) of subdivision (c), the department shall consult with designated public hospital systems to establish levels for these payments that, in combination with one another, are projected to result in aggregate payments that will advance the quality and access objectives reflected in prior payment enhancement mechanisms for designated public hospital systems. To the extent necessary to meet these objectives or to comply with any federal requirements, the department may, in consultation with the designated public hospital systems, adjust or modify either or both the directed payments or quality incentive payment program. Once these payment levels are established, the department shall consult with the designated public hospital systems and the Medi-Cal managed care plans in the development of the Medi-Cal managed care rates needed for the directed payments and the structure of the quality incentive payment program.

(2) (A) For the 2017–18 state fiscal year, the department shall, as soon as practicable after receipt of necessary federal approvals pursuant to paragraph (1) of subdivision (g), provide written notice of the directed payment and quality incentive payment amounts established pursuant to this section. A Medi-Cal managed care plan's obligation to pay the directed payments and quality incentive payments required under subdivisions (b) and (c), respectively, to a designated public hospital system for the 2017–18 state fiscal year shall be contingent on the receipt of the written notice described in this subparagraph.

(B) For each annual determination, commencing with the 2018–19 state fiscal year and each state fiscal year or rate year thereafter, the department shall provide written notice, as soon as practicable, to each affected Medi-Cal managed care plan, designated public hospital system, and, commencing with the 2020–21 state fiscal year, each district and municipal public hospital of the applicable Medi-Cal managed care plan's directed payment amounts, the classification of designated public hospital systems and district and municipal public hospitals, as applicable, quality incentive payment amounts, and any other information deemed necessary for the Medi-Cal managed care plan to fulfill its payment obligations under subdivisions (b) and (c),

as applicable, for the subject state fiscal year or rate year. If the modification of either or both directed payment amounts or quality incentive payment amounts is necessary after receipt of the written notification, the department shall notify the Medi-Cal managed care plan, designated public hospital system, and district and municipal public hospital, as applicable, in writing of the revised amounts before implementation of the revised amounts.

(e) (1) The provisions of paragraphs (3), (4), and (5) of subdivision (a), paragraphs (3) and (4) of subdivision (b), paragraphs (3) and (5) of subdivision (c), and paragraph (2) of subdivision (d) shall be deemed incorporated into each contract between a designated public hospital system and a Medi-Cal managed care plan, and its subcontractor or designee, as applicable, and any claim for breach of those provisions may be brought by the designated public hospital system or the Medi-Cal managed care plan directly in a court of competent jurisdiction.

(2) Commencing with the 2020–21 state fiscal year, the provisions of paragraph (4) of subdivision (c) and paragraph (2) of subdivision (d) shall be deemed incorporated into each contract between a district and municipal public hospital and a Medi-Cal managed care plan, and its subcontractor or designee, as applicable, and any claim for breach of those provisions may be brought by the district and municipal public hospital or the Medi-Cal managed care plan directly in a court of competent jurisdiction.

(f) (1) (A) The nonfederal share of the portion of the capitation rates specifically associated with directed payments required under subdivision (b) and the quality incentive payments established pursuant to subdivision (c) may consist of voluntary intergovernmental transfers of funds provided by designated public hospitals or district and municipal public hospitals and their affiliated governmental entities, or other public entities, pursuant to Section 14164. Upon providing any intergovernmental transfer of funds, each transferring entity shall certify that the transferred funds qualify for federal financial participation pursuant to applicable federal Medicaid laws, and in the form and manner specified by the department. Any intergovernmental transfer of funds made pursuant to this section shall be considered voluntary for purposes of all federal laws.

(B) Notwithstanding any other law, commencing with the 2025 calendar year, the department may, upon acceptance of the voluntary intergovernmental transfers described in subparagraph (A), assess a fee not to exceed 5 percent on intergovernmental transfers pursuant to this section to reimburse the department for the administrative costs of operating the programs pursuant to this section and for the support of the Medi-Cal program.

(2) (A) When applicable for voluntary intergovernmental transfers described in paragraph (1) that are associated with payments to designated public hospital systems, the department, in consultation with the designated public hospital systems, shall develop and maintain a protocol to determine the available funding for the nonfederal share associated with payments for each applicable state fiscal year or rate year pursuant to this section. The protocol developed and maintained pursuant to this paragraph shall account

for any applicable contributions made by public entities to the nonfederal share of Medi-Cal managed care expenditures, including, but not limited to, contributions previously made by those specific public entities for the 2015–16 state fiscal year pursuant to Section 14182.15 or 14199.2, but excluding any contributions made pursuant to Sections 14301.4 and 14301.5. Nothing in this section shall be construed to limit or otherwise alter any existing authority of the department to accept intergovernmental transfers for purposes of funding the nonfederal share of Medi-Cal managed care expenditures.

(B) When applicable for voluntary intergovernmental transfers described in paragraph (1) that are associated with payments to district and municipal public hospital systems, the department, in consultation with district and municipal public hospital systems, shall develop and maintain a protocol to determine the available funding for the nonfederal share associated with payments for each applicable state fiscal year or rate year pursuant to this section. Nothing in this section shall be construed to limit or otherwise alter any existing authority of the department to accept intergovernmental transfers for purposes of funding the nonfederal share of Medi-Cal managed care expenditures.

(g) (1) 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.

(2) For any state fiscal year in which this section is implemented, in whole or in part, and notwithstanding any other law, the department or a Medi-Cal managed care plan shall not be required to make any payment pursuant to Section 14182.15, 14199.2, or 14301.5. Nothing in this section shall be construed to preclude or otherwise impose limitations on payment amounts or arrangements that may be negotiated and agreed to between the relevant parties, including, but not limited to, the continuation of existing or the creation of new quality incentive or pay-for-performance programs in addition to the quality incentive payment program described in subdivision (c) and contract services payments that may be in excess of the directed payment amounts required under subdivision (b).

(h) (1) The department shall seek any necessary federal approvals for the directed payments and the quality incentive payments set forth in this section.

(2) The department shall consult with the designated public hospital systems and district and municipal public hospitals with regard to the development of the directed payment levels established pursuant to subdivisions (b) and (c) of this section, as applicable, and shall consult with designated public hospital systems, district and municipal public hospitals, and Medi-Cal managed care plans with regards to the implementation of payments under this section.

(3) The director, after consultation with the designated public hospital systems, district and municipal public hospitals, and Medi-Cal managed care plans, may modify the requirements set forth in this section to the extent necessary to meet federal requirements or to maximize available federal

financial participation. If federal approval is only available with significant limitations or modifications, or if there are changes to the federal Medicaid program that result in a loss of funding currently available to the designated public hospital systems or to the district and municipal public hospitals, the department shall consult with the designated public hospitals systems, the district and municipal public hospitals, and Medi-Cal managed care plans, as applicable, to consider alternative methodologies.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, provider bulletins, or other similar instructions, without taking regulatory action. The department shall make use of appropriate processes to ensure that affected designated public hospital systems, the district and municipal public hospitals, and Medi-Cal managed care plans, as applicable, are timely informed of, and have access to, applicable guidance issued pursuant to this authority, and that this guidance remains publicly available until all payments made pursuant to this section are finalized.

