Assembly Bill No. 118

CHAPTER 42

An act to amend Section 1295 of the Code of Civil Procedure, to amend Sections 12534, 16531.1, 53123.1.5, 53123.3, 53123.4, 53123.5, 100520.5, and 100800 of, and to add Section 53123.6 to, the Government Code, to amend Sections 27, 1352.1, 1363, 1367.041, 1367.24, 1374.724, 1417.2, 1797.100, 1797.101, 1862, 11830, 11831.12, 11831.6, 11831.7, 11833.01, 11833.05, 11836, 107065, 107075, 114850, 127691, 127692, 127693, 127696, 128560, and 129385 of, to add Section 1363.3 to, to add Chapter 7.1 (commencing with Section 11832) and Chapter 7.2 (commencing with Section 11833) to Part 2 of Division 10.5 of, to repeal Sections 11830.1, 11830.5, 11831.1, 11831.2, 11831.5, 11832, 11832.1, 11833, 114890, and 114895 of, and to repeal and add Sections 107070, 107165, and 107170 of, the Health and Safety Code, to amend Section 10144.57 of the Insurance Code, to amend Sections 1370 and 11105 of the Penal Code, to amend Section 41136 of, and to repeal and add Section 61035 of, the Revenue and Taxation Code, and to amend Sections 3200, 3201, 3203, 5402, 14005.7, 14005.9, 14005.12, 14005.13, 14005.21, 14005.26, 14005.32, 14005.41, 14005.42, 14009, 14011.65, 14011.7, 14011.8, 14015.12, 14016, 14019.4, 14021.6, 14054, 14064, 14094.5, 14094.7, 14094.11, 14094.12, 14094.17, 14105.075, 14105.192, 14105.194, 14110.8, 14132, 14132.24, 14132.56, 14132.95, 14132.99, 14146, 14146.5, 14154.5, 14169.81, 14184.102, 14184.200, 14184.201, 14184.403, 14717.1, 14717.2, and 15832 of, to amend and repeal Sections 14006, 14006.01, 14006.1, 14006.15, 14006.2, 14006.6, and 14015 of, to amend, repeal, and add Sections 14005.11, 14005.20, 14005.40, 14005.401, 14006.3, 14006.4, 14006.5, 14007.9, 14009.6, 14009.7, 14011, 14013.3, 14051, 14051.5, 14100.5, 14148.04, and 14148.5 of, and to add Sections 4046, 14005.95, 14051.7, 14051.8, 14105.076, 14105.200, 14105.201, and 14105.202 to, 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 July 10, 2023. Filed with Secretary of State July 10, 2023.]

LEGISLATIVE COUNSEL'S DIGEST

AB 118, Committee on Budget. Budget Act of 2023: health.

(1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law requires a health care service plan to provide disclosures regarding the benefits, services, and terms of the plan contract,

as specified, to provide the public, subscribers, and enrollees with a full and fair disclosure of the provisions of the plan.

This bill would require the department to develop standard templates for the disclosure form and evidence of coverage, to include, among other things, standard definitions, benefit descriptions, and any other information that the director determines, consistent with the goals of providing fair disclosures of the provisions of a health care service plan. The bill would require the department to consult with the Department of Insurance and interested stakeholders in developing the standard templates. The bill would require health care service plans, beginning January 1, 2025, to use the standard templates for any disclosure form or evidence of coverage published or distributed, except as specified. Because a willful violation of these requirements is a crime, the bill would impose a state-mandated local program.

This bill would authorize the department to develop standard templates for a schedule of benefits, an explanation of benefits, a cost-sharing summary, or any similar document. The bill would authorize the department to require health care service plans to use the standard templates, except as specified, and would authorize the director to require health care service plans to submit forms the health care service plan created based on the department's templates for the purpose of compliance review. The bill would additionally specify that the department may implement these provisions by issuing and modifying templates and all-plan letters or similar instructions, without taking regulatory action. The bill would also update cross-references in various provisions.

(2) Existing law requires a health care service plan contract or disability insurance policy to cover mental health and substance use disorder treatment, including medically necessary treatment of a mental health or substance use disorder provided by an in-network or out-of-network 988 center or mobile crisis team. Existing law prohibits a health care service plan or insurer from requiring prior authorization for medically necessary treatment of a mental health or substance use disorder provided by a 988 center or mobile crisis team.

This bill would instead specify that mental health and substance use disorder treatment includes behavioral health crisis services that are provided by a 988 center, mobile crisis team or other provider of behavioral health crisis services. The bill would prohibit a health care service plan or health insurer from requiring prior authorization for behavioral health crisis stabilization services and care, but would authorize prior authorization for medically necessary mental health or substance use disorder services following stabilization from a behavioral health crisis addressed by services provided through the 988 system.

This bill would require a health care service plan or health insurer that is contacted by a 988 center, mobile crisis team, or other provider of behavioral health crisis services to, within 30 minutes of initial contact, either authorize poststabilization care or inform the provider that it will arrange for the prompt transfer of the enrollee's care to another provider. The bill would

require the plan or insurer to reimburse a provider for poststabilization care in specified circumstances, including if the plan or insurer did not respond within 30 minutes to authorize care or arrange for transfer. The bill would require a plan or insurer to prominently display on its internet website its authorization telephone number for noncontracting providers, and would require the Department of Managed Health Care to post the telephone number on its internet website. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

(3) Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. PPACA generally requires an individual, and any dependents of the individual, to maintain minimum essential coverage. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law imposes the Individual Shared Responsibility Penalty for the failure to maintain minimum essential coverage, and requires the moneys collected to be deposited into the General Fund.

Existing law requires the Exchange to administer a financial assistance program to help low-income and middle-income Californians access affordable health care coverage through the Exchange. Existing law creates the Health Care Affordability Reserve Fund and requires moneys in the fund to be used, upon appropriation by the Legislature, for health care affordability programs operated by the Exchange.

This bill would require moneys collected from the Individual Shared Responsibility Penalty to be deposited into the Health Care Affordability Reserve Fund beginning July 1, 2023, and on every July 1 thereafter. The bill would authorize a loan from the Health Care Affordability Reserve Fund to the General Fund upon order of the Department of Finance.

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

Existing law requires that the Medi-Cal program covers specified health care services, including inpatient intensive rehabilitation hospital services, and requires those services consist of programs for, among other services, strengthening and training of selected muscle groups. Existing law requires those programs to provide for an initial evaluation for assessment of medical condition, functional limitations, possible need for surgery, attitude toward rehabilitation, functional goals and plans for discharge.

This bill would eliminate the requirement for the above-described initial evaluation, and would also make technical, nonsubstantive changes.

(5) This bill would, for dates of service no sooner than January 1, 2024, or on the effective date of any necessary federal approvals, whichever is later, require the reimbursement rates for primary care services, obstetric care services, doula services, and certain outpatient mental health services to be the greater of 87.5% of the lowest maximum allowance established by the federal Medicare Program for the same or similar services or the level of reimbursement, as specified. The bill would require the department to annually review and revise the reimbursement rates, and to develop and implement a methodology for establishing rates or payments for the services. The bill would require each Medi-Cal managed care plan to reimburse a network provider furnishing those services at least the amount the network provider would be paid for those services in the Medi-Cal fee-for-service delivery system, as specified. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would require the department to submit to the Legislature, as part of the 2024–25 Governor's Budget, a plan for targeted increases to Medi-Cal payments or other investments, in relation to certain domains.

Under the bill, the above-described payments would be supported by the managed care organization provider tax revenue, as specified, 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, as described below, and to the Healthcare Treatment Fund under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016, as specified.

The bill would create the Medi-Cal Provider Payment Reserve Fund. The bill would require the department, subject to an appropriation, to use the moneys transferred to the fund pursuant to other specified provisions 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. The bill would require the department to provide an annual report to all health plans accounting for the funds deposited in, and expended from, the fund.

The bill would require those expenditures to include increased costs as a result of the above-described reimbursement requirements, transfers to the Distressed Hospital Loan Program Fund, certain transfers or appropriations to the University of California to expand graduate medical education programs, as specified, and, effective no sooner than January 1, 2025, increased costs for targeted increases to Medi-Cal payments or other investments pursuant to the above-described plan.

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

This bill would make an additional exemption, for dates of service on and after July 1, 2022, or the effective date of any necessary federal approvals, whichever is later, for Community-Based Adult Services, as specified. The bill would make additional exemptions, for dates of service on and after January 1, 2024, or the effective date of specified payments, whichever is later.

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 and the California Health Facilities Financing Authority to implement the program.

This bill would authorize the Department of Finance to transfer 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, as specified, and would make a conforming change.

(6) Existing law requires Medi-Cal benefits to be provided to individuals eligible for services pursuant to prescribed standards, including a modified adjusted gross income (MAGI) eligibility standard. Existing law prohibits the use of an asset or resources test for individuals whose financial eligibility for Medi-Cal is determined based on the application of MAGI. Existing federal law authorizes a state to establish a non-MAGI standard for determining the eligibility of specified individuals, and existing law imposes the use of a resources test for establishing Medi-Cal eligibility for prescribed populations.

Existing law prohibits the use of resources, including property or other assets, to determine Medi-Cal eligibility for applicants or beneficiaries whose eligibility is not determined using the MAGI-based financial methods, and requires the department to seek federal authority to disregard all resources as authorized by the flexibilities provided pursuant to federal law. Existing law conditions implementation of that provision on the Director of Health Care Services determining that systems have been programmed for those disregards and their communicating that determination in writing to the Department of Finance, no sooner than January 1, 2024. Existing law also conditions implementation of that provision on the department obtaining any necessary federal approvals, and to the extent federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.

This bill, subject to the above-described timeline and implementation of the prohibition on the use of resources for determining Medi-Cal eligibility, would make various conforming changes to related provisions. Because this bill would increase county duties relating to the prohibition on the use of resources for determining Medi-Cal eligibility, the bill would impose a state-mandated local program.

(7) Existing law requires Medi-Cal reimbursement rates to be set by an applicable methodology for specified dates of service operative on August 1 of a given year.

This bill would, for dates of services on or after January 1, 2024, require the department to adopt a rate year based on the calendar year for intermediate care facilities for the developmentally disabled and facilities providing continuous skilled nursing care to developmentally disabled individuals, nursing facilities, licensed intermediate care facilities, freestanding pediatric subacute care units, and skilled nursing facilities, as specified. The bill would make these provisions subject to any necessary federal approvals and to the extent federal financial participation is available and is not otherwise jeopardized.

(8) Existing law requires the State Department of Health Care Services, no later than April 1, 2022, and until December 31, 2023, to convene a workgroup to examine the implementation of the doula benefit provided under the Medi-Cal program. Existing law requires the department, no later than July 1, 2024, to publish a report relating to Medi-Cal recipients utilizing doula services, as specified. Existing law repeals those provisions on January 1, 2025.

This bill would instead require the department to convene the workgroup no later than April 1, 2023, and until June 30, 2025, and to publish the report no later than July 1, 2025. The bill would extend the repeal date of those provisions to January 1, 2026.

(9) Existing law, until July 1, 2024, requires the State Department of Health Care Services to work with stakeholders to conduct a study to identify current requirements for medical interpretation services and make recommendations on strategies that may be employed regarding the provision of medical interpretation services for Medi-Cal beneficiaries who are limited English proficient (LEP). Existing law requires the department to establish a pilot project to evaluate certain factors, including whether disparities in care are reduced, with respect to LEP Medi-Cal beneficiaries compared with Medi-Cal beneficiaries who are proficient in English. Existing law requires the department to expend up to $5,000,000 for the pilot project pursuant to an appropriation made in the Budget Act of 2019, and makes those funds available for that purpose until June 30, 2024.

This bill would extend these provisions until July 1, 2025, and make those funds available until June 30, 2025. By extending the period of time in which previously appropriated funds are available for encumbrance, the bill would make an appropriation.

(10) Existing law establishes the Drug Medi-Cal Treatment Program (Drug Medi-Cal) under which the State Department of Health Care Services is authorized to enter into contracts with counties for various drug treatment services to Medi-Cal recipients, or is required to directly arrange for these services if a county elects not to do so. Existing law specifies the method of determining the maximum allowable reimbursement rates for Drug Medi-Cal and group outpatient drug free services, as described. Existing

law requires the claims for reimbursement of Drug Medi-Cal services to be submitted within 6 months from the date of service.

This bill would instead require claims for reimbursement of Drug Medi-Cal services to be submitted within 12 months from the date of service.

(11) Under existing law, certain medically needy persons, including those in long-term care, with higher incomes qualify for Medi-Cal with a share of cost, if they meet specified criteria. Under existing law, the term "share of cost" means the amount of the costs of health care that a specified person or family must incur prior to being certified by the department.

This bill would instead apply the term "spend down of excess income" to the above-described definition for "share of cost" for medically needy persons. The bill would change references from "share of cost" to "long-term care patient liability," in the context of those entering or in long-term care and define that term as the result of the "post-eligibility treatment of income" calculation and the amount of medical expenses the person in long-term care or an institutionalized spouse must incur or expect to incur. The bill would define the term "post-eligibility treatment of income" as the determination of long-term care patient liability for each month the person is in long-term care or as an institutionalized spouse, as specified.

(12) Existing law requires the State Department of Health Care Services to prepare and submit assumptions and estimates, as prescribed, relating to the Medi-Cal program to the Department of Finance on a semiannual basis for the purpose of clearly identifying changes within the Medi-Cal program and producing reliable forecasts of Medi-Cal expenditures. Existing law requires the department to separately identify expenditures for rate increases and fiscal intermediary services, requires that certain assumptions or estimates contain a narrative description of how the forecast is prepared, and requires that estimates compare budgeted to implemented rate increases for the current year, by provider category, among other things.

This bill would, effective July 1, 2023, strike these latter requirements and require, beginning with the estimates for the 2024–25 fiscal year, that they include separately identifying expenditures for county and other local assistance administration and a narrative description of how those forecasts were prepared.

(13) Existing law establishes the Medi-Cal Access Program, which provides health care services to a person who is pregnant or in their postpartum period and whose household income is between certain thresholds, and to a child under 2 years of age who is delivered by a mother enrolled in the program, as specified. Existing law requires the State Department of Health Care Services to provide presumptive eligibility to qualified individuals through programs in which authorized Medi-Cal providers make presumptive eligibility determinations.

Existing law requires the department to adopt the Newborn Hospital Gateway, which is an electronic process for families to enroll a deemed eligible newborn in the Medi-Cal program from hospitals that have elected to participate in the process. Existing law authorizes the expenditure of moneys in the Gateway Fund, upon appropriation, for purposes of

establishing and maintaining the gateway. Existing law conditions adoption of the gateway on the deposit of sufficient moneys in the Special Funds Account of the Gateway Fund and on the availability of sufficient new staff, as specified, and would require the department to implement the gateway within 12 months after the occurrence of those conditions.

This bill would require that the gateway be accessed through existing presumptive eligibility portals. The bill would require all qualified Medi-Cal providers participating in presumptive eligibility programs to use the gateway system to report a Medi-Cal eligible newborn born in their facilities, as specified, within 72 hours after birth, or one business day after discharge, whichever is sooner. The bill would impose a related requirement on Medi-Cal providers for purposes of reporting the birth of an infant eligible under the Medi-Cal Access Program, as specified.

The bill would delete the conditions of sufficient moneys and staff and the 12-month timeline from the above-described provisions. The bill would make other changes to related contracting provisions. The bill would make the above-described changes operative on July 1, 2024, or the effective date for implementation of the Children's Presumptive Eligibility Program portal, whichever is later.

Existing law requires the department to develop an electronic application to serve as the application for the Children's Presumptive Eligibility Program, to the extent allowed under federal law. Existing law authorizes the department to also use the electronic application as a means to enroll newborns into the Medi-Cal program as is authorized under specified federal law. Existing law conditions implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation.

This bill would authorize providers to submit newborn enrollments through the electronic application on behalf of patients without a patient's signature. To the extent that the above-described provisions would create new duties for counties relating to Medi-Cal eligibility determinations, the bill would impose a state-mandated local program.

(14) Existing law authorizes the State Department of Health Care Services to establish a Whole Child Model program, under which managed care plans served by a county organized health system or Regional Health Authority in designated counties provide California Children's Services (CCS) to Medi-Cal eligible CCS children and youth. Existing law, commencing no sooner than January 1, 2024, expands managed care plans under the Whole Child Model program to also include an alternate health care service plan (AHCSP), requires the department, in implementing the program, to develop specific CCS program monitoring and oversight standards for managed care plans, and establish a statewide Whole Child Model program stakeholder advisory group that includes specified persons, including CCS case managers, and to consult with that advisory group on prescribed matters. Existing law terminates the advisory group on December 31, 2023. Existing law requires a Medi-Cal managed care plan participating in the Whole Child Model program to meet certain requirements, such as ensuring that each

CCS-eligible child receives case management, care coordination, provider referral, and service authorization services from an employee or contractor of the plan, as described. Existing law imposes various requirements on a Medi-Cal managed care plan serving children and youth with CCS-eligible conditions under the CCS program, including, but not limited to, coordinating services, as specified, providing appropriate access to care, services, and information, and providing for case management, among others.

This bill, no sooner than January 1, 2025, would expand the above-described authorization to establish a Whole Child Model program to additional counties, as specified, and would extend the operation of the advisory group until December 31, 2026. The bill would require the department, no later than January 1, 2025, to take certain actions related to oversight standards, such as developing utilization and quality measures that relate to CCS specialty care and providing analysis regarding trends on CCS enrollment for Whole Child Model counties, among others. The bill would require a managed care plan participating in the Whole Child Model program to ensure that a CCS-eligible child has a primary point of contact who shall be responsible for the child's care coordination and would require a Medi-Cal managed care plan serving children and youth with CCS-eligible conditions under the CCS program to support the establish referral pathways in the non-Whole Child Model counties, as described.

Existing law authorizes the department to standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, subject to a Medi-Cal managed care plan readiness, continuity of care transition plan, and disenrollment process developed in consultation with stakeholders, in accordance with specified requirements and the CalAIM Terms and Conditions. Existing law, if the department standardizes those populations subject to mandatory enrollment, exempts dual and non-dual beneficiary groups from that mandatory enrollment, including, among others, non-dual-eligible beneficiaries eligible on the basis of their receipt of services through a state foster care program, but excludes from that exemption, those who reside in a county that is authorized to operate a county organized health system.

This bill would additionally exclude those non-dual-eligible beneficiaries who reside in a county operating a Single Plan model of managed care from that exemption, thereby subjecting that population to mandatory enrollment in a Medi-Cal managed care plan and would prescribe certain requirements for Medi-Cal managed care plans and the department in transitioning that population to a Medi-Cal managed care plan, such as compliance with access requirements and department guidance and use of a specified transfer process for immediate access to care and treatment services.

(15) Under existing law, specialty mental health services include federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services provided to eligible Medi-Cal beneficiaries under 21 years of age. Existing law requires each local mental health plan to establish a procedure to ensure access to outpatient specialty mental health services, as required by the

EPSDT program standards, for youth in foster care who have been placed outside their county of adjudication, as described.

Existing law requires the State Department of Health Care Services to issue policy guidance on the conditions for, and exceptions to, presumptive transfer of responsibility for providing or arranging for specialty mental health services to a foster youth from the county of original jurisdiction to the county in which the foster youth resides, as prescribed. On a case-by-case basis, and when consistent with the medical rights of children in foster care, existing law authorizes the waiver of presumptive transfer, with the responsibility for the provision of specialty mental health services remaining with the county of original jurisdiction if certain exceptions exist. Under existing law, the county probation agency or the child welfare services agency is responsible for determining whether waiver of the presumptive transfer is appropriate, with notice provided to the person requesting the exception.

Under existing law, commencing July 1, 2023, in the case of placement of foster children in short-term residential therapeutic programs, community treatment facilities, or group homes, or in the case of admission of foster children to children's crisis residential programs, the county of original jurisdiction is required to retain responsibility and presumptive transfer provisions apply only if certain circumstances exist.

This bill, for purposes of foster children placed or admitted in those specific settings, would delay, until July 1, 2024, the requirement on the county of original jurisdiction to retain responsibility and the limitation on the presumptive transfer provisions. By extending the period during which a county agency is responsible for making determinations about presumptive transfer waivers and making certain notifications, the bill would impose a state-mandated local program.

Existing law conditions implementation of the above-described provisions on the availability of federal financial participation and receipt of all necessary federal approvals. If the department makes the determination that it is necessary to seek federal approval, existing law requires the department to make an official request for approval from the federal government no later than July 1, 2024.

This bill would delay the deadline for any necessary federal approval requests to July 1, 2025.

(16) Existing law establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative, subject to receipt of any necessary federal approvals and the availability of federal financial participation, in order to, among other things, improve quality outcomes, reduce health disparities, and increase flexibility. Existing law authorizes the State Department of Health Care Services, to the extent authorized by the CalAIM Terms and Conditions, to claim federal financial participation for expenditures associated with the designated state health programs identified in those terms and conditions for use solely by the department. Existing law requires that any federal financial participation claimed be used to offset applicable General Fund expenditures. Existing law makes an appropriation of those

amounts to the department and makes them available for transfer to the General Fund for that purpose. Existing law appropriates an amount of General Fund moneys, equal to the federal financial participation that may be claimed, to the continuously appropriated Health Care Deposit Fund for use by the department for purposes of implementing the CalAIM initiative.

This bill would require the department to maintain reimbursement rates in the Medi-Cal program for primary care, obstetric care, and behavioral health services, and to increase reimbursement rates for those service codes as necessary to meet federally imposed minimum requirements specified in the terms and conditions for dates of service on or after January 1, 2024, to the extent required by the federal Centers for Medicare and Medicaid Services as a condition of claiming federal financial participation for designated state health programs as set forth in the above-described provisions, thereby making an appropriation. The bill would, to the extent required by the CalAIM Terms and Conditions, apply those provisions to claims for the identified codes paid by the department in fee-for-service and to claims paid by a Medi-Cal managed care plan.

Existing law requires the department to standardize applicable covered Medi-Cal benefits provided by Medi-Cal managed care plans under comprehensive risk contracts with the department on a statewide basis and across all models of Medi-Cal managed care in accordance with specified requirements and the CalAIM Terms and Conditions.

Existing law, commencing July 1, 2023, and subject to CalAIM implementation, requires the department to include, or continue to include, institutional long-term care services, with exceptions, as capitated benefits in the comprehensive risk contract with each Medi-Cal managed care plan. Existing law, for contract periods from July 1, 2023, to December 31, 2025, inclusive, requires each Medi-Cal managed care plan to reimburse a network provider furnishing those services to a Medi-Cal beneficiary enrolled in that plan, as specified.

This bill would delay the above-described requirements for institutional long-term care services, from July 1, 2023, to January 1, 2024.

Existing law, subject to implementation of the CalAIM initiative, requires each Medi-Cal behavioral health delivery system to comply with the behavioral health payment reform provisions approved in the CalAIM Terms and Conditions and any associated instruction issued by the department, as specified. Existing law requires the department, as a component of that reform, to design and implement an intergovernmental transfer-based reimbursement methodology to replace the use of certified public expenditures for claims associated with covered Specialty Mental Health and Drug Medi-Cal services provided through Medi-Cal behavioral health delivery systems. Existing law requires that the nonfederal share of any payments consist of voluntary intergovernmental transfers of funds provided by eligible governmental agencies or public entities associated with a respective Medi-Cal behavioral health delivery system. Existing law requires the department to establish and implement prospective reimbursement rate methodologies, as specified.

This bill would create the Medi-Cal County Behavioral Health Fund for the deposit of the nonfederal moneys collected by the department pursuant to the above-described provisions. Under the bill, deposited moneys would be continuously appropriated to the department for purposes of implementing those provisions. For counties that elect to participate in the offset and transfer of funds, moneys would be offset and transferred by the Controller into the fund from the Behavioral Health Subaccount in the Support Services Account in the Local Revenue Fund 2011, the Mental Health Subaccount in the Sales Tax Account in the Local Revenue Fund, and the Mental Health Services Fund. The bill would require that the fund contain all interest and dividends earned on moneys in the fund and be used only for the purpose of implementing those provisions. The bill would require the department to provide schedules under specified procedural steps and timelines.

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, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs. The MHSA may be amended by a ⅔ vote of each house of the Legislature if the amendment is consistent with, and furthers the intent of, the act. The Legislature may clarify procedures and terms of the act by majority vote.

This bill would make legislative findings that the above-described provisions are consistent with, and further the intent of, the MHSA.

(17) Existing law creates the continuously appropriated Medical Providers Interim Payment Fund for the purposes of paying Medi-Cal providers, providers of drug treatment services for persons infected with HIV, and providers of services for the developmentally disabled, during a fiscal year for which a budget has not yet been enacted or there is a deficiency in the Medi-Cal budget. During a fiscal year in which these payments are necessary, existing law requires the Controller to transfer up to $2,000,000,000 from the General Fund in the form of loans, and appropriates $2,000,000,000 from the Federal Trust Fund to the Medical Providers Interim Payment Fund.

This bill would increase the General Fund loan amount to up to 10% of the amount appropriated from the General Fund to Medi-Cal benefit costs from the most recent fiscal year. The bill would also appropriate an amount not to exceed 6% of the amount appropriated from the Federal Trust Fund to Medi-Cal benefit costs in the most recent fiscal year. By increasing the amount of an appropriation, the bill would make an appropriation.

(18) Existing law grants the State Department of Health Care Services the sole authority to issue, deny, suspend, or revoke the license of a driving-under-the-influence program.

This bill would require the department to develop regulations on or before January 1, 2026, governing the provision of alcohol or drug recovery services pursuant to those provisions in virtual settings. The bill would authorize the department to implement those provisions by means of all-county letters, plan letters, information notices, or similar instructions, until regulations are promulgated.

(19) Existing law requires the State Department of Health Care Services to license and regulate facilities that provide residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services. Existing law also requires the department to implement a voluntary certification procedure for alcohol and other drug treatment recovery services.

This bill would repeal the voluntary certification procedure for alcohol and other drug treatment recovery services, and would instead require those programs to be certified, except as specified. The bill would prohibit a program from offering alcohol and other drug treatment recovery services without certification, and would impose civil penalties on programs that violate those provisions, as specified. The bill would establish procedures for certification, as well as for inspections of certified programs and for revocation of certification from noncompliant programs.

(20) Existing federal law, the National Suicide Hotline Designation Act of 2020, designates the 3-digit telephone number "988" as the universal number within the United States for the purpose of the national suicide prevention and mental health crisis hotline system operating through the 988 Suicide & Crisis Lifeline.

Existing law, the Miles Hall Lifeline and Suicide Prevention Act, requires, among other things, the Office of Emergency Services (OES) to verify that technology that allows for transfers between 988 centers as well as between 988 centers and 911 public safety answering points, is available to 988 centers and 911 public safety answering points throughout the state, to appoint a 988 system director, and to verify interoperability between and across 911 and 988. Existing law defines "988" for these purposes as the 3-digit telephone number designated by the Federal Communications Commission (FCC) for the purpose of connecting individuals experiencing a behavioral health crisis with counselors trained in suicide prevention and behavioral health crisis and with the capacity to connect callers to behavioral health crisis services through the National Suicide Prevention Lifeline network. Existing law includes crisis receiving and stabilization services in the definition of "behavioral health crisis services."

This bill would instead define "988" as the 3-digit telephone number designated by the FCC for the purpose of connecting individuals experiencing a behavioral health crisis with the national suicide prevention and mental health hotline system in accordance with specified federal law. The bill would remove "crisis receiving services" from the definition of "behavioral health crisis services."

This bill would authorize the State Department of Health Care Services to enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis, and implement changes to existing information technology systems, as described. The bill would make conforming and other technical changes.

The act requires the agency to create, no later than December 31, 2023, a set of recommendations to support a 5-year implementation plan for a

comprehensive 988 system. Existing law requires the agency to convene a state 988 advisory group for purposes of advising the agency on the set of recommendations and requires the recommendations to include specified information. Existing law requires the advisory group to meet once per quarter until December 31, 2023, and prohibits the group from being disbanded before January 1, 2024. Existing law also requires the agency to annually report, commencing December 31, 2024, and until December 31, 2029, to the Legislature on the status of 988 implementation in the state, as provided.

This bill would instead extend the deadline for the recommendations to December 31, 2024, require the advisory group to meet once per quarter until December 31, 2024, and prohibit the group from disbanding before January 1, 2025. The bill would revise the information required in the set of recommendations. The bill would also remove the annual reporting requirement. The bill would require, until December 31, 2029, the California Health and Human Services Agency to post regular updates, no less than annually, regarding the implementation of 988 on its public internet website.

(21) Existing law, the Emergency Telephone Users Surcharge Act, creates a separate surcharge, beginning January 1, 2023, on each access line for each month or part thereof for which a service user subscribes with a service supplier, as described (988 surcharge). Existing law establishes the 988 State Suicide and Behavioral Health Crisis Services Fund and requires revenues generated from the 988 surcharge to be used for purposes of funding the operations of the 988 center and mobile crisis teams, as defined. Existing law, however, requires the 988 surcharge revenues to be used for certain refunds, costs of administering the surcharge, and OES costs related to the administration of the 988 Suicide & Crisis Lifeline, before being disbursed to OES for purposes of the act.

This bill would allow the 988 surcharge revenue to be used to pay state departments for their costs in administering the 988 Suicide & Crisis Lifeline before disbursement of the revenue to OES for purposes of the act. The bill would require the fund to consist of any other appropriations made to it by the Legislature. The bill would authorize the Legislature to consider additional uses for the revenue generated by the 988 surcharge based on recommendations made by the California Health and Human Services Agency and the advisory group, as specified.

Existing law sets forth priorities for the moneys in the fund and prohibits money in the fund from being transferred to any fund or from being transferred, assigned, or reassigned for any other use or purpose outside of the act. Existing law requires revenue generated by the 988 surcharge to be used to supplement and not supplant federal, state, and local funding for 988 centers and mobile crisis services.

Existing law requires an entity seeking funds available through the fund to annually file an expenditure and outcomes report, as described.

The bill would revise the priority uses for 988 surcharge revenues, as described. The bill would instead require the 988 surcharge revenue to be

used to supplement and not supplant federal, state, and local funding for 988 centers and behavioral health crisis services.

This bill would require the expenditure and outcomes report to include information regarding billing to and reimbursement by health care service plans or insurers, beginning January 1, 2030, and measures of system performance, beginning July 1, 2025.

(22) Existing law, the California Affordable Drug Manufacturing Act of 2020, requires CHHSA to enter into partnerships resulting in the production or distribution of generic prescription drugs to, among other things, increase patient access to affordable drugs. Existing law requires CHHSA to have the ability to hire staff to oversee and project-manage these partnerships. Existing law, for the purposes of implementing the California Affordable Drug Manufacturing Act of 2020, until December 31, 2027, permits CHHSA and its departments to enter into exclusive or nonexclusive contracts on a bid or negotiated basis.

This bill would require CHHSA to enter into these partnerships for the procurement of general prescription drugs and would also give CHHSA the ability to hire contractors to oversee and project-manage these partnerships. The bill would indefinitely authorize the CHHSA and its departments to enter into exclusive or nonexclusive contracts on a bid or negotiated basis.

(23) Existing law, contingent upon an appropriation in the annual Budget Act, requires CHHSA to establish a grant program to reduce fentanyl overdoses and use throughout the state by giving out 6 one-time grants to increase local efforts in education, testing, recovery, and support services, as specified. Existing law requires the participating entities to provide the agency with specified information on the results of the program and requires the agency to report those results to the Legislature and Governor's office on or before January 1, 2026.

This bill would require that, contingent upon an appropriation in the annual Budget Act, the State Department of Public Health is to establish the grant program, as specified. The bill would require that the department submit an interim report on the progress of the programs with all available information by January 1, 2026, and a final report with all specified information by January 1, 2028. The bill would extend these provisions until January 1, 2029.

(24) Existing law establishes the California Reproductive Health Service Corps within the Department of Health Care Access and Information for the purposes of recruiting, training, and retaining a diverse workforce of reproductive health care professionals who will be part of reproductive health care teams to work in underserved areas. For the purposes of this program, existing law defines "reproductive health care professionals" to include, among others, medical doctors, licensed midwives, registered nurses, and medical assistants.

This bill would add pharmacists to the list of reproductive health care professionals as defined under this program.

(25) Existing law, the Radiologic Technology Act, requires the State Department of Public Health to provide for the certification of radiologic

technologists and for granting limited permits to persons to conduct radiologic technology, as specified. Existing law also makes the department responsible for regulating people who perform nuclear medicine technology and mammography.

Existing law subjects a person who is regulated as radiologic technologist or competent to perform nuclear medicine technology to discipline for specified reasons, including habitual intemperance in the use of alcoholic beverages, narcotics, or stimulants, as to incapacitate for the performance of professional duties, incompetence, negligence, or gross negligence in performing their functions, and violation of specified statutes or regulations. Existing law also authorizes the department to deny, revoke, or suspend a certificate or permit for a conviction of more than one misdemeanor or a felony involving moral turpitude that was committed during the performance of radiologic technology duties.

This bill would revise and recast the provisions relating to the discipline of a radiologic technologist or a person competent to perform nuclear medicine technology by, among other things, expanding the list of conduct for which they may be disciplined, including the addition of unprofessional conduct and making or giving a false statement or information in conjunction with the application for establishment of competence.

Under existing law, a person who violates, or aids or abets the violation of, provisions relating to radiological technologists or nuclear medicine technology is guilty of a misdemeanor. A person who violates the provision relating to mammography is guilty of a misdemeanor punishable by a fine not to exceed $5,000 per day, per offense or by imprisonment in the county jail not to exceed 180 days, or by both the fine and imprisonment. Under existing law, a person who intentionally or through gross negligence violates the act relating to mammography, or who fails or refuses to comply with a cease and desist order or other order of the department and causes a substantial danger to the health of others is also liable for a civil penalty not to exceed $5,000 per day, per offense.

This bill would also make it a misdemeanor for an entity to violate, or aid and abet the violation of, the act. The bill would make any violation of the act punishable in the same manner as the provisions relating to mammography and would make conforming changes. By expanding the scope of existing crimes, this bill would create a state-mandated local program.

(26) Existing law establishes the Emergency Medical Services Authority, and requires the authority to be headed by a director who is a licensed physician and surgeon with substantial experience in the practice of emergency medicine.

This bill would remove the requirement that the director be a licensed physician with substantial experience in the practice of emergency medicine. The bill would require the authority to have a chief medical officer that is appointed by the Governor, upon nomination by the Secretary of California Health and Human Services, who is a physician and surgeon licensed in California, as specified, and who has substantial experience in the practice

of emergency medicine or emergency response in California. The bill would require the chief medical officer to provide clinical leadership and oversight concerning treatment, education, and other matters involving medical decisionmaking and delivery of patient care.

(27) Under existing law, an adult having capacity may execute an advance health care directive to set forth health care instructions. Existing law requires the Secretary of State to establish an Advance Health Care Directive Registry through which a person may register information regarding their advance directive in a central information center. Under existing law, a Physician Orders for Life Sustaining Treatment (POLST) form is a request regarding resuscitative measures. Existing law, the California POLST eRegistry Act, requires the Emergency Medical Services Authority to establish a statewide electronic POLST registry system to collect a patient's POLST information and disseminate that information to an authorized user. Existing law requires the authority to incorporate the Advance Health Care Directive Registry into the POLST eRegistry.

This bill would the delete the requirement that the authority incorporate the Advance Health Care Directive Registry into the POLST eRegistry.

(28) 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 of California is a party to certain opioid-related settlements, through which the state receives funds for opioid remediation.

Existing law also establishes the Opioid Settlements Fund (OSF) within the State Treasury, and requires the State Department of Health Care Services to administer the fund. Existing law requires the Controller, upon order of the Director of Finance, to transfer funds received in the LDF allocated to the state for state opioid remediation from the 2022 opioid settlements with specified pharmaceutical companies to the OSF. Existing law also requires funds received from those settlements and any future settlements for these purposes that are not deposited in the LDF to be deposited into the OSF. Existing law requires moneys in the OSF, upon appropriation by the Legislature, to be used for opioid remediation in accordance with the terms of the judgment or settlement from which the funds were received.

This bill would revise the above provision regarding the transfer of funds to the OSF from specified 2022 opioid settlements with pharmaceuticals to include Mallinckrodt Pharmaceuticals. The bill would also delete the above provision regarding the deposit of funds into the OSF.

The bill would also require the Controller, upon order of the Director of Finance, to transfer funds received in the LDF allocated to the state for opioid remediation from the 2023 opioid settlements with manufacturers Teva Pharmaceutical Industries Ltd. and Allergan, and pharmacies CVS, Walgreens, and Walmart to the OSF. The bill would further require the Controller, upon order of the Director of Finance, to transfer funds received in the LDF allocated to the state for state opioid remediation from any future judgments, bankruptcies, or settlements pursuant to future Budget Act

appropriation to the OSF. The bill would require funds received from the settlements outlined in the above provisions or from future judgments, bankruptcies, or settlements allocated to the state for state opioid remediation that are not deposited in the LDF to be deposited in the OSF.

(29) Existing law, the Lanterman-Petris-Short Act, provides for the involuntary commitment and treatment of a person who is a danger to themselves or others or who is gravely disabled. Existing law also provides for a conservator of the person or estate to be appointed for a person who is gravely disabled. Existing law requires the Director of Health Care Services to administer the act and adopt rules, regulations, and standards, as necessary. Existing law requires the State Department of Health Care Services to collect and publish annually quantitative information concerning the operation of various provisions relating to community mental health services, including the number of persons admitted for evaluation and treatment for certain periods, transferred to mental health facilities, or for whom certain conservatorships are established, as specified.

Existing law requires each county behavioral health director, each designated and approved facility, and each other entity, as specified, to provide accurate and complete data as prescribed by the department.

This bill would instead require those designated and approved facilities and other entities to collect and provide data to the county behavioral health director in the county in which they operate, as specified, and would authorize a county to establish policies and procedures for this purpose. The bill would require the data provided by each county behavioral health director to the department to include that accurate and complete data. By increasing the data reporting obligations of county behavioral health agencies, this bill would create a state-mandated local program.

Existing law authorizes the department to impose a plan of correction against a county that fails to submit data on a timely basis or as otherwise required.

This bill would also authorize the department to assess a civil money penalty, as specified, against a county for those same reasons. The bill would create an informal written appeals process for the civil money penalty and would require the department to make a determination on the appeal within 60 calendar days of receipt of the appeal. This bill would also authorize a designated and approved facility or county to request a formal hearing, as specified. The bill would require civil money penalties to accrue until the effective date of the department's final decision.

This bill would establish the Lanterman-Petris-Short Act Data and Reporting Oversight Fund, a continuously appropriated fund, to be administered by the State Department of Health Care Services. The bill would require civil money penalties assessed and collected to be deposited into the fund to be used for specified purposes. This bill would authorize the Controller to use moneys from the Lanterman-Petris-Short Act Data and Reporting Oversight Fund for cashflow loans to the General Fund. By continuously appropriating funds, this bill would make an appropriation.

(30) Existing law provides for the licensure of long-term health care facilities by the State Department of Public Health. Existing law establishes the Federal Health Facilities Citation Penalties Account into which moneys from civil penalties for violations of federal law are deposited. Existing law authorizes up to $130,000 of the money in that account to be used, upon appropriation by the Legislature, for the improvement of quality of care and quality of life for long-term health care facility residents, as specified.

This bill would delete the provision limiting how much money in the account can be used for that purpose.

(31) Existing law requires the Department of Justice to maintain state summary criminal history information, as defined, and to furnish this information to various state and local government officers, officials, and other prescribed entities, if needed in the course of their duties.

This bill would authorize the Department of Justice to furnish state summary criminal history to the State Department of State Hospitals for specified research and reporting purposes and would require the State Department of State Hospitals to use that information only for specified purposes.

(32) Existing law authorizes a court to grant pretrial diversion, as specified, to a defendant suffering from a mental disorder, on an accusatory pleading alleging the commission of a misdemeanor or felony offense, in order to allow the defendant to undergo mental health treatment. Existing law conditions eligibility on, among other criteria, the diagnosis of a mental disorder, as specified, and that the defendant's mental disorder played a significant role in the commission of the charged offense. Existing law makes defendants ineligible for the diversion program for certain offenses, including murder, voluntary manslaughter, and rape.

This bill would make technical changes to Section 1370 of the Penal Code that were necessitated by changes to these provisions that were enacted by Senate Bill 1223 of the 2021–2022 session.

(33) The Budget Act of 2022 made appropriations for the support of state government for the 2022–23 fiscal year.

This bill would revert specified items of appropriation regarding health care workforce grants to the General Fund and would state specified total program funding allocations for health care workforce grants that are reflected in the Budget Act of 2023.

(34) 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.

(35) Specified sections of this bill would become operative only if AB 119 or SB 119 of the 2023–24 Regular Session is enacted and takes effect on or before July 1, 2023.

(36) 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 1295 of the Code of Civil Procedure is amended to read:

1295. (a) Any contract for medical services which contains a provision for arbitration of any dispute as to professional negligence of a health care provider shall have such provision as the first article of the contract and shall be expressed in the following language: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."

(b) Immediately before the signature line provided for the individual contracting for the medical services must appear the following in at least 10-point bold red type:

"NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT."

(c) Once signed, such a contract governs all subsequent open-book account transactions for medical services for which the contract was signed until or unless rescinded by written notice within 30 days of signature. Written notice of such rescission may be given by a guardian or conservator of the patient if the patient is incapacitated or a minor.

(d) Where the contract is one for medical services to a minor, it shall not be subject to disaffirmance if signed by the minor's parent or legal guardian.

(e) Such a contract is not a contract of adhesion, nor unconscionable nor otherwise improper, where it complies with subdivisions (a), (b), and (c) of this section.

(f) Subdivisions (a), (b), and (c) shall not apply to any health care service plan contract offered by an organization registered pursuant to Article 2.5 (commencing with Section 12530) of Division 3 of Title 2 of the Government Code, or licensed pursuant to Chapter 2.2 (commencing with Section 1340)

of Division 2 of the Health and Safety Code, which contains an arbitration agreement if the plan complies with paragraph (10) of subdivision (b) of Section 1363 of the Health and Safety Code, or otherwise has a procedure for notifying prospective subscribers of the fact that the plan has an arbitration provision, and the plan contracts conform to subdivision (h) of Section 1373 of the Health and Safety Code.

(g) For the purposes of this section:

(1) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider;

(2) "Professional negligence" means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

SEC. 2. Section 12534 of the Government Code is amended to read:

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

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

(c) Upon order of the Director of Finance, the Controller shall transfer funds received in the Litigation Deposits Fund allocated to the state for state opioid remediation from the 2022 opioid settlements with Johnson & Johnson, Janssen Pharmaceuticals, McKesson, Cardinal Health, AmerisourceBergen, and Mallinckrodt Pharmaceuticals to the Opioid Settlements Fund.

(d) Upon order of the Director of Finance, the Controller shall transfer funds received in the Litigation Deposits Fund allocated to the state for state opioid remediation from the 2023 opioid settlements with manufacturers Teva Pharmaceutical Industries Ltd. and Allergan, and pharmacies CVS, Walgreens, and Walmart to the Opioid Settlements Fund.

(e) Upon order of the Director of Finance, the Controller shall transfer funds received in the Litigation Deposits Fund allocated to the state for state opioid remediation from any future judgments, bankruptcies, or settlements pursuant to future Budget Act appropriation to the Opioid Settlements Fund.

(f) Funds received from the settlements outlined in this section or any future judgments, bankruptcies, or settlements allocated to the state for state opioid remediation that are not deposited in the Litigation Deposits Fund shall be deposited in the Opioid Settlements Fund.

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

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

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

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

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

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

SEC. 3. Section 16531.1 of the Government Code is amended to read:

16531.1. (a) Notwithstanding any other law and without regard to fiscal year, if the annual State Budget is not enacted by June 30 of the fiscal year preceding the fiscal year to which the budget would apply or there is a deficiency in the Medi-Cal budget during a fiscal year, all of the following shall occur:

(1) The Controller shall annually transfer from the General Fund, upon order of the Department of Finance, in the form of one or more loans, an amount not to exceed a cumulative total of 10 percent of the amount appropriated from the General Fund for Medi-Cal benefit costs in the Budget Act of the most recent fiscal year, to the Medical Providers Interim Payment Fund, which is hereby created in the State Treasury. Notwithstanding Section 13340, the Medical Providers Interim Payment Fund is hereby continuously appropriated for the purpose of making payments to Medi-Cal providers, providers of services under Chapter 6 (commencing with Section 120950) of Part 4 of Division 105 of the Health and Safety Code, and providers of services under Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code, on or after July 1 of the fiscal year for which no budget has been enacted and before September 1 of that year or for the purpose of making payments to Medi-Cal providers, providers of services under Chapter 6 (commencing with Section 120950) of Part 4 of Division 105 of the Health and Safety Code, and providers of services under Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code, during the period in which the Medi-Cal program has a deficiency. Payments shall be made pursuant to this subdivision if both of the following conditions have been met:

(A) An invoice has been submitted for the services.

(B) Payment for the services is due and payable and the State Department of Health Care Services determines that payment would be valid.

(2) For any fiscal year to which this subdivision applies, there is hereby appropriated an amount not to exceed 6 percent of the amount appropriated from the Federal Trust Fund for Medi-Cal benefit costs in the annual Budget Act of the most recent fiscal year, from the Federal Trust Fund to the Medical Providers Interim Payment Fund.

(3) The Department of Finance shall notify the Legislature within 10 days of authorizing a transfer. The 10-day notification to the Legislature shall include the amount of the transfer, the reasons for the transfer, and the fiscal assumptions used to calculate the transfer amount.