(j) (1) (A) Directed payments and quality incentive payments to designated public hospital systems pursuant to subdivisions (b) and (c) shall cease to be operative on the first day of the state fiscal year or rate year beginning on or after the date the department determines, after consultation with the designated public hospital systems, that implementation of this section is no longer financially or programmatically supportive of the Medi-Cal program. This determination shall be based solely on the following factors:

(i) The projected amount of nonfederal share funds available is insufficient to support implementation of the payments to designated public hospital systems pursuant to subdivisions (b) and (c) in the subject state fiscal year or rate year.

(ii) The degree to which the payment arrangements for designated public hospital systems will no longer materially advance the goals and objectives reflected in this section and in the department's managed care quality strategy drafted and implemented pursuant to Section 438.340 of Title 42 of the Code of Federal Regulations in the subject state fiscal year or rate year.

(B) In making its determination, the department shall consider all reasonable options for mitigating the circumstances set forth in subparagraph (A), including, but not limited to, options for curing projected funding shortfalls and options for program revisions and strategy updates to better coordinate payment requirements with the goals and objectives of this section and the managed care quality strategy.

(C) The department shall post notice of the determination on its internet website, and shall provide written notice of the determination to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(2) (A) Directed payments and quality incentive payments to district and municipal public hospitals pursuant to subdivisions (b) and (c) shall cease to be operative on the first day of the state fiscal year or rate year

beginning on or after the date the department determines, after consultation with the district and municipal public hospitals, that implementation of this section is no longer financially or programmatically supportive of the Medi-Cal program. This determination shall be based solely on the following factors:

(i) The projected amount of nonfederal share funds available is insufficient to support implementation of the payments to district and municipal hospitals pursuant to subdivisions (b) and (c) in the subject state fiscal year or rate year.

(ii) The degree to which the payment arrangement for district and municipal hospitals will no longer materially advance the goals and objectives reflected in this section and in the department's managed care quality strategy drafted and implemented pursuant to Section 438.340 of Title 42 of the Code of Federal Regulations in the subject state fiscal year or rate year.

(B) In making its determination, the department shall consider all reasonable options for mitigating the circumstances set forth in subparagraph (A), including, but not limited to, options for curing projected funding shortfalls and options for program revisions and strategy updates to better coordinate payment requirements with the goals and objectives of this section and the managed care quality strategy.

(C) The department shall post notice of the determination on its internet website, and shall provide written notice of the determination to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(k) The department, in consultation with the designated public hospital systems and the Medi-Cal managed care plans, shall provide the Legislature with the federally approved evaluation plan required in Section 438.6(c)(2)(i)(D) of Title 42 of the Code of Federal Regulations to measure the degree to which the payments authorized under this section advance at least one of the goals and objectives of the department's managed care quality strategy. The department, in consultation with the designated public hospital systems and the Medi-Cal managed care plans, shall report to the Legislature the results of this evaluation once the department determines that the evaluation is finalized and complete according to the terms of any applicable federal approval and no earlier than January 1, 2021.

(*l*) (1) The department may, after consultation with the designated public hospital systems, the district and municipal public hospitals, and Medi-Cal managed care plans, as applicable, exclude certain Medi-Cal managed care enrollee categories of aid, or subcategories thereof, or certain categories of medical assistance provided under a Medi-Cal managed care plan, or subcategories thereof, from the definition of "contract services payments" for purposes of the directed payment requirements described in subdivision (b).

(2) The department shall seek federal approval to implement this subdivision.

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

(1) "Contract services payments" means the amount paid or payable to a designated public hospital system, including amounts paid or payable under fee-for-service, capitation amounts before any adjustments for service payment withholds or deductions, or payments made on any other basis, under a network provider contract with a Medi-Cal managed care plan for medically necessary and covered services, drugs, supplies, or other items provided to an eligible Medi-Cal beneficiary enrolled in the Medi-Cal managed care plan, excluding services provided to individuals who are dually eligible for both the Medicare and Medi-Cal programs and any additional exclusions that are approved pursuant to subdivision (*l*). Contract services includes all covered services, drugs, supplies, or other items the designated public hospital system provides, or is responsible for providing, or arranging or paying for, pursuant to a network provider contract entered into with a Medi-Cal managed care plan. If a Medi-Cal managed care plan subcontracts or delegates responsibility to a separate entity for either or both the arrangement or payment of services, "contract services payments" also include amounts paid or payable for the services provided by, or otherwise the responsibility of, the designated public hospital system that are within the scope of services of the subcontracted or delegated arrangement so long as the designated public hospital system holds a network provider contract with the primary Medi-Cal managed care plan.

(2) "Designated public hospital" has the same meaning as set forth in subdivision (f) of Section 14184.10.

(3) "Designated public hospital system" means a designated public hospital and its affiliated government entity clinics, practices, and other health care providers, including the respective affiliated hospital authority and county government entities described in Chapter 5 (commencing with Section 101850) and Chapter 5.5 (commencing with Section 101852), of Part 4 of Division 101 of the Health and Safety Code.

(4) (A) "Medi-Cal managed care plan" means an applicable organization or entity that enters into a contract with the department pursuant to any of the following:

(i) Article 2.7 (commencing with Section 14087.3).

(ii) Article 2.8 (commencing with Section 14087.5).

(iii) Article 2.81 (commencing with Section 14087.96).

(iv) Article 2.82 (commencing with Section 14087.98).

(v) Article 2.91 (commencing with Section 14089).

(vi) Chapter 8 (commencing with Section 14200).

(B) "Medi-Cal managed care plan" does not include any of the following:

(i) A mental health plan contracting to provide mental health care for Medi-Cal beneficiaries pursuant to Chapter 8.9 (commencing with Section 14700).

(ii) A plan not covering inpatient services, such as primary care case management plans, operating pursuant to Section 14088.85.

(iii) A Program of All-Inclusive Care for the Elderly organization operating pursuant to Chapter 8.75 (commencing with Section 14591).

(5) "Network provider" has the same meaning as that term is defined in Section 438.2 of Title 42 of the Code of Federal Regulations, and does not include arrangements where a designated public hospital system or a district and municipal public hospital provides or arranges for services under an agreement intended to cover a specific range of services for a single identified patient for a single inpatient admission, including any directly related followup care, outpatient visit or service, or other similar patient specific nonnetwork contractual arrangement, such as a letter of agreement or single case agreement, with a Medi-Cal managed care plan or subcontractor of a Medi-Cal managed care plan.

(6) "District and municipal public hospital" means a nondesignated public hospital, as defined in subdivision (k) of Section 14184.10, that is a contracted network provider of one or more Medi-Cal managed care plans, and that had an approved project plan under the PRIME program established pursuant to Section 14184.50 or is otherwise authorized to participate in a quality incentive directed payment program pursuant to the applicable terms of federal approval obtained by the department pursuant to paragraph (1) of subdivision (h).

SEC. 69. Section 14197.6 is added to the Welfare and Institutions Code, to read:

14197.6. (a) For purposes of this section, the following definitions apply:

(1) "Children's hospital" has the same meaning as that term is defined in Section 10727.

(2) "Medi-Cal managed care plan" has the same meaning as that term is defined in subdivision (j) of Section 14184.101.

(b) Notwithstanding any other law, for dates of service no sooner than July 1, 2024, the department shall establish a directed payment reimbursement methodology, or revise one or more existing directed payment reimbursement methodologies, applicable to children's hospitals. Medi-Cal managed care plans shall reimburse children's hospitals in accordance with the requirements of the directed payment arrangement established by the department pursuant to this section and guidance issued pursuant to subdivision (e).

(c) The department shall establish the form and manner of the directed payments authorized pursuant to this section, in consultation with representatives of children's hospitals and 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.

(d) In implementing this section, the department shall seek any federal approvals that it deems necessary. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(e) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section, in whole

or in part, by means of all-county letters, plan letters, provider bulletins, information notices, or other similar instructions, without taking any further regulatory action.

(f) The department shall develop the methodologies and parameters for the payments implemented pursuant to subdivisions (b) and (c) and may revise the methodologies and parameters for purposes, including, but not limited to, obtaining or maintaining any necessary federal approvals as required by subdivision (d).

(g) Commencing no sooner than July 1, 2024, and notwithstanding Section 13340 of the Government Code, one hundred fifteen million dollars ($115,000,000) annually shall be continuously appropriated to the department from the General Fund to support the payments implemented pursuant to this section, except that such amount may be adjusted pursuant to subdivision (h).

(h) If the Protect Access to Healthcare Act of 2024 (A.G. No. 23-0024) is approved by the voters, and if children's hospitals receive increased reimbursement rates or payments pursuant to Section 14199.108, 14199.108.3, 14199.112, or 14199.116, or if children's hospitals receive increased reimbursement rates or payments funded pursuant to subdivision (c) of Section 14105.200, then the amount available for directed payments to children's hospitals as specified in subdivision (g) and the amount directed pursuant to subdivision (c) may be reduced by the estimated total amount of such increases, as determined by the Department of Health Care Services, in an amount not to exceed seventy-five million dollars ($75,000,000) annually.

(i) It is the intent of the Legislature that the payments implemented pursuant to this section are to augment amounts that would otherwise be payable to children's hospitals by a Medi-Cal managed plan or the department. It is not the intent of the Legislature that the payments implemented pursuant to this section replace amounts that would otherwise be payable by a Medi-Cal managed care plan or the department to children's hospitals.

SEC. 70. Section 14197.7 of the Welfare and Institutions Code, as amended by Section 110 of Chapter 790 of the Statutes of 2023, is amended to read:

14197.7. (a) Notwithstanding any other law, if the director finds that any 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. 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) Except when the director determines that 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. The department shall present evidence at the hearing showing good cause for the termination. 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. 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 persons and organizations as the director may deem necessary. 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 any 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 any 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 any federal or state statute or regulation.

(2) The contractor violates any provision of its contract with the department.

(3) The contractor violates any 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) Any other mitigating factors presented by the contractor.

(h) 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 as the director may deem necessary. The notice shall include the effective date for, the duration of, and the reason for each sanction proposed by the director. 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. 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) 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. 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. The contractor shall have 30 calendar days from the date of receipt of the notice to file a written appeal with the department. 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. The hearing may be continued at the request of the contractor if a continuance is necessary to permit presentation of an adequate defense. 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 after the original hearing has been completed. 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.

(*l*) (1) Except as provided in paragraph (2), a contractor may request a hearing in connection with any 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. The department shall stay collection of monetary sanctions upon receipt of the request for a hearing. Collection of the sanction shall remain stayed until the effective date of the final decision of the department.

(2) With respect to mental health plans, the due process and appeals process specified in paragraph (4) of subdivision (b) of Section 14718 shall be made available in connection with any contract termination actions, temporary suspension orders, temporary withholds of funds pursuant to subdivision (o), and sanctions applied pursuant to subdivision (d) or (e).

(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 (4), 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 any other mental health or substance use disorder realignment funds 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).

(o) (1) Whenever the department determines that a mental health plan or any 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, or 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). 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. 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 mental health plan, or any 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). 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 to 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) 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). The department shall notify the Department of Finance of the percentage reduction for the affected county. 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. 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. 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.

(r) (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, 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.

(2) By July 1, 2025, the department shall adopt any regulations necessary to implement this section in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

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

(t) For purposes of this section, "contractor" means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(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.

(u) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on January 1, 2025, and as of that date is repealed.

SEC. 71. Section 14197.7 of the Welfare and Institutions Code, as added by Section 111 of Chapter 790 of the Statutes of 2023, 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.

(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. 72. Section 14199.72 of the Welfare and Institutions Code is amended to read:

14199.72. (a) Upon appropriation by the Legislature of funds for this purpose, the department shall establish a clinic workforce stabilization retention payment program to provide funds to eligible qualified clinics to make retention payments to their eligible employees for the public purposes specified in Section 14199.70.

(b) The department shall determine the conditions and data reporting requirements for qualified clinics to be eligible to receive funds. Within 90 days of the effective date of the act that added this article, the department shall notify all qualified clinics of those conditions and requirements, as well as the relevant portions of this article, including, but not limited to, the date of record set by the department, the information qualified clinics are required to submit pursuant to subdivision (c), the methodology for calculation of funds to be distributed pursuant to subdivision (d), how to pay retention payments pursuant to subdivision (e), and the consequences of noncompliance pursuant to Section 14199.74.

(c) (1) Each qualified clinic that intends to request funding shall submit the following information to the department no later than 30 days after the date of record:

(A) The name and mailing address of each eligible employee.

(B) The employee's professional license, certification, or registration, if applicable.

(C) Any other information as required by the department for purposes of implementing this article.

(2) The possession of a professional license, certification, or registration is not required for an employee to be eligible for a payment. All eligible employees, as defined in subdivision (c) of Section 14199.71, are eligible to receive payments.

(3) The information required by this section shall include an attestation, made under penalty of perjury, that the qualified clinic employee did not receive funds pursuant to the Hospital and Skilled Nursing Facility COVID-19 Retention Pay program set forth in Part 4.6 (commencing with Section 1490) of Division 2 of the Labor Code.

(d) The department shall distribute funds to each eligible qualified clinic based on the total number of eligible employees reported pursuant to subdivision (c). The amount of the payment shall be up to one thousand dollars ($1,000) per eligible employee, subject to available funding, and reduced on a pro rata basis if the requests exceed the amount of funds available. The department may distribute these funds to eligible qualified clinics using the existing Medi-Cal Checkwrite system.

(e) Within 60 days of receipt of funds from the department, a qualified clinic shall pay eligible employees a retention payment in the amount of up to one thousand dollars ($1,000) if no pro rata reduction is made pursuant to subdivision (d), or the pro rata reduced amount if a pro rata reduction is made pursuant to subdivision (d). An eligible employee who leaves employment between the date of record and the date a qualified clinic pays retention payments shall not be eligible for retention payments. Each qualified clinic that receives funds shall attest, in a form and manner specified by the department, and under penalty of perjury, that all funding received pursuant to this section, with the exception of any funding requested for eligible employees who left employment after the date of record, was provided to eligible employees within 60 days of receipt from the department. Each qualified clinic that receives funds shall immediately return to the department any funding received pursuant to this section that is not distributed within the timeline set forth in this subdivision, including funds that the department provided for eligible employees who left employment after the date of record.