(b) Notwithstanding any other law, including Section 14159 of the Welfare and Institutions Code, the amount of a loan made pursuant to subdivision (a) and for which moneys were expended from the Medical Providers Interim Payment Fund shall be repaid either in the same fiscal year in which it was made or in the subsequent fiscal year, as determined by the State Department of Health Care Services in consultation with the Department of Finance. The loan shall be repaid by debiting the appropriate Budget Act item or by using the proceeds of a supplemental appropriations bill, as determined by the State Department of Health Care Services in consultation with the Department of Finance.

(c) Within 30 days of the enactment of the annual Budget Act or a supplemental appropriations bill in a fiscal year to which subdivision (a) applies, the State Department of Health Care Services, in consultation with the Department of Finance, shall inform the Controller of its determination pursuant to subdivision (b) and shall designate the fiscal year and item of

the Budget Act to which any expenditures and unexpended funds in the Medical Providers Interim Payment Fund shall be transferred.

SEC. 4. Section 53123.1.5 of the Government Code is amended to read:

53123.1.5. For purposes of this article, the following definitions shall apply:

(a) "988" means the three-digit telephone number designated by the Federal Communications Commission for the purpose of connecting individuals experiencing a behavioral health crisis with the national suicide prevention and mental health crisis hotline system in accordance with Section 52.200 of Title 47 of the Code of Federal Regulations.

(b) "988 center" means a center operating on a county or regional basis in California and participating in the National Suicide Prevention Lifeline network to respond to statewide or regional 988 calls.

(c) "Agency" means the California Health and Human Services Agency.

(d) "Behavioral health crisis services" means the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a mental health or substance use disorder crisis that are wellness, resiliency, and recovery oriented. These include, but are not limited to, crisis intervention, including counseling provided by 988 centers, mobile crisis teams, and crisis stabilization services.

(e) "National Suicide Prevention Lifeline" or "988 Suicide & Crisis Lifeline" means the national network of local crisis hotline centers that provide free and confidential support to people in suicidal crisis or other behavioral health crisis 24 hours per day, seven days per week via a toll-free telephone hotline number that receives calls made through the 988 system. The toll-free telephone number is maintained by the Assistant Secretary for Mental Health and Substance Use under Section 520E-3 of the Public Health Service Act, Section 290bb-36c of Title 42 of the United States Code.

(f) "Office" means the Office of Emergency Services.

(g) "Substance Abuse and Mental Health Services Administration" means that agency of the United States Department of Health and Human Services.

SEC. 5. Section 53123.3 of the Government Code is amended to read:

53123.3. (a) (1) No later than December 31, 2024, the California Health and Human Services Agency shall create a set of recommendations to support a five-year implementation plan for a comprehensive 988 system.

(2) The California Health and Human Services Agency shall convene a state 988 advisory group for purposes of advising the California Health and Human Services Agency on the set of recommendations to support the five-year implementation plan. The recommendations shall specify what can be accomplished pursuant to existing administrative authority and what will require additional legislation for implementation.

(3) The advisory group shall include, but is not limited to, the State Department of Health Care Services, the office, the State Department of Public Health, representatives of counties, representatives of employees working for county behavioral health agencies and agencies who subcontract with county behavioral health agencies who provide these services, health

plans, emergency medical services, law enforcement, consumers, families, peers, 988 centers, and other local and statewide public agencies.

(4) The advisory group shall meet at least once per quarter until December 31, 2024.

(5) The advisory group may be disbanded at the discretion of the California Health and Human Services Agency, but shall not be disbanded before January 1, 2025.

(b) The California Health and Human Services Agency and the advisory group shall make recommendations on all of the following:

(1) Federal Substance Abuse and Mental Health Services Administration requirements and national best practices guidelines for operational and clinical standards, including training requirements and policies for transferring callers to an appropriate specialized center, or subnetworks, within or external to, the National Suicide Prevention Lifeline network.

(2) Maintenance of an active agreement with the administrator of the National Suicide Prevention Lifeline for participation within the network.

(3) Compliance with state technology requirements or guidelines for the operation of 988.

(4) A state governance structure to support the implementation and administration of behavioral health crisis services accessed through 988.

(5) 988 infrastructure, staffing, and training standards that will support statewide access to crisis counselors through telephone call, text, and chat, 24 hours per day, seven days per week.

(6) Access to crisis stabilization services and triage and response to warm handoffs from 911 and 988 call centers.

(7) Resources and policy changes to address statewide and regional needs in order to meet population needs for behavioral health crisis services.

(8) Statewide and regional public communications strategies informed by the National Suicide Prevention Lifeline and the Substance Abuse and Mental Health Services Administration to support public awareness and consistent messaging regarding 988 and behavioral health crisis services.

(9) Recommendations to achieve coordination between 988 and the continuum of behavioral health crisis services. Recommendations shall address strategies for verifying that behavioral health crisis services are coordinated for a timely response to clearly articulated suicidal or behavioral health contacts made or routed to 988 services as an alternative to a response from law enforcement, except in high-risk situations that cannot be safely managed without law enforcement response and achieving statewide provision of connection to mobile crisis services, when appropriate, to respond to individuals in crisis in a timely manner.

(10) Quantifiable goals for the provision of statewide and regional behavioral health crisis services, which consider factors such as reported rates of suicide attempts and deaths.

(11) A process for establishing outcome measures, benchmarks, and improvement targets for 988 centers and the behavioral health crisis services system. This may include recommendations regarding how to measure, the feasibility of measuring 988 system performance, including capacity, wait

time, and the ability to meet demand for services for 988 State Suicide and Behavioral Health Crisis Services Fund fund recipients. This may also include recommendations for how to determine and report the amount billed to and reimbursed by Medi-Cal or other public and private health care service plans or insurers related to 988 services.

(12) Findings from a comprehensive assessment of the behavioral health crisis services system that takes into account infrastructure projects that are planned and funded. These findings shall include an inventory of the infrastructure, capacity, and needs for all of the following:

(A) Statewide and regional 988 centers.

(B) Mobile crisis team services, including mobile crisis access and dispatch call centers.

(C) Other existing behavioral health crisis services and warm lines.

(D) Crisis stabilization services.

(13) Procedures for determining the annual operating budget for the purposes of establishing the rate of the 988 surcharge and how revenue will be dispersed to fund the 988 system consistent with Section 53123.4 and Section 251a of Title 47 of the United States Code.

(14) Strategies to support the behavioral health crisis service system is adequately funded, including mechanisms for reimbursement of behavioral health crisis response pursuant to Sections 1374.72 and 1374.721 of the Health and Safety Code, including, but not limited to:

(A) To the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized, seeking to maximize all available federal funding sources for the purposes of behavioral health crisis services and administrative activities related to 988 implementation, including federal Medicaid reimbursement for services; federal Medicaid reimbursement for administrative expenses, including the development and maintenance of information technology; and federal grants.

(B) Coordinating with the Department of Insurance and Department of Managed Health Care to verify reimbursement to 988 centers for behavioral health crisis services by health care service plans and disability insurers, pursuant to Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code and consistent with the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. Sec. 1185a).

(c) Until December 31, 2029, the California Health and Human Services Agency shall post regular updates, no less than annually, regarding the implementation of 988 on its public internet website.

SEC. 6. Section 53123.4 of the Government Code is amended to read:

53123.4. (a) The 988 State Suicide and Behavioral Health Crisis Services Fund is hereby established in the State Treasury.

(b) (1) The fund shall consist of the revenue generated by the 988 surcharge assessed on users under Section 41020 of the Revenue and Taxation Code, which revenue shall be used solely for the operations of the 988 center and mobile crisis teams, as defined in the American Rescue Plan Act of 2021 (Section 1947(b)(2) of Public Law 117-2). The fund shall also

consist of any other appropriations made to it by the Legislature. The Legislature may consider additional uses for the revenue generated by the 988 surcharge based on recommendations made by the California Health and Human Services Agency and the advisory group pursuant to subdivision (b) of Section 53123.3.

(2) The revenue generated by the 988 surcharge shall, to the extent not prohibited by Section 251a of Title 47 of the United States Code and any applicable rules or regulations adopted by the Federal Communications Commission and in compliance with subdivision (b) of Section 41136 of the Revenue and Taxation Code, be prioritized to fund the following:

(A) First, the 988 centers, including the efficient and effective routing of telephone calls, personnel, and the provision of acute behavioral health services through telephone call, text, and chat to the 988 number.

(B) Second, the operation of mobile crisis teams accessed via telephone calls, texts, or chats made to or routed through 988, as specified under Section 4(a)(2)(B) of Public Law 116-172.

(3) Money in the fund shall not be subject to transfer to any other fund or to transfer, assignment, or reassignment for any other use or purpose outside of those specified in this article.

(4) 988 surcharge revenue in the fund shall be available, upon appropriation by the Legislature, for the purposes specified in this article.

(5) The revenue generated by the 988 surcharge shall be used to supplement and not supplant federal, state, and local funding for 988 centers and behavioral health crisis services.

(6) The revenue generated by the 988 surcharge may only be used to fund service and operation expenses that are not reimbursable through Medicaid federal financial participation, Medicare, health care service plans, or disability insurers.

(c) The office, in consultation with the State Department of Health Care Services, may adopt regulations regarding how funds received shall be disseminated to support the operations of the 988 system and related behavioral health crisis services.

(d) The office shall require an entity seeking funds available through the 988 Suicide and Behavioral Health Crisis Services Fund to annually file an expenditure and outcomes report in a form and manner as determined by the office and the State Department of Health Care Services. The expenditure and outcomes report shall include, but is not limited to, the following:

(1) The total budget.

(2) Number and job classification of personnel.

(3) The number of individuals served.

(4) The outcomes for individuals served, if known.

(5) The health coverage status of individuals served, if known.

(6) Beginning July 1, 2025, to the extent feasible and consistent with paragraph (11) of subdivision (b) of Section 52123.3, measures of system performance, including capacity, wait times, and the ability to meet demand for services.

(7) Beginning January 1, 2030, to the extent feasible and consistent with paragraph (11) of subdivision (b) of Section 52123.3, the amount billed to and reimbursed by Medi-Cal or other public and private health care service plans or insurers.

(e) The State Treasurer shall report annually to the office on fund deposits and expenditures.

SEC. 7. Section 53123.5 of the Government Code is amended to read:

53123.5. Notwithstanding any law, including Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the office and the State Department of Health Care Services may implement, interpret, or make specific this article, in whole or in part, by means of all-county letters, plan letters, provider bulletins, information notices, regulations, or other similar instructions, without taking any further regulatory action.

SEC. 8. Section 53123.6 is added to the Government Code, immediately following Section 53123.5, to read:

53123.6. For purposes of implementing this article, the State Department of Health Care Services may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis, and may implement changes to existing information technology systems. Notwithstanding any law, contracts entered into or amended, or changes to existing information technology systems, pursuant to this section shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2, Section 19130, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

SEC. 9. 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 the 2025–26 fiscal year.

SEC. 10. Section 100800 of the Government Code is amended to read:

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

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

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

(1) A resolution adopted pursuant to this section shall not take effect until 10 days after notification in writing to the Joint Legislative Budget Committee.

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

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

(d) The program design adopted for a coverage year shall be based on funds appropriated to the program for that coverage year. An appropriation

made for the program shall contain provisional language directing the Exchange to provide a certain proportion of the funds to specified income ranges as determined by the Legislature and may provide other parameters guiding the design of the program.

(1) Pursuant to the Budget Act of 2023, the program shall be funded at an amount up to eighty-two million five hundred thousand dollars ($82,500,000) for coverage year 2024.

(2) It is the intent of the Legislature, beginning in the 2024–25 fiscal year, to appropriate up to one hundred sixty-five million dollars ($165,000,000) in the annual Budget Act to the program for each coverage year of the program after coverage year 2024.

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

SEC. 11. Section 27 of the Health and Safety Code is amended to read:

27. For purposes of this code:

(a) "Communicable Disease Prevention and Control Act" means Sections 104730, 104830 to 104860, inclusive, 113150, 113155, Part 1 (commencing with Section 120100) of, Chapter 1 (commencing with Section 120325, but excluding Section 120380) of Part 2 of, Part 3 (commencing with Section 120500) of, and Part 5 (commencing with Section 121350) of, Division 105.

(b) "Hereditary Disorders Act" means Article 1 (commencing with Section 124975) of Chapter 1 of Part 5 of Division 106, and Sections 125050, 125055, 125060, and 125065.

(c) "Maternal and Child Health Program Act" means Section 120380, Chapter 4 (commencing with Section 103925) of Part 2 of Division 102, Article 4 (commencing with Section 116875) of Chapter 5 of Part 12 of Division 104, Article 1 (commencing with Section 123225) of Chapter 1 of Part 2 of Division 106, Article 2 (commencing with Section 125000) of Chapter 1 of Part 5 of Division 106, and Sections 125075 to 125110, inclusive.

(d) "Miscellaneous Food, Food Facility, and Hazardous Substances Act" means Chapter 4 (commencing with Section 108100), Chapter 6 (commencing with Section 108675), and Chapter 7 (commencing with Section 108750) of Part 3 of, Chapter 3 (commencing with Section 111940), Chapter 4 (commencing with Section 111950), Chapter 5 (commencing with Section 112150), Chapter 6 (commencing with Section 112350), Chapter 7 (commencing with Section 112500), Chapter 8 (commencing with Section 112650), Chapter 9 (commencing with Section 112875), Chapter 10 (commencing with Section 113025), and Article 3 (commencing with Section 113250) of Chapter 11, of Part 6 of, and Chapter 4 (commencing with Section 113700) of Part 7 of, Division 104.

(e) "Primary Care Services Act" means Chapter 1 (commencing with Section 124400), Chapter 2 (commencing with Section 124475), Chapter 3 (commencing with Section 124550), Chapter 4 (commencing with Section 124575), Chapter 5 (commencing with Section 124600), Chapter 6

(commencing with Section 124800), and Article 1 (commencing with Section 124875) of Chapter 7 of, Part 4 of Division 106.

(f) "Radiologic Technology Act" means Sections 106965 to 107115, inclusive, and Chapter 6 (commencing with Section 114840) of Part 9 of Division 104.

SEC. 12. Section 1352.1 of the Health and Safety Code is amended to read:

1352.1. (a) Except as provided in subdivision (b), no plan shall enter into any new or modified plan contract or publish or distribute, or allow to be published or distributed on its behalf, any disclosure form or evidence of coverage, unless (1) a true copy thereof has first been filed with the director, at least 30 days prior to any such use, or any shorter period as the director by rule or order may allow, and (2) the director by notice has not found the plan contract, disclosure form, or evidence of coverage, wholly or in part, to be untrue, misleading, deceptive, or otherwise not in compliance with this chapter or the rules thereunder, and specified the deficiencies, within at least 30 days or any shorter time as the director by rule or order may allow.

(b) Except as provided in subdivision (d), a licensed plan which has been continuously licensed under this chapter for the preceding 18 months and which has had group contracts in effect at all times during that period may enter a new or modified group contract or may publish or distribute, or allow to be published or distributed on its behalf, any group disclosure form or evidence of coverage without having filed the same for the director's prior approval, if the plan and the materials comply with each of the following conditions:

(1) The contract, disclosure form, or evidence of coverage, or any material provision thereof, has not been previously disapproved by the director by written notice to the plan and the plan reasonably believes that the contract, disclosure form, and evidence of coverage do not violate any requirements of this chapter or the rules thereunder.

(2) The plan files the contract and any related disclosure form and evidence of coverage with the director not later than 10 business days after entering the contract, or within any additional period as the director by rule or order may provide.

(3) If the person or group entering into the contract with the plan is not an employee welfare benefit plan, as defined in the Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1001 et seq.), the person or group is not organized solely or principally for the purpose of providing health benefits to members of the group.

(c) Effective January 1, 2025, a plan shall utilize the standard templates developed by the department pursuant to Section 1363 for any disclosure form or evidence of coverage published or distributed. This subdivision shall not apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

(d) The director by order may require a plan which has entered any group contract or published or distributed, or allowed to be published or distributed on its behalf, any disclosure form or evidence of coverage in violation of this chapter or the rules thereunder to comply with subdivision (a) prior to entering group contracts, or a specified class of group contracts, and prior to publishing or distributing, or allowing to be published or distributed on its behalf, related disclosure forms and evidences of coverage. An order issued pursuant to this subdivision shall be effective for 12 months from its issuance, and may be renewed by order if the contracts, disclosure forms, or evidences of coverage submitted under this subdivision indicate difficulties of voluntary compliance with the applicable provisions of this chapter and the rules thereunder.

(e) A licensed plan or other person regulated under this chapter may, within 30 days after receipt of any notice or order under this section, file a written request for a hearing with the director.

SEC. 13. Section 1363 of the Health and Safety Code is amended to read:

1363. (a) (1) The director shall require the use by each plan of disclosure forms or materials containing information regarding the benefits, services, and terms of the plan contract as the director may require, so as to afford the public, subscribers, and enrollees with a full and fair disclosure of the provisions of the plan in readily understood language and in a clearly organized manner. Health care service plans shall present the materials in the uniform manner established by the department pursuant to paragraph (2) so as to facilitate comparisons between plan contracts of the same or other types of plans. Nothing contained in this chapter shall preclude the director from permitting the disclosure form to be included with the evidence of coverage or plan contract.

(2) The department shall develop standard templates for the disclosure form and evidence of coverage. The standard templates for the disclosure form and evidence of coverage may be consolidated into a single standard template. The standard template or templates may include standard definitions, notice and explanatory language, benefit and limitation descriptions, and any other information or formatting in the template that the director determines, consistent with the goals of this section. The department shall consult with the Department of Insurance and interested stakeholders in developing standard templates under this section.

(b) The disclosure form shall provide for at least the following information, in concise and specific terms, relative to the plan, together with additional information as may be required by the director, in connection with the plan or plan contract:

(1) The principal benefits and coverage of the plan, including coverage for acute care and subacute care.

(2) The exceptions, reductions, and limitations that apply to the plan.

(3) The full premium cost of the plan.

(4) Any copayment, coinsurance, or deductible requirements that may be incurred by the member or the member's family in obtaining coverage under the plan.

(5) The terms under which the plan may be renewed by the plan member, including any reservation by the plan of any right to change premiums.

(6) A statement that the disclosure form is a summary only, and that the plan contract itself should be consulted to determine governing contractual provisions. The first page of the disclosure form shall contain a notice that conforms with all of the following conditions:

(A) (i) States that the evidence of coverage discloses the terms and conditions of coverage.

(ii) States, with respect to individual plan contracts, small group plan contracts, and any other group plan contracts for which health care services are not negotiated, that the applicant has a right to view the evidence of coverage prior to enrollment, and, if the evidence of coverage is not combined with the disclosure form, the notice shall specify where the evidence of coverage can be obtained prior to enrollment.

(B) Includes a statement that the disclosure and the evidence of coverage should be read completely and carefully and that individuals with special health care needs should read carefully those sections that apply to them.

(C) Includes the plan's telephone number or numbers that may be used by an applicant to receive additional information about the benefits of the plan or a statement where the telephone number or numbers are located in the disclosure form.

(D) For individual contracts, and small group plan contracts as defined in Article 3.1 (commencing with Section 1357), the disclosure form shall state where the health plan benefits and coverage matrix is located.

(E) Is printed in type no smaller than that used for the remainder of the disclosure form and is displayed prominently on the page.

(7) A statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon an enrollee who is hospitalized or undergoing treatment for an ongoing condition.

(8) To the extent that the plan permits a free choice of provider to its subscribers and enrollees, the statement shall disclose the nature and extent of choice permitted and the financial liability that is, or may be, incurred by the subscriber, enrollee, or a third party by reason of the exercise of that choice.

(9) A summary of the provisions required by subdivision (g) of Section 1373, if applicable.

(10) If the plan utilizes arbitration to settle disputes, a statement of that fact.

(11) A summary of, and a notice of the availability of, the process the plan uses to authorize, modify, or deny health care services under the benefits provided by the plan, pursuant to Sections 1363.5 and 1367.01.

(12) A description of any limitations on the patient's choice of primary care physician, specialty care physician, or nonphysician health care

practitioner, based on service area and limitations on the patient's choice of acute care hospital care, subacute or transitional inpatient care, or skilled nursing facility.

(13) General authorization requirements for referral by a primary care physician to a specialty care physician or a nonphysician health care practitioner.

(14) Conditions and procedures for disenrollment.

(15) A description as to how an enrollee may request continuity of care as required by Section 1373.96 and request a second opinion pursuant to Section 1383.15.

(16) Information concerning the right of an enrollee to request an independent review in accordance with Article 5.55 (commencing with Section 1374.30).

(17) A notice as required by Section 1364.5.

(c) (1) As of July 1, 1999, the director shall require each plan offering a contract to an individual or small group to provide with the disclosure form for individual and small group plan contracts a uniform health plan benefits and coverage matrix containing the plan's major provisions in order to facilitate comparisons between plan contracts. The uniform matrix shall include the following category descriptions together with the corresponding copayments and limitations in the following sequence:

(A) Deductibles.
(B) Lifetime maximums.
(C) Professional services.
(D) Outpatient services.
(E) Hospitalization services.
(F) Emergency health coverage.
(G) Ambulance services.
(H) Prescription drug coverage.
(I) Durable medical equipment.
(J) Mental health services.
(K) Chemical dependency services.
(L) Home health services.
(M) Other.

(2) The following statement shall be placed at the top of the matrix in all capital letters in at least 10-point boldface type:

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

(3) (A) A health care service plan contract subject to Section 2715 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-15), shall satisfy the requirements of this subdivision by providing the uniform summary of benefits and coverage required under Section 2715 of the federal

Public Health Service Act (42 U.S.C. Sec. 300gg-15) and any rules or regulations issued thereunder. A health care service plan that issues the uniform summary of benefits referenced in this paragraph shall do both of the following:

(i) Ensure that all applicable benefit disclosure requirements specified in this chapter and in Title 28 of the California Code of Regulations are met in other health plan documents provided to enrollees under the provisions of this chapter.

(ii) Consistent with applicable law, advise applicants and enrollees, in a prominent place in the plan documents referenced in subdivision (a), that enrollees are not financially responsible in payment of emergency care services, in any amount that the health care service plan is obligated to pay, beyond the enrollee's copayments, coinsurance, and deductibles as provided in the enrollee's health care service plan contract.

(B) Commencing October 1, 2016, the uniform summary of benefits and coverage referenced in this paragraph shall constitute a vital document for the purposes of Section 1367.04. Not later than July 1, 2016, the department shall develop written translations of the template uniform summary of benefits and coverage for all language groups identified by the State Department of Health Care Services in all plan letters as of August 27, 2014, for translation services pursuant to Section 14029.91 of the Welfare and Institutions Code, except for any language group for which the United States Department of Labor has already prepared a written translation. Not later than July 1, 2016, the department shall make available on its internet website written translations of the template uniform summary of benefits and coverage developed by the department, and written translations prepared by the United States Department of Labor, if available, for any language group to which this subparagraph applies.

(C) Subdivision (d) shall not apply to a health care service plan contract subject to subparagraph (A).

(4) A health care service plan may satisfy the requirements of this subdivision for the dental services offered under a contract subject to Section 1363.04 by providing the uniform benefit disclosure benefits and coverage disclosure matrix consistent with the requirements of that section.

(d) Nothing in this section shall prevent a plan from using appropriate footnotes or disclaimers to reasonably and fairly describe coverage arrangements in order to clarify any part of the matrix that may be unclear.

(e) All plans, solicitors, and representatives of a plan shall, when presenting any plan contract for examination or sale to an individual prospective plan member, provide the individual with a properly completed disclosure form, as prescribed by the director pursuant to this section for each plan so examined or sold.

(f) In the case of group contracts, the completed disclosure form and evidence of coverage shall be presented to the contractholder upon delivery of the completed health care service plan agreement.

(g) Group contractholders shall disseminate copies of the completed disclosure form to all persons eligible to be a subscriber under the group

contract at the time those persons are offered the plan. If the individual group members are offered a choice of plans, separate disclosure forms shall be supplied for each plan available. Each group contractholder shall also disseminate or cause to be disseminated copies of the evidence of coverage to all applicants, upon request, prior to enrollment and to all subscribers enrolled under the group contract.

(h) In the case of conflicts between the group contract and the evidence of coverage, the provisions of the evidence of coverage shall be binding upon the plan notwithstanding any provisions in the group contract that may be less favorable to subscribers or enrollees.

(i) In addition to the other disclosures required by this section, every health care service plan and any agent or employee of the plan shall, when presenting a plan for examination or sale to any individual purchaser or the representative of a group consisting of 25 or fewer individuals, disclose in writing the ratio of premium costs to health services paid for plan contracts with individuals and with groups of the same or similar size for the plan's preceding fiscal year. A plan may report that information by geographic area, provided the plan identifies the geographic area and reports information applicable to that geographic area.

(j) Subdivision (c) shall not apply to any coverage provided by a plan for the Medi-Cal program or the Medicare Program pursuant to Title XVIII and Title XIX of the federal Social Security Act.

(k) Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code shall not be required to use the standard templates developed by the department pursuant to this section.

(*l*) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of issuing and modifying templates and all-plan letters or similar instructions, without taking regulatory action.

SEC. 14. Section 1363.3 is added to the Health and Safety Code, to read:

1363.3. (a) The department may develop standard templates for a schedule of benefits, an explanation of benefits, a cost-sharing summary, or any similar document. The standard template or templates may include standard definitions, notice and explanatory language, benefit and limitation descriptions, and any other information or formatting in the template that the director determines would provide the public, subscribers, and enrollees with a full and fair disclosure of the provisions of the plan in readily understood language and in a clearly organized manner. The department shall consult with the Department of Insurance and interested stakeholders in developing standard templates under this section.

(b) The department may require health care service plans to utilize the standard templates developed by the department pursuant to subdivision (a)

for any schedule of benefits, explanation of benefits, cost-sharing summaries, or similar documents published or distributed.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of issuing and modifying templates and all-plan letters or similar instructions, without taking regulatory action.

(d) The director may require a health care service plan to file any document the health care service plan developed using a standard template developed by the department for compliance review.

SEC. 15. Section 1367.041 of the Health and Safety Code is amended to read:

1367.041. (a) A health care service plan that advertises or markets products in the individual or small group health care service plan markets, or allows any other person or business to market or advertise on its behalf in the individual or small group health care service plan markets, in a non-English language that does not meet the requirements set forth in Sections 1367.04 and 1367.07, shall provide the following documents in the same non-English language:

(1) Welcome letters or notices of initial coverage, if provided.

(2) Applications for enrollment and any information pertinent to eligibility or participation.

(3) Notices advising limited-English-proficient persons of the availability of no-cost translation and interpretation services.

(4) Notices pertaining to the right and instructions on how an enrollee may file a grievance.

(5) The uniform summary of benefits and coverage required pursuant to subparagraph (A) of paragraph (3) of subdivision (c) of Section 1363.

(b) A health care service plan shall use a trained and qualified translator for all written translations of marketing and advertising materials relating to health care service plan products, and for all of the documents specified in subdivision (a).

(c) This section shall not apply to a specialized health care service plan that does not offer an essential health benefit as defined in Section 1367.005.

SEC. 16. Section 1367.24 of the Health and Safety Code is amended to read:

1367.24. (a) Every health care service plan that provides prescription drug benefits shall maintain an expeditious process by which prescribing providers may obtain authorization for a medically necessary nonformulary prescription drug. On or before July 1, 1999, every health care service plan that provides prescription drug benefits shall file with the department a description of its process, including timelines, for responding to authorization requests for nonformulary drugs. Any changes to this process shall be filed with the department pursuant to Section 1352. Each plan shall provide a written description of its most current process, including timelines, to its prescribing providers. For purposes of this section, a prescribing provider shall include a provider authorized to write a prescription, pursuant to

subdivision (a) of Section 4040 of the Business and Professions Code, to treat a medical condition of an enrollee.

(b) Any plan that disapproves a request made pursuant to subdivision (a) by a prescribing provider to obtain authorization for a nonformulary drug shall provide the reasons for the disapproval in a notice provided to the enrollee. The notice shall indicate that the enrollee may file a grievance with the plan if the enrollee objects to the disapproval, including any alternative drug or treatment offered by the plan. The notice shall comply with subdivision (b) of Section 1368.02. Any health plan that is required to maintain an external exception request review process pursuant to subdivision (k) shall indicate in the notice required under this subdivision that the enrollee may file a grievance seeking an external exception request review.

(c) The process described in subdivision (a) by which prescribing providers may obtain authorization for medically necessary nonformulary drugs shall not apply to a nonformulary drug that has been prescribed for an enrollee in conformance with the provisions of Section 1367.22.

(d) The process described in subdivision (a) by which enrollees may obtain medically necessary nonformulary drugs, including specified timelines for responding to prescribing provider authorization requests, shall be described in evidence of coverage and disclosure forms, as required by subdivisions (a) and (b) of Section 1363, issued on or after July 1, 1999.

(e) Every health care service plan that provides prescription drug benefits shall maintain, as part of its books and records under Section 1381, all of the following information, which shall be made available to the director upon request:

(1) The complete drug formulary or formularies of the plan, if the plan maintains a formulary, including a list of the prescription drugs on the formulary of the plan by major therapeutic category with an indication of whether any drugs are preferred over other drugs.

(2) Records developed by the pharmacy and therapeutic committee of the plan, or by others responsible for developing, modifying, and overseeing formularies, including medical groups, individual practice associations, and contracting pharmaceutical benefit management companies, used to guide the drugs prescribed for the enrollees of the plan, that fully describe the reasoning behind formulary decisions.

(3) Any plan arrangements with prescribing providers, medical groups, individual practice associations, pharmacists, contracting pharmaceutical benefit management companies, or other entities that are associated with activities of the plan to encourage formulary compliance or otherwise manage prescription drug benefits.

(f) If a plan provides prescription drug benefits, the department shall, as part of its periodic onsite medical survey of each plan undertaken pursuant to Section 1380, review the performance of the plan in providing those benefits, including, but not limited to, a review of the procedures and information maintained pursuant to this section, and describe the performance of the plan as part of its report issued pursuant to Section 1380.

(g) The director shall not publicly disclose any information reviewed pursuant to this section that is determined by the director to be confidential pursuant to state law.

(h) For purposes of this section, "authorization" means approval by the health care service plan to provide payment for the prescription drug.

(i) Nonformulary prescription drugs shall include any drug for which an enrollee's copayment or out-of-pocket costs are different than the copayment for a formulary prescription drug, except as otherwise provided by law or regulation or in cases in which the drug has been excluded in the plan contract pursuant to Section 1342.7.

(j) Nothing in this section shall be construed to restrict or impair the application of any other provision of this chapter, including, but not limited to, Section 1367, which includes among its requirements that a health care service plan furnish services in a manner providing continuity of care and demonstrate that medical decisions are rendered by qualified medical providers unhindered by fiscal and administrative management.

(k) For any individual, small group, or large health plan contracts, a health care service plan's process described in subdivision (a) shall comply with the request for exception and external exception request review processes described in subdivision (c) of Section 156.122 of Title 45 of the Code of Federal Regulations. This subdivision shall not apply to Medi-Cal managed care health care service plan contracts as described in subdivision (*l*).

(*l*) "Medi-Cal managed care health care service plan contract" means any entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

(m) Nothing in this section shall be construed to affect an enrollee's or subscriber's eligibility to submit a grievance to the department for review under Section 1368 or to apply to the department for an independent medical review under Section 1370.4, or Article 5.55 (commencing with Section 1374.30) of this chapter.

SEC. 17. Section 1374.724 of the Health and Safety Code is amended to read:

1374.724. (a) Coverage of mental health and substance use disorder treatment pursuant to Section 1374.72 includes behavioral health crisis services that are provided to an enrollee by a 988 center, mobile crisis team, or other provider of behavioral health crisis services, as set forth in Chapter 1 (commencing with Section 53000) of Part 1 of Division 2 of Title 5 of the Government Code, regardless of whether the service is provided by an in-network or out-of-network provider or facility. With respect to behavioral health crisis services provided to an enrollee by a 988 center or mobile crisis team, a health care service plan shall cover, at a minimum, all items and services that are eligible for coverage under the Medi-Cal program.

(b) (1) A health care service plan shall not require prior authorization for behavioral health crisis stabilization services and care provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services to an enrollee pursuant to Chapter 1 (commencing with Section 53000) of Part 1 of Division 2 of Title 5 of the Government Code.

(2) Notwithstanding any other law, payment for behavioral health crisis stabilization services and care pursuant to this section shall not be denied unless the health care service plan, or its contracting medical provider, reasonably determines that the services were never performed.

(3) If its prior authorization requirements comply with Section 1374.721, a health care service plan may require prior authorization as a prerequisite for payment for medically necessary mental health or substance use disorder services following stabilization from a behavioral health crisis addressed by services provided through the 988 system. If there is a disagreement between the health care service plan and the behavioral health crisis service provider or facility regarding the need for medically necessary mental health or substance use disorder services following stabilization of the enrollee, the plan shall assume responsibility for the care of the enrollee by arranging for services for the enrollee pursuant to Section 1374.72 at a level of care consistent with utilization review criteria pursuant to Section 1374.721.

(4) A health care service plan shall not require, under any circumstances, a behavioral health crisis services provider or facility to discharge or transfer an enrollee before stabilization has occurred or before utilization review consistent with Section 1374.721.

(c) (1) A health care service plan that is contacted by a 988 center, mobile crisis team, or other provider of behavioral health crisis services shall, within 30 minutes of the time the provider makes the initial telephone call requesting information, either authorize poststabilization care or inform the provider that it will arrange for the prompt transfer of the enrollee's care to another provider.

(2) A health care service plan that is contacted by a 988 center, mobile crisis team, or other provider of behavioral health crisis services shall reimburse the provider for poststabilization care rendered to the enrollee if any of the following occur:

(A) The health care service plan authorized the 988 center, mobile crisis team, or other provider of behavioral health crisis services to provide poststabilization care.

(B) The health care service plan did not respond to the provider's initial contact or did not make a decision regarding whether to authorize poststabilization care or to promptly transfer the enrollee's care within the timeframe set forth in paragraph (1).

(C) There is an unreasonable delay in the transfer of the enrollee's care to another provider, and the provider determines that the enrollee requires poststabilization care.

(3) A health care service plan shall prominently display on its internet website the specific telephone number for noncontracting providers to obtain prompt authorization for the transfer of a stabilized enrollee's care to another

provider or authorization to provide poststabilization care. The health care service plan shall ensure the telephone number published on its internet website is the correct telephone number for purposes of this paragraph. The health care service plan shall update the telephone number on the plan's internet website within one business day if the telephone number changes. A health care service plan shall provide the telephone number to the department, and the department shall post the telephone number on its internet website.

(4) To the extent permissible under federal law, a health care service plan shall not require a 988 center, mobile crisis team, or other provider of behavioral health crisis services to make more than one telephone call to the number provided in advance by the health care service plan. The representative of the 988 center, mobile crisis team, or other provider of behavioral health crisis services that makes the telephone call may be, but is not required to be, a physician or surgeon.

(5) A 988 center, mobile crisis team, or other provider of behavioral health crisis services shall not bill a patient who is an enrollee of a health care service plan for poststabilization care, except for the in-network cost-sharing amount as defined in paragraph (2) of subdivision (d). An enrollee who is billed in violation of this section may report receipt of the bill to the health care service plan and the department. The department shall forward that report to the State Department of Public Health.

(d) (1) Notwithstanding subdivision (f) of Section 1371.4, a health care service plan shall reimburse a 988 center, mobile crisis team, or other provider of behavioral health crisis services for emergency and nonemergency behavioral health crisis services and care pursuant to this section, consistent with the requirements of Section 1371.4 and any other applicable requirement of this chapter.

(2) If an enrollee receives services and care pursuant to this section from a 988 center, mobile crisis team, or other provider of behavioral health crisis services outside the plan network, the enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same services received from an in-network provider. This amount shall be referred to as the "in-network cost-sharing amount." An out-of-network 988 center, mobile crisis team, or other provider of behavioral health crisis services shall not bill or collect an amount from the enrollee for services subject to this section except for the in-network cost-sharing amount.

(e) For purposes of this section:

(1) "Behavioral health crisis services" has the same meaning as set forth in Section 53123.1.5 of the Government Code.

(2) "Behavioral health crisis stabilization services" means the services necessary to determine if a behavioral health crisis exists and, if a behavioral health crisis does exist, the care and treatment that is necessary to stabilize the behavioral health crisis within the capability of the 988 center, mobile crisis team, or other provider of behavioral health crisis services.

(3) "Poststabilization care" means medically necessary care provided after a behavioral health crisis has been stabilized.

(4) An enrollee is "stabilized" or "stabilization" has occurred when, in the opinion of the treating provider or facility, the enrollee's condition is such that, within reasonable medical probability, both of the following criteria are satisfied:

(A) Material deterioration of the enrollee's condition is unlikely to result from, or occur during, the discharge or transfer of the enrollee to the care of another provider.

(B) The enrollee is able to safely travel from the site of care using nonmedical transportation or nonemergency medical transportation. The health care service plan shall continue to cover all services and care as behavioral health crisis stabilization services and care until the enrollee is discharged or transferred.

(f) This section does not excuse a health care service plan from complying with Section 1374.72 or any other requirement of this chapter.

(g) This section does not apply to Medi-Cal managed care contracts entered pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.

SEC. 18. Section 1417.2 of the Health and Safety Code is amended to read:

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

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

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

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

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

(5) Support for the Long-Term Care Ombudsman Program established pursuant to Chapter 11 (commencing with Section 9700) of Division 8.5 of

the Welfare and Institutions Code in an amount appropriated from the State Health Facilities Citation Penalties Account for this purpose in the annual Budget Act.

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

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

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

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

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

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

SEC. 19. Section 1797.100 of the Health and Safety Code is amended to read:

1797.100. There is in the state government, in the California Health and Human Services Agency, the Emergency Medical Services Authority.

SEC. 20. Section 1797.101 of the Health and Safety Code is amended to read:

1797.101. (a) The Emergency Medical Services Authority shall be headed by the Director of the Emergency Medical Services Authority who shall be appointed by the Governor upon nomination by the Secretary of California Health and Human Services.

(b) The Emergency Medical Services Authority shall have a chief medical officer of the Emergency Medical Services Authority who shall be appointed by the Governor upon nomination by the Secretary of California Health and Human Services. The chief medical officer shall be a physician and surgeon licensed in California pursuant to the provisions of Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, and who has substantial experience in the practice of emergency medicine or emergency response in California.

(c) The chief medical officer shall provide clinical leadership and oversight concerning treatment, education, and other matters involving medical decisionmaking and delivery of patient care, including, but not limited to, scope of practice, trauma system organization, stroke and STEMI requirements, and first aid and CPR training.

SEC. 21. Section 1862 of the Health and Safety Code is amended to read:

1862. (a) The Emergency Medical Services Authority shall establish a POLST eRegistry, in consultation with the Coalition for Compassionate Care of California and other pertinent stakeholders, to operate a statewide electronic registry system for the purpose of collecting a patient's POLST information received from a physician, nurse practitioner, physician assistant, or the designee of a physician, nurse practitioner, or physician assistant, and disseminating the information to an authorized user.

(b) The authority shall adopt regulations for the operation of the POLST eRegistry and shall hold at least one public hearing regarding the proposed regulations. The regulations shall include, but not be limited to, standards and procedures regarding all of the following:

(1) The means by which initial or subsequent POLST information may be submitted to the POLST eRegistry, which shall include a method for electronic delivery of this information and the use of legally sufficient electronic signatures. Submitted information may include new, modified, updated, or voided POLST information.

(2) Methods by which the information in the POLST eRegistry may be disseminated to an authorized user, including a method for electronic access.

(3) Standards and procedures for verifying the identity of an authorized user.

(4) Standards and procedures to ensure the accuracy of, and to appropriately protect the confidentiality of, POLST information submitted to the POLST eRegistry, consistent with state and federal privacy laws.

(c) The authority shall implement the POLST eRegistry in conjunction with CEDRS. The authority shall ensure all of the following requirements are met and that the timing is consistent with the CEDRS project development timeline:

(1) An authorized user shall ensure that the most current version of all POLST forms they have signed have been submitted to the POLST eRegistry.

(2) An electronic version of a POLST shall be the only acceptable format to submit a form to the POLST eRegistry. This section does not prohibit an authorized user from printing out a paper copy of a POLST form for a patient to have on hand, upon request by a patient or the patient's legally recognized decisionmaker.

SEC. 22. Section 11830 of the Health and Safety Code is amended to read:

11830. The department shall take the following goals and objectives into consideration in the implementation of this part:

(a) The significance of community-based programs to alcohol and other drug abuse recovery shall not be diminished.

(b) Opportunities for low-income and special needs populations to receive alcohol and other drug abuse recovery or treatment services shall be encouraged.

SEC. 23. Section 11830.1 of the Health and Safety Code is repealed.

SEC. 24. Section 11830.5 of the Health and Safety Code is repealed.

SEC. 25. Section 11831.1 of the Health and Safety Code is repealed.

SEC. 26. Section 11831.12 of the Health and Safety Code is amended to read:

11831.12. (a) A facility licensed by the department pursuant to Chapter 7.5 (commencing with Section 11834.01) shall disclose its license number and the date that the license is scheduled to expire in all of the following circumstances:

(1) To any person who inquires about the facility's license in writing, verbally, electronically, or by any other method of communication between the person and the facility.

(2) By posting on the internet website of the facility in a clear and conspicuous manner the following language and a link to the department's internet website that contains the facility's license number and expiration date: "Licensed by the State Department of Health Care Services."

(3) Included in any print, audio, or electronic advertising or marketing of the facility in a clear and conspicuous manner. For the purpose of complying with this paragraph, a facility may include the following language and a link to the department's internet website that contains its license number and expiration date, as described in paragraph (2): "Licensed by the State Department of Health Care Services."

(b) A program certified by the department pursuant to Chapter 7.1 (commencing with Section 11832) shall disclose its certification number and the date that the certification is scheduled to expire in all of the following circumstances:

(1) To any person who inquires about the certification of the program or the services provided by the program in writing, verbally, electronically, or by any other method of communication between the person and the program.

(2) By posting on the internet website of the program or the services provided by the program in a clear and conspicuous manner the following language and a link to the department's internet website that contains its certification number and expiration date: "Certified by the State Department of Health Care Services."

(3) Included in any print, audio, or electronic advertising or marketing of the program or the services provided by the program in a clear and conspicuous manner. For the purpose of complying with this paragraph, a program may include the following language and a link to the department's internet website that contains its certification number and expiration date, as described in paragraph (2): "Certified by the State Department of Health Care Services."

SEC. 27. Section 11831.2 of the Health and Safety Code is repealed.

SEC. 28. Section 11831.5 of the Health and Safety Code is repealed.

SEC. 29. Section 11831.6 of the Health and Safety Code is amended to read:

11831.6. (a) The following persons, programs, or entities shall not give or receive remuneration or anything of value for the referral of a person who is seeking alcoholism or drug abuse recovery or treatment services:

(1) An alcoholism or drug abuse recovery or treatment facility licensed under this part.

(2) An owner, partner, officer, or director, or shareholder who holds an interest of at least 10 percent in an alcoholism or drug abuse recovery or treatment facility licensed under this part.

(3) A person employed by, or working for, an alcoholism or drug abuse recovery or treatment facility licensed under this part, including, but not limited to, registered and certified counselors and licensed professionals providing counseling services.

(4) An alcohol or other drug program certified by the department in accordance with Chapter 7.1 (commencing with Section 11832).

(5) An owner, partner, officer, or director, or shareholder who holds an interest of at least 10 percent in an alcohol or other drug program certified by the department in accordance with Chapter 7.1 (commencing with Section 11832).

(6) A person employed by, or working for, an alcohol or other drug program certified by the department in accordance with Chapter 7.1 (commencing with Section 11832), including, but not limited to, registered and certified counselors and licensed professionals providing counseling services.

(b) 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, if it deems appropriate, implement, interpret, or make specific this section by means of provider bulletins, written guidelines, or similar instructions from the department, until regulations are adopted.

SEC. 30. Section 11831.7 of the Health and Safety Code is amended to read:

11831.7. (a) The department may investigate allegations of violations of this chapter. The department may, upon finding a violation of this chapter or any regulation adopted pursuant to this chapter, do any of the following:

(1) Assess a penalty upon an alcoholism or drug abuse recovery or treatment facility licensed under this part.

(2) Suspend or revoke the license of an alcoholism or drug abuse recovery or treatment facility licensed under Chapter 7.5 (commencing with Section 11834.01), or deny an application for licensure, extension of the licensing period, or modification to a license. Article 4 (commencing with Section 11834.35) of Chapter 7.5 shall apply to any action taken pursuant to this paragraph.

(3) Assess a penalty upon an alcohol or other drug outpatient program certified by the department in accordance with Chapter 7.1 (commencing with Section 11832).

(4) Suspend or revoke the certification of an alcohol or other drug outpatient program certified by the department in accordance with Chapter 7.1 (commencing with Section 11832).

(5) Suspend or revoke the registration or certification of a counselor for a violation of this chapter.

(b) The department may investigate allegations against a licensed professional providing counseling services at an alcoholism or drug abuse

recovery or treatment program licensed, certified, or funded under this part, and recommend disciplinary actions, including, but not limited to, termination of employment at a program and suspension and revocation of licensure by the respective licensing board.

(c) The department shall establish an enforcement program focused on the oversight duties of this chapter. Staff of the enforcement program shall have responsibilities including, but not limited to, all of the following:

(1) Provide the department with analytical support for the development and administration of this chapter.

(2) Provide the department with general oversight and monitoring focused on investigations and enforcement of this chapter.