(f) The department shall post on its internet website the amount each clinic site received, and the total number of eligible employees reported by each clinic pursuant to subdivision (c).

(g) A qualified clinic shall not use retention payment funding to supplant other payments from the qualified clinic to eligible employees.

SEC. 73. Section 14705 of the Welfare and Institutions Code is amended to read:

14705. (a) (1) This section shall apply to specialty mental health services provided by counties to Medi-Cal eligible individuals. Counties shall provide services to Medi-Cal beneficiaries and seek the maximum

federal reimbursement possible for services rendered to persons with mental illnesses.

(2) To the extent permitted under federal law and Section 5892, funds distributed to the counties from the Mental Health Subaccount, the Mental Health Equity Subaccount, and the Vehicle License Collection Account of the Local Revenue Fund, funds from the Mental Health Account and the Behavioral Health Subaccount of the Local Revenue Fund 2011, funds from the Behavioral Health Services Fund, and any other funds from which the Controller makes distributions to the counties may be used to pay for services provided by these funds that the counties can then certify as public expenditures in order to achieve the maximum federal reimbursement possible for services pursuant to this chapter.

(3) The standards and guidelines for the administration of specialty mental health services to Medi-Cal eligible persons shall be consistent with federal Medicaid requirements, as specified in the approved Medicaid state plan and waivers to ensure full and timely federal reimbursement to counties for services that are rendered and claimed consistent with federal Medicaid requirements.

(b) With regard to each person receiving specialty mental health services from a mental health plan, the mental health plan shall verify whether the person is Medi-Cal eligible and, if determined to be Medi-Cal eligible, the person shall be referred when appropriate to a facility, clinic, or program that is certified for Medi-Cal reimbursement.

(c) With regard to county operated facilities, clinics, or programs for which claims are submitted to the department for Medi-Cal reimbursement for specialty mental health services to Medi-Cal eligible individuals, the county shall ensure that all requirements necessary for Medi-Cal reimbursement for these services are complied with, including, but not limited to, utilization review and the submission of yearend cost reports by December 31 following the close of the fiscal year.

(d) Counties shall certify to the state that they have incurred public expenditures prior to requesting the reimbursement of federal funds.

SEC. 74. Section 15832 of the Welfare and Institutions Code, as amended by Section 162 of Chapter 42 of the Statutes of 2023, is amended to read:

15832. (a) To be eligible to participate in the program, a person shall meet all of the requirements in either paragraph (1) or (2):

(1) (A) Be pregnant or in the postpartum period as specified in Section 15840 and a resident of the state. A person who is a member of a federally recognized California Indian tribe is a resident of the state for these purposes.

(B) Have a household income that is above 208 percent of the official federal poverty level but does not exceed 317 percent of the official federal poverty level.

(C) Agree to the payment of the complete subscriber contribution. A federally recognized California Indian tribal government may make the subscriber contributions on behalf of a member of the tribe only if a contribution on behalf of members of federally recognized California Indian tribes does not limit or preclude federal financial participation under Title

XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.). If a federally recognized California Indian tribal government makes a contribution on behalf of a member of the tribe, the tribal government shall ensure that the subscriber is made aware of all the health care delivery options available in the county where the member resides.

(2) (A) Be a child under two years of age who is delivered by a mother enrolled in the program under this chapter. Except as stated in this section, these infants shall be automatically enrolled in the program.

(B) For the applicable month, not be enrolled in employer-sponsored health care coverage, or have been enrolled in that health care coverage in the prior three months or enrolled in full-scope Medi-Cal without a share of cost. Exceptions may be identified in regulations or other guidance and shall, at minimum, include all exceptions applicable to the Healthy Families Program on and after March 23, 2010.

(C) Be subject to subscriber contributions as determined by the department.

(3) For infants identified in paragraph (2), all of the following shall apply:

(A) Enrollment in the program shall cover the first 12 months of the infant's life unless the infant is determined eligible for Medi-Cal benefits under Section 14005.26. An infant shall be screened for eligibility under Section 14005.26 immediately after the infant is born. If the infant is eligible under Section 14005.26, the infant shall be automatically enrolled in the Medi-Cal program on that basis.

(B) (i) At the end of the 12 months, as a condition of continued eligibility, the subscriber shall provide income information. The infant shall be disenrolled from the program if the annual household income exceeds 317 percent of the federal poverty level, or if the infant is eligible for full-scope Medi-Cal with no share of cost.

(ii) Effective January 1, 2014, when determining eligibility for benefits under the program, income shall be determined, counted, and valued in accordance with the requirements of Section 1397bb(b)(1)(B) of Title 42 of the United States Code as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148) and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

(C) At the end of their first and second year in the program, infants shall be screened for eligibility for the Medi-Cal program.

(4) If at any time the director determines that the eligibility criteria established under this chapter for the program may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), any amendment or extension of that act, or any similar federal legislation affecting federal financial participation, the director may alter the eligibility criteria to the extent necessary for the state to receive that federal financial participation.

(5) (A) Effective July 1, 2024, or the effective date for implementation of the Children's Presumptive Eligibility Program portal pursuant to Section 14011.7, whichever is later, all qualified Medi-Cal providers participating

in presumptive eligibility programs shall use the electronic Newborn Hospital Gateway process, as described in Section 14148.04, to report the birth of an infant eligible under this chapter who is born in their facilities, including hospitals, birthing centers, or other birthing settings, within 72 hours after the birth, or one business day after discharge, whichever is sooner.

(B) The inclusion of infants eligible under this chapter in the Newborn Hospital Gateway process shall commence on July 1, 2024, or on the effective date for implementation of the Children's Presumptive Eligibility Program portal pursuant to Section 14011.7, whichever is later.

(b) (1) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election and the conditions described in paragraph (1) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2025, or the date certified by the department pursuant to paragraph (2) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

(2) If the voters do not approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election and the conditions described in paragraph (1) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2026, or the date certified by the department pursuant to paragraph (2) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

SEC. 75. Section 15832 of the Welfare and Institutions Code, as amended by Section 163 of Chapter 42 of the Statutes of 2023, is amended to read:

15832. (a) To be eligible to participate in the program, a person shall meet all of the requirements in either paragraph (1) or (2):

(1) (A) Be pregnant or in the postpartum period as specified in Section 15840 and a resident of the state. A person who is a member of a federally recognized California Indian tribe is a resident of the state for these purposes.

(B) Have a household income that is above 208 percent of the official federal poverty level but does not exceed 317 percent of the official federal poverty level.

(C) Agree to the payment of the complete subscriber contribution. A federally recognized California Indian tribal government may make the subscriber contributions on behalf of a member of the tribe only if a contribution on behalf of members of federally recognized California Indian tribes does not limit or preclude federal financial participation under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.). If a federally recognized California Indian tribal government makes a contribution on behalf of a member of the tribe, the tribal government shall ensure that the subscriber is made aware of all the health care delivery options available in the county where the member resides.

(2) (A) Be a child under two years of age who is delivered by a mother enrolled in the program under this chapter. Except as stated in this section, these infants shall be automatically enrolled in the program.

(B) For the applicable month, not be enrolled in employer-sponsored health care coverage, or have been enrolled in that health care coverage in the prior three months or enrolled in full-scope Medi-Cal without a share of cost. Exceptions may be identified in regulations or other guidance and shall, at minimum, include all exceptions applicable to the Healthy Families Program on and after March 23, 2010.

(C) Be subject to subscriber contributions as determined by the department.

(3) For infants identified in paragraph (2), all of the following shall apply:

(A) Enrollment in the program shall cover the first 12 months of the infant's life unless the infant is determined eligible for Medi-Cal benefits under Section 14005.26. An infant shall be screened for eligibility under Section 14005.26 immediately after the infant is born. If the infant is eligible under Section 14005.26, the infant shall be automatically enrolled in the Medi-Cal program on that basis.

(B) (i) At the end of the 12 months, the infant shall remain continuously eligible for the Medi-Cal program until they are five years of age. A redetermination of Medi-Cal eligibility shall not be conducted before the child reaches five years of age, except as specified in Section 14005.255. This clause shall be implemented to the extent that any necessary federal approvals are obtained and federal financial participation is available. The department shall seek any necessary federal approvals to implement this clause.

(ii) Effective January 1, 2014, when determining eligibility for benefits under the program, income shall be determined, counted, and valued in accordance with the requirements of Section 1397bb(b)(1)(B) of Title 42 of the United States Code as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148) and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

(C) At the end of their first and second year in the program, and subsequent years, up to five years of age, the child shall be screened for eligibility for the Medi-Cal program.

(4) If at any time the director determines that the eligibility criteria established under this chapter for the program may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), any amendment or extension of that act, or any similar federal legislation affecting federal financial participation, the director may alter the eligibility criteria to the extent necessary for the state to receive that federal financial participation.

(5) (A) Effective July 1, 2024, or the effective date for implementation of the Children's Presumptive Eligibility Program portal pursuant to Section 14011.7, whichever is later, all qualified Medi-Cal providers participating in presumptive eligibility programs shall use the electronic Newborn Hospital

Gateway process, as described in Section 14148.04, to report the birth of an infant eligible under this chapter who is born in their facilities, including hospitals, birthing centers, or other birthing settings, within 72 hours after the birth, or one business day after discharge, whichever is sooner.

(B) The inclusion of infants eligible under this chapter in the Newborn Hospital Gateway process shall commence on July 1, 2024, or on the effective date for implementation of the Children's Presumptive Eligibility Program portal pursuant to Section 14011.7, whichever is later.

(b) (1) Implementation of this section is contingent on all of the following conditions:

(A) All necessary federal approvals have been obtained by the department pursuant to subdivision (d).

(B) The Legislature has appropriated funding to implement this section after a determination that ongoing General Fund resources are available to support the ongoing implementation of this section in the 2024–25 fiscal year and subsequent fiscal years.

(C) The department has determined that systems have been programmed to implement this section.

(2) The department shall issue a declaration certifying the date that all conditions in paragraph (1) have been met. The department shall post the declaration on its internet website and provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

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

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

(e) (1) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, this section shall become operative on January 1, 2025, or the date certified by the department pursuant to paragraph (2) of subdivision (b), whichever is later.

(2) If the voters do not approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, this section shall be repealed as of January 1, 2025.

SEC. 76. Section 15832 is added to the Welfare and Institutions Code, to read:

15832. (a) To be eligible to participate in the program, a person shall meet all of the requirements in either paragraph (1) or (2):

(1) (A) Be pregnant or in the postpartum period as specified in Section 15840 and a resident of the state. A person who is a member of a federally recognized California Indian tribe is a resident of the state for these purposes.

(B) Have a household income that is above 208 percent of the official federal poverty level but does not exceed 317 percent of the official federal poverty level.

(C) Agree to the payment of the complete subscriber contribution. A federally recognized California Indian tribal government may make the subscriber contributions on behalf of a member of the tribe only if a contribution on behalf of members of federally recognized California Indian tribes does not limit or preclude federal financial participation under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.). If a federally recognized California Indian tribal government makes a contribution on behalf of a member of the tribe, the tribal government shall ensure that the subscriber is made aware of all the health care delivery options available in the county where the member resides.

(2) (A) Be a child under two years of age who is delivered by a mother enrolled in the program under this chapter. Except as stated in this section, these infants shall be automatically enrolled in the program.

(B) For the applicable month, not be enrolled in employer-sponsored health care coverage, or have been enrolled in that health care coverage in the prior three months or enrolled in full-scope Medi-Cal without a share of cost. Exceptions may be identified in regulations or other guidance and shall, at minimum, include all exceptions applicable to the Healthy Families Program on and after March 23, 2010.

(C) Be subject to subscriber contributions as determined by the department.

(3) For infants identified in paragraph (2), all of the following shall apply:

(A) Enrollment in the program shall cover the first 12 months of the infant's life unless the infant is determined eligible for Medi-Cal benefits under Section 14005.26. An infant shall be screened for eligibility under Section 14005.26 immediately after the infant is born. If the infant is eligible under Section 14005.26, the infant shall be automatically enrolled in the Medi-Cal program on that basis.

(B) (i) At the end of the 12 months, the infant shall remain continuously eligible for the Medi-Cal program until they are five years of age. A redetermination of Medi-Cal eligibility shall not be conducted before the child reaches five years of age, except as specified in Section 14005.255. This clause shall be implemented to the extent that any necessary federal approvals are obtained and federal financial participation is available. The department shall seek any necessary federal approvals to implement this clause.

(ii) Effective January 1, 2014, when determining eligibility for benefits under the program, income shall be determined, counted, and valued in accordance with the requirements of Section 1397bb(b)(1)(B) of Title 42 of the United States Code as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148) and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

(C) At the end of their first and second year in the program, and subsequent years, up to five years of age, the child shall be screened for eligibility for the Medi-Cal program.

(4) If at any time the director determines that the eligibility criteria established under this chapter for the program may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), any amendment or extension of that act, or any similar federal legislation affecting federal financial participation, the director may alter the eligibility criteria to the extent necessary for the state to receive that federal financial participation.

(5) (A) Effective July 1, 2024, or the effective date for implementation of the Children's Presumptive Eligibility Program portal pursuant to Section 14011.7, whichever is later, all qualified Medi-Cal providers participating in presumptive eligibility programs shall use the electronic Newborn Hospital Gateway process, as described in Section 14148.04, to report the birth of an infant eligible under this chapter who is born in their facilities, including hospitals, birthing centers, or other birthing settings, within 72 hours after the birth, or one business day after discharge, whichever is sooner.

(B) The inclusion of infants eligible under this chapter in the Newborn Hospital Gateway process shall commence on July 1, 2024, or on the effective date for implementation of the Children's Presumptive Eligibility Program portal pursuant to Section 14011.7, whichever is later.

(b) (1) Implementation of this section is contingent on both of the following conditions:

(A) All necessary federal approvals have been obtained by the department pursuant to subdivision (d).

(B) The department has determined that systems have been programmed to implement this section.

(2) The department shall issue a declaration certifying the date that all conditions in paragraph (1) have been met. The department shall post the declaration on its internet website and provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

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

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

(e) (1) If the voters do not approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, this section shall become operative on January 1, 2026, or the date certified by the department pursuant to paragraph (2) of subdivision (b), whichever is later.