(3) Provide the department with legal guidance in the interpretation of this chapter.

(d) 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, if it deems appropriate, implement, interpret, or make specific this section by means of provider bulletins, written guidelines, or similar instructions from the department, until regulations are adopted.

SEC. 31. Section 11832 of the Health and Safety Code is repealed.

SEC. 32. Chapter 7.1 (commencing with Section 11832) is added to Part 2 of Division 10.5 of the Health and Safety Code, to read:

CHAPTER 7.1. CERTIFICATION OF ALCOHOL AND OTHER DRUG PROGRAMS

11832. (a) The department has the sole authority in state government to certify alcohol or other drug programs.

(b) In administering this chapter, the department shall issue certifications for a period of two years to those alcohol or other drug programs that meet the requirements set forth in this chapter.

11832.1. The department shall charge a fee for the certification of alcohol or other drug programs, in accordance with Chapter 7.3 (commencing with Section 11833.01).

11832.2. (a) As used in this chapter, "alcohol or other drug program" or "program" means a business entity with a physical location in the State of California that provides one or more of the following services to clients:

(1) Treatment services.

(2) Recovery services.

(3) Detoxification services.

(4) Medications for addiction treatment.

(b) An individual health care practitioner duly licensed and regulated under Division 2 (commencing with Section 500) of the Business and Professions Code, acting within the scope of their license or certificate is not a program as described in subdivision (a).

11832.3. (a) Except as provided in subdivision (b), any alcohol or other drug program shall be certified by the department in accordance with this chapter.

(b) Any alcohol or other drug program operating in the following settings are exempt from certification under this chapter:

(1) Adult alcoholism or drug abuse recovery or treatment facilities, driving-under-the-influence programs, and narcotic treatment programs licensed by the department.

(2) Clinics licensed by the State Department of Public Health in accordance with Chapter 1 (commencing with Section 1200) of Division 2.

(3) Health facilities licensed by the State Department of Public Health in accordance with Chapter 2 (commencing with Section 1250) of Division 2.

(4) Community care facilities licensed by the State Department of Social Services in accordance with Chapter 3 (commencing with Section 1500) of Division 2.

(5) Residential care facilities for persons with chronic, life-threatening illness licensed by the State Department of Social Services in accordance with Chapter 3.01 (commencing with Section 1568.01) of Division 2.

(6) Residential care facilities for the elderly licensed by the State Department of Social Services in accordance with Chapter 3.2 (commencing with Section 1569) of Division 2.

(7) Adult day health care centers licensed by the State Department of Social Services in accordance with Chapter 3.3 (commencing with Section 1570) of Division 2.

(8) Public elementary and secondary schools as defined in the Education Code.

(9) County jails and state correctional institutions, including juvenile justice facilities.

11832.4. A person or entity applying for a certification pursuant to this chapter shall submit all of the following to the department:

(a) A complete written application.

(b) A certification fee, as established in accordance with Chapter 7.3 (commencing Section 11833.01).

(c) An initial application fee.

(d) Any other documentation specified by the department.

11832.5. (a) The department may issue a certification to an alcohol or other drug program upon all of the following:

(1) Submission of a complete application, fees, and documentation in accordance with Section 11832.4.

(2) Completion of an onsite review.

(3) Determination that the applicant can comply with this chapter and any regulations adopted pursuant to this chapter.

(b) The department shall terminate review of an application for either of the following reasons:

(1) Failure to comply with Section 11832.4.

(2) Prior revocation of an applicant's certification issued by the department, or an adult alcoholism or drug abuse recovery or treatment facility license, within five years from the date of the application submission.

(c) Termination of review shall require submission of a new application.

(d) The department may deny the issuance of a certification for any of the following reasons:

(1) Failure of the applicant to demonstrate the ability to comply with this chapter or the regulations adopted pursuant to this chapter.

(2) Failure of the applicant to remedy any deficiency identified pursuant to this chapter or the regulations adopted pursuant to this chapter.

(3) Failure of the applicant to comply with this division or with Division 4 (commencing with Section 9000) of Title 9 of the California Code of Regulations.

11832.6. (a) A certification shall be valid for a period of two years from the date of issuance.

(b) The department may renew a certification for subsequent two-year periods if, prior to the expiration date on the certification, an alcohol or other drug program submits a completed written application for renewal, pays the required fees, and remains in compliance with this chapter and any regulations adopted pursuant to this chapter, as determined by the department.

(c) Failure to submit to the department the required written application for renewal, or failure to submit to the department the required fees prior to the expiration date on the certification, shall result in the automatic expiration of the certification at the end of the two-year period.

11832.7. Except as provided in subdivision (b) of Section 11832.3, no person, firm, partnership, association, or local government entity shall establish, operate, manage, conduct, or maintain an alcohol or other drug program within this state without first obtaining a certification pursuant to this chapter.

11832.8. (a) An alcohol or other drug program shall adopt policies and procedures that are consistent with this chapter and any regulations adopted pursuant to this chapter.

(b) All policies and procedures shall be kept in an operation manual and address and include, at a minimum, all of the following:

(1) Admission and discharge.

(2) Client rights.

(3) Services.

(4) Medications.

(5) Staff and client code of conduct.

11832.9. (a) Alcohol and other drug programs that are certified in accordance with this chapter shall either offer medications for addiction treatment (MAT) directly to clients, or have an effective referral process in place with narcotic treatment programs, community health centers, or other MAT providers.

(b) An effective referral process shall include an established relationship with an MAT provider and transportation to appointments for MAT.

Providing contact information for an MAT provider does not meet the requirement of an effective referral.

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

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

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

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

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

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

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

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

11832.10. (a) The department shall have the sole authority in state government to establish the minimum qualifications of an alcohol or other drug program administrator and staff who provide any of the services identified in Section 11832.2.

(b) Nothing in this section shall be construed to apply to credentialing or licensing of individuals or to certification qualifications established pursuant to Chapter 7.2 (commencing with Section 11833).

11832.11. (a) A program shall submit, in a form and manner determined by the department, a report to the department of any of the following events:

(1) Death of any person that occurs at the program.

(2) Injury of any client at the program that requires emergency medical treatment.

(3) Cases of communicable disease reportable under Sections 2500 and 2502 of Title 17 of the California Code of Regulations.

(4) Catastrophes such as flooding, tornado, earthquake, or any other natural disaster.

(5) Fires or explosions that occur in or on the premises.

(b) A program shall notify the department, in a timely manner, of any of the following:

(1) Change to the program's organizational structure.

(2) Change in the program's mailing address, facility telephone number, or email address.

(3) Change to the operational days and hours of the program, including any planned temporary pause in operations.

11832.12. (a) The department shall conduct onsite visits for compliance at least once during each certification period.

(b) The department may conduct announced or unannounced site visits at any time to any alcohol or other drug program certified pursuant to this chapter to determine compliance with applicable statutes and regulations.

11832.13. (a) The department may enter and inspect any building, or portion thereof, that contains an alcohol or other drug program and its records, at a reasonable time, with or without notice, to secure information regarding compliance with, or to prevent a violation of, this chapter or any regulation adopted pursuant to this chapter.

(b) Failure of an alcohol or other drug program to allow the department to enter and inspect the building and records shall result in the department taking legal action to gain entry by an inspection warrant issued pursuant to Title 13 (commencing with Section 1822.50) of Part 3 of the Code of Civil Procedure. The alcohol or other drug program shall pay for all costs associated with legal action required to gain entry.

11832.14. (a) The director may suspend or revoke any certification issued under this chapter, as well as any other certification issued under this chapter held by the same person or entity, or deny an application for certification, renewal of a certification, or modification of a certification, upon any of the following grounds and in the manner provided in this chapter:

(1) Violation by the program of any provision of this chapter or regulations adopted pursuant to this chapter.

(2) Repeated violation by the program of any of the provisions of this chapter or regulations adopted pursuant to this chapter.

(3) Aiding, abetting, or permitting the violation of, or any repeated violation of, any of the provisions described in paragraph (1) or (2).

(4) Conduct in the operation of a program that is inimical to the health, morals, welfare, or safety of an individual receiving services from the program or to the people of the State of California.

(5) Misrepresentation of any material fact in obtaining certification, including, but not limited to, providing false information or documentation to the department.

(6) Refusal to allow the department entry into the building to determine compliance with the requirements of this chapter or regulations adopted pursuant to this chapter.

(7) Failure to pay any civil penalties assessed by the department.

(b) The director may temporarily suspend any certification, as well as any other alcohol or other drug program certification issued under this chapter held by the same person or entity, prior to any hearing when, in the opinion of the director, the action is necessary to protect individuals who receive services from any substantial threat to health or safety. The director shall notify the program of the temporary suspension and the effective date of the temporary suspension and at the same time shall serve the program with an accusation. Upon receipt of a notice of defense to the accusation by the program, the director shall, within 15 days, set the matter for hearing, and the hearing shall be held as soon as possible. The temporary suspension shall remain in effect until the time the hearing is completed and the director

has made a final determination on the merits. However, the temporary suspension shall be deemed vacated if the director fails to make a final determination on the merits within 30 days after the department receives the proposed decision from the Office of Administrative Hearings.

(c) The department may terminate review of an application for a certification under this chapter from any person or entity that previously had a certification issued under this chapter suspended or revoked for a period of five years from the date of the final decision and order.

11832.15. (a) Proceedings for the suspension, revocation, or denial of a certification under this chapter shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the department shall have all the powers granted by those provisions. In the event of conflict between this chapter and the Government Code, the Government Code shall prevail.

(b) In all proceedings conducted in accordance with this section, the standard of proof to be applied shall be by the preponderance of the evidence.

(c) The department shall commence and process certification revocations under this chapter in a timely and expeditious manner.

11832.16. (a) The withdrawal of an application for a certification after it has been filed with the department shall not, unless the department consents in writing to the withdrawal, deprive the department of its authority to institute or continue a proceeding against the applicant for the denial of the certification upon any ground provided by law or to enter an order denying the certification upon any of these grounds.

(b) The suspension, expiration, or forfeiture by operation of law of a certification issued by the department, or its suspension, forfeiture, or cancellation by order of the department or by order of a court of law, or its surrender without the written consent of the department, shall not deprive the department of its authority to institute or continue a disciplinary proceeding against the program upon any ground provided by law or to enter an order suspending or revoking the certification or otherwise taking disciplinary action against the program on any ground provided by law.

11832.17. A certification shall terminate by operation of law, prior to its expiration date, when any of the following conditions occur:

(a) The program is sold or otherwise transferred.

(b) The program surrenders its certification to the department.

(c) The program relocates from the address identified on the certification to a different location.

(d) The certified alcohol or other drug program is operated by a sole proprietor and the sole proprietor dies.

(e) The program abandons the certification or otherwise ceases operation.

11832.18. (a) If a program is alleged to be in violation of Section 11832.7, the department shall conduct a site visit to investigate the allegation. If the department finds evidence that the program is providing treatment, recovery, detoxification, or medication-assisted treatment services without a certification, the department shall issue a written notice to the program

stating that it is operating in violation of Section 11832.7. The notice shall include all of the following:

(1) The date by which the program shall cease providing services.

(2) Notice that the department may assess against the program a civil penalty of two thousand dollars ($2,000) per day for every day the program continues to provide services beyond the date specified in the notice.

(3) Notice that the case may be referred for civil proceedings if the program continues to provide services beyond the date specified in the notice.

(4) Inform the program of the certification requirements of this chapter.

(b) A person or entity found to be in violation of Section 11832.7 shall be prohibited from applying for initial certification for a period of five years from the date of the notice specified in subdivision (a).

(c) The department may levy a civil penalty for a violation of Section 11832.7 in an amount not to exceed two thousand dollars ($2,000) per day for every day the program continues to provide services beyond the date specified in a notice pursuant to subdivision (a).

11832.19. (a) The director may bring an action to enjoin the violation of Section 11832.7 in the superior court in and for the county in which the violation occurred. Any proceeding under this section shall conform to the requirements of Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure, except that the director shall not be required to allege facts necessary to show or tending to show lack of adequate remedy at law or irreparable damage or loss.

(b) With respect to any and all actions brought pursuant to this section alleging an actual violation of Section 11832.7, the court shall, if it finds the allegations to be true, issue an order enjoining the program from continuance of the violation.

11832.20. (a) (1) In addition to the penalties of suspension or revocation of a certification issued under this chapter, the department may also levy a civil penalty for violation by a certificate holder of this chapter or the regulations adopted pursuant to this chapter.

(2) The amount of the civil penalty, as determined by the department, shall not be less than two hundred fifty dollars ($250) or more than five hundred dollars ($500) per day for each violation, except where the nature or seriousness of the violation or the frequency of the violation warrants a higher penalty or an immediate civil penalty assessment, or both, as determined by the department. In no event shall a civil penalty assessment exceed one thousand dollars ($1,000) per day.

(3) A program that is cited for repeating the same violation within 24 months of the first violation is subject to a civil penalty of five hundred dollars ($500) for the first day and seven hundred fifty dollars ($750) for each day the violation continues until the deficiency is corrected.

(4) A program that has been assessed a civil penalty pursuant to paragraph (3) that repeats the same violation within 24 months of the violation subject to paragraph (3) is subject to a civil penalty of five hundred dollars ($500)

for the first day and one thousand dollars ($1,000) for each day the violation continues until the deficiency is corrected.

(b) Prior to the assessment of any civil penalty, the department shall provide the program with notice requiring the program to correct the deficiency within the period of time specified in the notice.

11832.21. The civil and administrative remedies available to the department pursuant to this chapter are not exclusive, and may be sought and employed in any combination deemed advisable by the department to enforce this chapter.

11832.22. (a) Any alcohol or other program operating in a setting that is exempt from mandatory certification under subdivision (b) of Section 11832.3 may voluntarily apply to the department for certification.

(b) Any facility that voluntarily obtains certification pursuant to this section is subject to the enforcement and requirements of this chapter and any regulations adopted pursuant to this chapter.

11832.23. (a) The department shall adopt regulations necessary to implement this chapter.

(b) 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, if it deems appropriate, implement, interpret, or make specific this chapter by means of provider bulletins, written guidelines, or similar instructions from the department, until regulations are adopted.

11832.24. Any alcohol or other drug program certified by the department under the alcohol or other drug program certification standards developed in accordance with Section 11830.1, as it read on June 30, 2023, shall be deemed certified under this chapter until the expiration date set forth on the certification in place as of June 30, 2023. The alcohol or other drug program shall be subject to, and comply with, the requirements of this chapter, including the process to renew its certification.

11832.25. Notwithstanding Sections 11832.3 and 11832.7, any alcohol or other drug program that is not deemed certified pursuant to Section 11832.24 shall apply for certification no later than January 1, 2024, and shall obtain certification, and be in compliance with this chapter, no later than January 1, 2025.

SEC. 33. Section 11832.1 of the Health and Safety Code is repealed.

SEC. 34. Section 11833 of the Health and Safety Code is repealed.

SEC. 35. Chapter 7.2 (commencing with Section 11833) is added to Part 2 of Division 10.5 of the Health and Safety Code, to read:

Chapter 7.2. Personnel Requirements

11833. (a) The department shall have the sole authority in state government to determine the qualifications, including the appropriate skills, education, training, and experience of personnel working within alcoholism

or drug abuse recovery and treatment programs licensed, certified, or funded under this part.

(b) (1) The department shall determine the required core competencies for registered and certified counselors working within an alcoholism or drug abuse recovery and treatment program described in subdivision (a). The department shall consult with affected stakeholders in developing these requirements.

(2) Core competencies shall include all of the following elements:

(A) Knowledge of the current Diagnostic and Statistical Manual of Mental Disorders.

(B) Knowledge of the American Society of Addiction Medicine (ASAM) criteria and continuum of ASAM levels of care, or other similar criteria and standards as approved by the department.

(C) Cultural competence, including for people with disabilities, and its implication for treatment.

(D) Case management.

(E) Utilization of electronic health records systems.

(F) Knowledge of medications for addiction treatment.

(G) Clinical documentation.

(H) Knowledge of cooccurring substance use and mental health conditions.

(I) Confidentiality.

(J) Knowledge of relevant law and ethics.

(K) Understanding and practicing professional boundaries.

(L) Delivery of services in the behavioral health delivery system.

(3) Core competency requirements described in paragraph (2) shall align with national certification domains and competency exams. The hours completed for the core competency requirements under paragraph (2) shall count toward the education requirements for substance use disorder counselor certification.

(4) Hour requirements for registered counselors shall not be lower than the hour requirements approved by the department for certified peer support specialists.

(5) Counselors shall have six months from the time of registration to complete the core competency requirements under paragraph (2). A counselor shall provide to the certifying organization that they are registered with proof of completion of the required hours within that timeframe.

(6) The department shall not implement the core competency requirements described in paragraph (2) for registered and certified counselors registering or certifying with a state-approved substance use disorder counselor certifying organization before July 1, 2025.

(7) Counselors in good standing that registered with a state-approved substance use disorder counselor certifying organization prior to July 1, 2025, are exempt from the requirements detailed in paragraph (4).

(8) For the purposes of this subdivision, “in good standing” means registrants with an active registration status.

(9) Counselors in good standing that are registered with a state-approved substance use disorder counselor certifying organization and have a master's degree in psychology, social work, marriage and family therapy, or counseling are exempt from the core competency requirements in paragraph (2).

(10) The department shall not specify and implement the hour requirements pursuant to paragraph (4) before July 1, 2025.

(c) (1) Except as set forth in subdivision (d), an individual providing counseling services working within a program described in subdivision (a) shall be registered with, or certified by, a certifying organization approved by the department to register and certify counselors.

(2) The department shall not approve a certifying organization that does not, prior to registering or certifying an individual, contact other department-approved certifying organizations to determine whether the individual has ever had their registration or certification revoked or has been removed from a postgraduate practicum for an ethical or professional violation.

(d) (1) The following individuals are exempt from the requirement in paragraph (1) of subdivision (c) to be registered or certified by a department-approved certifying organization:

(A) A graduate student affiliated with university programs in psychology, social work, marriage and family therapy, or counseling, who is completing their supervised practicum hours to meet postgraduate requirements.

(B) An associate registered with the Board of Behavioral Sciences.

(C) A licensed professional, as defined by the department.

(2) A program providing practicum for graduate students exempted from registration or certification in paragraph (1) shall notify department-approved certifying organizations if a graduate student is removed from the practicum as a result of an ethical or professional conduct violation, as determined by either the university or the program.

(e) If a counselor's registration or certification has been previously revoked or the individual has been removed from a postgraduate practicum for an ethical or professional conduct violation, the certifying organization shall deny the request for registration and shall send the counselor a written notice of denial. The notice shall specify the counselor's right to appeal the denial in accordance with applicable statutes and regulations.

(f) The department shall have the authority to conduct periodic reviews of certifying organizations to determine compliance with all applicable laws and regulations, including subdivision (e), and to take actions for noncompliance, including revocation of the department's approval.

(g) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific the changes made to this section in the 2021–22 Legislative Session by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions.

(2) The department shall adopt regulations to implement the changes made to this section in the 2021–22 Legislative Session by December 31, 2025, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 36. Section 11833.01 of the Health and Safety Code is amended to read:

11833.01. This chapter applies to all programs, facilities, or services certified pursuant to Chapter 7.1 (commencing with Section 11832) or licensed pursuant to Chapter 7.5 (commencing with Section 11834.01), or both.

SEC. 37. Section 11833.05 of the Health and Safety Code is amended to read:

11833.05. (a) All programs certified by the department pursuant to Chapter 7.1 (commencing with Section 11832) or facilities licensed by the department pursuant to Chapter 7.5 (commencing with Section 11834.01) shall disclose to the department the following information:

(1) Ownership or control of, or financial interest in, a recovery residence.

(2) Any contractual relationship with an entity that regularly provides professional services or addiction treatment or recovery services to clients of programs certified or facilities licensed by the department, if the entity is not part of the program certified or facility licensed by the department.

(b) All programs certified or facilities licensed by the department shall make the disclosures pursuant to subdivision (a) upon initial licensure or certification, upon renewal of licensure or certification, and upon a licensed facility or certified program acquiring or starting a relationship that meets paragraph (1) or (2) of subdivision (a).

(c) The department may suspend or revoke the certification of a program or license of a facility for failing to disclose the information required in subdivision (a).

(d) The department shall take action pursuant to Section 11834.31 against an unlicensed facility that is disclosed as a recovery residence pursuant to paragraph (1) of subdivision (a). This subdivision does not require an investigation of a recovery residence that is not alleged to be operating in violation of Section 11834.30.

(e) The department may refer a substantiated complaint against a recovery residence to other enforcement entities as appropriate under state or federal law, including the Department of Insurance, the Department of Managed Health Care, the Attorney General, and the United States Attorney General.

(f) For the purposes of this section, “recovery residence” means a residential dwelling that provides primary housing for individuals who seek a cooperative living arrangement that supports personal recovery from a substance use disorder and that does not require licensure by the department or does not provide licensable services, pursuant to Chapter 7.5 (commencing with Section 11834.01). A recovery residence may include, but is not limited to, residential dwellings commonly referred to as “sober living homes,”

"sober living environments," or "unlicensed alcohol and drug free residences."

SEC. 38. Section 11836 of the Health and Safety Code is amended to read:

11836. (a) The department shall have the sole authority to issue, deny, suspend, or revoke the license of a driving-under-the-influence program. As used in this chapter, "program" means any firm, partnership, association, corporation, local governmental entity, agency, or place that has been initially recommended by the county board of supervisors, subject to any limitation imposed pursuant to subdivisions (c) and (d), and that is subsequently licensed by the department to provide alcohol or drug recovery services in that county to any of the following:

(1) A person whose license to drive has been administratively suspended or revoked for, or who is convicted of, a violation of Section 23152 or 23153 of the Vehicle Code, and admitted to a program pursuant to Section 13352, 13352.1, 23538, 23542, 23548, 23552, 23556, 23562, or 23568 of the Vehicle Code.

(2) A person who is convicted of a violation of subdivision (b), (c), (d), or (e) of Section 655 of the Harbors and Navigation Code, or of Section 655.4 of that code, and admitted to the program pursuant to Section 668 of that code.

(3) A person who has pled guilty or nolo contendere to a charge of a violation of Section 23103 of the Vehicle Code, under the conditions set forth in subdivision (c) of Section 23103.5 of the Vehicle Code, and who has been admitted to the program under subdivision (e) or (f) of Section 23103.5 of the Vehicle Code.

(4) A person whose license has been suspended, revoked, or delayed due to a violation of Section 23140, and who has been admitted to a program under Article 2 (commencing with Section 23502) of Chapter 1 of Division 11.5 of the Vehicle Code.

(b) If a firm, partnership, corporation, association, local government entity, agency, or place has, or is applying for, more than one license, the department shall treat each licensed program, or each program seeking licensure, as belonging to a separate firm, partnership, corporation, association, local government entity, agency, or place for the purposes of this chapter.

(c) For purposes of providing recommendations to the department pursuant to subdivision (a), a county board of supervisors may limit its recommendations to those programs that provide services for persons convicted of a first driving-under-the-influence offense, or services to those persons convicted of a second or subsequent driving-under-the-influence offense, or both services. If a county board of supervisors fails to provide recommendations, the department shall determine the program or programs to be licensed in that county.

(d) After determining a need, a county board of supervisors may also place one or more limitations on the services to be provided by a driving-under-the-influence program or the area the program may operate

within the county, when it initially recommends a program to the department pursuant to subdivision (a).

(1) For purposes of this subdivision, a board of supervisors may restrict a program for those convicted of a first driving-under-the-influence offense to providing only a three-month program, or may restrict a program to those convicted of a second or subsequent driving-under-the-influence offense to providing only an 18-month program, as a condition of its recommendation.

(2) A board of supervisors may not place restrictions on a program that would violate a statute or regulation.

(3) When recommending a program, if a board of supervisors fails to place any limitation on a program pursuant to this subdivision, the department may license that program to provide any driving-under-the-influence program services that are allowed by law within that county.

(4) This subdivision is intended to apply only to the initial recommendation to the department for licensure of a program by the county. It is not intended to affect a license that has been previously issued by the department or the renewal of a license for a driving-under-the-influence program. In counties where a contract or other written agreement is currently in effect between the county and a licensed driving-under-the-influence program operating in that county, this subdivision is not intended to alter the terms of that relationship or the renewal of that relationship.

(e) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code and Section 11835, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section for the purpose of alcohol or drug recovery services provided in virtual settings by means of all-county letters, plan letters, information notices, or similar instructions, until regulations are promulgated or amended in accordance with paragraph (2).

(2) On or before January 1, 2026, the department shall promulgate regulations, in accordance with Section 11835, governing the provision of alcohol or drug recovery services pursuant to this section in virtual settings.

SEC. 39. Section 107065 of the Health and Safety Code is amended to read:

107065. Every holder of a certificate or a permit issued pursuant to the Radiologic Technology Act (Section 27) may be disciplined as provided in Section 107070. The proceedings under Section 107070 shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the department shall have all of the powers granted therein.

SEC. 40. Section 107070 of the Health and Safety Code is repealed.

SEC. 41. Section 107070 is added to the Health and Safety Code, to read:

107070. Certificates and permits may be denied, revoked, or suspended by the department, for any of the following reasons:

(a) Use of a controlled substance as defined in Division 10 (commencing with Section 11000), a dangerous drug, as defined in Section 4022 of the

Business and Professions Code, or alcoholic beverages to an extent or in a manner dangerous or injurious to the certified or permitted individual, any other person, or the public or that would impair the ability to conduct, with safety to the public, the practice authorized by a certificate or permit, or more than one misdemeanor or a felony involving the use, consumption, or self-administration of any of the substances referred to in this subdivision, or any combination thereof.

(b) Unprofessional conduct, including, but not limited to, incompetence or gross negligence, physical, mental, or verbal abuse of patients, or misappropriation of property of patients or others.

(c) Conviction of practicing one of the healing arts without a license in violation of Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

(d) Knowingly making or signing a document relating to the practice of radiologic technology that falsely represents the existence or nonexistence of a state of facts.

(e) Making or giving a false statement or information in conjunction with the application for issuance of a certificate or permit and examination application.

(f) Impersonating an applicant, or acting as proxy for an applicant, in any examination required under the Radiologic Technology Act (Section 27) for the issuance of a certificate or permit.

(g) Impersonating another certified or permitted individual, or permitting or allowing another person to use a certificate or permit, for the purpose of providing radiologic technology services.

(h) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision or term of the Radiologic Technology Act (Section 27), Article 6 (commencing with Section 107150) of Chapter 4 of Part 1 of Division 104, or the Radiation Control Law (commencing with Section 114960), or regulations adopted pursuant to those provisions.

(i) Conviction of a crime substantially related to the qualifications, functions, and duties of a radiologic technologist, holder of a limited permit, or a certified supervisor or operator if the department determines that the applicant or certificate or permitholder has not adequately demonstrated that they have been rehabilitated and will present a threat to the health, safety, or welfare of patients. In determining whether or not to deny, suspend, or revoke an application for certification or permitting or renewal, the department shall take into consideration the following factors as evidence of good character and rehabilitation:

(1) The nature and seriousness of the conduct or crime under consideration and its relationship to the person’s employment duties and responsibilities.

(2) Activities since conviction, including employment or participation in therapy or education, that would indicate changed behavior.

(3) The period of time that has elapsed since the commission of the conduct or offense referred to in this subdivision and the number of offenses.

(4) The extent to which the person has complied with any terms of parole, probation, restitution, or any other sanction lawfully imposed against the person.

(5) Any rehabilitation evidence, including character references, submitted by the person.

(6) Employment history and current employer recommendations.

(7) Circumstances surrounding the commission of the offense that would demonstrate the unlikelihood of repetition.

(8) An order from a superior court pursuant to Section 1203.4, 1203.4a, or 1203.41 of the Penal Code.

(9) The granting by the Governor of a full and unconditional pardon.

(10) A certificate of rehabilitation from a superior court.

(j) Procuring a certificate or permit by fraud or misrepresentation or because of mistake.

(k) Use of a designation implying certification as a radiologic technologist by one not so certified, holding a limited permit by one not so permitted, or authorization as a certified supervisor or operator by one not so authorized.

(*l*) Willfully preventing, interfering with, or attempting to impede in any way the work of a duly authorized representative of the department or a local officer or agency authorized to enforce the Radiologic Technology Act (Section 27) or the Radiation Control Law (commencing with Section 114960) during the course of the representative's or officer's lawful enforcement of a provision of the Radiologic Technology Act (Section 27), the Radiation Control Law, or the rules and regulations adopted pursuant to those provisions.

(m) Nonpayment of fees prescribed in accordance with Section 107080.

(n) Loss of certification from another organization on which the department's issuance was based, if that loss was for cause.

SEC. 42. Section 107075 of the Health and Safety Code is amended to read:

107075. (a) A person or entity that violates or aids or abets the violation of any of the provisions of the Radiologic Technology Act (Section 27) or regulation of the department adopted pursuant to that act is guilty of a misdemeanor and shall be punished by a fine not to exceed five thousand dollars ($5,000) per day, per offense or by imprisonment in the county jail not to exceed 180 days, or by both the fine and imprisonment.

(b) (1) A person or entity that intentionally or through gross negligence violates a provision of the Radiologic Technology Act (Section 27) or a regulation adopted pursuant to that act, or who fails or refuses to comply with a cease and desist order or other order of the department issued thereunder, and the action causes a substantial danger to the health of others, shall be liable for a civil penalty not to exceed five thousand dollars ($5,000) per day, per offense.

(2) The remedies under this section are in addition to, and do not supersede or limit, any and all other remedies, civil or criminal.

SEC. 43. Section 107165 of the Health and Safety Code is repealed.

SEC. 44. Section 107165 is added to the Health and Safety Code, to read:

107165. (a) The establishment of a person as competent to perform nuclear medicine technology may be denied, revoked, or suspended by the department, for any of the following reasons:

(1) Use of a controlled substance as defined in Division 10 (commencing with Section 11000), a dangerous drug, as defined in Section 4022 of the Business and Professions Code, or alcoholic beverages to an extent or in a manner dangerous or injurious to the certified or permitted individual, any other person, or the public or that would impair the ability to conduct, with safety to the public, the practice of nuclear medicine technology, or more than one misdemeanor or a felony involving the use, consumption, or self-administration of any of the substances referred to in this subdivision, or any combination thereof.

(2) Unprofessional conduct, including, but not limited to, incompetence or gross negligence, physical, mental, or verbal abuse of patients, or misappropriation of property of patients or others.

(3) Conviction of practicing one of the healing arts without a license in violation of Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

(4) Knowingly making or signing a document relating to the practice of nuclear medicine technology that falsely represents the existence or nonexistence of a state of facts.

(5) Making or giving a false statement or information in conjunction with the application for establishment of competence to perform nuclear medicine technology and examination application.

(6) Impersonating an applicant, or acting as proxy for an applicant, in any examination required under this article for the establishment of competence to perform nuclear medicine technology.

(7) Impersonating another individual who has established competence to perform nuclear medicine technology under this article or permitting or allowing another person to use that establishment for the purpose of performing nuclear medicine technology.

(8) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violating of, or conspiring to violate any provision or term of this article, the Radiologic Technology Act (Section 27), or the Radiation Control Law (commencing with Section 114960), or regulations adopted pursuant to those provisions.

(9) Conviction of a crime substantially related to the qualifications, functions, and duties of a nuclear medicine technologist, if the department determines that the applicant or individual who has established competence to perform nuclear medicine technology has not adequately demonstrated that they have been rehabilitated, and will present a threat to the health, safety, or welfare of patients. In determining whether or not to deny, suspend, or revoke establishment of competence or renewal of such establishment, the department shall take into consideration the following factors as evidence of good character and rehabilitation:

(A) The nature and seriousness of the conduct or crime under consideration and its relationship to their employment duties and responsibilities.

(B) Activities since conviction, including employment or participation in therapy or education, that would indicate changed behavior.

(C) The period of time that has elapsed since the commission of the conduct or offense referred to in this subdivision and the number of offenses.

(D) The extent to which the person has complied with any terms of parole, probation, restitution, or any other sanction lawfully imposed against the person.

(E) Any rehabilitation evidence, including character references, submitted by the person.

(F) Employment history and current employer recommendations.

(G) Circumstances surrounding the commission of the offense that would demonstrate the unlikelihood of repetition.

(H) An order from a superior court pursuant to Section 1203.4, 1203.4a, or 1203.41 of the Penal Code.

(I) The granting by the Governor of a full and unconditional pardon.

(J) A certificate of rehabilitation from a superior court.

(10) Establishment of competence to perform nuclear medicine technology by fraud or misrepresentation or because of mistake.

(11) Use of a designation implying one has established with the department competence to perform nuclear medicine technology by one who has not so established competence.

(12) Willfully preventing, interfering with, or attempting to impede in any way the work of a duly authorized representative of the department or a local officer or agency authorized to enforce this article, the Radiologic Technology Act (Section 27), or the Radiation Control Law (commencing with Section 114960) during the course of that representative's or officer's lawful enforcement of any provision of this article, the Radiologic Technology Act (Section 27), the Radiation Control Law, or the rules and regulations adopted pursuant to those provisions.

(13) Nonpayment of fees prescribed in accordance with Section 107160.

(14) Loss of certification from another organization on which the department's issuance was based on, if that loss was for cause.

(b) The proceedings for denial, revocation, or suspension pursuant to this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the department shall have all of the powers granted therein.

SEC. 45. Section 107170 of the Health and Safety Code is repealed.

SEC. 46. Section 107170 is added to the Health and Safety Code, to read:

107170. (a) A person or entity that violates, or aids or abets the violation of, this article or a regulation adopted pursuant to this article shall be guilty of a misdemeanor and shall be punished by a fine not to exceed five thousand dollars ($5,000) per day, per offense or by imprisonment in the county jail not to exceed 180 days, or by both the fine and imprisonment.

(b) A person or entity who intentionally or through gross negligence violates a provision of this article or regulation adopted pursuant to this article, or who fails or refuses to comply with a cease and desist order or other order of the department issued thereunder, and the action causes a substantial danger to the health of others, shall be liable for a civil penalty not to exceed five thousand dollars ($5,000) per day, per offense.

(c) The remedies under this section are in addition to, and do not supersede or limit, any and all other remedies, civil or criminal.

SEC. 47. Section 114850 of the Health and Safety Code is amended to read:

114850. For the purposes of the Radiologic Technology Act (Section 27) and this chapter:

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

(b) "Committee" means the Radiologic Technology Certification Committee.

(c) "Radiologic technology" means the application of x-rays on human beings for diagnostic or therapeutic purposes.

(d) "Radiologic technologist" means any person, other than a licentiate of the healing arts, making application of x-ray to human beings for diagnostic, mammographic, or therapeutic purposes pursuant to subdivision (b) of Section 114870.

(e) "Limited permit" means a permit issued pursuant to subdivision (c) of Section 114870 or Section 114871 to persons to conduct radiologic technology limited to the performance of certain procedures or the application of x-rays to specific areas of the human body, except for a mammogram.

(f) "Approved school for radiologic technologists" means a school or approved educational program that the department has determined provides a course of instruction in radiologic technology that is adequate to meet the purposes of the Radiologic Technology Act (Section 27).

(g) "Supervision" means responsibility for, and control of, quality, radiation safety, and technical aspects of all x-ray examinations and procedures.

(h) (1) "Licentiate of the healing arts" means a person licensed under the provisions of the Medical Practice Act, the provisions of the initiative act entitled "An act prescribing the terms upon which licenses may be issued to practitioners of chiropractic, creating the State Board of Chiropractic Examiners and declaring its powers and duties, prescribing penalties for violation thereof, and repealing all acts and parts of acts inconsistent herewith," approved by electors November 7, 1922, as amended, or the Osteopathic Act.

(2) For purposes of Section 114872, a licentiate of the healing arts means a person licensed under the Physician Assistant Practice Act (Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code) who practices under the supervision of a qualified physician and surgeon pursuant to the act and pursuant to Division 13.8 of Title 16 of the California Code of Regulations.

(i) "Certified supervisor or operator" means a licentiate of the healing arts who has been certified under subdivision (e) or (f) of Section 114870 or 107111 to supervise the operation of x-ray machines or to operate x-ray machines, or both.

(j) "Student of radiologic technology" means a person who has started and is in good standing in a course of instruction that, if completed, would permit the person to be certified a radiologic technologist or granted a limited permit upon satisfactory completion of any examination required by the department. "Student of radiologic technology" does not include any person who is a student in a school of medicine, chiropractic, podiatry, dentistry, dental radiography, or dental hygiene.

(k) "Mammogram" means an x-ray image of the human breast.

(*l*) "Mammography" means the procedure for creating a mammogram.

SEC. 48. Section 114890 of the Health and Safety Code is repealed.

SEC. 49. Section 114895 of the Health and Safety Code is repealed.

SEC. 50. Section 127691 of the Health and Safety Code is amended to read:

127691. For purposes of this chapter, the following definitions apply:

(a) "Generic drug" means a drug that is approved pursuant to subdivision (j) of Section 355 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. Sec. 301 et seq.), or a biosimilar, as defined under the federal Public Health Service Act (42 U.S.C. Sec. 262).

(b) "Partnerships" include, but are not limited to, agreements for the procurement of generic prescription drugs by way of contracts, grant agreements, or purchasing by a payer, state governmental agency, group purchasing organization, nonprofit organization, or other entity.

(c) "California Health and Human Services Agency" or "CHHSA" means the California Health and Human Services Agency, or any of its departments, including the Department of Health Care Access and Information, selected to implement this chapter.

SEC. 51. Section 127692 of the Health and Safety Code is amended to read:

127692. (a) The California Health and Human Services Agency (CHHSA) or its departments shall enter into partnerships, consistent with subdivision (b) of Section 127693, in consultation with other state departments as necessary, to increase competition, lower prices, and address shortages in the market for generic prescription drugs, to reduce the cost of prescription drugs for public and private purchasers, taxpayers, and consumers, and to increase patient access to affordable drugs.

(b) For purposes of implementing this chapter, CHHSA and its departments, including the Department of Health Care Access and Information, may enter into exclusive or nonexclusive contracts on a bid or negotiated basis. Contracts entered into or amended pursuant to this section are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and are exempt from the review or approval of any division of the Department of

General Services. When appropriate, CHHSA shall establish initial and ongoing metrics to measure progress and efficiency, and remedies in the case those metrics are not met in any partnership contract entered into pursuant to this section.

(c) CHHSA shall have the ability to hire staff or contractors to oversee and project-manage the partnerships for manufacturing, procurement, or distribution of generic prescription drugs, contingent upon an appropriation by the Legislature for this purpose.

(d) It is the Legislature's intent that any manufacturing partnership contract entered into pursuant to subdivision (b) is a partnership intended to create a California-branded label for generic drugs. It is further the Legislature's intent that any manufacturing that is done under this section is intended to benefit the residents of this state by ensuring adequate supplies and access to generic prescription drugs and lowering health care costs through savings to public health care programs and private health insurance coverage.

SEC. 52. Section 127693 of the Health and Safety Code is amended to read:

127693. (a) CHHSA shall enter into partnerships resulting in the production, procurement, or distribution of generic prescription drugs, with the intent that these drugs be made widely available to public and private purchasers, providers and suppliers as defined in subdivision (b) of Section 1367.50, and pharmacies as defined in Section 4037 of the Business and Professions Code, as appropriate. The generic prescription drugs shall be produced or distributed by a drug company or generic drug manufacturer that is registered with the United States Food and Drug Administration.

(b) (1) CHHSA shall only enter into partnerships pursuant to subdivision (a) to produce a generic prescription drug at a price that results in savings, targets failures in the market for generic drugs, or improves patient access to affordable medications.

(2) For top drugs identified pursuant to the criteria listed in paragraph (5), CHHSA shall determine if viable pathways exist for partnerships to manufacture, procure, or distribute generic prescription drugs by examining the relevant legal, market, policy, and regulatory factors.

(3) CHHSA shall consider the following, if applicable, when setting the price of a generic prescription drug:

(A) United States Food and Drug Administration user fees.

(B) Abbreviated new drug application acquisition costs amortized over a five-year period.

(C) Mandatory rebates.

(D) Total contracting and production costs for the drug, including a reasonable amount for administrative, operating, and rate-of-return expenses of the drug company or generic drug manufacturer.

(E) Research and development costs attributed to the drug over a five-year period.

(F) Other initial start-up costs amortized over a five-year period.

(4) Each drug shall be made available to providers, patients, and purchasers, as appropriate, at a transparent price and without rebates, other than federally required rebates.

(5) CHHSA shall prioritize the selection of generic prescription drugs that have the greatest impact on lowering drug costs to patients, increasing competition and addressing shortages in the prescription drug market, improving public health, or reducing the cost of prescription drugs to public and private purchasers.

(c) (1) In identifying generic prescription drugs to be produced, CHHSA shall consider the report produced by the Department of Managed Health Care pursuant to subdivision (b) of Section 1367.243, the report produced by the Department of Insurance pursuant to subdivision (b) of Section 10123.205 of the Insurance Code, and pharmacy spending data from Medi-Cal and other entities for which the state pays the cost of generic prescription drugs.

(2) The partnerships entered into pursuant to subdivision (a) shall include the production of at least one form of insulin made available at production and dispensing costs, if one does not already exist in the market. Dispensing costs may include related expenses such as transportation, distribution, and market operations. Any partnership shall also consider:

(A) Guaranteeing priority access to insulin supply for the state.

(B) Guaranteeing the manufacture of at least four high-priority drugs for California, as identified pursuant to paragraph (5) of subdivision (b).

(C) Creating a state brand identifying biosimilar insulin and generic prescription drugs sold in California under this section.

(3) CHHSA shall prioritize drugs for chronic and high-cost conditions, and shall consider prioritizing those that can be delivered through mail order.

(d) CHHSA shall consult with all of the following public and private purchasers, as appropriate, to develop a list of generic prescription drugs to be manufactured or distributed through partnerships:

(1) The Public Employees' Retirement System, the State Department of Health Care Services, the California Health Benefit Exchange (Covered California), the State Department of Public Health, the Department of General Services, and the Department of Corrections and Rehabilitation, or the entities acting on behalf of each of those state purchasers.

(2) Licensed health care service plans.

(3) Health insurers holding a valid outstanding certificate of authority from the Insurance Commissioner.

(4) Hospitals.

(e) Before effectuating a partnership pursuant to this section, CHHSA shall consider the volume of each generic prescription drug over a multiyear period to support a market for a lower cost generic prescription drug, if volume is an important factor in driving down the cost of the drug. For partnerships involving procurement, CHHSA shall determine minimum thresholds for procurement of an entity's expected volume of a targeted drug from the company or manufacturer over a defined target period. In

making advance commitments, CHHSA may consult with the Statewide Pharmaceutical Program and the California Pharmaceutical Collaborative.

(f) The listed entities in paragraphs (2) to (4), inclusive, of subdivision (d) shall not be required to purchase prescription drugs from CHHSA or entities that contract or partner with CHHSA pursuant to this chapter.

(g) CHHSA shall not be required to consult with every entity listed in paragraphs (2) to (4), inclusive, of subdivision (d), so long as purchaser engagement includes a reasonable representation from these groups.

(h) Any partnership entered into pursuant to this section may include representation and involvement with the governance of the contractor entity.

SEC. 53. Section 127696 of the Health and Safety Code is amended to read:

127696. Notwithstanding any other provision of law, all nonpublic information and documents obtained or prepared under this chapter shall not be required to be disclosed pursuant to the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records.

SEC. 54. Section 128560 of the Health and Safety Code is amended to read:

128560. For purposes of this article:

(a) "Corps" means the California Reproductive Health Service Corps established pursuant to Section 128561.

(b) "Reproductive health" means health services relating to abortion care, sexual health counseling, contraception, sexually transmitted infections, reproductive tract infections, HIV, gynecology, perinatal care, midwifery care, gender affirming care, and gender-based violence prevention.

(c) "Reproductive health care professionals" means medical doctors, licensed midwives, certified nurse-midwives, nurse practitioners, registered nurses, physician's assistants, doulas, licensed vocational nurses, community health workers, medical assistants, and pharmacists.

(d) "Scholar" means a person in the corps who is a student who has been accepted in a school or a program on a part-time or full-time basis that graduates reproductive health care professionals or who is an existing reproductive health professional who desires more training and professional development in abortion care to provide this service.

SEC. 55. 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 June 30, 2026.

(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. 56. Section 10144.57 of the Insurance Code is amended to read:

10144.57. (a) Coverage of mental health and substance use disorder treatment pursuant to Section 10144.5 includes behavioral health crisis services that are provided to an insured by a 988 center, mobile crisis team, or other provider of behavioral health crisis services, as set forth in Chapter 1 (commencing with Section 53123.1) of Part 1 of Division 2 of Title 5 of the Government Code, regardless of whether the service is provided by an in-network or out-of-network provider or facility. With respect to behavioral health crisis services that are provided to an insured by a 988 center or mobile crisis team, a health insurance policy shall cover, at a minimum, all items and services that are eligible for coverage under the Medi-Cal program.

(b) (1) An insurer shall not require prior authorization for behavioral health crisis stabilization services and care provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services.

(2) Notwithstanding any other law, payment for behavioral health crisis stabilization services and care pursuant to this section shall not be denied unless a health insurer reasonably determines that care was not rendered.

(3) If its prior authorization requirements comply with Section 10144.4, a health insurer may require prior authorization for poststabilization care. If there is a disagreement between a health insurer and behavioral health crisis services provider or facility regarding the need for poststabilization care, an insurer shall assume responsibility for care of the insured by promptly arranging for care pursuant to Section 10144.5 at a level of care determined in accordance with utilization review criteria under Section 10144.52.