(2) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, this section is repealed as of January 1, 2025.

SEC. 77. Section 15840 of the Welfare and Institutions Code, as amended by Section 138 of Chapter 47 of the Statutes of 2022, is amended to read:

15840. (a) (1) At a minimum, coverage provided pursuant to this chapter shall be provided to subscribers during one pregnancy, and until the end of the month in which the 60th day after pregnancy occurs, and to eligible children less than two years of age who were born of a pregnancy covered under this program or the Access for Infants and Mothers program under former Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code to a woman enrolled in the Access for Infants and Mothers program.

(2) (A) Upon the effective date reflected in any necessary federal approvals obtained by the department pursuant to subdivision (c) of Section 14005.185, a subscriber described in paragraph (1) shall be eligible for an additional 10-month period following the 60-day postpartum period, for a total of 12 months of continuous eligibility after the end of pregnancy.

(B) This paragraph shall be implemented only if, and to the extent that, any necessary federal approvals are obtained pursuant to Section 14005.185 and federal financial participation is available, and subject to an annual appropriation by the Legislature for this purpose.

(b) Coverage provided pursuant to this chapter shall include, at a minimum, those services required to be provided by health care service plans approved by the Secretary of Health and Human Services as a federally qualified health care service plan pursuant to Section 417.101 of Title 42 of the Code of Federal Regulations.

(c) Medically necessary prescription drugs shall be a required benefit in the coverage provided pursuant to this chapter.

(d) To the extent required pursuant to Section 15818 to comply with paragraph (1) of subdivision (b) of Section 30122 of the Revenue and Taxation Code, health education services related to tobacco use shall be a benefit in the coverage provided under this chapter.

(e) (1) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, and the conditions described in paragraph (1) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2025, or the date certified by the department pursuant to paragraph (2) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

(2) If the voters do not approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, and the conditions described in paragraph (1) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, have been met, this section shall become inoperative

on January 1, 2026, or the date certified by the department pursuant to paragraph (2) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

SEC. 78. Section 15840 of the Welfare and Institutions Code, as added by Section 137 of Chapter 47 of the Statutes of 2022, is amended to read:

15840. (a) (1) At a minimum, coverage provided pursuant to this chapter shall be provided to subscribers during one pregnancy, and until the end of the month in which the 60th day after pregnancy occurs, and to eligible children less than two years of age, or less than five years of age pursuant to Section 15832, who were born of a pregnancy covered under this program or the Access for Infants and Mothers program under former Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code to a person enrolled in the Access for Infants and Mothers program.

(2) (A) Upon the effective date reflected in any necessary federal approvals obtained by the department pursuant to subdivision (c) of Section 14005.185, a subscriber described in paragraph (1) shall be eligible for an additional 10-month period following the 60-day postpartum period, for a total of 12 months of continuous eligibility after the end of pregnancy.

(B) This paragraph shall be implemented only if, and to the extent that, any necessary federal approvals are obtained pursuant to Section 14005.185 and federal financial participation is available, and subject to an annual appropriation by the Legislature for this purpose.

(b) Coverage provided pursuant to this chapter shall include, at a minimum, those services required to be provided by health care service plans approved by the Secretary of Health and Human Services as a federally qualified health care service plan pursuant to Section 417.101 of Title 42 of the Code of Federal Regulations.

(c) Medically necessary prescription drugs shall be a required benefit in the coverage provided pursuant to this chapter.

(d) To the extent required pursuant to Section 15818 to comply with paragraph (1) of subdivision (b) of Section 30122 of the Revenue and Taxation Code, health education services related to tobacco use shall be a benefit in the coverage provided under this chapter.

(e) (1) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, this section shall become operative on January 1, 2025, or the date certified by the department pursuant to paragraph (2) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

(2) If the voters do not approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, this section shall become operative on January 1, 2026, or the date certified by the department pursuant to paragraph (2) of subdivision (b) of Section 15832, as added by Section 137 of the act that

added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

SEC. 79. Section 15853 of the Welfare and Institutions Code, as amended by Section 20 of Chapter 738 of the Statutes of 2022, is amended to read:

15853. (a) (1) An applicant that will provide an intergovernmental transfer may submit a proposal to the department for funding for the purpose of providing comprehensive health insurance coverage to any child who meets citizenship and immigration status requirements that are applicable to persons participating in the program established by Title XXI of the Social Security Act, and whose family income is at or below 317 percent of the federal poverty level or, at the option of the applicant, at or below 411 percent of the federal poverty level, in specific geographic areas, as published quarterly in the Federal Register by the United States Department of Health and Human Services, as determined, counted and valued in accordance with the requirements of Section 1396a(e)(14) of Title 42 of the United States Code, as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148) and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments, and which child meets both of the following requirements:

(A) Does not qualify for the optional targeted low-income children group or the Access program.

(B) Does not qualify for Medi-Cal with no share of cost pursuant to Chapter 7 (commencing with Section 14000) of Part 3.

(2) In its application, the applicant shall specify the income level at or below 411 percent of the federal poverty level for which it will provide coverage.

(3) The intergovernmental transfer amount is limited to the expenditures which would be eligible for federal financial participation.

(b) The proposal shall guarantee at least one year of intergovernmental transfer funding by the applicant at a level that ensures compliance with the requirements of any applicable approved federal waiver or state plan amendment as well as the department's requirements for the sound operation of the proposed project, and shall, on an annual basis, either commit to fully funding the necessary intergovernmental amount or withdraw from the program. The department may identify specific geographical areas that, compared to the national level, have a higher cost of living or housing or a greater need for additional health services, using data obtained from the most recent federal census, the federal Consumer Expenditure Survey, or from other sources. The proposal may include an administrative mechanism for outreach and eligibility.

(c) The applicant may include in its proposal reimbursement of medical, dental, vision, or mental health services delivered to children who are eligible under the Access program or under the Medi-Cal program as an optional targeted low-income children group beneficiary, if these services are part of an overall program with the measurable goal of enrolling served children in the Access program or the optional targeted low-income children group.

(d) If a child is determined to be eligible for benefits for the treatment of an eligible medical condition under the California Children's Services Program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, the health, dental, or vision plan providing services to the child pursuant to this chapter shall not be responsible for the provision of, or payment for, those authorized services for that child. The proposal from an applicant shall contain provisions to ensure that a child whom the health, dental, or vision plan reasonably believes would be eligible for services under the California Children's Services Program is referred to that program. The California Children's Services Program shall provide case management and authorization of services if the child is found to be eligible for the California Children's Services Program. Diagnosis and treatment services that are authorized by the California Children's Services Program shall be performed by paneled providers for that program and approved special care centers of that program and approved by the California Children's Services Program. All other services provided under the proposal from the applicant shall be made available pursuant to this chapter to a child who is eligible for services under the California Children's Services Program.

(e) Notwithstanding any other provision of this section, an applicant may submit a proposal to the department for the purposes of providing comprehensive health insurance coverage to children whose coverage is not eligible for funding under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa, et seq.), or to a combination of children whose coverage is eligible for funding under Title XXI of the Social Security Act and children whose coverage is not eligible for that funding. To be approved by the department, these proposals shall comply with both of the following requirements:

(1) Meet all applicable requirements for funding under this chapter, except for availability of funding through Title XXI of the Social Security Act.

(2) Provide for the administration of children's coverage by the department through the administrative infrastructure serving the Medi-Cal program, and through health care service plans serving the Medi-Cal program.

(f) Implementation of this section is conditioned on the department obtaining necessary federal approval of these provisions.

(g) Notwithstanding any other provision of this part, the status of any application previously submitted to, and approved by, the Managed Risk Medical Insurance Board pursuant to former Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code shall not be altered as a result of the assumption by the department, pursuant to this chapter, of the responsibilities previously exercised by the Managed Risk Medical Insurance Board.

(h) (1) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, and the conditions described in paragraph (1) of

subdivision (k) of Section 15853, as added by Section 21 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2025, or the date certified by the department pursuant to paragraph (2) of subdivision (k) of Section 15853, as added by Section 21 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

(2) If the voters do not approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, and the conditions described in paragraph (1) of subdivision (k) of Section 15853, as added by Section 21 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2026, or the date certified by the department pursuant to paragraph (2) of subdivision (k) of Section 15853, as added by Section 21 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

SEC. 80. Section 15853 of the Welfare and Institutions Code, as added by Section 21 of Chapter 738 of the Statutes of 2022, is amended to read:

15853. (a) (1) An applicant that will provide an intergovernmental transfer may submit a proposal to the department for funding for the purpose of providing comprehensive health insurance coverage to any child who meets citizenship and immigration status requirements that are applicable to persons participating in the program established by Title XXI of the Social Security Act, and whose family income is at or below 317 percent of the federal poverty level or, at the option of the applicant, at or below 411 percent of the federal poverty level, in specific geographic areas, as published quarterly in the Federal Register by the United States Department of Health and Human Services, as determined, counted, and valued in accordance with the requirements of Section 1396a(e)(14) of Title 42 of the United States Code, as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148) and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments, and which child meets both of the following requirements:

(A) Does not qualify for the optional targeted low-income children group or the Access program.

(B) Does not qualify for Medi-Cal with no share of cost pursuant to Chapter 7 (commencing with Section 14000) of Part 3.

(2) In its application, the applicant shall specify the income level at or below 411 percent of the federal poverty level for which it will provide coverage.

(3) The intergovernmental transfer amount is limited to the expenditures which would be eligible for federal financial participation.

(b) The proposal shall guarantee at least one year of intergovernmental transfer funding by the applicant at a level that ensures compliance with the requirements of any applicable approved federal waiver or state plan amendment as well as the department's requirements for the sound operation of the proposed project, and shall, on an annual basis, either commit to fully

funding the necessary intergovernmental amount or withdraw from the program. The department may identify specific geographical areas that, compared to the national level, have a higher cost of living or housing or a greater need for additional health services, using data obtained from the most recent federal census, the federal Consumer Expenditure Survey, or from other sources. The proposal may include an administrative mechanism for outreach and eligibility.

(c) The applicant may include in its proposal reimbursement of medical, dental, vision, or mental health services delivered to children who are eligible under the Access program or under the Medi-Cal program as an optional targeted low-income children group beneficiary, if these services are part of an overall program with the measurable goal of enrolling served children in the Access program or the optional targeted low-income children group.

(d) If a child is determined to be eligible for benefits for the treatment of an eligible medical condition under the California Children's Services Program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, the health, dental, or vision plan providing services to the child pursuant to this chapter shall not be responsible for the provision of, or payment for, those authorized services for that child. The proposal from an applicant shall contain provisions to ensure that a child whom the health, dental, or vision plan reasonably believes would be eligible for services under the California Children's Services Program is referred to that program. The California Children's Services Program shall provide case management and authorization of services if the child is found to be eligible for the California Children's Services Program. Diagnosis and treatment services that are authorized by the California Children's Services Program shall be performed by paneled providers for that program and approved special care centers of that program and approved by the California Children's Services Program. All other services provided under the proposal from the applicant shall be made available pursuant to this chapter to a child who is eligible for services under the California Children's Services Program.

(e) Notwithstanding any other provision of this section, an applicant may submit a proposal to the department for the purposes of providing comprehensive health insurance coverage to children whose coverage is not eligible for funding under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa, et seq.), or to a combination of children whose coverage is eligible for funding under Title XXI of the Social Security Act and children whose coverage is not eligible for that funding. To be approved by the department, these proposals shall comply with both of the following requirements:

(1) Meet all applicable requirements for funding under this chapter, except for availability of funding through Title XXI of the Social Security Act.

(2) Provide for the administration of children's coverage by the department through the administrative infrastructure serving the Medi-Cal

program, and through health care service plans serving the Medi-Cal program.

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

(g) Notwithstanding any other provision of this part, the status of any application previously submitted to, and approved by, the Managed Risk Medical Insurance Board pursuant to former Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code shall not be altered as a result of the assumption by the department, pursuant to this chapter, of the responsibilities previously exercised by the Managed Risk Medical Insurance Board.

(h) If at any time the director determines that the eligibility criteria established for the program described in this section may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), any amendment or extension of that act, or any similar federal legislation affecting federal financial participation, the director may alter the eligibility criteria to the extent necessary for the state to receive that federal financial participation.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and Chapter 4 (commencing with Section 12693.25) and Chapter 9 (commencing with 12693.70) of Part 6.2 of Division 2 of the Insurance Code, the department may implement, interpret, or make specific this section, in whole or in part, through all-county letters or similar instructions, without taking any further regulatory action.

(j) For any child found eligible under this section, they shall remain continuously eligible until they are five years of age. A redetermination of eligibility shall not be conducted before the child reaches five years of age unless the department or county possesses facts indicating that the family has requested the child's voluntary disenrollment, the child is deceased, the child is no longer a state resident, or the child's original enrollment was based on a state or county error or on fraud, abuse, or perjury attributed to the child or the child's representative.

(k) (1) Implementation of this section is contingent on all of the following conditions:

(A) All necessary federal approvals have been obtained by the department pursuant to subdivision (f).

(B) The Legislature has appropriated funding to implement this section after a determination that ongoing General Fund resources are available to support the ongoing implementation of this section in the 2024–25 fiscal year and subsequent fiscal years.

(C) The department has determined that systems have been programmed to implement this section.

(2) The department shall issue a declaration certifying the date that all conditions in paragraph (1) have been met. The department shall post the

declaration on its internet website and provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(*l*) (1) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, this section shall become operative on January 1, 2025, or the date certified by the department pursuant to paragraph (2) of subdivision (k), whichever is later.

(2) If the voters do not approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, this section shall become operative on January 1, 2026, or the date certified by the department pursuant to paragraph (2) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

SEC. 81. Section 15877 is added to the Welfare and Institutions Code, to read:

15877. (a) The department shall direct the participating health plans to inform all program subscribers of the December 31, 2024, transition of coverage as follows:

(1) (A) On August 1, 2024, the participating health plans shall send an initial notification to all program subscribers. The initial notice will inform subscribers of all of the following:

(i) That a plan-based enroller shall assist the subscriber in applying to Medi-Cal or through the California Health Benefit Exchange for other health care coverage.

(ii) That assistance may be available through the California Health Benefit Exchange or clinic navigators and how to obtain that assistance.