(4) An insurer shall not require, under any circumstances, a behavioral health crisis services provider or facility to discharge or transfer an insured before stabilization has occurred or before it has conducted utilization review in accordance with Sections 10144.5 and 10144.52.

(c) (1) If prior authorization is required for poststabilization care, a health insurer that is contacted by a 988 center, mobile crisis team, or other provider of behavioral health crisis services shall, within 30 minutes of the time the provider makes the initial contact, either authorize poststabilization care or inform the provider that it will arrange for the prompt transfer of the insured's care to another provider.

(2) A health insurer that is contacted by a 988 center, mobile crisis team, or other provider of behavioral health crisis services shall reimburse the provider or facility for poststabilization care rendered to the insured if any of the following occur:

(A) The health insurer authorized the 988 center, mobile crisis team, or other provider of behavioral health crisis services to provide poststabilization care.

(B) The health insurer did not respond to the provider's initial contact or did not make a decision regarding whether to authorize poststabilization care or to promptly transfer the insured's care within the timeframe set forth in paragraph (1).

(C) There is an unreasonable delay in the transfer of the insured's care to another provider, and the provider determines that the insured requires poststabilization care.

(3) A health insurer shall prominently display on its internet website the specific telephone number for noncontracting providers to obtain prompt authorization for the transfer of a stabilized insured's care to another provider or authorization to provide poststabilization care. The health insurer shall ensure the telephone number published on its internet website is the correct telephone number for purposes of this paragraph. The health insurer shall update the telephone number on its internet website within one business day if the telephone number changes. A health insurer shall provide the telephone number to the department.

(4) A health insurer shall not require a 988 center, mobile crisis team, or other provider of behavioral health crisis services to make more than one telephone call to the number provided in advance by the health insurer. The representative of the 988 center, mobile crisis team, or other provider of behavioral health crisis services that makes the telephone call may be, but is not required to be, a physician or surgeon.

(5) A 988 center, mobile crisis team, or other provider of behavioral health crisis services shall not bill a patient who is an insured of a health insurer for poststabilization care, except for the in-network cost-sharing amount as defined in paragraph (2) of subdivision (d). An insured who is billed in violation of this section may report receipt of the bill to the health insurer and the department. The department shall forward that report to the State Department of Public Health.

(d) (1) An insurer shall reimburse a 988 center, mobile crisis team, or other provider of behavioral health crisis services for emergency or nonemergency behavioral health crisis services and care pursuant to this section, consistent with the requirements of Sections 10123.13, 10123.147, and any other applicable requirement of this part.

(2) If an insured receives behavioral health crisis services and care pursuant to this section from a 988 center, mobile crisis team, or other provider of behavioral health crisis services that is an out-of-network provider, the insured shall pay no more than the same cost sharing that the insured would pay for the same items or services received from an in-network provider. This amount shall be referred to as the "in-network cost-sharing amount." An out-of-network 988 center, mobile crisis team, or other provider of behavioral health crisis services shall not bill or collect an amount from the insured for services subject to this section except for the in-network cost-sharing amount.

(e) For purposes of this section:

(1) "Behavioral health crisis services" has the same meaning as set forth in Section 53123.1.5 of the Government Code.

(2) "Behavioral health crisis stabilization services" means health care items and services that are necessary to determine if a behavioral health crisis exists and, if a behavioral health crisis does exist, the care and treatment that is necessary to stabilize the behavioral health crisis, within

the capability of the 988 center, mobile crisis team, or other provider of behavioral health crisis services.

(3) "Poststabilization care" means medically necessary care provided after a behavioral health crisis has been stabilized.

(4) An insured is "stabilized" or "stabilization" has occurred when, in the opinion of the treating provider or facility, the insured's condition is such that, within reasonable medical probability, both of the following criteria are satisfied:

(A) Material deterioration of the insured's condition is unlikely to result from, or occur during, the discharge or transfer of the insured to the care of another provider or facility.

(B) The insured is able to travel safely from the site of care using nonmedical transportation or nonemergency medical transportation. The health insurer shall continue to cover all services and care as behavioral health crisis stabilization services until the insured is discharged or transferred.

(f) This section does not excuse a disability insurer from complying with Section 10144.5 or any other requirement of this part.

(g) This section does not apply to Medicare supplement, dental-only, or vision-only health insurance policies.

(h) The commissioner may promulgate regulations 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) to implement this section, and Section 10144.4, 10144.5, 10144.51, or 10144.52 of this code. This subdivision shall not be construed to impair or restrict the commissioner's rulemaking authority pursuant to another provision of this code or the Administrative Procedure Act.

SEC. 57. Section 1370 of the Penal Code is amended to read:

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

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

(i) The court shall order that the mentally incompetent defendant be delivered by the sheriff to a State Department of State Hospitals facility, as defined in Section 4100 of the Welfare and Institutions Code, as directed by the State Department of State Hospitals, or to any other available public or private treatment facility, including a community-based residential treatment system approved by the community program director, or their designee, that will promote the defendant's speedy restoration to mental competence, or placed on outpatient status as specified in Section 1600.

(ii) However, if the action against the defendant who has been found mentally incompetent is on a complaint charging a felony offense specified in Section 290, the prosecutor shall determine whether the defendant previously has been found mentally incompetent to stand trial pursuant to this chapter on a charge of a Section 290 offense, or whether the defendant

is currently the subject of a pending Section 1368 proceeding arising out of a charge of a Section 290 offense. If either determination is made, the prosecutor shall notify the court and defendant in writing. After this notification, and opportunity for hearing, the court shall order that the defendant be delivered by the sheriff to a State Department of State Hospitals facility, as directed by the State Department of State Hospitals, or other secure treatment facility for the care and treatment of persons with a mental health disorder, unless the court makes specific findings on the record that an alternative placement would provide more appropriate treatment for the defendant and would not pose a danger to the health and safety of others.

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

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

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

(v) If a defendant is found by the court to be an appropriate candidate for diversion pursuant to clause (iv), the defendant's eligibility shall be determined pursuant to Section 1001.36. A defendant granted diversion may participate for the lesser of the period specified in paragraph (1) of subdivision (c) or 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.

(vi) 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.

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

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

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

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

(F) A defendant charged with a violent felony may be placed on outpatient status, as specified in Section 1600, only if the court finds that the placement will not pose a danger to the health or safety of others. If the court places a defendant charged with a violent felony on outpatient status, as specified in Section 1600, the court shall serve copies of the placement order on defense counsel, the sheriff in the county where the defendant will be placed, and the district attorney for the county in which the violent felony charges are pending against the defendant.

(G) If, at any time after the court has declared a defendant incompetent to stand trial pursuant to this section, counsel for the defendant or a jail medical or mental health staff provider provides the court with substantial evidence that the defendant's psychiatric symptoms have changed to such a degree as to create a doubt in the mind of the judge as to the defendant's current mental incompetence, the court may appoint a psychiatrist or a licensed psychologist to opine as to whether the defendant has regained competence. If, in the opinion of that expert, the defendant has regained competence, the court shall proceed as if a certificate of restoration of competence has been returned pursuant to paragraph (1) of subdivision (a) of Section 1372.

(H) (i) The State Department of State Hospitals may, pursuant to Section 4335.2 of the Welfare and Institutions Code, conduct an evaluation of the defendant in county custody to determine any of the following:

(I) The defendant has regained competence.

(II) There is no substantial likelihood that the defendant will regain competence in the foreseeable future.

(III) The defendant should be referred to the county for further evaluation for potential participation in a county diversion program, if one exists, or to another outpatient treatment program.

(ii) If, in the opinion of the department's expert, the defendant has regained competence, the court shall proceed as if a certificate of restoration

of competence has been returned pursuant to paragraph (1) of subdivision (a) of Section 1372.

(iii) If, in the opinion of the department's expert, there is no substantial likelihood that the defendant will regain mental competence in the foreseeable future, the committing court shall proceed pursuant to paragraph (2) of subdivision (c) no later than 10 days following receipt of the report.

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

(A) (i) The court shall order the community program director or a designee to evaluate the defendant and to submit to the court within 15 judicial days of the order a written recommendation as to whether the defendant should be required to undergo outpatient treatment, or be committed to the State Department of State Hospitals or to any other treatment facility. A person shall not be admitted to a State Department of State Hospitals facility or other treatment facility or placed on outpatient status under this section without having been evaluated by the community program director or a designee. The community program director or designee shall evaluate the appropriate placement for the defendant between a State Department of State Hospitals facility or the community-based residential treatment system based upon guidelines provided by the State Department of State Hospitals.

(ii) Commencing on July 1, 2023, a defendant shall first be considered for placement in an outpatient treatment program, a community treatment program, or a diversion program, if any such program is available, unless a court, based upon the recommendation of the community program director or their designee, finds that either the clinical needs of the defendant or the risk to community safety, warrant placement in a State Department of State Hospitals facility.

(B) The court shall hear and determine whether the defendant lacks capacity to make decisions regarding the administration of antipsychotic medication. The court shall consider opinions in the reports prepared pursuant to subdivision (a) of Section 1369, as applicable to the issue of whether the defendant lacks capacity to make decisions regarding the administration of antipsychotic medication, and shall proceed as follows:

(i) The court shall hear and determine whether any of the following is true:

(I) Based upon the opinion of the psychiatrist or licensed psychologist offered to the court pursuant to subparagraph (A) of paragraph (2) of subdivision (a) of Section 1369, the defendant lacks capacity to make decisions regarding antipsychotic medication, the defendant's mental disorder requires medical treatment with antipsychotic medication, and, if the defendant's mental disorder is not treated with antipsychotic medication, it is probable that serious harm to the physical or mental health of the defendant will result. Probability of serious harm to the physical or mental health of the defendant requires evidence that the defendant is presently suffering adverse effects to their physical or mental health, or the defendant

has previously suffered these effects as a result of a mental disorder and their condition is substantially deteriorating. The fact that a defendant has a diagnosis of a mental disorder does not alone establish probability of serious harm to the physical or mental health of the defendant.

(II) Based upon the opinion of the psychiatrist or licensed psychologist offered to the court pursuant to subparagraph (A) of paragraph (2) of subdivision (a) of Section 1369, the defendant is a danger to others, in that the defendant has inflicted, attempted to inflict, or made a serious threat of inflicting substantial physical harm on another while in custody, or the defendant had inflicted, attempted to inflict, or made a serious threat of inflicting substantial physical harm on another that resulted in the defendant being taken into custody, and the defendant presents, as a result of mental disorder or mental defect, a demonstrated danger of inflicting substantial physical harm on others. Demonstrated danger may be based on an assessment of the defendant's present mental condition, including a consideration of past behavior of the defendant within six years prior to the time the defendant last attempted to inflict, inflicted, or threatened to inflict substantial physical harm on another, and other relevant evidence.

(III) The people have charged the defendant with a serious crime against the person or property, and based upon the opinion of the psychiatrist offered to the court pursuant to subparagraph (C) of paragraph (2) of subdivision (a) of Section 1369, the involuntary administration of antipsychotic medication is substantially likely to render the defendant competent to stand trial, the medication is unlikely to have side effects that interfere with the defendant's ability to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a reasonable manner, less intrusive treatments are unlikely to have substantially the same results, and antipsychotic medication is 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) When the court orders that the defendant be committed to a State Department of State Hospitals facility or other public or private treatment facility, the court shall provide copies of the following documents prior to the admission of the defendant to the State Department of State Hospitals or other treatment facility where the defendant is to be committed:

(A) The commitment order, which shall include a specification of the charges, an assessment of whether involuntary treatment with antipsychotic medications is warranted, and any orders by the court, pursuant to

subparagraph (B) of paragraph (2), authorizing involuntary treatment with antipsychotic medications.

(B) A computation or statement setting forth the maximum term of commitment in accordance with subdivision (c).

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

(ii) If a certificate of restoration of competency was filed with the court pursuant to Section 1372 and the court subsequently rejected the certification, a copy of the court order or minute order rejecting the certification shall be provided. The court order shall include a new computation or statement setting forth the amount of credit for time served, if any, to be deducted from the defendant's maximum term of commitment based on the court's rejection of the certification.

(D) State summary criminal history information.

(E) Jail classification records for the defendant's current incarceration.

(F) Arrest reports prepared by the police department or other law enforcement agency.

(G) Court-ordered psychiatric examination or evaluation reports.

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

(I) Records of a finding of mental incompetence pursuant to this chapter arising out of a complaint charging a felony offense specified in Section 290 or a pending Section 1368 proceeding arising out of a charge of a Section 290 offense.

(J) Medical records, including jail mental health records.

(4) When the defendant is committed to a treatment facility pursuant to clause (i) of subparagraph (B) of paragraph (1) or the court makes the findings specified in clause (ii) or (iii) of subparagraph (B) of paragraph (1) to assign the defendant to a treatment facility other than a State Department of State Hospitals facility or other secure treatment facility, the court shall order that notice be given to the appropriate law enforcement agency or agencies having local jurisdiction at the placement facility of a finding of mental incompetence pursuant to this chapter arising out of a charge of a Section 290 offense.

(5) When directing that the defendant be confined in a State Department of State Hospitals facility pursuant to this subdivision, the court shall commit the defendant to the State Department of State Hospitals.

(6) (A) If the defendant is committed or transferred to the State Department of State Hospitals pursuant to this section, the court may, upon receiving the written recommendation of the medical director of the State Department of State Hospitals facility and the community program director that the defendant be transferred to a public or private treatment facility approved by the community program director, order the defendant transferred to that facility. If the defendant is committed or transferred to a public or private treatment facility approved by the community program director, the court may, upon receiving the written recommendation of the community program director, transfer the defendant to the State Department of State

Hospitals or to another public or private treatment facility approved by the community program director. In the event of dismissal of the criminal charges before the defendant recovers competence, the person shall be subject to the applicable provisions of the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code). If either the defendant or the prosecutor chooses to contest either kind of order of transfer, a petition may be filed in the court for a hearing, which shall be held if the court determines that sufficient grounds exist. At the hearing, the prosecuting attorney or the defendant may present evidence bearing on the order of transfer. The court shall use the same standards as are used in conducting probation revocation hearings pursuant to Section 1203.2.

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

(B) If the defendant is initially committed to a State Department of State Hospitals facility or secure treatment facility pursuant to clause (ii) or (iii) of subparagraph (B) of paragraph (1) and is subsequently transferred to any other facility, copies of the documents specified in paragraph (3) shall be electronically transferred or taken with the defendant to each subsequent facility to which the defendant is transferred. The transferring facility shall also notify the appropriate law enforcement agency or agencies having local jurisdiction at the site of the new facility that the defendant is a person subject to clause (ii) or (iii) of subparagraph (B) of paragraph (1).

(7) (A) An order by the court authorizing involuntary medication of the defendant shall be valid for no more than one year. The court shall review the order at the time of the review of the initial report and the six-month progress reports pursuant to paragraph (1) of subdivision (b) to determine if the grounds for the authorization remain. In the review, the court shall consider the reports of the treating psychiatrist or psychiatrists and the defendant's patients' rights advocate or attorney. The court may require testimony from the treating psychiatrist and the patients' rights advocate or attorney, if necessary. The court may continue the order authorizing involuntary medication for up to another six months, or vacate the order, or make any other appropriate order.

(B) Within 60 days before the expiration of the one-year involuntary medication order, the district attorney, county counsel, or representative of any facility where a defendant found incompetent to stand trial is committed may petition the committing court for a renewal, subject to the same conditions and requirements as in subparagraph (A). The petition shall include the basis for involuntary medication set forth in clause (i) of subparagraph (B) of paragraph (2). Notice of the petition shall be provided to the defendant, the defendant's attorney, and the district attorney. The court shall hear and determine whether the defendant continues to meet the criteria set forth in clause (i) of subparagraph (B) of paragraph (2). The hearing on a petition to renew an order for involuntary medication shall be conducted prior to the expiration of the current order.

(8) For purposes of subparagraph (D) of paragraph (2) and paragraph (7), if the treating psychiatrist determines that there is a need, based on preserving their rapport with the defendant or preventing harm, the treating psychiatrist may request that the facility medical director designate another psychiatrist to act in the place of the treating psychiatrist. If the medical director of the facility designates another psychiatrist to act pursuant to this paragraph, the treating psychiatrist shall brief the acting psychiatrist of the relevant facts of the case and the acting psychiatrist shall examine the defendant prior to the hearing.

(b) (1) Within 90 days after a commitment made pursuant to subdivision (a), the medical director of the State Department of State Hospitals facility or other treatment facility to which the defendant is confined shall make a written report to the court and the community program director for the county or region of commitment, or a designee, concerning the defendant's progress toward recovery of mental competence and whether the administration of antipsychotic medication remains necessary.

If the defendant is in county custody, the county jail shall provide access to the defendant for purposes of the State Department of State Hospitals conducting an evaluation of the defendant pursuant to Section 4335.2 of the Welfare and Institutions Code. Based upon this evaluation, the State Department of State Hospitals may make a written report to the court within 90 days of a commitment made pursuant to subdivision (a) concerning the defendant's progress toward recovery of mental incompetence and whether the administration of antipsychotic medication is necessary. If the defendant remains in county custody after the initial 90-day report, the State Department of State Hospitals may conduct an evaluation of the defendant pursuant to Section 4335.2 of the Welfare and Institutions Code and make a written report to the court concerning the defendant's progress toward recovery of mental incompetence and whether the administration of antipsychotic medication is necessary.

If the defendant is on outpatient status, the outpatient treatment staff shall make a written report to the community program director concerning the defendant's progress toward recovery of mental competence. Within 90 days of placement on outpatient status, the community program director shall report to the court on this matter. If the defendant has not recovered mental competence, but the report discloses a substantial likelihood that the defendant will regain mental competence in the foreseeable future, the defendant shall remain in the State Department of State Hospitals facility or other treatment facility or on outpatient status. Thereafter, at six-month intervals or until the defendant becomes mentally competent, if the defendant is confined in a treatment facility, the medical director of the State Department of State Hospitals facility or person in charge of the facility shall report, in writing, to the court and the community program director or a designee regarding the defendant's progress toward recovery of mental competence and whether the administration of antipsychotic medication remains necessary. If the defendant is on outpatient status, after the initial 90-day report, the outpatient treatment staff shall report to the community

program director on the defendant's progress toward recovery, and the community program director shall report to the court on this matter at six-month intervals. A copy of these reports shall be provided to the prosecutor and defense counsel by the court.

(A) If the report indicates that there is no substantial likelihood that the defendant will regain mental competence in the foreseeable future, custody of the defendant shall be transferred without delay to the committing county and shall remain with the county until further order of the court. The defendant shall be returned to the court for proceedings pursuant to paragraph (2) of subdivision (c) no later than 10 days following receipt of the report. The court shall not order the defendant returned to the custody of the State Department of State Hospitals under the same commitment. The court shall transmit a copy of its order to the community program director or a designee.

(B) If the report indicates that there is no substantial likelihood that the defendant will regain mental competence in the foreseeable future, the medical director of the State Department of State Hospitals facility or other treatment facility to which the defendant is confined shall do both of the following:

(i) Promptly notify and provide a copy of the report to the defense counsel and the district attorney.

(ii) Provide a separate notification, in compliance with applicable privacy laws, to the committing county's sheriff that immediate transportation will be needed for the defendant pursuant to subparagraph (A).

(C) If a county does not take custody of a defendant committed to the State Department of State Hospitals within 10 calendar days following notification made pursuant to clause (ii) of subparagraph (B), the county shall be charged the daily rate for a state hospital bed, as established by the State Department of State Hospitals.

(2) The reports made pursuant to paragraph (1) concerning the defendant's progress toward regaining competency shall also consider the issue of involuntary medication. Each report shall include, but not be limited to, all of the following:

(A) Whether or not the defendant has the capacity to make decisions concerning antipsychotic medication.

(B) If the defendant lacks capacity to make decisions concerning antipsychotic medication, whether the defendant risks serious harm to their physical or mental health if not treated with antipsychotic medication.

(C) Whether or not the defendant presents a danger to others if the defendant is not treated with antipsychotic medication.

(D) Whether the defendant has a mental disorder for which medications are the only effective treatment.

(E) Whether there are any side effects from the medication currently being experienced by the defendant that would interfere with the defendant's ability to collaborate with counsel.

(F) Whether there are any effective alternatives to medication.

(G) How quickly the medication is likely to bring the defendant to competency.

(H) Whether the treatment plan includes methods other than medication to restore the defendant to competency.

(I) A statement, if applicable, that no medication is likely to restore the defendant to competency.

(3) After reviewing the reports, the court shall determine if grounds for the involuntary administration of antipsychotic medication exist, whether or not an order was issued at the time of commitment, and shall do one of the following:

(A) If the original grounds for involuntary medication still exist, any order authorizing the treating facility to involuntarily administer antipsychotic medication to the defendant shall remain in effect.

(B) If the original grounds for involuntary medication no longer exist, and there is no other basis for involuntary administration of antipsychotic medication, any order for the involuntary administration of antipsychotic medication shall be vacated.

(C) If the original grounds for involuntary medication no longer exist, and the report states that there is another basis for involuntary administration of antipsychotic medication, the court shall determine whether to vacate the order or issue a new order for the involuntary administration of antipsychotic medication. The court shall consider the opinions in reports submitted pursuant to paragraph (1) of subdivision (b), including any opinions rendered pursuant to Section 4335.2 of the Welfare and Institutions Code. The court may, upon a showing of good cause, set a hearing within 21 days to determine whether the order for the involuntary administration of antipsychotic medication shall be vacated or whether a new order for the involuntary administration of antipsychotic medication shall be issued. The hearing shall proceed as set forth in subparagraph (B) of paragraph (2) of subdivision (a). The court shall require witness testimony to occur remotely, including clinical testimony pursuant to subdivision (d) of Section 4335.2 of the Welfare and Institutions Code. In-person witness testimony shall only be allowed upon a court's finding of good cause.

(D) If the report states a basis for involuntary administration of antipsychotic medication and the court did not issue such order at the time of commitment, the court shall determine whether to issue an order for the involuntary administration of antipsychotic medication. The court shall consider the opinions in reports submitted pursuant to paragraph (1) of subdivision (b), including any opinions rendered pursuant to Section 4335.2 of the Welfare and Institutions Code. The court may, upon a finding of good cause, set a hearing within 21 days to determine whether an order for the involuntary administration of antipsychotic medication shall be issued. The hearing shall proceed as set forth in subparagraph (B) of paragraph (2) of subdivision (a). The court shall require witness testimony to occur remotely, including clinical testimony pursuant to subdivision (d) of Section 4335.2 of the Welfare and Institutions Code. In-person witness testimony shall only be allowed upon a court's finding of good cause.

(4) If it is determined by the court that treatment for the defendant's mental impairment is not being conducted, the defendant shall be returned

to the committing court, and, if the defendant is not in county custody, returned to the custody of the county. The court shall transmit a copy of its order to the community program director or a designee.

(5) At each review by the court specified in this subdivision, the court shall determine if the security level of housing and treatment is appropriate and may make an order in accordance with its determination. If the court determines that the defendant shall continue to be treated in the State Department of State Hospitals facility or on an outpatient basis, the court shall determine issues concerning administration of antipsychotic medication, as set forth in subparagraph (B) of paragraph (2) of subdivision (a).

(c) (1) At the end of two years from the date of commitment or a period of commitment equal to the maximum term of imprisonment provided by law for the most serious offense charged in the information, indictment, or 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. 58. Section 11105 of the Penal Code is amended to read:

11105. (a) (1) The Department of Justice shall maintain state summary criminal history information.

(2) As used in this section:

(A) "State summary criminal history information" means the master record of information compiled by the Attorney General pertaining to the identification and criminal history of a person, such as name, date of birth, physical description, fingerprints, photographs, dates of arrests, arresting agencies and booking numbers, charges, dispositions, sentencing information, and similar data about the person.

(B) "State summary criminal history information" does not refer to records and data compiled by criminal justice agencies other than the Attorney General, nor does it refer to records of complaints to or investigations conducted by, or records of intelligence information or security procedures of, the office of the Attorney General and the Department of Justice.

(b) The Attorney General shall furnish state summary criminal history information to the following, if needed in the course of their duties, provided that when information is furnished to assist an agency, officer, or official of state or local government, a public utility, or any other entity, in fulfilling employment, certification, or licensing duties, Chapter 1321 of the Statutes of 1974 and Section 432.7 of the Labor Code shall apply:

(1) The courts of the state.

(2) Peace officers of the state, as defined in Section 830.1, subdivisions (a) and (e) of Section 830.2, subdivision (a) of Section 830.3, subdivision (a) of Section 830.31, and subdivisions (a) and (b) of Section 830.5.

(3) District attorneys of the state.

(4) Prosecuting city attorneys or city prosecutors of a city within the state.

(5) City attorneys pursuing civil gang injunctions pursuant to Section 186.22a, or drug abatement actions pursuant to Section 3479 or 3480 of the Civil Code, or Section 11571 of the Health and Safety Code.

(6) Probation officers of the state.

(7) Parole officers of the state.

(8) A public defender or attorney of record when representing a person in proceedings upon a petition for a certificate of rehabilitation and pardon pursuant to Section 4852.08.

(9) A public defender or attorney of record when representing a person in a criminal case or a juvenile delinquency proceeding, including all appeals and postconviction motions, or a parole, mandatory supervision pursuant to paragraph (5) of subdivision (h) of Section 1170, or postrelease community supervision revocation or revocation extension proceeding, if the information is requested in the course of representation.

(10) An agency, officer, or official of the state if the state summary criminal history information is required to implement a statute or regulation that expressly refers to specific criminal conduct applicable to the subject person of the state summary criminal history information, and contains requirements or exclusions, or both, expressly based upon that specified

criminal conduct. The agency, officer, or official of the state authorized by this paragraph to receive state summary criminal history information may perform state and federal criminal history information checks as provided for in subdivision (u). The Department of Justice shall provide a state or federal response to the agency, officer, or official pursuant to subdivision (p).

(11) A city, county, city and county, or district, or an officer or official thereof, if access is needed in order to assist that agency, officer, or official in fulfilling employment, certification, or licensing duties, and if the access is specifically authorized by the city council, board of supervisors, or governing board of the city, county, or district if the state summary criminal history information is required to implement a statute, ordinance, or regulation that expressly refers to specific criminal conduct applicable to the subject person of the state summary criminal history information, and contains requirements or exclusions, or both, expressly based upon that specified criminal conduct. The city, county, city and county, district, or the officer or official thereof authorized by this paragraph may also transmit fingerprint images and related information to the Department of Justice to be transmitted to the Federal Bureau of Investigation.

(12) The subject of the state summary criminal history information under procedures established under Article 5 (commencing with Section 11120).

(13) A person or entity when access is expressly authorized by statute if the criminal history information is required to implement a statute or regulation that expressly refers to specific criminal conduct applicable to the subject person of the state summary criminal history information, and contains requirements or exclusions, or both, expressly based upon that specified criminal conduct.

(14) Health officers of a city, county, city and county, or district when in the performance of their official duties enforcing Section 120175 of the Health and Safety Code.

(15) A managing or supervising correctional officer of a county jail or other county correctional facility.

(16) A humane society, or society for the prevention of cruelty to animals, for the specific purpose of complying with Section 14502 of the Corporations Code for the appointment of humane officers.

(17) Local child support agencies established by Section 17304 of the Family Code. When a local child support agency closes a support enforcement case containing state summary criminal history information, the agency shall delete or purge from the file and destroy documents or information concerning or arising from offenses for or of which the parent has been arrested, charged, or convicted, other than for offenses related to the parent's having failed to provide support for minor children, consistent with the requirements of Section 17531 of the Family Code.

(18) County child welfare agency personnel who have been delegated the authority of county probation officers to access state summary criminal history information pursuant to Section 272 of the Welfare and Institutions Code for the purposes specified in Section 16504.5 of the Welfare and

Institutions Code. Information from criminal history records provided pursuant to this subdivision shall not be used for a purpose other than those specified in this section and Section 16504.5 of the Welfare and Institutions Code. When an agency obtains records both on the basis of name checks and fingerprint checks, final placement decisions shall be based only on the records obtained pursuant to the fingerprint check.

(19) The court of a tribe, or court of a consortium of tribes, that has entered into an agreement with the state pursuant to Section 10553.1 of the Welfare and Institutions Code. This information may be used only for the purposes specified in Section 16504.5 of the Welfare and Institutions Code and for tribal approval or tribal licensing of foster care or adoptive homes. Article 6 (commencing with Section 11140) shall apply to officers, members, and employees of a tribal court receiving state summary criminal history information pursuant to this section.

(20) Child welfare agency personnel of a tribe or consortium of tribes that has entered into an agreement with the state pursuant to Section 10553.1 of the Welfare and Institutions Code and to whom the state has delegated duties under paragraph (2) of subdivision (a) of Section 272 of the Welfare and Institutions Code. The purposes for use of the information shall be for the purposes specified in Section 16504.5 of the Welfare and Institutions Code and for tribal approval or tribal licensing of foster care or adoptive homes. When an agency obtains records on the basis of name checks and fingerprint checks, final placement decisions shall be based only on the records obtained pursuant to the fingerprint check. Article 6 (commencing with Section 11140) shall apply to child welfare agency personnel receiving criminal record offender information pursuant to this section.

(21) An officer providing conservatorship investigations pursuant to Sections 5351, 5354, and 5356 of the Welfare and Institutions Code.

(22) A court investigator providing investigations or reviews in conservatorships pursuant to Section 1826, 1850, 1851, or 2250.6 of the Probate Code.

(23) A person authorized to conduct a guardianship investigation pursuant to Section 1513 of the Probate Code.

(24) A humane officer pursuant to Section 14502 of the Corporations Code for the purposes of performing the officer's duties.

(25) A public agency described in subdivision (b) of Section 15975 of the Government Code, for the purpose of oversight and enforcement policies with respect to its contracted providers.

(26) (A) A state entity, or its designee, that receives federal tax information. A state entity or its designee that is authorized by this paragraph to receive state summary criminal history information also may transmit fingerprint images and related information to the Department of Justice to be transmitted to the Federal Bureau of Investigation for the purpose of the state entity or its designee obtaining federal-level criminal offender record information from the Department of Justice. This information shall be used only for the purposes set forth in Section 1044 of the Government Code.

(B) For purposes of this paragraph, "federal tax information," "state entity" and "designee" are as defined in paragraphs (1), (2), and (3), respectively, of subdivision (f) of Section 1044 of the Government Code.

(27) The director of the State Department of State Hospitals, or their designee, for use related to research and evaluation studies described in Section 4046 of the Welfare and Institutions Code, and subject to the limitations described in that section.

(c) The Attorney General may furnish state summary criminal history information and, when specifically authorized by this subdivision, federal-level criminal history information upon a showing of a compelling need to any of the following, provided that when information is furnished to assist an agency, officer, or official of state or local government, a public utility, or any other entity in fulfilling employment, certification, or licensing duties, Chapter 1321 of the Statutes of 1974 and Section 432.7 of the Labor Code shall apply:

(1) A public utility, as defined in Section 216 of the Public Utilities Code, that operates a nuclear energy facility when access is needed in order to assist in employing persons to work at the facility, provided that, if the Attorney General supplies the data, the Attorney General shall furnish a copy of the data to the person to whom the data relates.

(2) A peace officer of the state other than those included in subdivision (b).

(3) An illegal dumping enforcement officer as defined in subdivision (i) of Section 830.7.

(4) A peace officer of another country.

(5) Public officers, other than peace officers, of the United States, other states, or possessions or territories of the United States, provided that access to records similar to state summary criminal history information is expressly authorized by a statute of the United States, other states, or possessions or territories of the United States if the information is needed for the performance of their official duties.

(6) A person when disclosure is requested by a probation, parole, or peace officer with the consent of the subject of the state summary criminal history information and for purposes of furthering the rehabilitation of the subject.

(7) The courts of the United States, other states, or territories or possessions of the United States.

(8) Peace officers of the United States, other states, or territories or possessions of the United States.

(9) An individual who is the subject of the record requested if needed in conjunction with an application to enter the United States or a foreign nation.

(10) (A) (i) A public utility, as defined in Section 216 of the Public Utilities Code, or a cable corporation as defined in subparagraph (B), if receipt of criminal history information is needed in order to assist in employing current or prospective employees, contract employees, or subcontract employees who, in the course of their employment, may be seeking entrance to private residences or adjacent grounds. The information

provided shall be limited to the record of convictions and arrests for which the person is released on bail or on their own recognizance pending trial.

(ii) If the Attorney General supplies the data pursuant to this paragraph, the Attorney General shall furnish a copy of the data to the current or prospective employee to whom the data relates.

(iii) State summary criminal history information is confidential and the receiving public utility or cable corporation shall not disclose its contents, other than for the purpose for which it was acquired. The state summary criminal history information in the possession of the public utility or cable corporation and all copies made from it shall be destroyed not more than 30 days after employment or promotion or transfer is denied or granted, except for those cases where a current or prospective employee is out on bail or on their own recognizance pending trial, in which case the state summary criminal history information and all copies shall be destroyed not more than 30 days after the case is resolved.

(iv) A violation of this paragraph is a misdemeanor, and shall give the current or prospective employee who is injured by the violation a cause of action against the public utility or cable corporation to recover damages proximately caused by the violations. A public utility's or cable corporation's request for state summary criminal history information for purposes of employing current or prospective employees who may be seeking entrance to private residences or adjacent grounds in the course of their employment shall be deemed a "compelling need" as required to be shown in this subdivision.

(v) This section shall not be construed as imposing a duty upon public utilities or cable corporations to request state summary criminal history information on current or prospective employees.

(B) For purposes of this paragraph, "cable corporation" means a corporation or firm that transmits or provides television, computer, or telephone services by cable, digital, fiber optic, satellite, or comparable technology to subscribers for a fee.

(C) Requests for federal-level criminal history information received by the Department of Justice from entities authorized pursuant to subparagraph (A) shall be forwarded to the Federal Bureau of Investigation by the Department of Justice. Federal-level criminal history information received or compiled by the Department of Justice may then be disseminated to the entities referenced in subparagraph (A), as authorized by law.

(11) A campus of the California State University or the University of California, or a four-year college or university accredited by a regional accreditation organization approved by the United States Department of Education, if needed in conjunction with an application for admission by a convicted felon to a special education program for convicted felons, including, but not limited to, university alternatives and halfway houses. Only conviction information shall be furnished. The college or university may require the convicted felon to be fingerprinted, and any inquiry to the department under this section shall include the convicted felon's fingerprints and any other information specified by the department.

(12) A foreign government, if requested by the individual who is the subject of the record requested, if needed in conjunction with the individual's application to adopt a minor child who is a citizen of that foreign nation. Requests for information pursuant to this paragraph shall be in accordance with the process described in Sections 11122 to 11124, inclusive. The response shall be provided to the foreign government or its designee and to the individual who requested the information.

(d) Whenever an authorized request for state summary criminal history information pertains to a person whose fingerprints are on file with the Department of Justice and the department has no criminal history of that person, and the information is to be used for employment, licensing, or certification purposes, the fingerprint card accompanying the request for information, if any, may be stamped "no criminal record" and returned to the person or entity making the request.

(e) Whenever state summary criminal history information is furnished as the result of an application and is to be used for employment, licensing, or certification purposes, the Department of Justice may charge the person or entity making the request a fee that it determines to be sufficient to reimburse the department for the cost of furnishing the information. In addition, the Department of Justice may add a surcharge to the fee to fund maintenance and improvements to the systems from which the information is obtained. Notwithstanding any other law, a person or entity required to pay a fee to the department for information received under this section may charge the applicant a fee sufficient to reimburse the person or entity for this expense. All moneys received by the department pursuant to this section, Sections 11105.3 and 26190, and former Section 13588 of the Education Code shall be deposited in a special account in the General Fund to be available for expenditure by the department to offset costs incurred pursuant to those sections and for maintenance and improvements to the systems from which the information is obtained upon appropriation by the Legislature.

(f) Whenever there is a conflict, the processing of criminal fingerprints and fingerprints of applicants for security guard or alarm agent registrations or firearms qualification permits submitted pursuant to Section 7583.9, 7583.23, 7596.3, or 7598.4 of the Business and Professions Code shall take priority over the processing of other applicant fingerprints.

(g) It is not a violation of this section to disseminate statistical or research information obtained from a record, provided that the identity of the subject of the record is not disclosed.

(h) It is not a violation of this section to include information obtained from a record in (1) a transcript or record of a judicial or administrative proceeding or (2) any other public record if the inclusion of the information in the public record is authorized by a court, statute, or decisional law.

(i) Notwithstanding any other law, the Department of Justice or a state or local law enforcement agency may require the submission of fingerprints for the purpose of conducting state summary criminal history information checks that are authorized by law.

(j) The state summary criminal history information shall include any finding of mental incompetence pursuant to Chapter 6 (commencing with Section 1367) of Title 10 of Part 2 arising out of a complaint charging a felony offense specified in Section 290.

(k) (1) This subdivision shall apply whenever state or federal summary criminal history information is furnished by the Department of Justice as the result of an application by an authorized agency or organization and the information is to be used for peace officer employment or certification purposes. As used in this subdivision, a peace officer is defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2.

(2) Notwithstanding any other law, whenever state summary criminal history information is initially furnished pursuant to paragraph (1), the Department of Justice shall disseminate the following information:

(A) Every conviction rendered against the applicant.

(B) Every arrest for an offense for which the applicant is presently awaiting trial, whether the applicant is incarcerated or has been released on bail or on their own recognizance pending trial.

(C) Every arrest or detention, except for an arrest or detention resulting in an exoneration, provided, however, that where the records of the Department of Justice do not contain a disposition for the arrest, the Department of Justice first makes a genuine effort to determine the disposition of the arrest.

(D) Every successful diversion.

(E) Every date and agency name associated with all retained peace officer or nonsworn law enforcement agency employee preemployment criminal offender record information search requests.

(F) Sex offender registration status of the applicant.

(G) Sentencing information, if present in the department's records at the time of the response.

(*l*) (1) This subdivision shall apply whenever state or federal summary criminal history information is furnished by the Department of Justice as the result of an application by a criminal justice agency or organization as defined in Section 13101, and the information is to be used for criminal justice employment, licensing, or certification purposes.

(2) Notwithstanding any other law, whenever state summary criminal history information is initially furnished pursuant to paragraph (1), the Department of Justice shall disseminate the following information:

(A) Every conviction rendered against the applicant.

(B) Every arrest for an offense for which the applicant is presently awaiting trial, whether the applicant is incarcerated or has been released on bail or on their own recognizance pending trial.

(C) Every arrest for an offense for which the records of the Department of Justice do not contain a disposition or that did not result in a conviction, provided that the Department of Justice first makes a genuine effort to determine the disposition of the arrest. However, information concerning an arrest shall not be disclosed if the records of the Department of Justice indicate or if the genuine effort reveals that the subject was exonerated,

successfully completed a diversion or deferred entry of judgment program, or the arrest was deemed a detention, or the subject was granted relief pursuant to Section 851.91.

(D) Every date and agency name associated with all retained peace officer or nonsworn law enforcement agency employee preemployment criminal offender record information search requests.

(E) Sex offender registration status of the applicant.

(F) Sentencing information, if present in the department's records at the time of the response.

(m) (1) This subdivision shall apply whenever state or federal summary criminal history information is furnished by the Department of Justice as the result of an application by an authorized agency or organization pursuant to Section 1522, 1568.09, 1569.17, or 1596.871 of the Health and Safety Code, or a statute that incorporates the criteria of any of those sections or this subdivision by reference, and the information is to be used for employment, licensing, or certification purposes.

(2) Notwithstanding any other law, whenever state summary criminal history information is initially furnished pursuant to paragraph (1), the Department of Justice shall disseminate the following information:

(A) Every conviction of an offense rendered against the applicant, except a conviction for which relief has been granted pursuant to Section 1203.49.

(B) Every arrest for an offense for which the applicant is presently awaiting trial, whether the applicant is incarcerated or has been released on bail or on their own recognizance pending trial.

(C) Every arrest for an offense for which the Department of Social Services is required by paragraph (1) of subdivision (a) of Section 1522 of the Health and Safety Code to determine if an applicant has been arrested. However, if the records of the Department of Justice do not contain a disposition for an arrest, the Department of Justice shall first make a genuine effort to determine the disposition of the arrest.

(D) Sex offender registration status of the applicant.

(E) Sentencing information, if present in the department's records at the time of the response.

(3) Notwithstanding the requirements of the sections referenced in paragraph (1) of this subdivision, the Department of Justice shall not disseminate information about an arrest subsequently deemed a detention or an arrest that resulted in the successful completion of a diversion program, exoneration, or a grant of relief pursuant to Section 851.91.

(n) (1) This subdivision shall apply whenever state or federal summary criminal history information, to be used for employment, licensing, or certification purposes, is furnished by the Department of Justice as the result of an application by an authorized agency, organization, or individual pursuant to any of the following:

(A) Paragraph (10) of subdivision (c), when the information is to be used by a cable corporation.

(B) Section 11105.3 or 11105.4.

(C) Section 15660 of the Welfare and Institutions Code.

(D) A statute that incorporates the criteria of any of the statutory provisions listed in subparagraph (A), (B), or (C), or of this subdivision, by reference.

(2) With the exception of applications submitted by transportation companies authorized pursuant to Section 11105.3, and notwithstanding any other law, whenever state summary criminal history information is initially furnished pursuant to paragraph (1), the Department of Justice shall disseminate the following information:

(A) Every conviction, except a conviction for which relief has been granted pursuant to Section 1203.49, rendered against the applicant for a violation or attempted violation of an offense specified in subdivision (a) of Section 15660 of the Welfare and Institutions Code. However, with the exception of those offenses for which registration is required pursuant to Section 290, the Department of Justice shall not disseminate information pursuant to this subdivision unless the conviction occurred within 10 years of the date of the agency's request for information or the conviction is over 10 years old but the subject of the request was incarcerated within 10 years of the agency's request for information.

(B) Every arrest for a violation or attempted violation of an offense specified in subdivision (a) of Section 15660 of the Welfare and Institutions Code for which the applicant is presently awaiting trial, whether the applicant is incarcerated or has been released on bail or on their own recognizance pending trial.

(C) Sex offender registration status of the applicant.

(D) Sentencing information, if present in the department's records at the time of the response.

(o) (1) This subdivision shall apply whenever state or federal summary criminal history information is furnished by the Department of Justice as the result of an application by an authorized agency or organization pursuant to Section 379 or 1300 of the Financial Code, or a statute that incorporates the criteria of either of those sections or this subdivision by reference, and the information is to be used for employment, licensing, or certification purposes.

(2) Notwithstanding any other law, whenever state summary criminal history information is initially furnished pursuant to paragraph (1), the Department of Justice shall disseminate the following information:

(A) Every conviction rendered against the applicant for a violation or attempted violation of an offense specified in Section 1300 of the Financial Code, except a conviction for which relief has been granted pursuant to Section 1203.49.

(B) Every arrest for a violation or attempted violation of an offense specified in Section 1300 of the Financial Code for which the applicant is presently awaiting trial, whether the applicant is incarcerated or has been released on bail or on their own recognizance pending trial.

(C) Sentencing information, if present in the department's records at the time of the response.

(p) (1) This subdivision shall apply whenever state or federal criminal history information is furnished by the Department of Justice as the result of an application by an agency, organization, or individual not defined in subdivision (k), (*l*), (m), (n), or (o), or by a transportation company authorized pursuant to Section 11105.3, or a statute that incorporates the criteria of that section or this subdivision by reference, and the information is to be used for employment, licensing, or certification purposes.

(2) Notwithstanding any other law, whenever state summary criminal history information is initially furnished pursuant to paragraph (1), the Department of Justice shall disseminate the following information:

(A) Every conviction rendered against the applicant, except a conviction for which relief has been granted pursuant to Section 1203.4, 1203.4a, 1203.41, 1203.42, 1203.425, or 1203.49. The Commission on Teacher Credentialing, school districts, county offices of education, charter schools, private schools, state special schools for the blind and deaf, or any other entity required to have a background check because of a contract with a school district, county office of education, charter school, private school, or state special school for the blind and deaf, shall receive every conviction rendered against an applicant, retroactive to January 1, 2020, regardless of relief granted pursuant to Section 1203.4, 1203.4a, 1203.41, 1203.42, 1203.425, or 1203.49.

(B) Notwithstanding subparagraph (A) or any other law, information for a conviction for a controlled substance offense listed in Section 11350 or 11377, or former Section 11500 or 11500.5, of the Health and Safety Code that is more than five years old, for which relief is granted pursuant to Section 1203.4, 1203.4a, 1203.41, 1203.42, 1203.425, or 1203.49, shall not be disseminated.

(C) Every arrest for an offense for which the applicant is presently awaiting trial, whether the applicant is incarcerated or has been released on bail or on their own recognizance pending trial.

(D) Sex offender registration status of the applicant.

(E) Sentencing information, if present in the department's records at the time of the response.

(q) All agencies, organizations, or individuals defined in subdivisions (k), (*l*), (m), (n), (o), and (p) may contract with the Department of Justice for subsequent notification pursuant to Section 11105.2. This subdivision shall not supersede sections that mandate an agency, organization, or individual to contract with the Department of Justice for subsequent notification pursuant to Section 11105.2.

(r) This section does not require the Department of Justice to cease compliance with any other statutory notification requirements.

(s) The provisions of Section 50.12 of Title 28 of the Code of Federal Regulations are to be followed in processing federal criminal history information.

(t) Whenever state or federal summary criminal history information is furnished by the Department of Justice as the result of an application by an authorized agency, organization, or individual defined in subdivisions (k)

to (p), inclusive, and the information is to be used for employment, licensing, or certification purposes, the authorized agency, organization, or individual shall expeditiously furnish a copy of the information to the person to whom the information relates if the information is a basis for an adverse employment, licensing, or certification decision. When furnished other than in person, the copy shall be delivered to the last contact information provided by the applicant.

(u) (1) If a fingerprint-based criminal history information check is required pursuant to any statute, that check shall be requested from the Department of Justice and shall be applicable to the person identified in the referencing statute. The agency or entity identified in the statute shall submit to the Department of Justice fingerprint images and related information required by the Department of Justice of the types of applicants identified in the referencing statute, for the purpose of obtaining information as to the existence and content of a record of state or federal convictions and state or federal arrests and also information as to the existence and content of a record of the state or federal arrests for which the Department of Justice establishes that the person is free on bail or on their own recognizance pending trial or appeal.

(2) If requested, the Department of Justice shall transmit fingerprint images and related information received pursuant to this section to the Federal Bureau of Investigation for the purpose of obtaining a federal criminal history information check. The Department of Justice shall review the information returned from the Federal Bureau of Investigation, and compile and disseminate a response or a fitness determination, as appropriate, to the agency or entity identified in the referencing statute.

(3) The Department of Justice shall provide a state- or federal-level response or a fitness determination, as appropriate, to the agency or entity identified in the referencing statute, pursuant to the identified subdivision.

(4) The agency or entity identified in the referencing statute shall request from the Department of Justice subsequent notification service, as provided pursuant to Section 11105.2, for persons described in the referencing statute.

(5) The Department of Justice shall charge a fee sufficient to cover the reasonable cost of processing the request described in this subdivision.

SEC. 59. Section 41136 of the Revenue and Taxation Code is amended to read:

41136. (a) From the funds in the State Emergency Telephone Number Account, all amounts of the 911 surcharge collected shall, when appropriated by the Legislature, be spent solely for the following purposes:

(1) To pay refunds authorized by this part.

(2) To pay the department for the cost of the administration of the 911 surcharge under this part.

(3) To pay the Office of Emergency Services for its costs in administration of the “911” emergency telephone number system.

(4) To pay bills submitted to the Office of Emergency Services by service suppliers or communications equipment companies for the installation of, and ongoing expenses for, the following communications services supplied

to local agencies in connection with the "911" emergency phone number system:

(A) A basic system, defined as 911 systems, including, but not limited to, Next Generation 911, and the subsequent technologies, and interfaces needed to deliver 911 voice and data information from the 911 caller to the emergency responder and the subsequent technologies, and interfaces needed to send information, including, but not limited to, alerts and warnings, to potential 911 callers.

(B) A basic system with telephone central office identification.

(C) A system employing automatic call routing.

(D) Approved incremental costs.

(5) To pay claims of local agencies for approved incremental costs, not previously compensated for by another governmental agency.

(6) To pay claims of local agencies for incremental costs and amounts, not previously compensated for by another governmental agency, incurred prior to the effective date of this part, for the installation and ongoing expenses for the following communication services supplied in connection with the "911" emergency telephone number system:

(A) A basic system, defined as 911 systems, including, but not limited to, Next Generation 911, and the subsequent technologies, and interfaces needed to deliver 911 voice and data information from the 911 caller to the emergency responder and the subsequent technologies, and interfaces needed to send information, including, but not limited to, alerts and warnings, to potential 911 callers.

(B) A basic system with telephone central office identification.

(C) A system employing automatic call routing.

(D) Approved incremental costs. Incremental costs shall not be allowed unless the costs are concurred in by the Office of Emergency Services.

(b) (1) From the funds in the 988 State Suicide and Behavioral Health Crisis Services Fund, all amounts of the 988 surcharge collected shall be spent for purposes identified in Section 53123.4 of the Government Code. However, before funds are disbursed as provided in Section 53123.4 of the Government Code, funds shall be used for all of the following:

(A) To pay refunds authorized by this part.

(B) To pay the department for the cost of the administration of the 988 surcharge under this part.

(C) To pay other state departments for their costs in administration of the 988 Suicide & Crisis Lifeline.

(2) The remainder of the revenue shall be disbursed to the Office of Emergency Services for the purposes identified in Section 53123.4 of the Government Code.

SEC. 60. Section 61035 of the Revenue and Taxation Code is repealed.

SEC. 61. Section 61035 is added to the Revenue and Taxation Code, to read:

61035. Beginning July 1, 2023, and on July 1 annually thereafter, moneys collected from the Individual Shared Responsibility Penalty shall be deposited into the Health Care Affordability Reserve Fund.

SEC. 62. Section 3200 of the Welfare and Institutions Code is amended to read:

3200. (a) The State Department of Public Health shall establish a grant program to reduce fentanyl overdoses and use throughout the state. Six one-time grants shall be made; two in northern California, two in the central valley, and two in southern California.

(b) Grant moneys may be used for any of the following purposes:

(1) Education programs in local schools.

(2) Increasing testing abilities for fentanyl.

(3) Overdose prevention and recovery programs, including making naloxone or other overdose recovery drugs more available in the community.

(4) Increasing social services and substance use recovery services to those addicted to fentanyl or other opioids.

(c) A local jurisdiction or agency, or a group comprised of local jurisdictions and agencies working in concert, shall submit an application and plan to the department in a form required by the department. The department shall award grants based on need, evidence-based likelihood of success, and the number of people proposed to be served.

SEC. 63. Section 3201 of the Welfare and Institutions Code is amended to read:

3201. (a) As a condition of receiving a grant pursuant to this chapter, the applying entity shall agree to provide the department with information on the program, including, but not limited to, all of the following:

(1) How the grant moneys were used.

(2) The number of people served.

(3) All of the following for both the year prior to the grant and the years the grant was used:

(A) The number of hospitalizations due to fentanyl.

(B) The number of overdoses from fentanyl.

(C) The number of overdose deaths from fentanyl.

(4) Any other information the department requires.

(b) (1) On or before January 1, 2026, the department shall submit an interim report on the progress of the programs for which grants were provided to the Legislature and the Governor's office, including, but not limited to, all available information provided by the programs pursuant to subdivision (a).

(2) On or before January 1, 2028, the department shall submit a final report on the efficacy of the programs for which grants were provided to the Legislature and the Governor's office, including, but not limited to, all of the information provided by the programs pursuant to subdivision (a).

(3) Reports submitted pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code.

SEC. 64. Section 3203 of the Welfare and Institutions Code is amended to read:

3203. This chapter shall remain in effect only until January 1, 2029, and as of that date is repealed.

SEC. 65. Section 4046 is added to the Welfare and Institutions Code, to read:

4046. Notwithstanding any other law, designated staff of the State Department of State Hospitals shall have access to state summary criminal history information for patients and formerly committed patients necessary to submit legislative reports for facility and community treatment programs, as well as for research, evaluation, and data analytics. Criminal history records may include individually disaggregated data of arrests, charging offenses, pretrial proceedings, the nature and disposition of criminal charges, and information pertaining to sentencing, incarceration, rehabilitation, and release. Information from criminal history records provided pursuant to this section shall not be used for any purpose other than those specified in this article. The State Department of State Hospitals and the Department of Corrections and Rehabilitation may exchange criminal identification and information numbers (CII) for the purposes of research and program evaluation under this section.

SEC. 66. Section 5402 of the Welfare and Institutions Code is amended to read:

5402. (a) The State Department of Health Care Services shall collect data quarterly and publish, on or before May 1 of each year, a report including quantitative, deidentified information concerning the operation of this division. The report shall include an evaluation of the effectiveness of achieving the legislative intent of this part pursuant to Section 5001. Based on information that is available from each county, the report shall include all of the following information:

(1) The number of persons in designated and approved facilities admitted or detained for 72-hour evaluation and treatment, admitted for 14-day and 30-day periods of intensive treatment, and admitted for 180-day postcertification intensive treatment in each county.

(2) The number of persons transferred to mental health facilities pursuant to Section 4011.6 of the Penal Code in each county.

(3) The number of persons for whom temporary conservatorships are established in each county.

(4) The number of persons for whom conservatorships are established in each county.

(5) The number of persons admitted or detained either once, between two and five times, between six and eight times, and greater than eight times for each type of detention, including 72-hour evaluation and treatment, 14-day and 30-day periods of intensive treatment, and 180-day postcertification intensive treatment.

(6) The clinical outcomes for individuals identified in paragraphs (1) to (4), inclusive.

(7) The services provided or offered to individuals identified in paragraphs (1) to (4), inclusive. Data pertaining to services provided or offered to individuals placed on each type of hold shall include, but not be limited to, assessment, evaluation, medication treatment, crisis intervention, and

psychiatric and psychological treatment services. Data pertaining to services shall specify the payer information or funding used to pay for services.

(8) The waiting periods for individuals prior to receiving an evaluation in a designated and approved facility pursuant to Section 5150 or 5151 and waiting periods for individuals prior to receiving treatment services in a designated facility, including the reasons for waiting periods. The waiting period shall be calculated from the date and time when the hold began and end on the date and time when the individual received an evaluation or received evaluation and treatment services in a designated facility.

(9) If the source of admission is an emergency department, the date and time of service and release from emergency care.

(10) Demographic data of those receiving care, including age, sex, gender identity, race, ethnicity, primary language, sexual orientation, veteran status, and housing status, to the extent those data are available.

(11) The number of all county-contracted beds.

(12) The number and outcomes of all of the following:

(A) The certification review hearings held pursuant to Section 5256.

(B) The petitions for writs of habeas corpus filed pursuant to Section 5275.

(C) The judicial review hearings held pursuant to Section 5276.

(D) The petitions for capacity hearings filed pursuant to Section 5332.

(E) The capacity hearings held pursuant to Section 5334 in each superior court.

(13) Analysis and evaluation of the efficacy of mental health assessments, detentions, treatments, and supportive services provided both under this part and subsequent to release.

(14) Recommendations for improving mental health assessments, detentions, treatments, and supportive services provided under this part and subsequent to release.

(15) An assessment of the disproportionate use of detentions and conservatorships on various groups, including an assessment of use by the race, ethnicity, gender identity, age group, veteran status, housing status, and Medi-Cal enrollment status of detained and conserved persons. This assessment shall evaluate disproportionate use at the county, regional, and state levels.

(16) An explanation for the absence of any data required pursuant to this section that are not included in the report.

(17) Beginning with the report due May 1, 2025, the report shall also include the progress that has been made on implementing recommendations from prior reports issued under this subdivision.

(b) (1) (A) Each county behavioral health director shall provide accurate and complete data to the department in a form and manner, and in accordance with timelines, prescribed by the department.

(B) County behavioral health directors shall provide the data specified in paragraphs (1) to (11), inclusive, of subdivision (a), and any other information, records, and reports that the department deems necessary for the purposes of this section.

(C) Data shall be submitted on a quarterly basis, or more frequently, as required by the department. The department shall not have access to patient name identifiers.

(2) (A) Each designated and approved facility that admits, detains, or provides services to persons pursuant to this part and Part 1.5 (commencing with Section 5585) and each other entity involved in implementing Section 5150 shall collect and provide accurate and complete data to the county behavioral health director in the county in which they operate to meet the reporting obligations specified in paragraphs (1) to (11), inclusive, of subdivision (a) and any other information, records, and reports that the county or the department deems necessary for the purposes of this section.

(B) A county may establish policies and procedures for this paragraph to ensure compliance with the requirements of this section. These facilities and entities shall collect and report data to the county behavioral health director consistent with the county's policies and procedures, if established.

(C) Data shall be submitted to the county behavioral health director on a quarterly basis, or more frequently, as required by the county.

(3) A county behavioral health director shall provide the accurate and complete data it receives pursuant to paragraph (2) to the department pursuant to paragraph (1).

(4) All data submitted to the department by each county behavioral health director shall be transmitted in a secure manner in compliance with all applicable state and federal requirements, including, but not limited to, Section 164.312 of Title 45 of the Code of Federal Regulations.

(c) Information published pursuant to subdivision (a) shall not contain data that may lead to the identification of patients receiving services under this division and shall contain statistical data only. Data published by the department shall be deidentified in compliance with subdivision (b) of Section 164.514 of Title 45 of the Code of Federal Regulations.

(d) The Judicial Council shall provide the department, by October 1 of each year, with data from each superior court to complete the report described in this section, including the number and outcomes of certification review hearings held pursuant to Section 5256, petitions for writs of habeas corpus filed pursuant to Section 5275, judicial review hearings held pursuant to Section 5276, petitions for capacity hearings filed pursuant to Section 5332, and capacity hearings held pursuant to Section 5334 in each superior court. The department shall not have access to patient name identifiers.

(e) The department shall make the report publicly available on the department's internet website.

(f) (1) The department may impose a plan of correction or assess civil money penalties, pursuant to paragraph (3), or both, against a designated and approved facility that fails to submit data on a timely basis or as otherwise required by this section.

(2) The department may impose a plan of correction or assess civil money penalties, pursuant to paragraph (3), or both, against a county that fails to submit data on a timely basis or as otherwise required by this section.

(3) The department may assess civil money penalties against a designated and approved facility or county in the amount of fifty dollars ($50) per day from the date specified in the notice to impose civil money penalties from the department.

(4) (A) A designated and approved facility or county may submit an informal written appeal of a civil money penalty to the department within 30 calendar days of the date of issuance of a notice to impose civil money penalties.

(B) The designated and approved facility or county shall include any supporting documentation and explain any mitigating circumstances.

(C) The department shall make a determination on the appeal within 60 calendar days of receipt of the informal written appeal.

(5) (A) A designated and approved facility or county may request a formal hearing within 30 calendar days following the issuance of the department's final determination on the appeal pursuant to paragraph (4).

(B) All hearings to review the imposition of civil money penalties shall be held pursuant to the procedures set forth in Section 100171 of the Health and Safety Code.

(C) Civil money penalties imposed upon a designated and approved facility or county shall continue to accrue until the effective date of the final decision of the department.

(g) (1) The Lanterman-Petris-Short Act Data and Reporting Oversight Fund is hereby created in the State Treasury.

(2) The Lanterman-Petris-Short Act Data and Reporting Oversight Fund shall be administered by the State Department of Health Care Services.

(3) Civil money penalties assessed and collected pursuant to subdivision (f) shall be deposited into this fund.

(4) (A) Notwithstanding Section 13340 of the Government Code, moneys deposited in the Lanterman-Petris-Short Act Data and Reporting Oversight Fund shall be continuously appropriated, without regard to fiscal year, to the State Department of Health Care Services for the purposes of funding its oversight activities and administrative costs associated with implementing this section.

(B) Notwithstanding any other law, the Controller may use the moneys in the Lanterman-Petris-Short Act Data and Reporting Oversight Fund for cashflow loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code.

(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 information notices, provider bulletins, or other similar instructions, without taking any further regulatory action.

(i) The department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis for purposes of administering or implementing the requirements of this section. Contracts entered into or amended pursuant to this section shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of

Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

SEC. 67. Section 14005.7 of the Welfare and Institutions Code is amended to read:

14005.7. (a) Medically needy persons and medically needy family persons are entitled to health care services under Section 14005 providing all eligibility criteria established pursuant to this chapter are met.

(b) Except as otherwise provided in this chapter or in Title XIX of the federal Social Security Act, no medically needy family person, medically needy person or state-only Medi-Cal persons shall be entitled to receive health care services pursuant to Section 14005 during any month in which their spend down of excess income has not been met.

(c) In the case of a medically needy person, monthly income, as determined, defined, counted, and valued, in accordance with Title XIX of the federal Social Security Act, in excess of the amount required for maintenance established pursuant to Section 14005.12, exclusive of any amounts considered exempt as income under Chapter 3 (commencing with Section 12000), less amounts paid for Medicare and other health insurance premiums shall be the spend down of excess income to be met under Section 14005.9.

(d) In the case of a medically needy family person or state-only Medi-Cal person, monthly income, as determined, defined, counted, and valued, in accordance with Title XIX of the federal Social Security Act, in excess of the amount required for maintenance established pursuant to Section 14005.12, exclusive of any amounts considered exempt as income under Chapter 2 (commencing with Section 11200), less amounts paid for Medicare and other health insurance premiums shall be the spend down of excess income to be met under Section 14005.9.

(e) In determining the income of a medically needy person residing in a licensed community care facility, income shall be determined, defined, counted, and valued, in accordance with Title XIX of the federal Social Security Act, any amount paid to the facility for residential care and support that exceeds the amount needed for maintenance shall be deemed unavailable for the purposes of this chapter.

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

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

(B) "MNL" means the income standard of the Medi-Cal medically needy program defined in Section 14005.12.

(C) Board and care "personal care services" or "PCS" deduction means the income disregard that is applied to a resident in a licensed community care facility, in lieu of the board and care deduction specified in subdivision (e) of Section 14005.7, when the PCS deduction is greater than the board and care deduction.

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

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

(i) If the deduction specified in subdivision (e) is applicable to the individual, the amount, not to exceed the amount by which the SSI recipient retention amount exceeds twenty dollars ($20), nor to be less than zero, by which the sum of the amount that the individual pays to their licensed community care facility and the SSI recipient retention amount exceed the sum of the individual's MNL, the individual's board and care deduction, and twenty dollars ($20).

(ii) If the deduction specified in paragraph (1) is applicable to the individual, an amount, not to exceed the amount by which the SSI recipient retention amount exceeds twenty dollars ($20), nor to be less than zero, by which the sum of the amount that the individual pays to their community care facility and the SSI recipient retention amount exceed the sum of the individual's MNL, the individual's PCS deduction and twenty dollars ($20).

(3) In determining the countable income of a medically needy individual residing in a licensed community care facility, the individual shall have deducted from their income the amount specified in subparagraph (B) of paragraph (2).

(g) No later than one month after the effective date of subparagraph (B) of paragraph (2) of subdivision (f), the department shall submit to the federal medicaid administrator a state plan amendment seeking approval of the income deduction specified in subdivision (f), and of federal financial participation for the costs resulting from that income deduction.

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

SEC. 68. Section 14005.9 of the Welfare and Institutions Code is amended to read:

14005.9. (a) The spend down amount of excess income necessary to become eligible for Medi-Cal shall be determined on a monthly basis. No person or family shall be required to incur more than one month's spend down amount of excess income to become eligible for Medi-Cal prior to being certified as specified in Section 14018.

(b) Once the beneficiary has incurred expenses for Medicare and other health insurance deductibles or coinsurance charges and necessary medical and remedial services that are not subject to payment by a third party and that equal or exceed their spend down of excess income to become eligible

for Medi-Cal, the individual is entitled to receive health care services pursuant to Section 14005 if all other applicable conditions of eligibility under this chapter are met.

SEC. 69. Section 14005.11 of the Welfare and Institutions Code is amended to read:

14005.11. (a) To the extent required by federal law for qualified Medicare beneficiaries, the department shall pay the premiums, deductibles, and coinsurance for elderly and disabled persons entitled to benefits under Title XVIII of the federal Social Security Act, whose income does not exceed the federal poverty level and whose resources do not exceed 200 percent of the Supplemental Security Income program standard.

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

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

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

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

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

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

SEC. 70. Section 14005.11 is added to the Welfare and Institutions Code, to read:

14005.11. (a) To the extent required by federal law for qualified beneficiaries enrolled in the Medicare Program, the department shall pay the premiums, deductibles, and coinsurance for elderly and disabled persons

entitled to benefits under Title XVIII of the federal Social Security Act, whose income does not exceed the federal poverty level.

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

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

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

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

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

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

SEC. 71. Section 14005.12 of the Welfare and Institutions Code, as amended by Section 72 of Chapter 47 of the Statutes of 2022, is amended to read:

14005.12. (a) For the purposes of Sections 14005.4 and 14005.7, the department shall establish the income levels for maintenance need at the lowest levels that reasonably permit medically needy persons to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under Title XIX of the federal Social Security Act. It is the intent of the Legislature that the income levels for maintenance need for medically needy aged, blind, and disabled adults, in particular, shall be based upon amounts that adequately reflect their needs.

(1) Subject to paragraph (2), reductions in the maximum aid payment levels set forth in subdivision (a) of Section 11450 in the 1991–92 fiscal year, and thereafter, shall not result in a reduction in the income levels for maintenance under this section.

(2) (A) The department shall seek any necessary federal authorization for maintaining the income levels for maintenance at the levels in effect June 30, 1991.

(B) If federal authorization is not obtained, medically needy persons shall not be required to pay the difference between the spend down of excess income as determined based on the payment levels in effect on June 30, 1991, under Section 11450, and the spend down of excess income as determined based on the payment levels in effect on July 1, 1991, and thereafter.

(3) Any medically needy person who was eligible for benefits under this chapter as categorically needy for the calendar month immediately preceding the effective date of the reductions in the minimum basic standards of adequate care for the Aid to Families with Dependent Children program as set forth in Section 11452.018 made in the 1995–96 Regular Session of the Legislature shall not be responsible for paying their spend down of excess income if all of the following apply:

(A) The person had eligibility as categorically needy terminated by the reductions in the minimum basic standards of adequate care.

(B) The person, but for the reductions, would be eligible to continue receiving benefits under this chapter as categorically needy.

(C) The person is ineligible to receive benefits without a spend down of excess income as a medically needy person pursuant to paragraph (1) or (2).

(b) In the case of a single individual, the amount of the income level for maintenance per month shall be 80 percent of the highest amount that would ordinarily be paid to a family of two persons, without any income or resources, under subdivision (a) of Section 11450, multiplied by the federal financial participation rate.

(c) In the case of a family of two adults, the income level for maintenance per month shall be the highest amount that would ordinarily be paid to a family of three persons without income or resources under subdivision (a) of Section 11450, multiplied by the federal financial participation rate.

(d) For the purposes of Sections 14005.4 and 14005.7, for a person in a medical institution or nursing facility, or for a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization pursuant to Chapter 8.75 (commencing with Section 14591), the amount considered as required for maintenance per month shall be computed in accordance with, and for those purposes required by, Title XIX of the federal Social Security Act, and regulations adopted pursuant thereto. Those amounts shall be computed pursuant to regulations that include providing for the following purposes:

(1) Personal and incidental needs in the amount of not less than thirty-five dollars ($35) per month while a patient. The department may, by regulation, increase this amount as necessitated by increasing costs of personal and incidental needs. A long-term health care facility shall not charge an individual for the laundry services or periodic hair care specified in Section 14110.4.

(2) The upkeep and maintenance of the home.

(3) The support and care of their minor children, or any disabled relative for whose support they have contributed regularly, if there is no community spouse.

(4) If the person is an institutionalized spouse, for the support and care of their community spouse, minor or dependent children, dependent parents, or dependent siblings of either spouse, provided the individuals are residing with the community spouse.

(5) The community spouse monthly income allowance shall be established at the maximum amount permitted in accordance with Section 1924(d)(1)(B) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396r-5(d)(1)(B)).

(6) The family allowance for each family member residing with the community spouse shall be computed in accordance with the formula established in Section 1924(d)(1)(C) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396r-5(d)(1)(C)).

(e) For the purposes of Sections 14005.4 and 14005.7, with regard to a person in a licensed community care facility, the amount considered as required for maintenance per month shall be computed pursuant to regulations adopted by the department that provide for the support and care of their spouse, minor children, or any disabled relative for whose support they have contributed regularly.

(f) The income levels for maintenance per month, except as specified in subdivisions (b) to (d), inclusive, shall be equal to the highest amounts that would ordinarily be paid to a family of the same size without any income or resources under subdivision (a) of Section 11450, multiplied by the federal financial participation rate.

(g) The "federal financial participation rate," as used in this section, shall mean 133 ⅓ percent, or such other rate set forth in Section 1903 of the federal Social Security Act (42 U.S.C. Sec. 1396(b)), or its successor provisions.

(h) The income levels for maintenance per month shall not be decreased to reflect the presence in the household of persons receiving forms of aid other than Medi-Cal.

(i) When family members maintain separate residences, but eligibility is determined as a single unit under Section 14008, the income levels for maintenance per month shall be established for each household in accordance with subdivisions (b) to (h), inclusive. The total of these levels shall be the level for the single eligibility unit.

(j) The income levels for maintenance per month established pursuant to subdivisions (b) to (i), inclusive, shall be calculated on an annual basis, rounded to the next higher multiple of one hundred dollars ($100), and then prorated.

(k) If the conditions described in paragraph (2) of subdivision (b) of Section 14005.12, as added by Section 73 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2025, or the date certified by the department pursuant to paragraph (3)

of subdivision (b) of Section 14005.12, as added by Section 73 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

SEC. 72. Section 14005.12 of the Welfare and Institutions Code, as added by Section 73 of Chapter 47 of the Statutes of 2022, is amended to read:

14005.12. (a) For the purposes of Sections 14005.4 and 14005.7, the department shall establish the income levels for maintenance need at the lowest levels that reasonably permit medically needy persons to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under Title XIX of the federal Social Security Act. It is the intent of the Legislature that the income levels for maintenance need for medically needy aged, blind, and disabled adults, in particular, shall be based upon amounts that adequately reflect their needs.

(1) Subject to paragraph (2), reductions in the maximum aid payment levels set forth in subdivision (a) of Section 11450 in the 1991–92 fiscal year, and thereafter, shall not result in a reduction in the income levels for maintenance under this section.

(2) (A) The department shall seek any necessary federal authorization for maintaining the income levels for maintenance at the levels in effect June 30, 1991, and, commencing no sooner than January 1, 2025, as described in subdivision (b).

(B) If federal authorization is not obtained, medically needy persons shall not be required to pay the difference between the spend down of excess income as determined based on the payment levels in effect on June 30, 1991, under Section 11450, and the spend down of excess income as determined based on the payment levels in effect on July 1, 1991, and thereafter.

(3) Any medically needy person who was eligible for benefits under this chapter as categorically needy for the calendar month immediately preceding the effective date of the reductions in the minimum basic standards of adequate care for the Aid to Families with Dependent Children program as set forth in Section 11452.018 made in the 1995–96 Regular Session of the Legislature shall not be responsible for paying their spend down of excess income if all of the following apply:

(A) The person had eligibility as categorically needy terminated by the reductions in the minimum basic standards of adequate care.

(B) The person, but for the reductions, would be eligible to continue receiving benefits under this chapter as categorically needy.

(C) The person is ineligible to receive benefits without a spend down of excess income as a medically needy person pursuant to paragraph (1) or (2).

(b) (1) Effective no sooner than January 1, 2025, and to the extent the department determines the conditions described in paragraph (2) have been met, the amount of the income level for maintenance per month shall be equal to the income limit for Medi-Cal without a spend down of excess income for individuals described in Section 1396a(m)(1)(A) of Title 42 of

the United States Code, as that income limit is calculated pursuant to paragraph (3) of subdivision (c) of Section 14005.40.

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

(A) All necessary federal approvals have been obtained by the department.

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

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

(c) For the purposes of Sections 14005.4 and 14005.7, for a person in a medical institution or nursing facility, or for a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization pursuant to Chapter 8.75 (commencing with Section 14591), the amount considered as required for maintenance per month shall be computed in accordance with, and for those purposes required by, Title XIX of the federal Social Security Act, and regulations adopted pursuant thereto. Those amounts shall be computed pursuant to regulations that include providing for the following purposes:

(1) Personal and incidental needs in the amount of not less than thirty-five dollars ($35) per month while a patient. The department may, by regulation, increase this amount as necessitated by increasing costs of personal and incidental needs. A long-term health care facility shall not charge an individual for the laundry services or periodic hair care specified in Section 14110.4.

(2) The upkeep and maintenance of the home.

(3) The support and care of their minor children, or any disabled relative for whose support they have contributed regularly, if there is no community spouse.

(4) If the person is an institutionalized spouse, for the support and care of their community spouse, minor or dependent children, dependent parents, or dependent siblings of either spouse, provided the individuals are residing with the community spouse.

(5) The community spouse monthly income allowance shall be established at the maximum amount permitted in accordance with Section 1924(d)(1)(B) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396r-5(d)(1)(B)).

(6) The family allowance for each family member residing with the community spouse shall be computed in accordance with the formula established in Section 1924(d)(1)(C) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396r-5(d)(1)(C)).

(d) For the purposes of Sections 14005.4 and 14005.7, with regard to a person in a licensed community care facility, the amount considered as

required for maintenance per month shall be computed pursuant to regulations adopted by the department that provide for the support and care of their spouse, minor children, or any disabled relative for whose support they have contributed regularly.

(e) The income levels for maintenance per month shall not be decreased to reflect the presence in the household of persons receiving forms of aid other than Medi-Cal.

(f) When family members maintain separate residences, but eligibility is determined as a single unit under Section 14008, the income levels for maintenance per month shall be established for each household in accordance with subdivisions (b) to (e), inclusive. The total of these levels shall be the level for the single eligibility unit.

(g) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of all-county letters, provider bulletins or notices, policy letters, or other similar instructions, without taking any further regulatory action. Within two calendar years of implementing subdivision (d) of Section 14005.12, the department shall adopt, amend, or repeal any necessary regulations.

(h) This section shall become operative on January 1, 2025, or the date certified by the department pursuant to paragraph (3) of subdivision (b), whichever is later.

SEC. 73. Section 14005.13 of the Welfare and Institutions Code, as amended by Section 74 of Chapter 47 of the Statutes of 2022, is amended to read:

14005.13. (a) Notwithstanding Section 14005.12, when an individual residing in a long-term care facility would incur a long-term care patient liability for services under this chapter due to income that exceeds that allowed for the incidental and personal needs of the individual, a specified portion of the individual's earned income from therapeutic wages shall be exempt. Therapeutic wages are wages earned by the individual under all of the following conditions:

(1) A physician who does not have a financial interest in the long-term care facility in which the individual resides, and who is in charge of the individual's case, prescribes work as therapy for the individual.

(2) The individual must be employed within the same long-term care facility where they reside.

(3) The individual's employment does not displace any existing employees.

(4) The individual has resided in a long-term care facility for a continuous period commencing at least five years prior to the date of the addition of this section as originally adopted during the 1983–84 Regular Session.

(b) The amount of earned income from therapeutic wages that shall be exempt shall be the lesser of 70 percent of the gross therapeutic wages or 70 percent of the maintenance level for a noninstitutionalized person or family of corresponding size as described in subdivision (b), (c), or (e) of Section 14005.12.

(c) The provisions of this section shall be given retroactive effect for the period commencing June 1, 1983.

(d) This section shall not become operative unless and until the necessary waivers are obtained from the United States Department of Health and Human Services.

(e) The director shall adopt regulations implementing this section as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For the purposes of the Administrative Procedure Act, the adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, emergency regulations adopted by the department in order to implement this section shall not be subject to the review and approval of the Office of Administrative Law. These regulations shall become effective immediately upon filing with the Secretary of State.

(f) If the conditions described in paragraph (2) of subdivision (b) of Section 14005.12, as added by Section 73 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2025, or the date certified by the department pursuant to paragraph (3) of subdivision (b) of Section 14005.12, as added by Section 73 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

SEC. 74. Section 14005.13 of the Welfare and Institutions Code, as amended by Section 15 of Chapter 738 of the Statutes of 2022, is amended to read:

14005.13. (a) Notwithstanding Section 14005.12, when an individual residing in a long-term care facility would incur a long-term care patient liability for services under this chapter due to income that exceeds that allowed for the incidental and personal needs of the individual, a specified portion of the individual's earned income from therapeutic wages shall be exempt. Therapeutic wages are wages earned by the individual under all of the following conditions:

(1) A physician who does not have a financial interest in the long-term care facility in which the individual resides, and who is in charge of the individual's case, prescribes work as therapy for the individual.

(2) The individual must be employed within the same long-term care facility where they reside.

(3) The individual's employment does not displace any existing employees.

(4) The individual has resided in a long-term care facility for a continuous period commencing at least five years prior to the date of the addition of this section as originally adopted during the 1983–84 Regular Session.

(b) The amount of earned income from therapeutic wages that shall be exempt shall be the lesser of 70 percent of the gross therapeutic wages or

70 percent of the maintenance level as described in subdivision (b) of Section 14005.12.

(c) The provisions of this section shall be given retroactive effect for the period commencing June 1, 1983.

(d) This section shall not become operative unless and until the necessary waivers are obtained from the United States Department of Health and Human Services.

(e) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of all-county letters, provider bulletins or notices, policy letters, or other similar instructions, without taking any further regulatory action. Within two calendar years of implementing subdivision (d) of Section 14005.12, the department shall adopt, amend, or repeal any necessary regulations.

(f) This section shall become operative on January 1, 2025, or the date certified by the department pursuant to paragraph (3) of subdivision (b) of Section 14005.12, as added by Section 73 of Chapter 47 of the Statutes of 2022, whichever is later.

SEC. 75. Section 14005.20 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

SEC. 76. Section 14005.20 is added to the Welfare and Institutions Code, to read:

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

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

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

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

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

SEC. 77. Section 14005.21 of the Welfare and Institutions Code is amended to read:

14005.21. (a) Any medically needy aged, blind, or disabled person who was categorically needy under this chapter on the basis of eligibility under Chapter 3 (commencing with Section 12000) or Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code for the month of August 1993, and was discontinued as of September 1, 1993, and who, but for the addition of Section 12200.015, would be eligible to receive benefits without a spend down of excess income in September 1993 under this chapter, shall remain eligible to receive benefits without a spend down of excess income under this chapter as if that person were categorically needy as long as they meet other applicable requirements.

(b) Any medically needy aged, blind, or disabled person who was eligible for benefits under this chapter as categorically needy or medically needy under subdivision (a) for the month of August 1994, shall not be responsible for paying their spend down of excess income if they had that eligibility for benefits without a spend down of excess income interrupted or terminated by the addition of Section 12200.017, and if they, but for Section 12200.017, would be eligible to continue receiving benefits under this chapter without a spend down of excess income.

(c) Any medically needy aged, blind, or disabled person who was eligible for benefits under this chapter as categorically needy, or as medically needy under subdivision (a) or (b), for the calendar month immediately preceding the date that the reductions in maximum aid payments for the state supplementary program established in Chapter 3 (commencing with Section 12000) of Part 3 of Division 9 made in the 1995–96 Regular Session of the Legislature are effective shall not be responsible for paying their spend down of excess income if they had that eligibility for benefits without a spend down of excess income interrupted or terminated by the reductions in maximum aid payments, and if they, but for the reductions, would be eligible to continue receiving benefits under this chapter without a spend down of excess income.

(d) Any medically needy aged, blind, or disabled person who was eligible for benefits under this chapter as categorically needy, or as medically needy under subdivisions (a), (b), or (c) for the calendar month immediately preceding the date that the reductions in maximum aid payments for the state supplementary program established in Chapter 3 (commencing with Section 12000) made in the 1996 portion of the 1995-96 Regular Session of the Legislature are effective shall not be responsible for paying their spend down of excess income if they had that eligibility for benefits without a spend down of excess income interrupted or terminated by the reductions in maximum aid payments, and if they, but for these reductions, would be eligible to continue receiving benefits under this chapter without a spend down of excess income.

(e) The department shall implement this section regardless of the availability of federal financial participation for the spend down of excess income paid from state funds pursuant to subdivisions (a), (b), (c), and (d).

SEC. 78. Section 14005.26 of the Welfare and Institutions Code is amended to read:

14005.26. (a) (1) Except as provided in subdivision (b), the department shall exercise the option pursuant to Section 1902(a)(l0)(A)(ii)(XIV) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIV)) to provide full-scope benefits with no spend down of excess income under this chapter and Chapter 8 (commencing with Section 14200) to optional targeted low-income children pursuant to Section 1905(u)(2)(B) of the federal Social Security Act (42 U.S.C. Sec. 1396d(u)(2)(B)), with family incomes up to and including 200 percent of the federal poverty level. The department shall seek federal approval of a state plan amendment to implement this subdivision.

(2) (A) Pursuant to Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)), the department shall adopt the option to use less restrictive income and resource methodologies to exempt all resources and disregard income at or above 200 percent and up to and including 250 percent of the federal poverty level for the individuals described in paragraph (1). The department shall seek federal approval of a state plan amendment to implement this subdivision.

(B) This paragraph shall be inoperative on January 1, 2014.

(b) Effective January 1, 2014, the federal poverty level percentage income eligibility threshold used pursuant to subdivision (c) of Section 14005.64 to determine eligibility for medical assistance under subdivision (a) shall equal 261 percent of the federal poverty level.

(c) For purposes of carrying out the provisions of this section, the department may adopt the option pursuant to Section 1902(e)(13) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(13)) to rely upon findings of the Managed Risk Medical Insurance Board (MRMIB) regarding one or more components of eligibility.

(d) (1) (A) Except as provided in subparagraph (B) and subparagraph (D) of paragraph (2), the department shall exercise the option pursuant to Section 1916A of the federal Social Security Act (42 U.S.C. Sec. 1396o-1) to impose premiums for individuals described in subdivision (a) whose family income has been determined to be above 150 percent and up to and including 200 percent of the federal poverty level, after application of the income disregard pursuant to paragraph (2) of subdivision (a). The department shall not impose premiums under this subdivision for individuals described in subdivision (a) whose family income has been determined to be at or below 150 percent of the federal poverty level, after application of the income disregard pursuant to paragraph (2) of subdivision (a). The department shall obtain federal approval for the implementation of this subdivision.

(B) Except as provided in subparagraph (D) of paragraph (2), the department shall impose a premium pursuant to subparagraph (A) for individuals whose family income has been determined to be above 160 percent and up to and including 261 percent of the federal poverty level, as determined, counted, and valued in accordance with the requirements of Section 14005.64.

(2) (A) Monthly premiums imposed under this section shall equal thirteen dollars ($13) per child with a maximum contribution of thirty-nine dollars ($39) per family.

(B) Families that pay three months of required premiums in advance shall receive the fourth consecutive month of coverage with no premium required. For purposes of the discount provided by this subparagraph, family contributions paid in the Healthy Families Program for children transitioned to Medi-Cal pursuant to Section 14005.27 shall be credited as Medi-Cal premiums paid.

(C) Families that pay the required premium by an approved means of electronic funds transfer, including credit card payment, shall receive a 25-percent discount from the required premium. If the department and the Managed Risk Medical Insurance Board determine that it is feasible, the department shall treat an authorization for electronic funds transfer or credit card payment to the Healthy Families Program as an authorization for electronic funds transfer or credit card payment to Medi-Cal.

(D) (i) Effective July 1, 2022, to the extent allowable under federal law, and notwithstanding the provisions of this section to the contrary, the department may elect not to impose premiums for an applicable coverage

period on individuals whose family income has been determined to be above 160 percent and up to and including 261 percent of the federal poverty level as described in this subdivision.

(ii) If the department elects to not impose premiums for an applicable coverage period pursuant to clause (i) or elects to reinstate such premiums for a subsequent coverage period, the department shall specify that election in the published Medi-Cal Local Assistance Estimate for the impacted state fiscal year or years, subject to appropriation by the annual Budget Act.

(e) This section shall be implemented only to the extent that all necessary federal approvals and waivers described in this section have been obtained and the enhanced rate of federal financial participation under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.) is available for targeted low-income children pursuant to that act.

(f) The department shall not enroll targeted low-income children described in this section in the Medi-Cal program until all necessary federal approvals and waivers have been obtained, and no sooner than January 1, 2013.

(g) (1) (A) Except as provided in subparagraph (B), to the extent the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is not fully operational, for the purposes of implementing this section, for individuals described in subdivision (a) whose family income has been determined to be up to and including 150 percent of the federal poverty level, as determined pursuant to paragraph (2) of subdivision (a), the department shall utilize the budgeting methodology for this population as contained in the November 2011 Medi-Cal Local Assistance Estimate for Medi-Cal county administration costs for eligibility operations.

(B) Effective January 1, 2014, to the extent the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is not fully operational, for purposes of implementing this section for individuals whose family income has been determined to be up to and including 160 percent of the federal poverty level, the department shall utilize the budgeting methodology for this population as contained in the November 2011 Medi-Cal Local Assistance Estimate for Medi-Cal county administration costs for eligibility operations.

(2) (A) Except as provided in subparagraph (B), for purposes of implementing this section, the department shall include in the Medi-Cal Local Assistance Estimate an amount for Medi-Cal eligibility operations associated with the individuals whose family income is determined to be above 150 percent and up to and including 200 percent of the federal poverty level, after application of the income disregard pursuant to paragraph (2) of subdivision (a). In developing an estimate for this activity, the department shall consider the projected number of final eligibility determinations each county will process and projected county costs. Within 60 days of the passage of the annual Budget Act, the department shall notify each county of their allocation for this activity based upon the amount allotted in the annual Budget Act for this purpose.

(B) Effective January 1, 2014, for purposes of implementing this section, the department shall include in the Medi-Cal Local Assistance Estimate an

amount for Medi-Cal eligibility operations associated with the individuals whose family income is determined to be above 160 percent and up to and including 261 percent of the federal poverty level.

(h) When the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is fully operational, the new budget methodology shall be utilized to reimburse counties for eligibility determinations made for individuals pursuant to this section.

(i) Eligibility determinations and annual redeterminations made pursuant to this section shall be performed by county eligibility workers.

(j) In conducting eligibility determinations for individuals pursuant to this section and Section 14005.27, the following reporting and performance standards shall apply to all counties:

(1) Counties shall report to the department, in a manner and for a time period prescribed by the department, in consultation with the County Welfare Directors Association, the number of applications processed on a monthly basis, a breakout of the applications based on income using the federal percentage of poverty levels, the final disposition of each application, including information on the approved Medi-Cal program, if applicable, and the average number of days it took to make the final eligibility determination for applications submitted directly to the county and from the single point of entry (SPE).

(2) Notwithstanding any other law, the following performance standards shall be applied to counties regarding eligibility determinations for individuals eligible pursuant to this section:

(A) For children whose applications are received by the county human services department from the SPE, the following standards shall apply:

(i) Applications for children who are granted accelerated enrollment by the SPE shall be processed according to the timeframes specified in subdivision (d) of Section 14154.

(ii) Applications for children who are not granted accelerated enrollment by the SPE due to the existence of an already active Medi-Cal case shall be processed according to the timeframes specified in subdivision (d) of Section 14154.

(iii) For applications for children who are not described in clause (i) or (ii), 90 percent shall be processed within 10 working days of being received, complete and without client errors.

(iv) If an application described in this section also contains adults, and the adult applicants are required to submit additional information beyond the information provided for the children, the county shall process the eligibility for the child or children without delay, consistent with this section while gathering the necessary information to process eligibility for the adults.

(B) The department, in consultation with the County Welfare Directors Association, shall develop reporting requirements for the counties to provide regular data to the state regarding the timeliness and outcomes of applications processed by the counties that are received from the SPE.

(C) Performance thresholds and corrective action standards as set forth in Section 14154 shall apply.

(D) For applications submitted directly to the county, these applications shall be processed by the counties in accordance with the performance standards established under subdivision (d) of Section 14154.

(3) This subdivision shall be implemented no sooner than January 1, 2013.

(4) Twelve months after implementation of this section pursuant to subdivision (f), the department shall provide enrollment information regarding individuals determined eligible pursuant to subdivision (a) to the fiscal and appropriate policy committees of the Legislature.

(k) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, for purposes of this transition, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. It is the intent of the Legislature that the department be allowed temporary authority as necessary to implement program changes until completion of the regulatory process.

(2) To the extent otherwise required by Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall adopt emergency regulations implementing this section no later than July 1, 2014. The department may thereafter readopt the emergency regulations pursuant to that chapter. The adoption and readoption, by the department, of regulations implementing this section shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

(*l*) To implement this section, the department may enter into and continue contracts with the Healthy Families Program administrative vendor, for the purposes of implementing and maintaining the necessary systems and activities for providing health care coverage to optional targeted low-income children in the Medi-Cal program for purposes of accelerated enrollment application processing by single point of entry, noneligibility-related case maintenance and premium collection, maintenance of the Health-E-App Web portal, call center staffing and operations, certified application assistant services, and reporting capabilities. To further implement this section, the department may also enter into a contract with the Health Care Options Broker of the department for purposes of managed care enrollment activities. The contracts entered into or amended under this section may initially be completed on a noncompetitive bid basis and are exempt from the Public Contract Code. Contracts thereafter shall be entered into or amended on a competitive bid basis and shall be subject to the Public Contract Code.

(m) (1) If at any time the director determines that this section or any part of this section may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), or any amendment or extension of that act,

or any additional federal funds that the director, in consultation with the Department of Finance, determines would be advantageous to the state, the director shall give notice to the fiscal and policy committees of the Legislature and to the Department of Finance. After giving notice, this section or any part of this section shall become inoperative on the date that the director executes a declaration stating that the department has determined, in consultation with the Department of Finance, that it is necessary to cease to implement this section or a part or parts thereof, in order to receive federal financial participation, any increase in the federal medical assistance percentage available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, has determined would be advantageous to the state.

(2) The director shall retain the declaration described in paragraph (1), shall provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel, and shall post the declaration on the department's internet website.

(3) In the event that the director makes a determination under paragraph (1) and this section ceases to be implemented, the children shall be enrolled back into the Healthy Families Program.

SEC. 79. Section 14005.32 of the Welfare and Institutions Code is amended to read:

14005.32. (a) (1) If the county has evidence clearly demonstrating that a beneficiary is not eligible for benefits under this chapter pursuant to Section 14005.30, but is eligible for benefits under this chapter pursuant to other provisions of law, the county shall transfer the individual to the corresponding Medi-Cal program in conformity with and subject to the requirements of Section 14005.37. Eligibility under Section 14005.30 shall continue until the transfer is complete.

(2) The department, in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers, shall prepare a simple, clear, consumer-friendly notice to be used by the counties to inform beneficiaries that their Medi-Cal benefits have been transferred pursuant to paragraph (1) and to inform them about the program to which they have been transferred. To the extent feasible, the notice shall be issued with the notice of discontinuance from cash aid, and shall include all of the following:

(A) A statement that Medi-Cal benefits will continue under another program, even though aid under Chapter 2 (commencing with Section 11200) has been terminated.