(iii) Information regarding where and how subscribers can apply to the California Health Benefit Exchange for alternate health care coverage.

(B) If a participating health plan has plan-based enrollers through the California Health Benefit Exchange, the plan shall direct the plan-based enrollers to assist the subscribers in understanding their coverage options.

(C) Assistance to subscribers by plans shall provide information on continuity with an existing provider to the extent possible.

(2) On October 1, 2024, the participating health plans shall send a second notification informing all program subscribers that coverage shall transition on December 31, 2024, for those who are eligible for other coverage, and the notice shall include all of the information that was included in the initial notification sent on August 1, 2024.

(3) On December 1, 2024, the participating health plans shall send a third notification informing all program subscribers that coverage shall transition on December 31, 2024, for those who are eligible for other coverage, and the notice shall include all of the information that was included in the initial notification sent on August 1, 2024.

(b) (1) Upon request from the California Health Benefit Exchange, the department may disclose information to the Exchange to assist program subscribers to transition into new coverage pursuant to this section.

(2) The Exchange may disclose information obtained from the department to outreach and marketing vendors under contract to the Exchange.

(3) The Exchange shall not disclose information obtained from the department to a certified insurance agent, a certified enrollment counselor, or any other entity without the consent of the applicant, except as provided in paragraph (2).

(4) Any outreach and marketing conducted pursuant to this section shall include, in a conspicuous and easy-to-access manner, the ability for individuals to decline all future outreach and marketing.

(5) The Exchange shall take all necessary measures to safeguard the confidentiality of any information obtained from the department and shall at no time use or disclose that information for any purpose other than to market and publicize the availability of health care coverage through the Exchange to individuals whose information the Exchange receives pursuant to subdivision (c). The Exchange shall at all times only request, use, or disclose the minimum amount of information necessary to accomplish the purposes for which it was obtained.

(6) A person or entity that receives information from the Exchange pursuant to this section shall take all necessary measures to safeguard the confidentiality of any information obtained from the Exchange and shall at no time use or disclose that information for any purpose other than to market and publicize the availability of health care coverage through the Exchange to individuals, as directed by the Exchange. A person or entity shall at all times only request from the Exchange, use, or disclose the minimum amount of information necessary to accomplish the purposes for which it was received.

(7) Information received by the Exchange from the department shall both:

(A) At all times be subject to applicable privacy and information security-related requirements arising under both federal and state law.

(B) Be destroyed in a manner that maintains confidentiality.

(8) The Exchange shall ensure that information disclosed to outreach and marketing vendors or any other entity pursuant to this section complies with paragraph (7).

(c) Sections 1373.65, 1373.95, and 1373.96 of the Health Safety Code shall apply, whether or not the plan is licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(d) The department shall cease to provide coverage through the program on December 31, 2024, and on that date shall cease to operate the program except as necessary to comply with subdivision (e).

(e) The department shall complete payments to, or payment reconciliations with, participating health plans or other contractors, process appeals, and conduct other necessary termination activities.

(f) Commencing November 1, 2024, and ending when the transition of coverage is complete, the department shall provide monthly updates to the Assembly Committees on Health and Budget and the Senate Committees on Health and Budget and Fiscal Review on the status of the transition of subscribers to other coverage. These updates shall include the number of subscribers who have transitioned and, to the extent available, to where, the number remaining in the program, and any available demographic information of each subscriber.

SEC. 82. Section 15893 of the Welfare and Institutions Code is amended to read:

15893. (a) There is hereby continued in existence in the State Treasury a special fund known as the Major Risk Medical Insurance Fund that is, notwithstanding Section 13340 of the Government Code, continuously appropriated to the department for the purposes specified in Section 15894, Section 10127.16 of the Insurance Code, and Section 1373.622 of the Health and Safety Code.

(b) Funds may be deposited in the Major Risk Medical Insurance Fund from one or more of the following accounts in the Cigarette and Tobacco Products Surtax Fund:

(1) The Hospital Services Account.

(2) The Physician Services Account.

(3) The Unallocated Account.

(c) Effective July 1, 2017, the Major Risk Medical Insurance Fund in the State Treasury is abolished and all moneys in the fund shall be transferred to the Health Care Services Plan Fines and Penalties Fund created pursuant to subdivision (d). Any remaining balance, assets, liabilities, and encumbrances of the Major Risk Medical Insurance Fund as of July 1, 2017, shall be transferred to, and become part of, the Health Care Services Plan Fines and Penalties Fund.

(d) There is hereby created in the State Treasury a special fund known as the Health Care Services Plan Fines and Penalties Fund that is, notwithstanding Section 13340 of the Government Code, continuously appropriated to the department for the purpose of funding the nonfederal share of health care services for children, adults, seniors, persons with disabilities, and dual-eligible beneficiaries in the Medi-Cal program.

(e) Any law that refers to the Major Risk Medical Insurance Fund, including, but not limited to, a reference in this chapter to the Major Risk Medical Insurance Fund or the "fund," shall be construed to refer to the Health Care Services Plan Fines and Penalties Fund, effective July 1, 2017.

(f) Notwithstanding any other law, the Controller may use the funds in the Health Care Services Plan Fines and Penalties Fund for cashflow loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code.

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, 2024, to the Transgender, Gender Nonconforming, and Intersex Wellness and Equity Fund to fund services related to care and treatment for eligible individuals living with HIV and AIDS.

(5) Allocate ten million dollars ($10,000,000) annually for three years, beginning July 1, 2024, to fund the Harm Reduction Supply Clearinghouse to fund HIV prevention supplies to California syringe access programs.

(6) Allocate two hundred thousand dollars ($200,000) in the 2024–25 fiscal year, available until June 30, 2027, for the Office of AIDS to create, develop, or contract out for a needs assessment and analysis to identify needs for client navigation and retention services for clients enrolled in a Ryan White HIV/AIDS Program through the Office of AIDS.

(7) Allocate two hundred thousand dollars ($200,000) in the 2024–25 fiscal year, available until June 30, 2027, for the Office of AIDS to create, develop, or contract out for a needs assessment and analysis aimed at understanding the potential needs for the Pre-Exposure Prophylaxis (PrEP) Navigation Services Program.

(8) Allocate five million dollars ($5,000,000) in the 2024–25 fiscal year, available until June 30, 2027, to distribute funding to a community-based organization to make internal and external condoms available pursuant to Section 35292.7 of the Education Code, if Senate Bill 954 of the 2023–24 Regular Session becomes effective, 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. 84. The Legislature finds and declares that Section 22 of this act, which adds Section 131380 to the Health and Safety Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to protect personally identifying information of people presenting with reportable and nonreportable health conditions, it is necessary to limit access to this information if it is provided to other public entities pursuant to Section 131375 of the Health and Safety Code.

SEC. 85. The amendments to Sections 7903, 16310, and 30026.5 of the Government Code, Section 51312 of the Health and Safety Code, and Sections 5014, 5349, 5813.5, 5840.6, 5847, 5849.35, 5890, 5891, 5893, 5895, 5899, and 14705 of the Welfare and Institutions Code, as amended by the act that added this section, shall become operative January 1, 2025.

SEC. 86. 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. 87. 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.

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