(B) The name of the program under which benefits will continue and an explanation of that program.

(C) A statement that continued receipt of Medi-Cal benefits will not be counted against any time limits in existence for receipt of cash aid under the CalWORKs program.

(D) A statement that the Medi-Cal beneficiary does not need to fill out monthly status reports in order to remain eligible for Medi-Cal, but may be required to submit annual reaffirmation forms. In addition, if the person or persons to whom the notice is directed has been found eligible for transitional

Medi-Cal as described in Section 14005.8 or 14005.85, the statement shall explain the reporting requirements and duration of benefits under those programs and shall further explain that, at the end of the duration of these benefits, a redetermination, as provided in Section 14005.37, shall be conducted to determine whether benefits are available under any other law.

(E) A statement describing the beneficiary's responsibility to report to the county, within 10 days, significant changes that may affect eligibility or spend down of excess income.

(F) A telephone number to call for more information.

(G) A statement that the beneficiary's eligibility worker will not change, or, if the case has been reassigned, the new worker's name, address, and telephone number, and the hours during which the county's Medi-Cal eligibility workers can be contacted.

(b) This section shall be implemented only to the extent that federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is available.

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

(d) This section shall become operative on January 1, 2014.

SEC. 80. Section 14005.40 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(h) No later than one month after the effective date of subdivision (g), the department shall submit to the federal Medicaid program administrator

a state plan amendment seeking approval of the income deduction specified in paragraph (3) of subdivision (g), and of federal financial participation for the costs resulting from that income deduction.

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

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

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

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

SEC. 81. Section 14005.40 is added to the Welfare and Institutions Code, to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) For purposes of calculating income under this section during any calendar year, increases in social security benefit payments under Title II of the federal Social Security Act (42 U.S.C. Sec. 401 et seq.) arising from cost-of-living adjustments shall be disregarded commencing in the month

that these social security benefit payments are increased by the cost-of-living adjustment through the month before the month in which a change in the federal poverty level requires the department to modify the income level described in subdivision (c).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 82. Section 14005.401 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

SEC. 83. Section 14005.401 is added to the Welfare and Institutions Code, to read:

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

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

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

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

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

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

SEC. 84. Section 14005.41 of the Welfare and Institutions Code is amended to read:

14005.41. (a) Notwithstanding any other law, the department shall deem to have met the income documentation requirements for participation in the Medi-Cal program, without a spend down of excess income, any child who

is less than six years of age and who has been determined to be eligible for free meals through a federally funded program using the National School Lunch Program application provided for pursuant to Chapter 13 (commencing with Section 1751) of Title 42 of the United States Code.

(b) Notwithstanding any other law, with regard to any child who is enrolled in and attending public school in the State of California, the department shall accept documentation of enrollment for free meals under the National School Lunch Program as sufficient documentation of California residency for that child for the purposes of the Medi-Cal program.

(c) (1) (A) Notwithstanding any other law, each county shall participate in a statewide pilot project to determine Medi-Cal program eligibility for any child under six years of age and currently enrolled in school in the State of California who is eligible for free meals under the National School Lunch Program upon receipt of proof of participation in the National School Lunch Program and a signed Medi-Cal application, which may be the supplemented application, described in subdivision (i). Counties shall notify the parent or guardian of the results of the eligibility determination.

(B) Notwithstanding any other law, each county shall participate in a statewide pilot project to use the procedure described in this subdivision to determine Medi-Cal eligibility without a spend down of excess income, and, if eligible, shall enroll in the Medi-Cal program, any child six years of age or older currently enrolled in school in the State of California who is eligible for free meals under the National School Lunch Program, upon receipt of proof of participation in the National School Lunch Program and a signed Medi-Cal application, which may be the supplemented application, described in subdivision (i). If the county determines from the supplemented application described in subdivision (i) that the child meets the eligibility requirements for participation in the Medi-Cal program, the county shall notify the parent or guardian that the child has been found eligible for the Medi-Cal program. If the county is unable to determine from the information on the application as described in subdivision (i) whether the child is eligible, the county shall contact the family to seek any additional information regarding income, household composition, or deductions that the department, in consultation with the county welfare departments, may determine to be necessary to complete the Medi-Cal application. If the county determines that the child does not meet the income eligibility requirements for participation in the full-scope no-cost Medi-Cal program, the county shall notify the parent or guardian of the determination and shall forward the school lunch application and any supplemental forms as described in subdivision (i) to the Healthy Families Program. If an applicant is determined to be ineligible for the full-scope no-cost Medi-Cal program and for the Healthy Families Program, the school lunch application and any supplemental forms as described in subdivision (i) shall be forwarded to a county- or local-sponsored health insurance program, as applicable, if the parent or guardian has provided consent. For purposes of this section, a county- or local-sponsored health insurance program includes a county agency, a local initiative, a county-organized health system, or other local

entity that provides health care coverage to children who do not qualify for the full-scope no-cost Medi-Cal program or for the Healthy Families Program.

(2) Each county shall ask the parent or guardian of each child identified in subparagraph (A) of paragraph (1) and the parent or guardian of each child whom the county determines to meet the income eligibility requirements for participation in the Medi-Cal program under subparagraph (B) of paragraph (1) to provide additional documentation as required by current law necessary for retention of eligibility in the Medi-Cal program. If a parent or guardian does not provide the documentation required for retention of full-scope Medi-Cal program eligibility, the county shall continue the child's enrollment in the Medi-Cal program, but only for the limited scope of Medi-Cal program benefits as described in Section 14007.5. If applicable, the county shall also forward the school lunch application and any supplemental forms as described in subdivision (i), for applicants who are determined to be ineligible for the full-scope no-cost Medi-Cal program and for the Healthy Families Program, to a county- or local-sponsored health insurance program if the parent or guardian has provided consent.

(d) Nothing in this section shall be construed as preventing the department from verifying eligibility through the Income Eligibility Verification System match mandated by Section 1137 of the federal Social Security Act (42 U.S.C. Sec. 1320b-7) or from requesting additional information or documentation required by federal law.

(e) Each county shall include its cost of implementing this section in its annual Medi-Cal administrative budget requests submitted to the department.

(f) For purposes of this section, the Medi-Cal program application date shall be the date on which the school lunch application information is received by the local agency determining eligibility under the Medi-Cal program.

(g) (1) This section shall be implemented only if, and to the extent that, federal financial participation is available for the services provided and only for the period of time the free National School Lunch Program utilizes a gross income standard at or below 133 percent of the federal poverty level. This section shall be implemented in a manner consistent with any federal approval.

(2) Notwithstanding paragraph (1), if the department determines that one or more state plan amendments are necessary to ensure full federal financial participation in the provisions of this section, the department shall prepare and submit requests for the state plan amendments to the federal government, after which this section shall not be implemented until the department receives approval of all necessary state plan amendments.

(h) (1) Notwithstanding subdivision (g), not later than March 1, 2003, the department, in consultation with the State Department of Education and representatives of the school districts, county superintendents of schools, local agencies that administer the Medi-Cal program, consumer advocates, and other stakeholders, shall develop and distribute the policies and

procedures, including any all-county letters, necessary to implement Section 49557.2 of the Education Code and this section.

(2) The policies and procedures required to be developed and distributed pursuant to subdivision (a) shall include, at a minimum, both of the following:

(A) Processes for the school districts, county superintendents of schools, and local agencies that administer the Medi-Cal program to use in forwarding and processing free school lunch application information pursuant to Section 49557.2 of the Education Code, and in following up with the applicants to obtain any necessary documentation required by federal law.

(B) Instructions for implementing the eligibility provisions of this chapter.

(3) The policies and procedures required to be developed pursuant to subdivision (a) shall specify all of the following:

(A) The information on the school lunch application may be used to initiate a Medi-Cal program application only when the applicant has provided their consent pursuant to Section 49557.2 of the Education Code.

(B) The date of the Medi-Cal program application shall be the date on which the school lunch application was received by the local agency that determines eligibility under the Medi-Cal program.

(C) The county, in determining eligibility for the Medi-Cal program, shall request additional documentation only as required by federal law, and shall enroll any child whose parent or guardian does not provide the necessary documentation for full-scope benefits under the Medi-Cal program in the Medi-Cal program with limited scope benefits, as described in Section 14007.5.

(i) To the extent federal financial participation is available, and to the extent administratively feasible, the department shall utilize the free National School Lunch Program application developed under Section 49557.2 of the Education Code, if supplemented as needed by simplified forms and disclosures, including Medi-Cal rights and responsibility notices and privacy notices, as a Medi-Cal application for children described in this section.

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

(k) The department shall review the effectiveness of the statewide pilot project and make recommendations regarding appropriate ways to expand the use of the approaches contained in this section.

(*l*) In order to expedite health coverage for children who have been determined eligible for free meals under the National School Lunch Program, the department, at its discretion, may choose to implement this section in whole or in part by exercising the option described in Section 1396r-1a of Title 42 of the United States Code to allow information provided on the National School Lunch Program application referred to, and supplemented

as described, in paragraph (1) of subdivision (a) of Section 49557.2 of the Education Code to serve as a basis for a preliminary eligibility determination by a qualified entity designated by the department.

(m) County- and local-sponsored health program agencies are authorized to use the supplemental application described in subdivision (i) and received pursuant to subdivision (c) to make an eligibility determination for those respective programs, and shall request additional information only as needed to complete the eligibility process.

(n) A county may, at its option, and with the consent of the parent or guardian as provided in paragraph (3) of subdivision (a) of Section 49557.2 of the Education Code, notify the school of the names and contact information of children who are in jeopardy of losing accelerated Medi-Cal coverage because a child's parent or guardian has not provided required followup information to the county. This notice shall be limited to the names and contact information, and shall not specify what information is missing. This shall be done for the sole purpose of enabling the school, at its option, to conduct outreach activities to encourage or assist those parents or guardians to complete and submit the required followup information.

SEC. 85. Section 14005.42 of the Welfare and Institutions Code is amended to read:

14005.42. (a) The department shall provide full-scope benefits under this chapter, without spend down of excess income, to all individuals on behalf of whom kinship guardians are receiving aid under any of the Kinship Guardian Assistance Payment Programs pursuant to Article 4.5 (commencing with Section 11360) of Chapter 2.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department and the State Department of Social Services may implement, without taking regulatory action, this section by means of all county letters or similar instruction. Thereafter, as needed, the departments shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) To the extent that federal financial participation is not available, the cost of benefits provided under this section shall be covered only by state funds.

(d) The department and the State Department of Social Services shall work cooperatively to develop procedures that maximize the availability of federal financial participation for the cost of benefits provided under this section. The procedures shall include conforming the application and eligibility determination process for this population to meet the requirements of federal Medicaid law.

SEC. 86. Section 14005.95 is added to the Welfare and Institutions Code, to read:

14005.95. (a) For persons in long-term care, any income deductions, with the exception of other health insurance premiums under Sections 14005.4 and 14005.7, shall not be deducted in the post-eligibility treatment

of income determination pursuant to Section 14051.7 to the extent allowable under federal law or regulations.

(b) Once the beneficiary has medical expenses that are not subject to payment by a third party and are equal to or exceed their long-term care patient liability amount, the individual is entitled to receive health care services pursuant to Section 14005 if all other applicable eligibility criteria established pursuant to this chapter are met. Those medical expenses may include, but are not limited to, any of the following:

(1) Medicare health insurance deductibles and coinsurance charges.

(2) Other health insurance deductibles and coinsurance charges.

(3) Necessary medical and remedial services.

(4) Expected expenses for inpatient long-term care in a medical facility.

SEC. 87. Section 14006 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

shall be the cash value as of the policy anniversary nearest the date of such application.

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

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

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

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

SEC. 88. Section 14006.01 of the Welfare and Institutions Code is amended to read:

14006.01. (a) This section applies to any individual who is residing in a continuing care retirement community, as defined in paragraph (10) of subdivision (c) of Section 1771 of the Health and Safety Code, pursuant to a continuing care contract, as defined in paragraph (8) of subdivision (c) of Section 1771 of the Health and Safety Code, or pursuant to a life care contract, as defined in subdivision (*l*) of Section 1771 of the Health and Safety Code, that collects an entrance fee from its residents upon admission.

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

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

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

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

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

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

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

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

SEC. 89. Section 14006.1 of the Welfare and Institutions Code is amended to read:

14006.1. (a) The State Director of Health Services shall adopt emergency regulations pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code to implement subdivision (b) of Section 14006. The adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health or safety. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, emergency regulations adopted by the Department of Health Services in order to implement subdivision (b) of Section 14006 shall not be subject to the review and approval of the Office of Administrative Law. These regulations shall become effective immediately upon filing with the Secretary of State.

(b) Any provision of Section 14006 that is in conflict with any federal statute or regulation shall be inapplicable to the extent of this conflict, but the provision and the remainder of the provisions shall be unaffected to the extent that no conflict exists.

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

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

SEC. 90. Section 14006.15 of the Welfare and Institutions Code is amended to read:

14006.15. (a) For the purposes of this section, "equity interest" means the lesser of the following:

(1) The assessed value of the principal residence determined under the most recent tax assessment, less any encumbrances of record.

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

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

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

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

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

(3) The department determines that ineligibility for medical assistance for home and facility care would result in demonstrated hardship on the individual. For purposes of this section, demonstrated hardship shall include, but need not be limited to, any of the following circumstances:

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

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

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

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

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

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

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

(d) To the extent that federal financial participation is unavailable to cover the costs associated with subparagraph (C) of paragraph (3) of subdivision (c), state general funds shall be used.

(e) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act, and except for subparagraph (C) of paragraph (3) of subdivision (c), and subdivision (d), only to the extent that federal financial participation is available.

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

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

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

SEC. 91. Section 14006.2 of the Welfare and Institutions Code is amended to read:

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

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

may the department count the separate property in the eligibility determination of the nonowner spouse.

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

(b) The department shall furnish to all Medi-Cal applicants a clear and simple statement in writing advising them that (1) in the case of an individual who is an inpatient in a nursing facility, if the individual or the individual's conservator transferred to the individual's spouse all of the interest in a home, the individual shall not be considered ineligible for Medi-Cal by reason of the transfer; and that (2) if the individual and the individual's spouse execute a written interspousal agreement that divides and transmutes nonexempt community property into equal shares of separate property, the separate property of the individual's spouse shall not be considered available to the individual and need not be spent by the spouse for the individual's care in a nursing facility or other medical institution. The statement provided for in this subdivision shall also be furnished to each individual admitted to a nursing facility, along with, but separately from, the statement required under Section 72527 of Title 22 of the California Code of Regulations.

(c) In order to qualify for Medi-Cal benefits pursuant to Section 14005.4 or 14005.7, a married individual who resides in a nursing facility, and who is in a Medi-Cal budget unit separate from that of their spouse, shall be required to expend their other resources for their own benefit, so that the amount that remains does not exceed the limit established pursuant to subdivision (c) of Section 14006. In the event that the married individual expends their resources for expenses associated with or for improvements to property, those expenditures shall be considered to be for their own benefit only to the extent that the expenditures are proportionate to the ownership interest the individual has in the property. For purposes of this section, the term "their other resources" shall be limited to the following:

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

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

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

(e) The statement furnished pursuant to subdivision (b) shall advise all persons entering a long-term care facility, and all Medi-Cal applicants that

only their half of the community property shall be taken into account in determining their eligibility for Medi-Cal, whether or not they execute the written interspousal agreement referred to in the statement.

(f) This section shall not apply to an institutionalized spouse.

(g) This section shall apply to the full extent to an institutionalized spouse if Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is amended to authorize the consideration of state community property law in determining eligibility under this chapter, or the federal government authorizes the state to apply community property laws in making that determination.

(h) (1) Subdivision (f) shall become inoperative if the federal government amends Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) to allow state community property laws to be considered for Medi-Cal eligibility purposes, or the federal government authorizes the state to apply community property laws in making that determination.

(2) The department shall report to the appropriate committees of the Legislature upon the occurrence of the amendment of federal law or receipt of federal authorization as specified in paragraph (1).

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

SEC. 92. Section 14006.3 of the Welfare and Institutions Code is amended to read:

14006.3. (a) The department, at the time of application or the assessment pursuant to Section 14006.6, and any nursing facility enrolled as a provider in the Medi-Cal program, prior to admitting any person, shall provide a clear and simple statement, in writing, in a form and language specified by the department, to that person, and that person's spouse, legal representative, or agent, if any, that explains the resource and income requirements of the Medi-Cal program, including, but not limited to, certain exempt resources, certain protections against spousal impoverishment, and certain circumstances under which an interest in a home may be transferred without affecting Medi-Cal eligibility.

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

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

SEC. 93. Section 14006.3 is added to the Welfare and Institutions Code, to read:

14006.3. (a) The department, at the time of application or the assessment pursuant to former Section 14006.6, and any nursing facility enrolled as a provider in the Medi-Cal program, before admitting any person, shall provide a clear and simple statement, in writing, in a form and language specified by the department, to that person, and that person's spouse, legal representative, or agent, if any, that explains the income requirements of the Medi-Cal program, including, but not limited to, certain protections against spousal impoverishment.

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

SEC. 94. Section 14006.4 of the Welfare and Institutions Code is amended to read:

14006.4. (a) The statement required by Sections 14006.2 and 14006.3 shall be in the following form:

"NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY

If you or your spouse is in or is entering a nursing facility, read this important message!

You or your spouse do not have to use all your resources, such as savings, before Medi-Cal might help pay for all or some of the costs of a nursing facility.

You should be aware of the following to take advantage of these provisions of the law:

UNMARRIED RESIDENT

An unmarried resident is financially eligible for Medi-Cal benefits if they have less than (insert amount of individual's resource allowance) in available resources. A home is an exempt resource and is not considered against the resource limit, as long as the resident states on the Medi-Cal application that they intend to return home. Clothes, household furnishings, irrevocable burial plans, burial plots, and an automobile are examples of other exempt resources.

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

amount of health insurance premiums paid monthly. The remainder of the monthly income is paid to the nursing facility as a monthly deductible called the "Medi-Cal long-term care patient liability."

MARRIED RESIDENT

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

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

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

An at-home spouse also may obtain a court order to increase the amount of income and resources that they are allowed to retain, or to transfer property from the spouse in the nursing facility to the at-home spouse. You should contact a knowledgeable attorney for further information regarding court orders.

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

knowledgeable attorney should be obtained prior to the signing of this type of agreement.

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

TRANSFER OF HOME FOR BOTH A MARRIED AND AN UNMARRIED RESIDENT

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

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

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

(1) The resident's spouse.

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

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

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

This is only a brief description of the Medi-Cal eligibility rules, for more detailed information, you should call your county welfare department. You will probably want to consult with the local branch of the state long-term care ombudsman, an attorney, or a legal services program for seniors in your area.

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

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

(c) Any nursing facility that willfully fails to comply with this section shall be subject to a class "B" citation, as defined by Section 1424 of the Health and Safety Code.

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

(e) This section shall become inoperative on the later of either January 1, 2024, or the date on which the determination of the Director of Health

Care Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain inoperative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.

SEC. 95. Section 14006.4 is added to the Welfare and Institutions Code, to read:

14006.4. (a) The statement required by Section 14006.3 shall be in the following form:

"NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY

If you or your spouse is in or is entering a nursing facility, read this important message!

You or your spouse do not have to use all your resources, such as savings, before Medi-Cal might help pay for all or some of the costs of a nursing facility.

You should be aware of the following to take advantage of these provisions of the law:

UNMARRIED RESIDENT

An unmarried resident is financially eligible for Medi-Cal benefits if they meet income requirements. Resources, including property and assets, are not considered in determining Medi-Cal eligibility.

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

MARRIED RESIDENT

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

If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least their individual monthly income or (insert amount of Minimum Monthly Maintenance Needs Allowance), whichever is greater. Of the couple's remaining monthly income, the spouse in the nursing facility is allowed to keep a personal allowance of (insert amount of personal needs allowance)

plus the amount of health insurance premiums paid monthly. The remaining money, if any, generally must be paid to the nursing facility as the Medi-Cal share of cost. The Medi-Cal program will pay remaining nursing facility costs.

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

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

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

This is only a brief description of the Medi-Cal eligibility rules, for more detailed information, you should call your county welfare department. You will probably want to consult with the local branch of the state long-term care ombudsman, an attorney, or a legal services program for seniors in your area.

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

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

(c) Any nursing facility that willfully fails to comply with this section shall be subject to a class "B" citation, as defined by Section 1424 of the Health and Safety Code.

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

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

SEC. 96. Section 14006.5 of the Welfare and Institutions Code is amended to read:

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

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

SEC. 97. Section 14006.5 is added to the Welfare and Institutions Code, to read:

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

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

SEC. 98. Section 14006.6 of the Welfare and Institutions Code is amended to read:

14006.6. (a) To the extent required by Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and regulations adopted pursuant thereto, upon the request of either an institutionalized spouse or a community spouse, and upon receipt of relevant documentation of resources, the department shall promptly assess and document the total value of the couple's resources to the extent either the institutionalized spouse or the community spouse has an ownership interest. Upon completion of the assessment and documentation, the department shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment.

(b) If the assessment is not part of an application for Medi-Cal, the department may, as a condition of providing the assessment, require payment of a fee not to exceed the reasonable expenses of providing and documenting the assessment.

(c) For purposes of completing the assessment, resources shall be determined, defined, counted, and valued in accordance with subdivision (c) of Section 14006.

(d) At the time of providing the copy of the assessment to the couple, the department shall include a notice indicating that either spouse will have a right to a fair hearing to the extent required by federal law.

(e) (1) This section shall remain operative only until Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is amended to

authorize the consideration of state community property law in determining eligibility under this chapter, or the federal government authorizes the state to apply community property laws in making that determination.

(2) The department shall report to the appropriate committees of the Legislature upon the occurrence of the amendment of federal law or the receipt of federal authorization to apply community property law, as specified in paragraph (1).

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

SEC. 99. Section 14007.9 of the Welfare and Institutions Code, as amended by Section 83 of Chapter 47 of the Statutes of 2022, is amended to read:

14007.9. (a) The department shall adopt the option made available under Section 1902(a)(10)(A)(ii)(XIII) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIII)). In order to be eligible for benefits under this section, an individual shall be required to meet all of the following requirements:

(1) The individual's net countable income is less than 250 percent of the federal poverty level for one person or, if the deeming of spousal income applies to the individual, the individual's net countable income is less than 250 percent of the federal poverty level for two persons.

(2) The individual is disabled under Title II of the Social Security Act (Subch. 2 (commencing with Sec. 401), Ch. 7, Title 42 U.S.C.), Title XVI of the Social Security Act (Subch. 16 (commencing with Sec. 1381), Ch. 7, Title 42, U.S.C.), or Section 1902(v) of the Social Security Act (42 U.S.C. Sec. 1396a(v)). An individual shall be determined to be eligible under this section without regard to the individual's ability to engage in, or actual engagement in, substantial gainful activity, as defined in Section 223(d)(4) of the Social Security Act (42 U.S.C. Sec. 423(d)(4)).

(3) Except as otherwise provided in this section, the individual's net nonexempt resources, which shall be determined in accordance with the methodology used under Title XVI of the federal Social Security Act (42 U.S.C. Sec. 1381 et seq.), are not in excess of the limits provided for under those provisions.

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

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

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

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

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

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

(d) Individuals eligible for Medi-Cal benefits under this section shall be subject to the payment of premiums determined under this subdivision, except as provided in subdivision (j). The department shall establish sliding-scale premiums that are based on countable income, with a minimum premium of twenty dollars ($20) per month and a maximum premium of two hundred fifty dollars ($250) per month, and shall, by regulations, annually adjust the premiums. Prior to adjustment of any premiums pursuant to this subdivision, the department shall submit a report of proposed premium adjustments to the appropriate committees of the Legislature as part of the annual budget act process.

(e) The department shall adopt regulations specifying the process for discontinuance of eligibility under this section for nonpayment of premiums for more than two months by a beneficiary.

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

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

(h) Notwithstanding any other law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation is available pursuant to Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(i) Subject to subdivision (h), this section shall be implemented commencing April 1, 2000.

(j) (1) Effective July 1, 2022, to the extent allowable under federal law, and notwithstanding the provisions of this section to the contrary, the department may elect not to impose premiums on individuals eligible under this section for an applicable coverage period.

(2) If the department elects to not impose premiums for an applicable coverage period pursuant to paragraph (1) or elects to reinstate such premiums for a subsequent coverage period, the department shall specify that election in the published Medi-Cal Local Assistance Estimate for the impacted state fiscal year or years, subject to appropriation by the annual Budget Act.

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

SEC. 100. Section 14007.9 is added to the Welfare and Institutions Code, to read:

14007.9. (a) The department shall adopt the option made available under Section 1902(a)(10)(A)(ii)(XIII) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIII)). In order to be eligible for benefits under this section, an individual shall be required to meet all of the following requirements:

(1) The individual's net countable income is less than 250 percent of the federal poverty level for one person or, if the deeming of spousal income applies to the individual, the individual's net countable income is less than 250 percent of the federal poverty level for two persons.

(2) The individual is disabled under Title II of the Social Security Act (Subch. 2 (commencing with Sec. 401), Ch. 7, Title 42 U.S.C.), Title XVI of the Social Security Act (Subch. 16 (commencing with Sec. 1381), Ch. 7, Title 42, U.S.C.), or Section 1902(v) of the Social Security Act (42 U.S.C. Sec. 1396a(v)). An individual shall be determined to be eligible under this section without regard to the individual's ability to engage in, or actual engagement in, substantial gainful activity, as defined in Section 223(d)(4) of the Social Security Act (42 U.S.C. Sec. 423(d)(4)).

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

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

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

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

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

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

(d) Individuals eligible for Medi-Cal benefits under this section shall be subject to the payment of premiums determined under this subdivision, except as provided in subdivision (j). The department shall establish sliding-scale premiums that are based on countable income, with a minimum premium of twenty dollars ($20) per month and a maximum premium of two hundred fifty dollars ($250) per month, and shall, by regulations, annually adjust the premiums. Prior to adjustment of any premiums pursuant to this subdivision, the department shall submit a report of proposed premium adjustments to the appropriate committees of the Legislature as part of the annual budget act process.

(e) The department shall adopt regulations specifying the process for discontinuance of eligibility under this section for nonpayment of premiums for more than two months by a beneficiary.

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

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

(h) Notwithstanding any other law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation is available pursuant to Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(i) Subject to subdivision (h), this section shall be implemented commencing April 1, 2000.

(j) (1) Effective July 1, 2022, to the extent allowable under federal law, and notwithstanding the provisions of this section to the contrary, the department may elect not to impose premiums on individuals eligible under this section for an applicable coverage period.

(2) If the department elects to not impose premiums for an applicable coverage period pursuant to paragraph (1) or elects to reinstate such premiums for a subsequent coverage period, the department shall specify that election in the published Medi-Cal Local Assistance Estimate for the impacted state fiscal year or years, subject to appropriation by the annual Budget Act.

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

SEC. 101. Section 14007.9 of the Welfare and Institutions Code, as amended by Section 84 of Chapter 47 of the Statutes of 2022, is amended to read:

14007.9. (a) (1) The department shall adopt the option made available under Section 1902(a)(10)(A)(ii)(XIII) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIII)). In order to be eligible for benefits under this section, an individual shall be required to meet all of the following requirements:

(A) The individual's net countable income is less than 250 percent of the federal poverty level for one person or, if the deeming of spousal income applies to the individual, the individual's net countable income is less than 250 percent of the federal poverty level for two persons.

(B) The individual is disabled under Title II of the federal Social Security Act (42 U.S.C. Sec. 401 et seq.), Title XVI of the federal Social Security Act (42 U.S.C. Sec. 1381 et seq.), or Section 1902(v) of the federal Social Security Act (42 U.S.C. Sec. 1396a(v)). An individual shall be determined to be eligible under this section without regard to their ability to engage in, or actual engagement in, substantial gainful activity, as defined in Section 223(d)(4) of the federal Social Security Act (42 U.S.C. Sec. 423(d)(4)).

(C) Except as otherwise provided in this section, the individual's net nonexempt resources, which shall be determined in accordance with the methodology used under Title XVI of the federal Social Security Act (42

U.S.C. Sec. 1381 et seq.), are not in excess of the limits provided for under those provisions.

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

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

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

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

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

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

(4) Retained earned income of an eligible individual who is receiving health care benefits under this section shall be considered an exempt resource when held in a separately identifiable account and not commingled with other resources, as authorized by Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)).

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

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

exemption, and the exemption shall be implemented only if, and to the extent that, the state plan amendment is approved.

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

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

(f) (1) Individuals eligible for Medi-Cal benefits under this section shall be subject to the payment of premiums determined under this subdivision, except as provided in subdivision (m). Each individual shall pay a monthly premium that is equal to 5 percent of their individual countable income, as described in subdivision (d), or if the deeming of spousal income of an ineligible spouse applies, a monthly premium that is equal to 5 percent of the total countable income of both spouses, except that the minimum premium payment per eligible individual shall be twenty dollars ($20) per month, and the maximum premium payment per eligible individual shall be two hundred fifty dollars ($250) per month.

(2) The amendments made to this subdivision by Chapter 282 of the Statutes of 2009 shall be implemented no later than 90 days after the operative date specified in paragraph (2) of subdivision (k).

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

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

(i) Notwithstanding any other law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation is available pursuant to Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and only to the extent that the department seeks and obtains approval of all necessary Medicaid state plan amendments.

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

(k) (1) Except as provided in paragraph (2), the amendments made to this section by Chapter 282 of the Statutes of 2009 shall not become operative until 30 days after the date that the increase in the state's federal medical assistance percentage (FMAP) pursuant to the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5) is no longer available under that act or any extension of that act.

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

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

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

(*l*) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement subdivision (k) by means of all-county letters or similar instruction, without taking regulatory action.

(m) (1) Effective July 1, 2022, to the extent allowable under federal law, and notwithstanding the provisions of this section to the contrary, the

department may elect not to impose premiums on individuals eligible under this section for an applicable coverage period.

(2) If the department elects to not impose premiums for an applicable coverage period pursuant to paragraph (1) or elects to reinstate such premiums for a subsequent coverage period, the department shall specify that election in the published Medi-Cal Local Assistance Estimate for the impacted state fiscal year or years, subject to appropriation by the annual Budget Act.

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

SEC. 102. Section 14007.9 is added to the Welfare and Institutions Code, to read:

14007.9. (a) (1) The department shall adopt the option made available under Section 1902(a)(10)(A)(ii)(XIII) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIII)). In order to be eligible for benefits under this section, an individual shall be required to meet all of the following requirements:

(A) The individual's net countable income is less than 250 percent of the federal poverty level for one person or, if the deeming of spousal income applies to the individual, the individual's net countable income is less than 250 percent of the federal poverty level for two persons.

(B) The individual is disabled under Title II of the federal Social Security Act (42 U.S.C. Sec. 401 et seq.), Title XVI of the federal Social Security Act (42 U.S.C. Sec. 1381 et seq.), or Section 1902(v) of the federal Social Security Act (42 U.S.C. Sec. 1396a(v)). An individual shall be determined to be eligible under this section without regard to their ability to engage in, or actual engagement in, substantial gainful activity, as defined in Section 223(d)(4) of the federal Social Security Act (42 U.S.C. Sec. 423(d)(4)).

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

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

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

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

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

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

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

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

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

(e) (1) Individuals eligible for Medi-Cal benefits under this section shall be subject to the payment of premiums determined under this subdivision, except as provided in subdivision (m). Each individual shall pay a monthly premium that is equal to 5 percent of their individual countable income, as described in subdivision (c), or if the deeming of spousal income of an ineligible spouse applies, a monthly premium that is equal to 5 percent of the total countable income of both spouses, except that the minimum premium payment per eligible individual shall be twenty dollars ($20) per month, and the maximum premium payment per eligible individual shall be two hundred fifty dollars ($250) per month.

(2) The amendments made to this subdivision by Chapter 282 of the Statutes of 2009 shall be implemented no later than 90 days after the operative date specified in paragraph (2) of subdivision (j).

(f) In order to implement the collection of premiums under this section, the department may develop and execute a contract with a public or private entity to collect premiums, or may amend any existing or future premium-collection contract that it has executed. Notwithstanding any other

law, any contract developed and executed or amended pursuant to this subdivision is exempt from the approval of the Director of General Services and from the Public Contract Code.

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

(h) Notwithstanding any other law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation is available pursuant to Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and only to the extent that the department seeks and obtains approval of all necessary Medicaid state plan amendments.

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

(j) (1) Except as provided in paragraph (2), the amendments made to this section by Chapter 282 of the Statutes of 2009 shall not become operative until 30 days after the date that the increase in the state's federal medical assistance percentage (FMAP) pursuant to the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5) is no longer available under that act or any extension of that act.

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

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

the Department of Finance, has determined would be advantageous to the state, in which case, subdivision (c) of this section, as stated by Section 32 of Chapter 5 of the Fourth Extraordinary Session of the Statutes of 2009, shall be operative.

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

(k) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement subdivision (j) by means of all-county letters or similar instruction, without taking regulatory action.

(*l*) (1) Effective July 1, 2022, to the extent allowable under federal law, and notwithstanding the provisions of this section to the contrary, the department may elect not to impose premiums on individuals eligible under this section for an applicable coverage period.

(2) If the department elects to not impose premiums for an applicable coverage period pursuant to paragraph (1) or elects to reinstate such premiums for a subsequent coverage period, the department shall specify that election in the published Medi-Cal Local Assistance Estimate for the impacted state fiscal year or years, subject to appropriation by the annual Budget Act.

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

SEC. 103. Section 14009 of the Welfare and Institutions Code is amended to read:

14009. (a) Any applicant for, or beneficiary of Medi-Cal, or person acting on behalf of an applicant or beneficiary shall be informed as to the provisions of eligibility and, in writing, of their responsibility for reporting facts material to a correct determination of eligibility and spend down of excess income.

(b) Any applicant for, or beneficiary of Medi-Cal, or person acting on behalf of an applicant or beneficiary shall be responsible for reporting accurately and completely within their competence those facts required of them pursuant to subdivision (a) and to report promptly any changes in those facts.

(c) If, because of a failure to report facts in accordance with subdivision (b), the beneficiary received health care to which they were not entitled, they shall be liable to repay any overpayment. The amount of overpayment shall be based on the amount of excess income or resources and computed in accordance with overpayment regulations promulgated by the director.

(d) No liability for overpayment shall result from circumstances where there is a failure on the part of an applicant or beneficiary to perform an act constituting a condition of eligibility, if the failure is caused by an error made by the department or a county welfare department, or where the beneficiary reported facts in accordance with subdivision (b) but a county welfare department failed to act on those facts.

(e) When the department determines that an overpayment has occurred, the department shall seek to recover the full amount of the overpayment by appropriate action under state law against the income or resources of the beneficiary or the income and resources of any person who is financially responsible for the cost of their health care pursuant to Section 14008.

(f) The department shall advise the beneficiary of the overpayment, the amount they are liable to repay, and of their entitlement to a hearing on the propriety of the action pursuant to Chapter 7 (commencing with Section 10950) of Part 2.

(g) No civil or criminal action may be commenced against any person based on alleged unlawful application for or receipt of health care services, where the case record of the person has been destroyed after the expiration of the retention period provided pursuant to Section 10851.

SEC. 104. Section 14009.6 of the Welfare and Institutions Code is amended to read:

14009.6. (a) As a result of providing medical assistance for home and facility care to an individual, the state shall, by operation of law, become a remainder beneficiary, to the extent required by Section 1917(e) of the federal Social Security Act (42 U.S.C. Sec. 1396p(e)), of annuities purchased in whole or in part by the individual or the individual's spouse in which the individual or the individual's spouse is an annuitant, except as provided in Section 14009.7, unless the individual or the individual's spouse notifies the department in writing that they prohibit the state from acquiring a remainder interest in their annuity, in which case subdivision (d) shall apply.

(b) This section shall only apply to the following annuities:

(1) Those purchased on or after February 8, 2006.

(2) Those purchased before February 8, 2006, and subjected to a transaction that occurred on or after February 8, 2006.

(A) For the purposes of this paragraph, "transaction" includes, but is not limited to, any action taken by the individual or the individual's spouse that changes the course of payments to be made by the annuity or the treatment of the income or principal of the annuity.

(B) For the purpose of this paragraph, "transaction" shall not include any of the following:

(i) Routine changes and automatic events that do not require any action or decision on or after February 8, 2006.

(ii) Changes that occur based on the terms of the annuity that existed prior to February 8, 2006, and that do not require a decision, election, or action to take effect.

(iii) Changes that are beyond the control of the individual or the individual's spouse.

(c) Any provision in any annuity subject to this section that has the effect of restricting the right of the state to become a remainder beneficiary is void.

(d) If an individual or the individual's spouse notifies the department in writing that they prohibit the state from acquiring a remainder interest in their annuity, the purchase of the annuity shall be treated as the transfer of an asset for less than fair market value that is subject to Section 14015.

(e) (1) When the state becomes aware of an annuity in which it has acquired a remainder interest, the department shall notify the issuer of the annuity of the state's acquisition of its remainder beneficiary interest.

(2) The issuer of the annuity shall, upon notification by the department, immediately inform the department of the amount of income and principal being withdrawn from the annuity as of the date of the individual's disclosure of the annuity.

(3) The issuer of the annuity shall, upon request by the department or any agent of the department, immediately disclose to the department the amount of income and principal being withdrawn from the annuity.

(4) The issuer of the annuity shall immediately notify the department if there is any change in either of the following:

(A) The amount of income or principal being withdrawn from that annuity.

(B) The named beneficiaries of the annuity.

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

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

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

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

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

SEC. 105. Section 14009.6 is added to the Welfare and Institutions Code, to read:

14009.6. (a) As a result of providing medical assistance for home and facility care to an individual, the state shall, by operation of law, become a remainder beneficiary, to the extent required by Section 1917(e) of the federal Social Security Act (42 U.S.C. Sec. 1396p(e)), of annuities purchased in whole or in part by the individual or the individual's spouse in which the individual or the individual's spouse is an annuitant, except as provided in Section 14009.7, unless the individual or the individual's spouse notifies the department in writing that they prohibit the state from acquiring a remainder interest in their annuity.

(b) This section shall only apply to the following annuities:

(1) Those purchased on or after February 8, 2006.

(2) Those purchased before February 8, 2006, and subjected to a transaction that occurred on or after February 8, 2006.

(A) For the purposes of this paragraph, "transaction" includes, but is not limited to, any action taken by the individual or the individual's spouse that changes the course of payments to be made by the annuity or the treatment of the income or principal of the annuity.

(B) For the purpose of this paragraph, "transaction" shall not include any of the following:

(i) Routine changes and automatic events that do not require any action or decision on or after February 8, 2006.

(ii) Changes that occur based on the terms of the annuity that existed prior to February 8, 2006, and that do not require a decision, election, or action to take effect.

(iii) Changes that are beyond the control of the individual or the individual's spouse.

(c) Any provision in any annuity subject to this section that has the effect of restricting the right of the state to become a remainder beneficiary is void.

(d) (1) When the state becomes aware of an annuity in which it has acquired a remainder interest, the department shall notify the issuer of the annuity of the state's acquisition of its remainder beneficiary interest.

(2) The issuer of the annuity shall, upon notification by the department, immediately inform the department of the amount of income and principal being withdrawn from the annuity as of the date of the individual's disclosure of the annuity.

(3) The issuer of the annuity shall, upon request by the department or any agent of the department, immediately disclose to the department the amount of income and principal being withdrawn from the annuity.

(4) The issuer of the annuity shall immediately notify the department if there is any change in either of the following:

(A) The amount of income or principal being withdrawn from that annuity.

(B) The named beneficiaries of the annuity.

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

(f) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.)

and any regulations adopted pursuant to that act, and only to the extent that federal financial participation is available.

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

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

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

SEC. 106. Section 14009.7 of the Welfare and Institutions Code is amended to read:

14009.7. (a) If an annuity is considered part or all of the community spouse resource allowance allowed under subdivision (c) of Section 14006, the state shall only become a remainder beneficiary of that portion of the annuity that is not a part of that community spouse resource allowance.

(b) The state shall not become a remainder beneficiary of an annuity that is any of the following:

(1) Purchased by a community spouse with resources of the community spouse during the continuous period in which the individual is receiving medical assistance for home and facility care and after the month in which the individual is determined eligible for these benefits.

(2) Contained in a retirement plan qualified under Title 26 of the United States Code, established by an employer or an individual, including, but not limited to, an Individual Retirement Annuity or Account (IRA), Roth IRA, or Keogh fund.

(3) An annuity that is all of the following:

(A) The annuity is irrevocable and nonassignable.

(B) The annuity is actuarially sound.

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

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

(d) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.)

and any regulations adopted pursuant to that act, and only to the extent that federal financial participation is available.

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

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

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

SEC. 107. Section 14009.7 is added to the Welfare and Institutions Code, to read:

14009.7. (a) The state shall not become a remainder beneficiary of an annuity that is any of the following:

(1) Purchased by a community spouse with resources of the community spouse before or during the continuous period in which the individual is receiving medical assistance for home and facility care and after the month in which the individual is determined eligible for these benefits.

(2) Contained in a retirement plan qualified under Title 26 of the United States Code, established by an employer or an individual, including, but not limited to, an Individual Retirement Annuity or Account (IRA), Roth IRA, or Keogh fund.

(3) An annuity that is all of the following:

(A) The annuity is irrevocable and nonassignable.

(B) The annuity is actuarially sound.

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

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

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

(d) To the extent that regulations are necessary to implement this section, the department shall promulgate regulations using the nonemergency

regulatory process described in Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of the Government Code.

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

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

SEC. 108. Section 14011 of the Welfare and Institutions Code is amended to read:

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

(b) To the extent permitted by federal law, eligibility for medical assistance for applicants shall not be granted until the applicant or designated representative provides independent documentation verifying statements of gross income by type and source; income amounts withheld for taxes, health care benefits available through employment, retirement, military service, work related injuries or settlements from prior injuries, employee retirement contributions, and other employee benefit contributions, deductible expenses for maintenance or improvement of income-producing property and status and value of property owned, other than property exempt under Section 14006. The director may prescribe those items of exempt property that the director deems should be verified as to status and value in order to reasonably assure a correct designation of those items as exempt.

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

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

(e) To the extent permitted by federal law, in addition to the other verification requirements of this section, a county department may require

verification of any other applicant statements, or conduct a full and complete investigation of the statements, whenever a verification or investigation is warranted in the judgment of the county department.

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

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

SEC. 109. Section 14011 is added to the Welfare and Institutions Code, to read:

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

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

(1) Gross income by type and source.

(2) Income amounts withheld for taxes.

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

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

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

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

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

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

SEC. 110. Section 14011.65 of the Welfare and Institutions Code is amended to read:

14011.65. (a) To the extent allowed under federal law and only if federal financial participation is available under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.), the state shall administer the Medi-Cal to Healthy Families Accelerated Enrollment program, to provide any child who meets the criteria set forth in subdivision (b) with temporary health benefits for the period described in paragraph (2) of subdivision (b), as established under Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.

(b) (1) Any child who meets all of the following requirements, shall be eligible for temporary health benefits under this section:

(A) The child, or their parent or guardian, submits an application for the Medi-Cal program directly to the county.

(B) The child's income, as determined on the basis of the application described in subparagraph (A), is within the income limits established by the Healthy Families Program.

(C) The child is under 19 years of age at the time of the application.

(D) The county determines, on the basis of the application described in subparagraph (A), that the child is eligible for full scope Medi-Cal with a spend down of excess income.

(E) The child is not receiving Medi-Cal benefits at the time that the application is submitted.

(F) The child, or their parent or guardian, gives, or has given consent for the application to be shared with the Healthy Families Program for purposes of determining the child's Healthy Families Program eligibility.

(2) The period of accelerated eligibility provided for under this section begins on the first day of the month that the county finds that the child meets all of the criteria described in paragraph (1) and concludes on the last day of the month that the child either is fully enrolled in, or has been determined ineligible for, the Healthy Families Program.

(3) For any child who meets the requirements for temporary health benefits under this section, the county shall forward to the Healthy Families Program sufficient information from the child's application to determine eligibility for the Healthy Families Program. To the extent possible, submission of that information to the Healthy Families Program shall be

accomplished using an electronic process developed for use in the Medi-Cal-to-Healthy Families Bridge Benefits Program. The department shall give the Healthy Families Program a daily electronic file of all children provided temporary health benefits pursuant to this section.

(4) The temporary health benefits provided under this section shall be identical to the benefits provided to children who receive full-scope Medi-Cal benefits without a spend down of excess income and shall only be made available through a Medi-Cal provider.

(c) The department, in consultation with the Managed Risk Medical Insurance Board and representatives of the local agencies that administer the Medi-Cal program, consumer advocates, and other stakeholders, shall develop and distribute the policies and procedures, including any all-county letters, necessary to implement this section.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of all-county letters or similar instructions, without taking any further regulatory action. Thereafter, the department may adopt regulations, as necessary, to implement this section in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(e) The department shall seek approval of any amendments to the state plan necessary to implement this section, in accordance with Title XIX (42 U.S.C. Sec. 1396 et seq.) of the Social Security Act. Notwithstanding any other law, only when all necessary federal approvals have been obtained shall this section be implemented.

(f) Under no circumstances shall this section be implemented unless the state has sought and obtained approval of any amendments to its state plan, as described in Section 12693.50 of the Insurance Code, necessary to implement this section and obtain funding under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.) for the provision of benefits provided under this section. Notwithstanding any other law, and only when all necessary federal approvals have been obtained by the state, this section shall be implemented only to the extent federal financial participation under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.) is available to fund benefits provided under this section.

(g) The department shall commence implementation of this section on the first day of the third month following the month in which federal approval of the state plan amendment or amendments described in subdivision (f), and subdivision (b) of Section 12693.50 of the Insurance Code is received, or on August 1, 2006, whichever is later.

(h) This section shall cease to be implemented on the date that the director executes a declaration, pursuant to subdivision (h) of Section 14011.65, stating that implementation of Section 14011.65a has commenced. Implementation of this section shall resume on the date that Section 14011.65a becomes inoperative, pursuant to subdivision (h) of that section.

SEC. 111. Section 14011.7 of the Welfare and Institutions Code is amended to read:

14011.7. (a) To the extent allowed under federal law and only if federal financial participation is available, the department shall exercise the option provided in Section 1396r-1a of Title 42 of the United States Code and the option provided in Section 1397gg(e)(1)(D) of Title 42 of the United States Code to implement a program for preenrollment of children into the Medi-Cal program. Upon the exercise of both of the federal options described in this subdivision, the department shall implement the Children's Presumptive Eligibility Program for the preenrollment of children into the Medi-Cal program.

(b) (1) Before July 1, 2003, the department shall develop an electronic application to serve as the application for the Children's Presumptive Eligibility Program, to the extent allowed under federal law.

(2) The department may, at its option, also use the electronic application developed pursuant to paragraph (1), as a means to enroll newborns into the Medi-Cal program as is authorized under Section 1396a(e)(4) of Title 42 of the United States Code. Providers may submit newborn enrollments through the electronic application on behalf of patients without a patient's signature.

(c) (1) The department may designate, as necessary, Medi-Cal providers as qualified entities who are authorized to determine eligibility for preenrollment into the Medi-Cal program as authorized under this section.

(2) The provider shall assist the parent or guardian of the child seeking eligibility for preenrollment into the Medi-Cal program in completing the electronic application.

(d) The electronic application developed pursuant to subdivision (b) may only be filed when the child is in need of Medi-Cal.

(e) (1) The electronic application developed pursuant to subdivision (b) shall request all information necessary for a provider to make an immediate determination as to whether a child meets the eligibility requirements for preenrollment into the Medi-Cal program pursuant to the federal options described in Section 1396r-1a or 1397gg(e)(1)(D) of Title 42 of the United States Code.

(2) (A) If the electronic application indicates that the child is seeking eligibility for no cost full-scope Medi-Cal benefits, the department shall mail to the child's parent or guardian a followup application for Medi-Cal program eligibility. The parent or guardian of the child shall be advised to complete and submit to the appropriate entity the followup application.

(B) The followup application, at a minimum, shall include all notices and forms necessary for the Medi-Cal program eligibility determination under state and federal law, including, but not limited to, any information and documentation that is required for the joint application package described in Section 14011.1.

(C) The date of application for the Medi-Cal program is the date the completed followup application is submitted with the appropriate entity by the parent or guardian.

(3) Upon making a determination pursuant to paragraph (1) that a child is eligible, the provider shall inform the child's parent or guardian of both of the following:

(A) That the child has been determined to be eligible for preenrollment into the Medi-Cal program.

(B) That if the child has been determined to be eligible for preenrollment into the Medi-Cal program, the period of preenrollment eligibility will end on the last day of the month following the month in which the determination of preenrollment eligibility is made, unless the parent or guardian completes and returns to the appropriate entity the followup application described in paragraph (2) on or before that date.

(4) If the followup application described in paragraph (2) is submitted on or before the last day of the month following the month in which a determination is made that the child is eligible for preenrollment into the Medi-Cal program, the period of preenrollment eligibility shall continue until the completion of the determination process for the applicable program or programs.

(f) The department shall seek approval of any amendments to the state plan, necessary to implement this section, for purposes of funding under Title XIX (42 U.S.C. 1396 et seq.) and Title XXI (42 U.S.C. 1397aa et seq.) of the Social Security Act. Notwithstanding any other provision of law and only when all necessary federal approvals have been obtained, this section shall be implemented only to the extent federal financial participation is available.

(g) To implement this section, the department may contract with public or private entities, or utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary, only if services provided under the program are specifically identified and reimbursed in a manner that appropriately claims federal financial reimbursement. Contracts, including the Medi-Cal fiscal intermediary contracts and contract amendments, any system change pursuant to a change order, and any project or systems development notice shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, and any policies, procedures, or regulations authorized by these laws.

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

SEC. 112. Section 14011.8 of the Welfare and Institutions Code is amended to read:

14011.8. (a) Benefits provided to an individual pursuant to a preliminary determination as described in Section 1396r-1, 1396r-1a, or 1396r-1b of Title 42 of the United States Code shall end, without the necessity for any

further review or determination by the department, on or before the last day of the month following the month in which the preliminary determination was made, unless an application for medical assistance under the state plan is filed on or before that date.

(b) If an application for medical assistance is filed on or before the last day of the month following the month in which the preliminary determination was made, preliminary benefits shall continue until the regular eligibility determination based on the application has been completed. The application shall be treated in all respects as an initial application for benefits and the following shall apply:

(1) In the case of an applicant who is found eligible for medical assistance, benefits shall be granted in an amount and under those conditions, including imposition of a spend down of excess income, as have been found applicable pursuant to the regular eligibility determination.

(2) In the case of all other applicants, provision of preliminary benefits shall end on the day that the regular eligibility determination is made.

(c) Notwithstanding any other law, medical assistance pursuant to a preliminary determination as described in Section 1396r-1, 1396r-1a, or 1396r-1b of Title 42 of the United States Code shall be provided only if and to the extent federal financial participation is available.

SEC. 113. Section 14013.3 of the Welfare and Institutions Code is amended to read:

14013.3. (a) When determining whether an individual is eligible for Medi-Cal benefits, the department shall verify the accuracy of the information identified in this section that is provided as a part of the application or redetermination process in conformity with this section.

(b) Prior to requesting additional verification from an applicant or beneficiary for information they provide as part of the application or redetermination process, the department shall obtain information about an individual that is available electronically from other state and federal agencies and programs in determining an individual's eligibility for Medi-Cal benefits or for potential eligibility for an insurance affordability program offered through the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code. Needed information shall be obtained from the following sources, including any other source the department determines is useful:

(1) Information related to wages, net earnings from self-employment, unearned income, and resources from any of the following:

(A) The State Wage Information Collection Agency.

(B) The federal Internal Revenue Service.

(C) The federal Social Security Administration.

(D) The Employment Development Department.

(E) The state administered supplementary payment program under Section 1382e of Title 42 of the United States Code.

(F) Any state program administered under a plan approved under Titles I, X, XIV, or XVI of the federal Social Security Act.

(2) Information related to eligibility or enrollment from any of the following:

(A) The CalFresh program pursuant to Chapter 10 (commencing with Section 18900) of Part 6.

(B) The CalWORKs program.

(C) The state's children's health insurance program under Title XXI of the federal Social Security Act (42 U.S.C. 1397aa et seq.).

(D) The California Health Benefit Exchange established pursuant Title 22 (commencing with Section 100500) of the Government Code.

(E) The electronic service established in accordance with Section 435.949 of Title 42 of the Code of Federal Regulations.

(c) (1) If the income information obtained by the department pursuant to subdivision (b) is reasonably compatible with the information provided by or on behalf of the individual, the department shall accept the information provided by or on behalf of the individual as being accurate.

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

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

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

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

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

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

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

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

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

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

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

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

(i) This section shall become operative on January 1, 2014.

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

SEC. 114. Section 14013.3 is added to the Welfare and Institutions Code, to read:

14013.3. (a) When determining whether an individual is eligible for Medi-Cal benefits, the department shall verify the accuracy of the information identified in this section that is provided as a part of the application or redetermination process in conformity with this section.

(b) Before requesting additional verification from an applicant or beneficiary for information they provide as part of the application or redetermination process, the department shall obtain information about an

individual that is available electronically from other state and federal agencies and programs in determining an individual's eligibility for Medi-Cal benefits or for potential eligibility for an insurance affordability program offered through the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code. Needed information shall be obtained from the following sources, including any other source the department determines is useful:

(1) Information related to wages, net earnings from self-employment, and unearned income from any of the following:

(A) The State Wage Information Collection Agency.

(B) The federal Internal Revenue Service.

(C) The federal Social Security Administration.

(D) The Employment Development Department.

(E) The state administered supplementary payment program under Section 1382e of Title 42 of the United States Code.

(F) Any state program administered under a plan approved under Titles I, X, XIV, or XVI of the federal Social Security Act.

(2) Information related to eligibility or enrollment from any of the following:

(A) The CalFresh program pursuant to Chapter 10 (commencing with Section 18900) of Part 6.

(B) The CalWORKs program.

(C) The state's children's health insurance program under Title XXI of the federal Social Security Act (42 U.S.C. 1397aa et seq.).

(D) The California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code.

(E) The electronic service established in accordance with Section 435.949 of Title 42 of the Code of Federal Regulations.

(c) (1) If the income information obtained by the department pursuant to subdivision (b) is reasonably compatible with the information provided by or on behalf of the individual, the department shall accept the information provided by or on behalf of the individual as being accurate.

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

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

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

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

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

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

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

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

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

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

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

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

(i) This section shall become operative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care

Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain operative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.

SEC. 115. Section 14015 of the Welfare and Institutions Code is amended to read:

14015. (a) (1) The providing of health care under this chapter shall not impose any limitation or restriction upon the person's right to sell, exchange or change the form of property holdings nor shall the care provided constitute any encumbrance on the holdings. However, the transfer or gift of assets, including income and resources, for less than fair market value shall, pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act, result in a period of ineligibility for medical assistance for home and facility care, which may include partial months of ineligibility, applied in accordance with federal law.

(2) Any items, including notes, loans, life estates, or annuities that are held and distributed in a manner that is not in conformity with the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and regulations adopted pursuant to that act, shall be treated as a transferred asset and may result in a period of ineligibility as described in paragraph (1), as required by Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act.

(b) Pursuant to Section 1917 (c)(2)(C)(ii) of the federal Social Security Act (42 U.S.C. Sec. 1396p(c)(2)(C)(ii)), a satisfactory showing that assets transferred exclusively for a purpose other than to qualify for medical assistance shall not result in ineligibility for Medi-Cal and shall include, but not be limited to, the following:

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

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

(3) Assets for which adequate consideration is received.

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

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

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

(c) In administering this section, it shall be presumed that assets transferred by the applicant or beneficiary prior to the look-back period established by the department preceding the date of initial application were

not transferred to establish eligibility or reduce the spend down of excess income. These assets shall not be considered in determining eligibility.

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

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

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

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

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

SEC. 116. Section 14015.12 of the Welfare and Institutions Code is amended to read:

14015.12. (a) For the purposes of this section, the following definitions shall apply:

(1) “Opposite-sex spouse” means a person of the opposite sex who is legally married to an applicant for, or recipient of, home and facility care.

(2) “Registered domestic partner” means a person that meets the requirements of Section 297 of the Family Code and with whom the applicant for, or recipient of, home and facility care shares the common residence.

(3) “Same-sex spouse” means a person of the same sex who is legally married to an applicant for, or recipient of, home and facility care.

(b) In addition to the requirements of Section 14015.1, the department shall consider, at initial application or redetermination, whether an undue hardship, as described in subdivision (c), exists prior to finding that an applicant or recipient is subject to a period of ineligibility for medical assistance for home and facility care pursuant to this article. No person shall be subject to a period of ineligibility for medical assistance for home and

facility care at the time of the initial application or redetermination if the department determines that an undue hardship exists.

(c) An undue hardship shall be found to exist under any of the following circumstances:

(1) The applicant for, or recipient of, home and facility care transferred all or any portion of their ownership interest in the shared principal residence to their same-sex spouse or registered domestic partner.

(2) (A) Subject to the requirements of subparagraph (B), the applicant for, or recipient of, home and facility care transferred their ownership interest in resources other than the shared principal residence to their same-sex spouse or registered domestic partner and the value of those resources does not exceed the value of resources that the individual could transfer to their same-sex spouse or registered domestic partner and does not exceed the community spouse resource allowance that would be available to that person if they were an opposite-sex spouse. When considering whether an undue hardship exists under this paragraph, the Medi-Cal eligibility determination rules applicable to resource evaluations for an applicant for, or recipient of, home and facility care and their opposite-sex spouse shall be used to determine the resources available to an applicant for, or recipient of, home and facility care and their same-sex spouse or registered domestic partner.

(B) If the value of the resources transferred exceeds the limit specified in subparagraph (A), the amount of resources transferred that meet the limit shall be subject to the undue hardship exception specified in subparagraph (A) and the amount of resources transferred in excess of the limit shall not be subject to an undue hardship exception under this section and shall be considered a transfer of assets for less than fair market value.

(3) (A) Subject to the requirements of subparagraph (B), the applicant for, or recipient of, home and facility care transferred their income or right to receive income to their same-sex spouse or registered domestic partner and the amount of the transferred income does not exceed the amount of income that the individual could transfer to their same-sex spouse or registered domestic partner and does not exceed the maximum monthly spousal income allowance that would be available to that person if they were an opposite-sex spouse. When considering whether an undue hardship exists under this paragraph, the Medi-Cal eligibility determination rules applicable to income evaluations for an applicant for, or recipient of, home and facility care and their opposite-sex spouse shall be used to determine the income available to an applicant for, or recipient of, home and facility care and their same-sex spouse or registered domestic partner.

(B) If the amount of income transferred exceeds the limit specified in subparagraph (A), the amount of income transferred that meets the limit shall be subject to the undue hardship exception specified in subparagraph (A) and the amount of income transferred in excess of the limit shall not be subject to an undue hardship exception under this section and shall continue to be included in the applicant's or recipient's spend down of excess income. To the extent that the excess income transferred was the applicant's or recipient's right to receive a future income stream and that transfer can be

revoked, the applicant or recipient shall revoke the transfer. To the extent that the transferred income stream cannot be revoked, that future income stream shall be considered a transfer of assets for less than fair market value.

(d) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act.

(e) (1) The department shall submit a state plan amendment or seek other federal approval before implementing the undue hardship circumstances identified in this section. The department shall request, in the state plan amendment or other federal approval request, that the effective date of approval be retroactive to January 1, 2012.

(2) This section shall be implemented only if, and to the extent that, a state plan amendment is approved or other federal approval is obtained and federal financial participation is available.

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

SEC. 117. Section 14016 of the Welfare and Institutions Code is amended to read:

14016. (a) The county in which the person resides, except as specified in subdivision (d), shall determine the eligibility of each person pursuant to Sections 14005.1, 14005.4, and 14005.7 and Article 4.4 (commencing with Section 14140), except that the department may contract with the federal Social Security Administration for the determination of Medi-Cal eligibility of persons eligible under Title XVI of the Social Security Act. Upon termination of such assistance, the county shall determine whether the person remains eligible for Medi-Cal coverage under one of these sections.

(b) The department shall institute an eligibility quality control program, to verify the eligibility determination of a sample of persons in each county granted Medi-Cal eligibility under Section 14005.4, 14005.7, or 14005.8 or Article 4. 4 (commencing with Section 14140).

(c) A review period shall be defined as one year and shall coincide with the federal fiscal year. The department shall draw a random sample of cases for each period. The random sample shall be drawn to ensure a minimum number of cases reviewed in each county in each review period according to the following:

(1) All cases shall be sampled in any county with less than 50 Medi-Cal cases.

(2) Fifty cases in any county with greater than 0.01 percent and less than or equal to .50 percent of the Medi-Cal cases.

(3) Seventy-five cases in any county with greater than .50 percent and less than or equal to 1 percent of the Medi-Cal cases.

(4) One hundred cases in any county with greater than 1 percent and less than or equal to 3 percent of the Medi-Cal cases.

(5) One hundred twenty-five cases in any county with greater than 3 percent and less than or equal to 10 percent of the Medi-Cal cases.

(6) Six hundred fifty cases in any county with greater than 10 percent of the Medi-Cal cases.

(d) When family members maintain separate residences, but eligibility is determined as a single unit because of the provisions of Section 14008, the county in which the parent or parents reside shall determine the eligibility for the entire unit.

(e) In administering the provisions of law and regulations related to eligibility determination the director shall impose such fiscal penalties as provided by this section to assure adequate county administrative performance.

(f) The director shall hold counties financially liable for payments made on behalf of ineligible persons or persons with an incorrect spend down of excess income. When a sample case is found to include an ineligible person or a person with an understated spend down of excess income, written notification shall be sent to the county department that describes the error and requests a written response within two weeks. The county shall indicate whether it agrees or disagrees with the findings. If the county disagrees, the department shall reevaluate the error findings, taking into consideration any additional facts contained in the county's response. The department shall again notify the county of the department's findings. If the county continues to disagree with the error findings, the county may appeal to the Chief of the Medi-Cal Policy Division, requesting that the department review the case and render a final decision. The director may reduce or waive the fiscal liability of a county if the department is unable to meet the minimum sample required, as defined in subdivision (c), or if an individual county experienced a natural disaster, job actions, or other occurrences that impacted the findings in an individual county as determined by the director.

(g) The department shall utilize the methodology detailed in this subdivision to establish counties' fiscal penalties. The department shall determine each county's case error rate for each review period by dividing the number of completed case reviews in that county found in error by the number of case reviews in that county. State caused errors shall be determined by the department and shall not be included in this calculation. Case error rates shall be arrayed from highest to lowest. From this array, the department shall determine the percentage of counties liable as follows:

(1) The 60 percent of counties with the highest case error rates shall be liable if the state's dollar error rate exceeds the federal standard by 0.01 percent to 1 percent.

(2) The 70 percent of counties with the highest case error rates shall be liable if the state's dollar error rate exceeds the federal standard by greater than 1 percent and less than or equal to 2 percent.

(3) The 80 percent of counties with the highest case error rates shall be liable if the state's dollar error rate exceeds the federal standard by greater than 2 percent and less than or equal to 3 percent.

(4) The 90 percent of counties with the highest case error rates shall be liable if the state's dollar error rate exceeds the federal standard by greater than 3 percent and less than or equal to 4 percent.

(5) All counties shall be liable if the state's dollar error rate exceeds the federal standard by greater than 4 percent.

As used herein, "the state's dollar error rate" means the Medicaid dollar error rate reported to the department by the United States Department of Health and Human Services, less any portion of this error rate attributable to state caused errors. The term "federal standard" means the Medicaid dollar error rate standard to which the state is held accountable.

For each county determined liable, the department shall calculate a penalty multiple that shall be the product of a liable county's case error rate multiplied by the liable county's percentage of statewide Medi-Cal cases. Each county's fiscal penalty shall be the product of a county's penalty multiple divided by the sum of all penalty multiples, multiplied times the penalty bank. The penalty bank includes only quality control federal fiscal sanctions, federal withholds, federal disallowances, and any associated General Fund expenditures, minus the value of any state assumed errors and the General Fund share of the value of client caused errors. The case error rate and penalty multiple shall be adjusted by excluding client errors for the purpose of determining the associated General Fund expenditures.

If, after the department has assessed penalties to counties, the federal government reduces or eliminates any quality control federal fiscal sanction, federal withhold or federal disallowance, the department shall reduce or eliminate the corresponding fiscal penalty assessment including any associated General Fund expenditures to liable counties.

(h) When a county welfare department contravenes state eligibility processing regulations and written instructions in a way that produces increased program benefits or administrative expenses but doesn't result in an increase in the eligibility dollar error rate, the director shall recoup from that county the additional administrative or program benefit costs above those that would have been incurred had that county not contravened the established state eligibility processing regulations and written instructions. This section shall not be construed to interfere with the rights of counties to out-station eligibility staff.

Notwithstanding the number of counties determined liable for fiscal penalties under this section, individual county corrective action plans as prescribed by the department shall be required from all counties that exceed a 15 percent case error rate.

(i) Any penalties imposed under this system shall be collected through direct repayment from liable counties rather than through any reduction in funds otherwise due to counties.

SEC. 118. Section 14019.4 of the Welfare and Institutions Code is amended to read:

14019.4. (a) A provider of health care services who obtains a label or copy from the Medi-Cal card or other proof of eligibility pursuant to this chapter shall not seek reimbursement nor attempt to obtain payment for the

cost of those covered health care services from the eligible applicant or recipient, or a person other than the department or a third-party payor who provides a contractual or legal entitlement to health care services.

(b) Whenever a service or set of services rendered to a Medi-Cal beneficiary results in the submission of a claim in excess of five hundred dollars ($500), and the beneficiary has given the provider proof of eligibility to receive the service or services, the provider shall issue the beneficiary a receipt to document that appropriate proof of eligibility has been provided. The form and content of those receipts shall be determined by the provider but shall be sufficient to comply with the intent of this subdivision. Nursing facilities and all categories of intermediate care facilities for the developmentally disabled are exempt from the requirements of this subdivision.

(c) In addition to being subject to applicable sanctions set forth in law or regulation, a provider of health care services who obtains a label from, or copy of, the Medi-Cal card or other proof of eligibility pursuant to this chapter, and who subsequently pursues reimbursement or payment for the cost of covered services from the beneficiary or fails to cease collection efforts against the beneficiary for covered services as required by subdivision (d), may be subject to a penalty, payable to the department, not to exceed three times the amount payable by the Medi-Cal program. In implementing this subdivision, mitigating circumstances, which include, but are not limited to, clerical error and good faith mistake, shall be considered when assessing the penalty. Providers subject to penalties under this subdivision shall have the right to appeal the assessed penalty, consistent with department procedures.

(d) When a Medi-Cal provider receives proof of a patient's Medi-Cal eligibility and that provider has previously referred an unpaid bill for services rendered to the patient to a debt collector, the Medi-Cal provider shall promptly notify the debt collector of the patient's Medi-Cal coverage, instruct the debt collector to cease collection efforts on the unpaid bill for the covered services, and notify the patient accordingly.

(e) If a patient provides proof of Medi-Cal eligibility to a debt collector, and the debt collector fails to notify the provider of this proof, the provider shall not be responsible for ensuring that collection efforts against the patient cease pursuant to subdivision (d) until either the patient or the debt collector provides the provider with proof of the patient's Medi-Cal eligibility.

(f) A Medi-Cal provider or debt collector shall be deemed to be in violation of subdivision (a) of Section 1785.25 of the Civil Code if more than 30 days after receiving proof of Medi-Cal coverage the provider or debt collector does either of the following:

(1) Furnishes information regarding the rendering of the Medi-Cal covered services to a consumer credit reporting agency.

(2) Fails to provide corrections of, or instructions to delete, as appropriate, information regarding Medi-Cal covered services previously furnished by that Medi-Cal provider or debt collector to a consumer reporting agency.

(g) This section shall not apply to the Medi-Cal spend down of excess income owed by a Medi-Cal beneficiary, unless the beneficiary's spend down of excess income has been met for the month in which services were rendered.

(h) For purposes of this section, "debt collector" includes any person who regularly engages in debt collection, as defined by Section 1788.2 of the Civil Code, but does not include the original Medi-Cal provider.

SEC. 119. Section 14021.6 of the Welfare and Institutions Code is amended to read:

14021.6. (a) For the fiscal years prior to the 2004–05 fiscal year, and subject to the requirements of federal law, the maximum allowable rates for the Drug Medi-Cal Treatment Program shall be determined by computing the median rate from available cost data by modality from the fiscal year that is two years prior to the year for which the rate is being established.

(b) (1) For the 2007–08 fiscal year, and subsequent fiscal years, and subject to the requirements of federal law, the maximum allowable rates for the Drug Medi-Cal Treatment Program shall be determined by computing the median rate from the most recently completed cost reports, by specific service codes that are consistent with the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg).

(2) For the 2005–06 and 2006–07 fiscal years, if the State Department of Health Care Services determines that reasonably reliable and complete cost report data are available, the methodology specified in this subdivision shall be applied to either or both of those years. If reasonably reliable and complete cost report data are not available, the State Department of Health Care Services shall establish rates for either or both of those years based upon the usual, customary, and reasonable charge for the services to be provided, as the department may determine in its discretion. This subdivision does not modify subdivision (h) of Section 14124.24, which requires certain providers to submit performance reports.

(c) Notwithstanding subdivision (a), for the 1996–97 fiscal year, the rates for nonperinatal outpatient methadone maintenance services shall be set at the rate established for the 1995–96 fiscal year.

(d) Notwithstanding subdivision (a), the maximum allowable rate for group outpatient drug free services shall be set on a per person basis. A group shall consist of a minimum of 2 and a maximum of 12 individuals, at least one of which shall be a Medi-Cal eligible beneficiary. For groups consisting of two individuals, if one of the individuals is ineligible for Medi-Cal, the individual who is ineligible for Medi-Cal shall be receiving outpatient drug free services for a substance use disorder diagnosed by a physician.

(e) The department shall develop individual and group rates for extensive counseling for outpatient drug free treatment, based on a 50-minute individual or a 90-minute group hour, not to exceed the total rate established for subdivision (d).

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

may implement, interpret, or make specific this section by means of bulletins or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 1, 2020, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of the act that added this paragraph, and notwithstanding Section 10231.5 of the Government Code, the department shall, on a semiannual basis and in compliance with Section 9795 of the Government Code, provide a status report to the Legislature until the regulations have been adopted.

(2) Notwithstanding paragraph (1) and Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may annually establish and update the statewide maximum allowable reimbursement rates specified in this section by means of bulletins or similar instructions.

(g) Bills for services under the Drug Medi-Cal Treatment Program shall be submitted no later than 12 months from the date of service.

SEC. 120. Section 14051 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

SEC. 121. Section 14051 is added to the Welfare and Institutions Code, to read:

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

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

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

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

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

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

SEC. 122. Section 14051.5 of the Welfare and Institutions Code is amended to read:

14051.5. (a) "Medically needy person" also means any person who receives in-home supportive services pursuant to Section 12305.5 and whose income and resources are insufficient to provide for the costs of health care or coverage.

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

SEC. 123. Section 14051.5 is added to the Welfare and Institutions Code, to read:

14051.5. (a) "Medically needy person" also means any person who receives in-home supportive services pursuant to Section 12305.5 and whose income is insufficient to provide for the costs of health care or coverage.

(b) This section shall become operative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care

Services is communicated to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain operative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.

SEC. 124. Section 14051.7 is added to the Welfare and Institutions Code, to read:

14051.7. "Post-eligibility treatment of income" means the determination of long-term care patient liability for each month in which the patient is described in Section 14050.3 or as an institutionalized spouse described in Section 14002.5 determined in accordance with Section 435.725 of Title 42 of the Code of Federal Regulations, without regard to paragraph (1) of subsection (b) of that section, and Sections 435.832, and 435.845 of Title 42 of the Code of Federal Regulations, as appropriate.

SEC. 125. Section 14051.8 is added to the Welfare and Institutions Code, to read:

14051.8. "Long-term care patient liability" is the term given to the result of the post-eligibility treatment of income calculation under Section 14051.7. The person in long-term care or an institutionalized spouse shall incur or expect to incur an amount of medical expenses that equal this amount pursuant to subdivision (d) of Section 14005.12.

SEC. 126. Section 14054 of the Welfare and Institutions Code is amended to read:

14054. (a) "Share of cost" or "spend down of excess income" means the amount of the costs of health care that a person or family eligible under Section 14005.4 or 14005.7 shall incur prior to being certified by the department as specified in Section 14018.

(b) Upon the effective date of the act that added this subdivision, any reference to "share of cost" in this chapter or elsewhere in this code that relates to an individual Medi-Cal beneficiary's or applicant's eligibility under the medically needy persons or medically needy family persons categories shall be read as "spend down of excess income" and the definition in subdivision (a) shall apply.

SEC. 127. Section 14064 of the Welfare and Institutions Code is amended to read:

14064. (a) Inpatient intensive rehabilitation hospital services shall consist of programs for:

(1) Strengthening and training of selected muscle groups.

(2) Preservation and restoration of joint mobility (prevention and correction of contractures).

(3) Training in application and use of equipment.

(4) Training in activities of daily living, self-care, locomotion and homemaking skills.

(5) Cognitive reorganization and communication skills.

(6) Resolution of psychological and social problems which are impeding rehabilitation.

(b) These programs shall use a multidiscipline approach carried out under the general or direct supervision of a physician with special training or experience in the field of rehabilitation. When medically indicated, a program of this scope includes but is not limited to:

(1) Skilled rehabilitation nursing care.

(2) Physical therapy.

(3) Occupational therapy.

(4) Speech therapy.

(5) Prosthetic or orthotic services.

(6) Psychologist services.

(7) Medical social worker services.

SEC. 128. Section 14094.5 of the Welfare and Institutions Code is amended to read:

14094.5. (a) No sooner than July 1, 2017, the department may establish a Whole Child Model program for Medi-Cal eligible CCS children and youth enrolled in a managed care plan served by a county organized health system or Regional Health Authority, or commencing no sooner than January 1, 2024, an alternate health care service plan contracted with the department pursuant to Section 14197.11, in the following counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo.

(b) No sooner than January 1, 2025, the department may establish a Whole Child Model program for Medi-Cal eligible CCS children and youth enrolled in a managed care plan served by a county organized health system or Regional Health Authority in the following counties: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba, Mariposa, and San Benito.

SEC. 129. Section 14094.7 of the Welfare and Institutions Code is amended to read:

14094.7. (a) No sooner than July 1, 2017, the department may implement the Whole Child Model program established under this section, pursuant to the criteria described in this article. The director shall provide notice to the Legislature, the federal Centers for Medicare and Medicaid Services, counties, CCS providers, and CCS families when each managed care plan, including a transition plan with the county CCS program, has been reviewed and certified as ready to enroll children based on the criteria described in this article.

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

(1) Develop specific CCS program monitoring and oversight standards for managed care plans that are subject to this article, including access monitoring, quality measures, and ongoing public data reporting. No later than January 1, 2025, the department shall, at minimum, do all of the following:

(A) Annually provide an analysis on its internet website regarding trends on CCS enrollment for Whole Child Model counties and non-Whole Child

Model counties, in a way that enables a comparison of trends between the two categories of CCS counties.

(B) Develop utilization and quality measures, to be reported on an annual basis in a form and manner specified by the department, that relate specifically to CCS specialty care and report such measures for both Whole Child Model counties and non-Whole Child Model counties. When developing measures, the department shall consider both of the following:

(i) Recommendations of the CCS Redesign Performance Measure Quality Subcommittee established by the department as part of the CCS Advisory Group pursuant to subdivision (c) of Section 14097.17.

(ii) Available data regarding the percentage of children with CCS eligible conditions who receive an annual special care center visit.

(C) Require, as part of its monitoring and oversight responsibilities, any Whole Child Model plan, as applicable, that is subject to one or more findings in its most recent annual medical audit pertaining to access or quality of care in the CCS program to implement quality improvement strategies that are specifically targeted to the CCS population, as determined by the department.

(2) Establish a stakeholder process pursuant to Section 14094.17.

(3) Consult with the statewide stakeholder advisory group established pursuant to Section 14094.17 to develop and implement robust monitoring processes to ensure that managed care plans are in compliance with all of the provisions of this section. The department shall monitor managed care plan compliance with the provisions of this section on at least an annual basis and post CCS-specific monitoring dashboards on its internet website on at least an annual basis.

(c) (1) In order to aid the transition of CCS services into Medi-Cal managed care plans participating in the Whole Child Model program, commencing January 1, 2017, and continuing through the completion of the transition of CCS enrollees into the Whole Child Model program, the department shall begin requesting and collecting from Medi-Cal managed care plans information about each health plan's provider network, including, but not limited to, the contracting primary care, specialty care providers, and hospital facilities contracting with the Medi-Cal managed care plan.

(2) The department shall analyze the existing Medi-Cal managed care delivery system network and the CCS fee-for-service provider networks to determine the overlap of the provider networks in each county and shall furnish this information to the Medi-Cal managed care plan.

(d) A managed care plan shall not be approved to participate in the Whole Child Model program unless all of the following conditions have been satisfied:

(1) The managed care plan has obtained written approval from the director.

(2) The department has obtained any necessary federal approvals.

(3) The Medi-Cal managed care plan has established a local stakeholder process with the meaningful engagement of a diverse group of families that represent a range of conditions, disabilities, and demographics, and local

providers, including, but not limited to, the parent centers, such as family resource centers, family empowerment centers, and parent training and information centers, that support families in the affected county.

(4) The director has verified the readiness of the managed care plan to address the unique needs of CCS-eligible beneficiaries, including, but not limited to, the requirements set forth in subdivision (b) of Section 14087.48, subdivisions (b) to (f), inclusive, of Section 14093.05, and all of the following:

(A) That the managed care contractor has demonstrated the availability of an appropriate provider network to serve the needs of children and youth with CCS conditions, including primary care physicians, pediatric specialists and subspecialists, professional, allied, and medical supportive personnel, licensed acute care hospitals, and special care centers.

(B) That the Medi-Cal managed care plan has established and maintains an updated and accessible listing of providers and their specialties and subspecialties and makes it available to CCS-eligible children and youth and their parents or guardians, at a minimum by telephone, written material, and internet website.

(C) That the Medi-Cal managed care plan has entered into an agreement with the county CCS program or the state, or both, for the transition of CCS care coordination and service authorization and how the plan will work with the CCS program to ensure continuity and consistency of CCS program expertise for that role, in accordance with this section.

(e) A Medi-Cal managed care plan, prior to implementation of the Whole Child Model program, shall review historical CCS fee-for-service utilization data for CCS-eligible children and youth upon transition of CCS services to managed care plans so that the managed care plans are better able to assist CCS-eligible children and youth and prioritize assessment and care planning.

SEC. 130. Section 14094.11 of the Welfare and Institutions Code is amended to read:

14094.11. A Medi-Cal managed care plan participating in the Whole Child Model program shall meet all of the following requirements:

(a) Ensure that each CCS-eligible child or youth receives case management, care coordination, provider referral, and service authorization services from an employee or contractor of the plan who has knowledge of, and receives adequate training on, the CCS program, and who has clinical experience with the CCS population, or clinical experience with pediatric patients with complex medical conditions. In addition, the plan shall ensure that a CCS-eligible child has a primary point of contact who shall be responsible for the child's care coordination.

(b) Work with the state or county CCS program, as appropriate, to ensure that, at a minimum, and in addition to other statutory and contractual requirements, care coordination and care management activities do all of the following:

(1) Reflect a CCS child or youth family-centered, outcome-based approach to care planning.

(2) Ensure families have access to ongoing information, education, and support so that they understand the care plan for their child or youth and their role in the individual care process, the benefits of mental health services, what self-determination means, and what services might be available.

(3) Adhere to the CCS child's or youth's or the CCS child's or youth's family's determination about the appropriate involvement of their medical providers and caregivers, according to the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(4) Include individual care plans for CCS-eligible children and youth based on the results of the risk assessment process with a particular focus on CCS specialty care.

(5) Consider behavioral health needs of CCS-eligible children and youth and coordinate those services as part of the CCS child's or youth's individual care plan, when appropriate, and facilitate a CCS child's or youth's ability to access appropriate community resources and other agencies, including referrals, as necessary and appropriate, for behavioral services, such as specialty mental health services and substance use disorder services.

(6) Ensure that children and youth and their families have appropriate access to transportation and other support services necessary to receive treatment.

(c) Incorporate all of the following into the CCS child's or youth's plan of care:

(1) Access for families so that families know where to go for ongoing information, education, and support in order that they understand the goals, treatment plan, and course of care for their child or youth and their role in the process, what it means to have primary or specialty care for their child or youth, when it is time to call a specialist, primary, urgent care, or emergency room, what an interdisciplinary team is, and what the community resources are.

(2) A primary or specialty care physician who is the primary clinician for the CCS-eligible child or youth and who provides core clinical management functions.

(3) Care management and care coordination for the CCS-eligible child or youth across the health care system, including transitions among levels of care and interdisciplinary care teams.

(4) Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the managed care plan.

(d) Use clinical data to identify CCS-eligible children or youth at the care site with chronic illness or other significant health issues.

(e) Arrange for timely preventive, acute, and chronic illness treatment of CCS-eligible children or youth in the appropriate setting.

SEC. 131. Section 14094.12 of the Welfare and Institutions Code is amended to read:

14094.12. A Medi-Cal managed care plan serving children and youth with CCS-eligible conditions under the CCS program shall do all of the following:

(a) Coordinate with each regional center operating within the plan's service area to assist CCS-eligible children and youth with developmental disabilities and their families in understanding and accessing services and act as a central point of contact for questions related to health care access and care concerns, and problem resolution.

(b) Coordinate with the local CCS Medical Therapy Unit (MTU) to ensure appropriate access to MTU services. The Medi-Cal managed care plan shall enter into a memorandum of understanding or similar agreement with the county regarding coordination of MTU services and other non-MTU services provided by the plan.

(c) Ensure that families have access to ongoing information, education, and support so they understand the care plan, course of treatment, and expected outcomes for their child or youth, the assessment process, what it means, their role in the process, and what services their child or youth may be eligible for.

(d) Facilitate communication among a CCS child's or youth's health care and personal care providers, including in-home supportive services and behavioral health providers, when appropriate, with the CCS-eligible child or youth, parent, or guardian.

(e) Facilitate timely access to primary care, specialty care, pharmacy, and other health services provided by CCS providers and facilities with clinical expertise in treating the enrollee's specific CCS condition that are needed by the CCS child or youth, including referrals to address any physical or cognitive disabilities.

(f) Provide information for families about managed care processes and how to navigate a health plan, including their rights to appeal any service denials, and how to request continuity of care for pharmacy, specialized durable medical equipment, and health care providers pursuant to Section 14094.13.

(g) Establish a mechanism to provide information on how to access local family resource centers or family empowerment centers.

(h) Provide that communication to, and services for, the CCS-eligible children or youth and their families are available in alternative formats that are culturally, linguistically, and physically appropriate through means, including, but not limited to, assistive listening systems, sign language interpreters, captioning, written communication, plain language, and written translations in the applicable Medi-Cal threshold languages.

(i) Provide that materials are available and provided to inform CCS children and youth and their families of procedures for obtaining CCS specialty services and Medi-Cal primary care and mental health benefits, including grievance and appeals procedures that are offered by the managed care plan or are available through the Medi-Cal program.

(j) Identify and track children and youth with CCS-eligible conditions for the duration of the child's or youth's participation in the Whole Child

Model program and for children and youth who age into adult Medi-Cal systems and who continue to be enrolled in the same Medi-Cal managed care plan for at least three years into adulthood, to the extent feasible.

(k) (1) Comply with Medi-Cal due process requirements and provide timely processes for accepting and acting upon complaints and grievances, including procedures for appealing decisions regarding coverage or benefits. The grievance process shall comply with Section 14450 of this code, and Sections 1368 and 1368.01 of the Health and Safety Code and applicable federal law and regulations.

(2) Upon denial, denial of reauthorization, or termination of services, a notice of action shall be sent to the CCS-eligible child or youth, or person legally authorized to act on behalf of the child or youth. The notice of action shall include information about the option to file a Medi-Cal appeal and Medi-Cal due process rights.

(*l*) Comply with Section 1383.15 of the Health and Safety Code by allowing a child or youth or the parent or guardian of a child or youth to receive a second opinion from an appropriately qualified health care professional.

(m) Support the established referral pathways in the non-Whole Child Model counties, including, but not limited to, identifying children who may be eligible for the CCS program through internal reports, provider directed referrals, or direct referrals from the Medi-Cal managed care plan.

SEC. 132. Section 14094.17 of the Welfare and Institutions Code is amended to read:

14094.17. (a) A Medi-Cal managed care plan participating in the Whole Child Model program shall create and maintain a clinical advisory committee, composed of the managed care contractor's chief medical officer or the equivalent, the county CCS medical director, and at least four CCS-paneled providers, to advise on clinical issues relating to CCS conditions, including treatment authorization guidelines, and serve as clinical advisers on other clinical issues relating to CCS conditions.

(b) (1) A Medi-Cal managed care plan participating in the Whole Child Model program shall establish a family advisory group for CCS families.

(2) Family representatives who serve on this advisory group may receive a reasonable per diem payment to enable in-person participation in the advisory group. A plan may conduct family advisory group meetings by teleconference or through other similar electronic means to facilitate family participation in this advisory group.

(3) A representative of this local group shall be invited to serve on the department's statewide stakeholder advisory group established pursuant to subdivision (c).

(c) (1) The department shall establish a statewide Whole Child Model program stakeholder advisory group, or modify an existing Whole Child Model program stakeholder advisory group, composed of representatives of CCS providers, county CCS program administrators, health plans, family resource centers, regional centers, recognized exclusive representatives of CCS county providers, CCS case managers, CCS medical therapy units,

and representatives from family advisory groups established pursuant to subdivision (b). Participation on the statewide stakeholder advisory group shall be voluntary, and members shall be ineligible for travel or other per diem payments.

(2) The department shall consult with the stakeholder advisory group on the implementation of the Whole Child Model program and shall consider the recommendations of the stakeholder advisory group in developing the monitoring processes and outcome measures by which the plans participating in the Whole Child Model program shall be monitored and evaluated.

(3) The statewide Whole Child Model program stakeholder advisory group, as established under this section, shall terminate on December 31, 2026.

SEC. 133. Section 14100.5 of the Welfare and Institutions Code is amended to read:

14100.5. The department shall prepare and submit Medi-Cal program assumptions and estimates to the Department of Finance. The purpose of the assumptions and estimates shall be to clearly identify changes within the Medi-Cal program which have policy or fiscal implications, and to produce reliable forecasts of Medi-Cal expenditures.

Medi-Cal program assumptions and estimates shall be organized by and correspond to Budget Act or Budget Bill item numbers, separately identifying expenditures for all of the following:

(a) Purchase of medical care and services.

(b) Rate increases.

(c) County administration.

(d) Fiscal intermediary services.

Estimates and assumptions shall indicate state and federal, as well as total, funds expended.

The department shall submit, by September 10 and March 1 of each year, to the Department of Finance for its approval, all assumptions underlying all Medi-Cal program estimates. The Department of Finance shall approve or modify, in writing, the assumptions underlying all estimates within 15 working days of their receipt. If the Department of Finance does not so approve or modify the assumptions by that date, the assumptions, as presented by the department, shall be deemed to be approved by the Department of Finance as of that date.

The department shall submit an estimate of Medi-Cal program expenditures to the Department of Finance by November 1 of each year, and April 20 of each year. All approved estimates and supporting data provided by the department or developed independently by the Department of Finance, shall be made available to the legislative fiscal committees following approval by the Department of Finance. However, departmental estimates with supporting data shall be forwarded to the legislative fiscal committees on or about January 10 and May 15 of each year in the event this information has not been released earlier.

Each Medi-Cal assumption shall contain a clear narrative description of the statutory, regulatory, or policy change, or other change, that has occurred

or will occur which affects Medi-Cal program expenditures or which is of policy importance. Each assumption shall include a cost estimate which contains relevant workload, caseload, unit cost and other data or information needed to support the estimate.

The assumptions related to purchase of medical care and services shall include a section with a nontechnical description of the major variables used to produce a base projection. This section shall further contain an estimate of the fiscal impact of the use of these variables. The estimates related to purchase of medical care and services shall include current and budget year base projections of eligibles, users, expenditures and cost per user by quarter with sufficient past actual data to permit evaluation of the projections. The projections shall be prepared by service category and aid category. The Department of Finance shall identify a high, mid, and low range of Medi-Cal service expenditures, which shall be accompanied by assumptions, when the estimates are released to the Legislature.

The assumptions or estimates related to fiscal intermediary services shall contain a narrative description of how the forecasts are prepared. Sufficient historical workload by claim type and expenditure data shall accompany the forecasts to permit evaluation. Change orders to the fiscal intermediary contract shall be fully described and costs estimated. In addition, important modifications to the Medi-Cal claims processing system not associated with change orders shall be described and, if appropriate, costs or savings, estimated.

Assumptions or estimates related to Medi-Cal county administration costs shall contain a narrative description of how the forecast was prepared. Current and budget year estimates by county shall be prepared. The estimates shall compare past actual and projected workload and expenditures in a format which will permit evaluation of forecasts. Changes in expenditure estimates for individual counties resulting from allocation of funds or other factors shall be identified in subsequent estimates. Unallocated funds and funds for special projects or special problems shall be separately identified. The department shall compare budgeted and actual expenditures by county as soon as the information from county quarterly costs reports becomes available.

The estimates shall compare budgeted to implemented rate increases for the current year. The comparisons shall be by provider category and shall compare budgeted to implemented increases in terms of percentage increases, date of implementation, and revised estimated cost.

This section shall become inoperative on July 1, 2023, and, as of January 1, 2024, is repealed.

SEC. 134. Section 14100.5 is added to the Welfare and Institutions Code, to read:

14100.5. (a) The department shall prepare and submit Medi-Cal program assumptions and estimates to the Department of Finance. The purpose of the assumptions and estimates shall be to clearly identify changes within the Medi-Cal program which have policy or fiscal implications, and to produce reliable forecasts of Medi-Cal expenditures.

(b) (1) Beginning with the estimates for the 2024–25 fiscal year, Medi-Cal program assumptions and estimates shall be organized by and correspond to Budget Act or Budget Bill item numbers, separately identifying expenditures for all of the following:

(A) Purchase of medical care and services.

(B) County and other local assistance administration.

(C) Rate increases.

(2) Estimates and assumptions shall indicate state and federal, as well as total, funds expended.

(c) The department shall submit, by September 10 and March 1 of each year, to the Department of Finance for its approval, all assumptions underlying all Medi-Cal program estimates. The Department of Finance shall approve or modify, in writing, the assumptions underlying all estimates within 15 working days of their receipt. If the Department of Finance does not so approve or modify the assumptions by that date, the assumptions, as presented by the department, shall be deemed to be approved by the Department of Finance as of that date.

(d) The department shall submit an estimate of Medi-Cal program expenditures to the Department of Finance by November 1 and April 20 of each year. All approved estimates and supporting data provided by the department or developed independently by the Department of Finance, shall be made available to the legislative fiscal committees following approval by the Department of Finance. However, departmental estimates with supporting data shall be forwarded to the legislative fiscal committees on or about January 10 and May 15 of each year in the event this information has not been released earlier.

(e) Each Medi-Cal assumption shall contain a clear narrative description of the statutory, regulatory, or policy change, or other change, that has occurred or will occur which affects Medi-Cal program expenditures or which is of policy importance. Each assumption shall include a cost estimate which contains relevant workload, caseload, unit cost and other data or information needed to support the estimate.

(f) The assumptions related to purchase of medical care and services shall include a section with a nontechnical description of the major variables used to produce a base projection. This section shall further contain an estimate of the fiscal impact of the use of these variables. The estimates related to purchase of medical care and services shall include current and budget year base projections of eligibles, users, expenditures and cost per user by quarter with sufficient past actual data to permit evaluation of the projections. The projections shall be prepared by service category and aid category.

(g) Assumptions or estimates related to Medi-Cal county and other local assistance administration costs shall contain a narrative description of how the forecast was prepared. The estimates shall compare past actual and projected workload and expenditures in a format which will permit evaluation of forecasts. Unallocated funds and funds for special projects or special problems shall be separately identified.

(h) The estimates shall compare budgeted to implemented rate increases for the current year. The comparisons shall be by provider category and shall compare budgeted to implemented increases in terms of percentage increases, date of implementation, and revised estimated cost.

(i) This section shall become operative on July 1, 2023.

SEC. 135. Section 14105.075 of the Welfare and Institutions Code is amended to read:

14105.075. (a) (1) Notwithstanding any other law, for dates of service on or after August 1, 2016, payments to intermediate care facilities for the developmentally disabled that are licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, and to facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20, as determined by the applicable methodology for setting reimbursement rates for those facilities, shall be the reimbursement rates that were applicable to those facilities in the 2008–09 rate year, increased by 3.7 percent. Payments to the facilities pursuant to this section shall also include the projected cost of complying with new state or federal mandates to the extent applicable to the reimbursement methodology associated with the type of facility.

(2) Notwithstanding paragraph (1) and Sections 14105.191 and 14105.192, and for dates of service on or after August 1, 2021, the reimbursement rates for intermediate care facilities for the developmentally disabled and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to Section 14132.20 shall be determined without applying to that rate any reduction, limitation, or increase, including the 3.7-percent increase, specified in paragraph (1), as described in this section or Sections 14105.191 and 14105.192.

(b) (1) For dates of service on or after August 1, 2021, and for each rate year thereafter, the department shall calculate and publish the reimbursement rates, as specified in paragraph (2) of subdivision (a), plus the projected cost of complying with new state or federal mandates.

(2) For the 2021–22 fiscal year, and for each fiscal year thereafter, the reimbursement rates for intermediate care facilities for the developmentally disabled or facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to Section 14132.20, or both, shall account for, and be inclusive of, supplemental payments, as described under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016, or Proposition 56, if the Budget Act of that fiscal year appropriates funds from the Healthcare Treatment Fund, as established pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code, to the department to make those supplemental payments to these facilities.

(3) For dates of service on or after August 1, 2021, and for each rate year thereafter, the reimbursement rate established for an intermediate care facility for the developmentally disabled or a facility providing continuous skilled nursing care to developmentally disabled individuals pursuant to Section 14132.20 shall be the greater of that facility's reimbursement rate established

pursuant to paragraphs (1) and (2), or the approved Medi-Cal State Plan reimbursement rate, inclusive of the temporary increased Medicaid payments associated with the COVID-19 Public Health Emergency, plus the Proposition 56 supplemental payment amount, in effect for that facility on the last day of the COVID-19 Public Health Emergency.

(4) For dates of service on or after January 1, 2024, the department shall adopt a rate year based on the calendar year for intermediate care facilities for the developmentally disabled and facilities providing continuous skilled nursing care to developmentally disabled individuals, pursuant to Section 14132.20.

(c) In implementing this section, the department shall seek any federal approvals it deems necessary. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(d) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section, in whole or in part, by means of provider bulletins or other similar instructions, without taking regulatory action.

(e) (1) The department may modify any methodology or provision specified in this section to the extent it deems necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure federal financial participation is available or is not otherwise jeopardized, only if that modification does not violate the spirit, purposes, and intent of this section.

(2) If the department determines that a modification is necessary pursuant to paragraph (1), the department shall consult with affected providers and stakeholders to the extent practicable.

SEC. 136. Section 14105.076 is added to the Welfare and Institutions Code, to read:

14105.076. (a) Notwithstanding any other law, for dates of service on or after January 1, 2024, the department shall adopt a rate year based on the calendar year for nursing facilities providing level A services in accordance with Sections 51120 and 51510 of Title 22 of the California Code of Regulations, and intermediate care facilities that are licensed pursuant to subdivision (d) of Section 1250 of the Health and Safety Code.

(b) In implementing this section, the department shall seek any federal approvals it deems necessary. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(c) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section, in whole or in part, by means of provider bulletins or other similar instructions, without taking regulatory action.

SEC. 137. 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).

(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. 138. Section 14105.194 of the Welfare and Institutions Code is amended to read:

14105.194. (a) (1) Notwithstanding Sections 14105.191, 14105.192, and 14105.193, and for dates of service on or after August 1, 2021, the reimbursement rates for freestanding pediatric subacute care units, as defined in Section 51215.8 of Title 22 of the California Code of Regulations, shall be determined without applying any reductions or limitations as set forth under Sections 14105.191, 14105.192, and 14105.193.

(2) For dates of service on or after August 1, 2021, and for each rate year thereafter, the department shall calculate and publish the reimbursement rates, as specified in paragraph (1), plus the projected cost of complying with new state or federal mandates.

(3) For the 2021–22 fiscal year, and for each fiscal year thereafter, the reimbursement rates for freestanding pediatric subacute care units shall account for, and be inclusive of, supplemental payments, as described under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016, or Proposition 56, if the Budget Act of that fiscal year appropriates funds from the Healthcare Treatment Fund, as established pursuant to

subdivision (a) of Section 30130.55 of the Revenue and Taxation Code, to the department to make those supplemental payments to the freestanding pediatric subacute care units.

(4) Effective for dates of service August 1, 2022, to December 31, 2023, inclusive, the reimbursement rates for freestanding pediatric subacute care units shall continue to be the reimbursement rate in effect on August 1, 2022, inclusive of any federally authorized temporary Medicaid payments.

(5) Effective for dates of service on or after January 1, 2024, the department shall adopt a rate year based on the calendar year for freestanding pediatric subacute care units.

(6) Effective for rate years beginning on or after January 1, 2024, the reimbursement rates for freestanding pediatric subacute care units shall be no less than the reimbursement rate, inclusive of the federally authorized temporary increased Medicaid payments or an equivalent amount described in paragraph (4), in effect for that facility on December 31, 2023.

(b) In implementing this section, the department shall seek any federal approvals it deems necessary. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(c) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section, in whole or in part, by means of provider bulletins or other similar instructions, without taking regulatory action.

(d) (1) The department may modify any methodology or provision specified in this section to the extent it deems necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure federal financial participation is available or is not otherwise jeopardized, only if that modification does not violate the spirit, purposes, and intent of this section.

(2) If the department determines that a modification is necessary pursuant to paragraph (1), the department shall consult with affected providers and stakeholders to the extent practicable.

SEC. 139. Section 14105.200 is added to the Welfare and Institutions Code, immediately preceding Section 14105.201, 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 University of California in the amount of seventy-five million dollars ($75,000,000) each calendar year to expand graduate medical education programs, in order to achieve the goal of increasing the number of primary care and specialty care physicians in the state based on demonstrated workforce needs and priorities.

(D) 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.

(E) Effective no sooner than January 1, 2025, increased costs for targeted increases to Medi-Cal payments or other investments pursuant to the plan described in Section 14105.202.

(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 as 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.

SEC. 140. Section 14105.201 is added to the Welfare and Institutions Code, immediately preceding Section 14105.202, 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 (d), whichever is later, the reimbursement rates for the following services, as determined in accordance with subdivision (f), 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 (e).

(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) 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 (a) and (b), 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) For purposes of this section, the following definitions shall apply:

(1) "Medi-Cal managed care plan" has the same meaning as that term is defined in subdivision (j) of Section 14184.101.

(2) "Network provider" has the same meaning as that term is defined in Section 438.2 of Title 42 of the Code of Federal Regulations.

(h) 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. 141. Section 14105.202 is added to the Welfare and Institutions Code, immediately preceding Section 14105.2, to read:

14105.202. (a) The department shall submit to the Legislature, as part of the 2024–25 Governor's Budget, a plan for targeted increases to Medi-Cal payments or other investments as described in subdivision (c) of Section 14105.200. The targeted increases or other investments shall be designed to advance access, quality, and equity for Medi-Cal beneficiaries and promote provider participation in the Medi-Cal program in the following domains, pursuant to criteria established by the department, which may

account for, and be inclusive of, the exemption of applicable services from payment reductions pursuant to Section 14105.192:

(1) (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) Specialty care services.

(3) Community or hospital outpatient procedures and services.

(4) Family planning services and women's health providers.

(5) Hospital-based emergency and emergency physician services.

(6) Ground emergency transport services.

(7) Designated public hospitals, as defined in subdivision (f) of Section 14184.101.

(8) Behavioral health care for beneficiaries in hospital and institutional long-term care settings.

(9) Investments to maintain and grow the health care workforce.

(b) (1) The payments implemented pursuant to subdivision (a) 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, for applicable services as determined by the department, 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 subdivision (a) 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 services identified in subdivision (a), as applicable, 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) are effective.

SEC. 142. Section 14110.8 of the Welfare and Institutions Code is amended to read:

14110.8. (a) For the purposes of this section:

(1) "Facility" means any long-term health care facility as defined in subdivisions (c), (d), (e), (g), and (h) of Section 1250 of the Health and Safety Code.

(2) "Resident" means a person who is a facility resident or patient and a Medi-Cal beneficiary and whose facility care is being paid for in whole or in part by Medi-Cal.

(3) "Agent" means a person who manages, uses, or controls those funds or assets of the resident that legally are required to be used to pay the resident's long-term care patient liability and other charges not paid for by the Medi-Cal program.

(4) "Responsible party" means a person other than the resident or potential resident, who, by virtue of signing or cosigning an admissions agreement of a facility, either together with, or on behalf of, a potential resident, becomes personally responsible or liable for payment of any portion of the charges incurred by the resident while in the facility. A person who signs or cosigns a facility's admissions agreement by virtue of being an agent under a power of attorney for health care or an attorney-in-fact under a durable power of attorney executed by the potential resident, a conservator of the person or estate of the potential resident, or a representative payee, is not a responsible party under this section, and does not thereby assume personal responsibility or liability for payment of any charges incurred by the resident, except to the extent that the person, or the resident's conservator or representative payee is an agent as defined in paragraph (3).

(b) No facility may require or solicit, as a condition of admission into the facility, that a Medi-Cal beneficiary have a responsible party sign or cosign the admissions agreement. No facility may accept or receive, as a condition of admission into the facility, the signature or cosignature of a responsible party for a Medi-Cal beneficiary.

(c) A facility may require, as a condition of admission, where a resident has an agent, that the resident's agent sign or cosign the admissions agreement and agree to distribute to the facility promptly when due, the long-term care patient liability and any other charges not paid for by the Medi-Cal program that the resident or their agent has agreed to pay. The financial obligation of the agent shall be limited to the amount of the resident's funds received but not distributed to the facility. A new agent who did not sign or cosign the admissions agreement shall be held responsible to distribute funds in accordance with this section.

(d) When a resident on non-Medi-Cal status converts to Medi-Cal coverage, any security deposit paid to the facility by the resident or on the resident's behalf as a condition of admission to the facility shall be returned and the obligations and responsibilities of the resident or responsible party during the time period when the resident is covered by Medi-Cal shall be limited to the obligations and responsibilities provided for under the Medi-Cal program. In the event that the resident becomes ineligible for Medi-Cal coverage at any time subsequent to converting to Medi-Cal coverage, the resident and responsible party shall be bound by the terms of the original admission agreement, or any admission agreement in effect at the time the Medi-Cal coverage commenced.

(e) When a resident on non-Medi-Cal status converts to Medi-Cal coverage, the facility shall make a reasonable attempt to assist the resident in contacting the county to obtain an estimate of the resident's long-term care patient liability.

(f) A resident and their agent shall pay to the facility the long-term care patient liability, for which they are responsible under the Medi-Cal program, unless otherwise exempted by law.

(g) If a resident or their agent disputes the amount of the long-term care patient liability owed to a facility, the resident or agent may apply for a state hearing pursuant to Section 10950 for a determination of the amount owed to the facility.

(h) Any agent who willfully violates the requirements of this section is guilty of a misdemeanor, and upon conviction thereof, shall be punished by a fine not to exceed two thousand five hundred dollars ($2,500) or by imprisonment in the county jail not to exceed 180 days, or both.

SEC. 143. Section 14132 of the Welfare and Institutions Code is amended to read:

14132. The following is the schedule of benefits under this chapter:

(a) Outpatient services are covered as follows:

Physician, hospital or clinic outpatient, surgical center, respiratory care, optometric, chiropractic, psychology, podiatric, occupational therapy, physical therapy, speech therapy, audiology, acupuncture to the extent federal matching funds are provided for acupuncture, and services of persons rendering treatment by prayer or healing by spiritual means in the practice of any church or religious denomination insofar as these can be encompassed by federal participation under an approved plan, subject to utilization controls.

(b) (1) Inpatient hospital services, including, but not limited to, physician and podiatric services, physical therapy, and occupational therapy, are covered subject to utilization controls.

(2) For a Medi-Cal fee-for-service beneficiary, emergency services and care that are necessary for the treatment of an emergency medical condition and medical care directly related to the emergency medical condition. This paragraph does not change the obligation of Medi-Cal managed care plans to provide emergency services and care. For the purposes of this paragraph, “emergency services and care” and “emergency medical condition” have the same meanings as those terms are defined in Section 1317.1 of the Health and Safety Code.

(c) Nursing facility services, subacute care services, and services provided by any category of intermediate care facility for the developmentally disabled, including podiatry, physician, nurse practitioner services, and prescribed drugs, as described in subdivision (d), are covered subject to utilization controls. Respiratory care, physical therapy, occupational therapy, speech therapy, and audiology services for patients in nursing facilities and any category of intermediate care facility for persons with developmental disabilities are covered subject to utilization controls.

(d) (1) Purchase of prescribed drugs is covered subject to the Medi-Cal List of Contract Drugs and utilization controls.

(2) Purchase of drugs used to treat erectile dysfunction or any off-label uses of those drugs are covered only to the extent that federal financial participation is available.

(3) (A) To the extent required by federal law, the purchase of outpatient prescribed drugs, for which the prescription is executed by a prescriber in written, nonelectronic form on or after April 1, 2008, is covered only when executed on a tamper resistant prescription form. The implementation of this paragraph shall conform to the guidance issued by the federal Centers for Medicare and Medicaid Services, but shall not conflict with state statutes on the characteristics of tamper resistant prescriptions for controlled substances, including Section 11162.1 of the Health and Safety Code. The department shall provide providers and beneficiaries with as much flexibility in implementing these rules as allowed by the federal government. The department shall notify and consult with appropriate stakeholders in implementing, interpreting, or making specific this paragraph.

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instructions without taking regulatory action.

(4) (A) (i) For the purposes of this paragraph, nonlegend has the same meaning as defined in subdivision (a) of Section 14105.45.

(ii) Nonlegend acetaminophen-containing products, including children's acetaminophen-containing products, selected by the department are covered benefits.

(iii) Nonlegend cough and cold products selected by the department are covered benefits.

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instruction without taking regulatory action.

(e) Outpatient dialysis services and home hemodialysis services, including physician services, medical supplies, drugs, and equipment required for dialysis, are covered, subject to utilization controls.

(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetist services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and x-ray services are covered, subject to utilization controls. This subdivision does not require prior authorization for anesthesiologist services provided as part of an outpatient medical procedure or for portable x-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously

furnished prostheses that are lost or destroyed due to circumstances beyond the beneficiary's control. Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions that preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children's Services program.

(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:

(A) Periodontal treatment is not a benefit.

(B) Endodontic therapy is not a benefit except for vital pulpotomy.

(C) Laboratory processed crowns are not a benefit.

(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.

(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

(F) Notwithstanding the conditions specified in subparagraphs (A) to (E), inclusive, the department may approve services for persons with special medical disorders subject to utilization review.

(3) Paragraph (2) shall become inoperative on July 1, 1995.

(i) Medical transportation is covered, subject to utilization controls.

(j) Home health care services are covered, subject to utilization controls.

(k) (1) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

(2) Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated is covered, subject to utilization controls. If there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.

(3) Therapeutic shoes and inserts are covered when provided to a beneficiary with a diagnosis of diabetes, subject to utilization controls, to the extent that federal financial participation is available.

(*l*) Hearing aids are covered, subject to utilization controls. Utilization controls shall allow replacement of hearing aids necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls shall allow the replacement of durable medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

The utilization controls shall allow authorization of durable medical equipment needed to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian, subject to the availability of federal financial participation. The department shall adopt emergency regulations to define and establish criteria for assistive durable medical equipment in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(n) Family planning services are covered, subject to utilization controls. However, for Medi-Cal managed care plans, utilization controls shall be subject to Section 1367.25 of the Health and Safety Code.

(o) Inpatient intensive rehabilitation hospital services, including respiratory rehabilitation services, in a general acute care hospital are covered, subject to utilization controls, when either of the following criteria are met:

(1) A patient with a permanent disability or severe impairment requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to develop function beyond the limited amount that would occur in the normal course of recovery.

(2) A patient with a chronic or progressive disease requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to maintain the patient's present functional level as long as possible.

(p) (1) Adult day health care is covered in accordance with Chapter 8.7 (commencing with Section 14520).

(2) Commencing 30 days after the effective date of the act that added this paragraph, and notwithstanding the number of days previously approved through a treatment authorization request, adult day health care is covered for a maximum of three days per week.

(3) As provided in accordance with paragraph (4), adult day health care is covered for a maximum of five days per week.

(4) As of the date that the director makes the declaration described in subdivision (g) of Section 14525.1, paragraph (2) shall become inoperative and paragraph (3) shall become operative.

(q) (1) Application of fluoride, or other appropriate fluoride treatment as defined by the department, and other prophylaxis treatment for children 17 years of age and under are covered.

(2) All dental hygiene services provided by a registered dental hygienist, registered dental hygienist in extended functions, and registered dental hygienist in alternative practice licensed pursuant to Sections 1753, 1917, 1918, and 1922 of the Business and Professions Code may be covered as long as they are within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental hygienist, registered dental hygienist in extended functions, or registered dental hygienist in alternative practice.

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under former Article 3 (commencing with Section

1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of former Section 1482 of the article.

(2) A provider enrolled under this subdivision shall satisfy all applicable statutory and regulatory requirements for becoming a Medi-Cal provider.

(3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.

(s) (1) In-home medical care services are covered when medically appropriate and subject to utilization controls, for a beneficiary who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be provided to a patient placed in a shared or congregate living arrangement, if a home setting is not medically appropriate or available to the beneficiary.

(2) As used in this subdivision, "in-home medical care service" includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

(3) As used in this subdivision, in-home medical care services include, but are not limited to:

(A) Level-of-care and cost-of-care evaluations.

(B) Expenses, directly attributable to home care activities, for materials.

(C) Physician fees for home visits.

(D) Expenses directly attributable to home care activities for shelter and modification to shelter.

(E) Expenses directly attributable to additional costs of special diets, including tube feeding.

(F) Medically related personal services.

(G) Home nursing education.

(H) Emergency maintenance repair.

(I) Home health agency personnel benefits that permit coverage of care during periods when regular personnel are on vacation or using sick leave.

(J) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.

(K) Emergency and nonemergency medical transportation.

(L) Medical supplies.

(M) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.

(N) Utility use directly attributable to the requirements of home care activities that are in addition to normal utility use.

(O) Special drugs and medications.

(P) Home health agency supervision of visiting staff that is medically necessary, but not included in the home health agency rate.

(Q) Therapy services.

(R) Household appliances and household utensil costs directly attributable to home care activities.

(S) Modification of medical equipment for home use.

(T) Training and orientation for use of life-support systems, including, but not limited to, support of respiratory functions.

(U) Respiratory care practitioner services as defined in Sections 3702 and 3703 of the Business and Professions Code, subject to prescription by a physician and surgeon.

(4) A beneficiary receiving in-home medical care services is entitled to the full range of services within the Medi-Cal scope of benefits as defined by this section, subject to medical necessity and applicable utilization control. Services provided pursuant to this subdivision, which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with a home- and community-based services waiver.

(t) Home- and community-based services approved by the United States Department of Health and Human Services are covered to the extent that federal financial participation is available for those services under the state plan or waivers granted in accordance with Section 1315 or 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and community-based services approvable under Section 1315 or 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers.

(u) Comprehensive perinatal services, as provided through an agreement with a health care provider designated in Section 14134.5 and meeting the standards developed by the department pursuant to Section 14134.5, subject to utilization controls.

The department shall seek any federal waivers necessary to implement the provisions of this subdivision. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained or for which waivers are not required shall be implemented notwithstanding any inability to obtain federal waivers for the other provisions. No provision of this subdivision shall be implemented unless matching funds from Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are available.

(v) Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(w) Hospice service that is Medicare-certified hospice service is covered, subject to utilization controls. Coverage shall be available only to the extent that no additional net program costs are incurred.

(x) When a claim for treatment provided to a beneficiary includes both services that are authorized and reimbursable under this chapter and services that are not reimbursable under this chapter, that portion of the claim for the treatment and services authorized and reimbursable under this chapter shall be payable.

(y) Home- and community-based services approved by the United States Department of Health and Human Services for a beneficiary with a diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex, who requires intermediate care or a higher level of care.

Services provided pursuant to a waiver obtained from the Secretary of the United States Department of Health and Human Services pursuant to this subdivision, and that are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with the waiver, and subject to the terms, conditions, and duration of the waiver. These services shall be provided to a beneficiary in accordance with the client's needs as identified in the plan of care, and subject to medical necessity and applicable utilization control.

The director may, under this section, contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to an eligible beneficiary. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract Code.

(z) Respiratory care when provided in organized health care systems as defined in Section 3701 of the Business and Professions Code, and as an in-home medical service as outlined in subdivision (s).

(aa) (1) There is hereby established in the department a program to provide comprehensive clinical family planning services to any person who has a family income at or below 200 percent of the federal poverty level, as revised annually, and who is eligible to receive these services pursuant to the waiver identified in paragraph (2). This program shall be known as the Family Planning, Access, Care, and Treatment (Family PACT) Program.

(2) The department shall seek a waiver in accordance with Section 1315 of Title 42 of the United States Code, or a state plan amendment adopted in accordance with Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code, which was added to Section 1396a of Title 42 of the United States Code by Section 2303(a)(2) of the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), for a program to provide comprehensive clinical family planning services as described in paragraph (8). Under the waiver, the program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. Under the state plan amendment, which shall replace the waiver and shall be known as the Family PACT successor state plan amendment, the program shall be operated only in accordance with this subdivision and the statutes and regulations in paragraph (4). The state shall use the standards and processes imposed by the state on January 1, 2007, including the application of an eligibility discount factor to the extent required by the federal Centers for Medicare and Medicaid Services, for purposes of determining eligibility as permitted under Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code. To the extent that federal financial participation is available, the program shall continue to conduct education, outreach, enrollment, service delivery, and evaluation services as specified under the waiver. The

services shall be provided under the program only if the waiver and, when applicable, the successor state plan amendment are approved by the federal Centers for Medicare and Medicaid Services and only to the extent that federal financial participation is available for the services. This section does not prohibit the department from seeking the Family PACT successor state plan amendment during the operation of the waiver.

(3) Solely for the purposes of the waiver or Family PACT successor state plan amendment and notwithstanding any other law, the collection and use of an individual's social security number shall be necessary only to the extent required by federal law.

(4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005, and 24013, and any regulations adopted under these statutes shall apply to the program provided for under this subdivision. No other law under the Medi-Cal program or the State-Only Family Planning Program shall apply to the program provided for under this subdivision.

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, without taking regulatory action, the provisions of the waiver after its approval by the federal Centers for Medicare and Medicaid Services and the provisions of this section by means of an all-county letter or similar instruction to providers. Thereafter, the department shall adopt regulations to implement this section and the approved waiver in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of the act adding this subdivision, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(6) If the Department of Finance determines that the program operated under the authority of the waiver described in paragraph (2) or the Family PACT successor state plan amendment is no longer cost effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no spend down of excess income, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a spend down of excess income or if they are otherwise eligible under Section 24003.

(8) For purposes of this subdivision, "comprehensive clinical family planning services" means the process of establishing objectives for the

number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies, natural family planning, abstinence methods, and basic, limited fertility management. Comprehensive clinical family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Comprehensive clinical family planning services shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that is not incident to the diagnosis of pregnancy. Comprehensive clinical family planning services shall be subject to utilization control and include all of the following:

(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

(B) All United States Department of Agriculture, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.

(C) Culturally and linguistically appropriate health education and counseling services, including informed consent, that include all of the following:

(i) Psychosocial and medical aspects of contraception.

(ii) Sexuality.

(iii) Fertility.

(iv) Pregnancy.

(v) Parenthood.

(vi) Infertility.

(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

(x) Use of contraceptive methods, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies.

(xi) Possible contraceptive consequences and followup.

(xii) Interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(D) A comprehensive health history, updated at the next periodic visit (between 11 and 24 months after initial examination) that includes a complete

obstetrical history, gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.

(E) A complete physical examination on initial and subsequent periodic visits.

(F) Services, drugs, devices, and supplies deemed by the federal Centers for Medicare and Medicaid Services to be appropriate for inclusion in the program.

(G) (i) Home test kits for sexually transmitted diseases, including any laboratory costs of processing the kit, that are deemed medically necessary or appropriate and ordered directly by an enrolled Medi-Cal or Family PACT clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.

(ii) For purposes of this subparagraph, "home test kit" means a product used for a test recommended by the federal Centers for Disease Control and Prevention guidelines or the United States Preventive Services Task Force that has been CLIA-waived, FDA-cleared or -approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting.

(iii) Reimbursement under this subparagraph shall be contingent upon the addition of codes specific to home test kits in the Current Procedural Terminology or Healthcare Common Procedure Coding System to comply with Health Insurance Portability and Accountability Act requirements. The home test kit shall be sent by the enrolled Family PACT provider to a Medi-Cal-enrolled laboratory with fee based on Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule.

(9) In order to maximize the availability of federal financial participation under this subdivision, the director shall have the discretion to implement the Family PACT successor state plan amendment retroactively to July 1, 2010.

(ab) (1) Purchase of prescribed enteral nutrition products is covered, subject to the Medi-Cal list of enteral nutrition products and utilization controls.

(2) Purchase of enteral nutrition products is limited to those products to be administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube. A beneficiary under the Early and Periodic Screening, Diagnostic, and Treatment Program shall be exempt from this paragraph.

(3) Notwithstanding paragraph (2), the department may deem an enteral nutrition product, not administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube, a benefit for patients with diagnoses, including, but not limited to, malabsorption and inborn errors of metabolism, if the product has been shown to be neither investigational nor experimental when used as part of a therapeutic regimen to prevent serious disability or death.

(4) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement the amendments to this subdivision made by the act that added this paragraph by means of all-county letters, provider bulletins, or similar instructions, without taking regulatory action.

(5) The amendments made to this subdivision by the act that added this paragraph shall be implemented June 1, 2011, or on the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later.

(ac) Diabetic testing supplies are covered when provided by a pharmacy, subject to utilization controls.

(ad) (1) Nonmedical transportation is covered, subject to utilization controls and permissible time and distance standards, for a beneficiary to obtain covered Medi-Cal services.

(2) (A) (i) Nonmedical transportation includes, at a minimum, round trip transportation for a beneficiary to obtain covered Medi-Cal services by passenger car, taxicab, or any other form of public or private conveyance, and mileage reimbursement when conveyance is in a private vehicle arranged by the beneficiary and not through a transportation broker, bus passes, taxi vouchers, or train tickets.

(ii) Nonmedical transportation does not include the transportation of a sick, injured, invalid, convalescent, infirm, or otherwise incapacitated beneficiary by ambulance, litter van, or wheelchair van licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations.

(B) Nonmedical transportation shall be provided for a beneficiary who can attest in a manner to be specified by the department that other currently available resources have been reasonably exhausted. For a beneficiary enrolled in a managed care plan, nonmedical transportation shall be provided by the beneficiary's managed care plan. For a Medi-Cal fee-for-service beneficiary, the department shall provide nonmedical transportation when those services are not available to the beneficiary under Sections 14132.44 and 14132.47.

(3) Nonmedical transportation shall be provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the beneficiary and consistent with applicable state and federal disability rights laws.

(4) It is the intent of the Legislature in enacting this subdivision to affirm the requirement under Section 431.53 of Title 42 of the Code of Federal Regulations, in which the department is required to provide necessary transportation, including nonmedical transportation, for recipients to and from covered services. This subdivision shall not be interpreted to add a new benefit to the Medi-Cal program.

(5) The department shall seek any federal approvals that may be required to implement this subdivision, including, but not limited to, approval of revisions to the existing state plan that the department determines are necessary to implement this subdivision.

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

(7) Prior to the effective date of any necessary federal approvals, nonmedical transportation was not a Medi-Cal managed care benefit with the exception of when provided as an Early and Periodic Screening, Diagnostic, and Treatment service.

(8) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. By July 1, 2018, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Commencing January 1, 2018, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(9) This subdivision shall not be implemented until July 1, 2017.

(ae) (1) No sooner than January 1, 2022, Rapid Whole Genome Sequencing, including individual sequencing, trio sequencing for a parent or parents and their baby, and ultra-rapid sequencing, is a covered benefit for any Medi-Cal beneficiary who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit.

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

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

(af) (1) Home test kits for sexually transmitted diseases that are deemed medically necessary or appropriate and ordered directly by an enrolled Medi-Cal clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.

(2) For purposes of this subdivision, “home test kit” means a product used for a test recommended by the federal Centers for Disease Control and Prevention guidelines or the United States Preventive Services Task Force that has been CLIA-waived, FDA-cleared or -approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting.

(3) Reimbursement under this subparagraph shall be contingent upon the addition of codes specific to home test kits in the Current Procedural

Terminology or Healthcare Common Procedure Coding System to comply with Health Insurance Portability and Accountability Act requirements. The home test kit shall be sent by the enrolled Medi-Cal provider to a Medi-Cal-enrolled laboratory with fee based on Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule.

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

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking any further regulatory action.

(ag) (1) Violence prevention services are covered, subject to medical necessity and utilization controls.

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

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

(4) The department shall post on its internet website the date upon which violence prevention services may be provided and billed pursuant to this subdivision.

(5) "Violence prevention services" means evidence-based, trauma-informed, and culturally responsive preventive services provided to reduce the incidence of violent injury or reinjury, trauma, and related harms and promote trauma recovery, stabilization, and improved health outcomes.

SEC. 144. Section 14132.24 of the Welfare and Institutions Code is amended to read:

14132.24. (a) No later than April 1, 2023, and until June 30, 2025, the State Department of Health Care Services shall convene a workgroup to examine the implementation of the doula benefit provided under the Medi-Cal program. The workgroup shall be comprised of doulas, health care providers, consumer and community advocates, health plans, county representatives, and other stakeholders with experience with doula services as determined by the department.

(b) The workgroup shall consider all of the following:

(1) Ensuring that doula services are available to Medi-Cal beneficiaries who are eligible for and want doula services.

(2) Minimizing barriers and delays in payments to a Medi-Cal doula or in reimbursement to Medi-Cal recipients for doula services received.

(3) Making recommendations for outreach efforts so that all Medi-Cal recipients within the eligible and other target populations are aware of the option to use doula services.

(c) (1) No later than July 1, 2025, the department shall publish a report that provides the number of Medi-Cal recipients utilizing doula services, broken down by race, ethnicity, primary language, health plan, and county. The report shall also identify any barriers that impede access to doula services in the prenatal, labor and delivery, and postpartum periods and make recommendations to the department and the Legislature to reduce any identified barriers.

(2) The report shall provide a numerical comparison in the birthing outcomes of Medi-Cal recipients who receive doula services with those who do not, including, but not limited to, rates of cesarean delivery births, maternal or infant mortality, other maternal morbidity, and, to the extent available through information voluntarily provided by the Medi-Cal recipient, breast and chest feeding outcomes.

(3) The report shall utilize standard public health reporting practices for accurate dissemination of these data elements, especially with regard to the reporting of small numbers so as to avoid inadvertently risking a breach of confidentiality or other disclosure.

(4) The department shall post this report on the department's internet website.

(d) This section shall remain in effect only until January, 1, 2026, and as of that date is repealed. The repeal of this section shall not prevent the department from continuing to convene the workgroup referenced in subdivision (a) or issuing reports referenced in subdivision (c), should the department determine that either activity is helpful or necessary in order to monitor, evaluate, or expand access to Medi-Cal doula services.

SEC. 145. Section 14132.56 of the Welfare and Institutions Code is amended to read:

14132.56. (a) (1) Only to the extent required by the federal government and effective no sooner than required by the federal government, behavioral health treatment (BHT) shall be a covered Medi-Cal service for individuals under 21 years of age.

(2) It is the intent of the Legislature that, to the extent the federal government requires BHT to be a covered Medi-Cal service, the department shall seek statutory authority to implement this new benefit in Medi-Cal.

(3) For purposes of this section, "behavioral health treatment" or "BHT" means professional services and treatment programs, including applied behavior analysis (ABA) and evidence-based intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and are administered by the department as described in the approved state plan.

(b) The department shall implement, or continue to implement, this section only after all of the following occurs or has occurred:

(1) The department receives all necessary federal approvals to obtain federal funds for the service.

(2) The department seeks an appropriation that would provide the necessary state funding estimated to be required for the applicable fiscal year.

(3) The department consults with stakeholders.

(c) The department shall develop and define eligibility criteria, provider participation criteria, utilization controls, and delivery system structure for services under this section, subject to limitations allowable under federal law, in consultation with stakeholders.

(d) (1) The department, commencing on the effective date of the act that added this subdivision until March 31, 2017, inclusive, may make available to individuals described in paragraph (2) contracted services to assist those individuals with health insurance enrollment, without regard to whether federal funds are available for the contracted services.

(2) The contracted services described in paragraph (1) may be provided only to an individual under 21 years of age whom the department identifies as no longer eligible for Medi-Cal solely due to the transition of BHT coverage from the waiver program under Section 1915(c) of the federal Social Security Act to the Medi-Cal state plan in accordance with this section and who meets all of the following criteria:

(A) They were enrolled in the home and community-based services waiver for persons with developmental disabilities under Section 1915(c) of the Social Security Act as of January 31, 2016.

(B) They were deemed to be institutionalized in order to establish eligibility under the terms of the waiver.

(C) They have not been found eligible under any other federally funded Medi-Cal criteria without a spend down of excess income.

(D) They have received a BHT service from a regional center for persons with developmental disabilities as provided in Chapter 5 (commencing with Section 4620) of Division 4.5.

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

(f) For the purposes of implementing this section, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis, including contracts for the purpose of obtaining subject matter expertise or other technical assistance. Contracts may be statewide or on a more limited geographic basis. Contracts entered into or amended under this subdivision shall be exempt from Part 2 (commencing with Section 10100) of Division

2 of the Public Contract Code, Section 19130 of the Government Code, and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of the Government Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(g) The department may seek approval of any necessary state plan amendments or waivers to implement this section. The department shall make any state plan amendments or waiver requests public at least 30 days prior to submitting to the federal Centers for Medicare and Medicaid Services, and the department shall work with stakeholders to address the public comments in the state plan amendment or waiver request.

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

SEC. 146. Section 14132.95 of the Welfare and Institutions Code is amended to read:

14132.95. (a) Personal care services, when provided to a categorically needy person as defined in Section 14050.1 is a covered benefit to the extent federal financial participation is available if these services are:

(1) Provided in the beneficiary's home and other locations as may be authorized by the director subject to federal approval.

(2) Authorized by county social services staff in accordance with a plan of treatment.

(3) Provided by a qualified person.

(4) Provided to a beneficiary who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services described in this section.

(b) The department shall seek federal approval of a state plan amendment necessary to include personal care as a Medicaid service pursuant to subdivision (f) of Section 440.170 of Title 42 of the Code of Federal Regulations. For any persons who meet the criteria specified in subdivision (a) or (p), but for whom federal financial participation is not available for a service or services under this section, eligibility for the service or services shall be determined according to the waiver authorized pursuant to Section 14132.951. If federal financial participation for the service or services is not available under this section or Section 14132.951, eligibility for the service or services shall be determined pursuant to Article 7 (commencing with Section 12300) of Chapter 3.

(c) Subdivision (a) shall not be implemented unless the department has obtained federal approval of the state plan amendment described in subdivision (b), and the Department of Finance has determined, and has informed the department in writing, that the implementation of this section will not result in additional costs to the state relative to state appropriation for in-home supportive services under Article 7 (commencing with Section 12300) of Chapter 3, in the 1992–93 fiscal year.

(d) (1) For purposes of this section, personal care services shall mean all of the following:

(A) Assistance with ambulation.
(B) Bathing, oral hygiene and grooming.
(C) Dressing.
(D) Care and assistance with prosthetic devices.
(E) Bowel, bladder, and menstrual care.
(F) Skin care.
(G) Repositioning, range of motion exercises, and transfers.
(H) Feeding and assurance of adequate fluid intake.
(I) Respiration.
(J) Paramedical services.
(K) Assistance with self-administration of medications.

(2) Ancillary services including meal preparation and cleanup, routine laundry, shopping for food and other necessities, and domestic services may also be provided as long as these ancillary services are subordinate to personal care services. Ancillary services may not be provided separately from the basic personal care services.

(e) (1) (A) After consulting with the State Department of Social Services, the department shall adopt emergency regulations to establish the amount, scope, and duration of personal care services available to persons described in subdivision (a) in the fiscal year whenever the department determines that General Fund expenditures for personal care services provided under this section and expenditures of both General Fund moneys and federal funds received under Title XX of the federal Social Security Act for services pursuant to Article 7 (commencing with Section 12300) of Chapter 3, are expected to exceed the General Fund appropriation and the federal appropriation under Title XX of the federal Social Security Act provided for the 1992–93 fiscal year pursuant to Article 7 (commencing with Section 12300) of Chapter 3, as it read on June 30, 1992, as adjusted for caseload growth or as increased in the Budget Act or appropriated by statute. At least 30 days prior to filing these regulations with the Secretary of State, the department shall give notice of the expected content of these regulations to the fiscal committees of both houses of the Legislature.

(B) In establishing the amount, scope, and duration of personal care services, the department shall ensure that General Fund expenditures for personal care services provided for under this section and expenditures of both General Fund moneys and federal funds received under Title XX of the federal Social Security Act for services pursuant to Article 7 (commencing with Section 12300) of Chapter 3, do not exceed the General Fund appropriation and the federal appropriation under Title XX of the federal Social Security Act provided for the 1992–93 fiscal year pursuant to Article 7 (commencing with Section 12300) of Chapter 3, as it read on June 30, 1992, as adjusted for caseload growth or as increased in the Budget Act or appropriated by statute.

(C) For purposes of this subdivision, "caseload growth" means an adjustment factor determined by the department based on (1) growth in the number of persons eligible for benefits under Chapter 3 (commencing with Section 12000) on the basis of their disability, (2) the average increase in

the number of hours in the program established pursuant to Article 7 (commencing with Section 12300) of Chapter 3 in the 1988–89 to 1992–93 fiscal years, inclusive, due to the level of impairment, and (3) any increase in program costs that is required by an increase in the mandatory minimum wage.

(2) In establishing the amount, scope, and duration of personal care services pursuant to this subdivision, the department may define and take into account, among other things:

(A) The extent to which the particular personal care services are essential or nonessential.

(B) Standards establishing the medical necessity of the services to be provided.

(C) Utilization controls.

(D) A minimum number of hours of personal care services that must first be assessed as needed as a condition of receiving personal care services pursuant to this section.

The level of personal care services shall be established so as to avoid, to the extent feasible within budgetary constraints, medical out-of-home placements.

(3) To the extent that General Fund expenditures for services provided under this section and expenditures of both General Fund moneys and federal funds received under Title XX of the federal Social Security Act for services pursuant to Article 7 (commencing with Section 12300) of Chapter 3 in the 1992–93 fiscal year, adjusted for caseload growth, exceed General Fund expenditures for services provided under this section and expenditures of both General Fund moneys and federal funds received under Title XX of the federal Social Security Act for services pursuant to Article 7 (commencing with Section 12300) of Chapter 3 in any fiscal year, the excess of these funds shall be expended for any purpose as directed in the Budget Act or as otherwise statutorily disbursed by the Legislature.

(f) Services pursuant to this section shall be rendered, under the administrative direction of the State Department of Social Services, in the manner authorized in Article 7 (commencing with Section 12300) of Chapter 3, for the In-Home Supportive Services program. A provider of personal care services shall be qualified to provide the service and shall be a person other than a member of the family. For purposes of this section, a family member means a parent of a minor child or a spouse.

(g) The maximum number of hours available under the In-Home Supportive Services program pursuant to Article 7 (commencing with Section 12300) of Chapter 3, Section 14132.951, and this section, combined, shall be 283 hours per month.

(h) Personal care services shall not be provided to residents of facilities licensed by the department, and shall not be provided to residents of a community care facility or a residential care facility for the elderly licensed by the Community Care Licensing Division of the State Department of Social Services.

(i) Subject to any limitations that may be imposed pursuant to subdivision (e), determination of need and authorization for services shall be performed in accordance with Article 7 (commencing with Section 12300) of Chapter 3.

(j) (1) To the extent permitted by federal law, reimbursement rates for personal care services shall be equal to the rates in each county for the same mode of services in the In-Home Supportive Services program pursuant to Article 7 (commencing with Section 12300) of Chapter 3, plus any increase provided in the annual Budget Act for personal care services rates or included in a county budget pursuant to paragraph (2).

(2) (A) The department shall establish a provider reimbursement rate methodology to determine payment rates for the individual provider mode of service that does all of the following:

(i) Is consistent with the functions and duties of entities created pursuant to Section 12301.6.

(ii) Makes any additional expenditure of state general funds subject to appropriation in the annual Budget Act.

(iii) Permits county-only funds to draw down federal financial participation consistent with federal law.

(B) This ratesetting method shall be in effect in time for any rate increases to be included in the annual Budget Act.

(C) The department may, in establishing the ratesetting method required by subparagraph (A), do both of the following:

(i) Deem the market rate for like work in each county, as determined by the Employment Development Department, to be the cap for increases in payment rates for individual practitioner services.

(ii) Provide for consideration of county input concerning the rate necessary to ensure access to services in that county.

(D) If an increase in individual practitioner rates is included in the annual Budget Act, the state-county sharing ratio shall be as established in Section 12306. If the annual Budget Act does not include an increase in individual practitioner rates, a county may use county-only funds to meet federal financial participation requirements consistent with federal law.

(3) (A) By November 1, 1993, the department shall submit a state plan amendment to the federal Health Care Financing Administration to implement this subdivision. To the extent that any element or requirement of this subdivision is not approved, the department shall submit a request to the federal Health Care Financing Administration for any waivers as would be necessary to implement this subdivision.

(B) The provider reimbursement ratesetting methodology authorized by the amendments to this subdivision in the 1993–94 Regular Session of the Legislature shall not be operative until all necessary federal approvals have been obtained.

(k) (1) The State Department of Social Services shall, by September 1, 1993, notify the following persons that they are eligible to participate in the personal care services program:

(A) Persons eligible for services pursuant to the Pickle Amendment, as adopted October 28, 1976.

(B) Persons eligible for services pursuant to subsection (c) of Section 1383c of Title 42 of the United States Code.

(2) The State Department of Social Services shall, by September 1, 1993, notify persons to whom paragraph (1) applies and who receive advance payment for in-home supportive services that they will qualify for services under this section without a spend down of excess income if they elect to accept payment for services on an arrears rather than an advance payment basis.

(*l*) An individual who is eligible for services subject to the maximum amount specified in subdivision (b) of Section 12303.4 shall be given the option of hiring their own provider.

(m) The county welfare department shall inform in writing any individual who is potentially eligible for services under this section of their right to the services.

(n) It is the intent of the Legislature that this entire section be an inseparable whole and that no part of it be severable. If any portion of this section is found to be invalid, as determined by a final judgment of a court of competent jurisdiction, this section shall become inoperative.

(o) Paragraphs (2) and (3) of subdivision (a) shall be implemented so as to conform to federal law authorizing their implementation.

(p) (1) Personal care services shall be provided as a covered benefit to a medically needy aged, blind, or disabled person, as defined in subdivision (a) of Section 14051, to the same extent and under the same requirements as they are provided under subdivision (a) of this section to a categorically needy, aged, blind, or disabled person, as defined in subdivision (a) of Section 14050.1, and to the extent that federal financial participation is available.

(2) The department shall seek federal approval of a state plan amendment necessary to include personal care services described in paragraph (1) as a Medicaid service pursuant to subdivision (f) of Section 440.170 of Title 42 of the Code of Federal Regulations.

(3) In the event that the Department of Finance determines that expenditures of both General Fund moneys for personal care services provided under this subdivision to medically needy aged, blind, or disabled persons together with expenditures of both General Fund moneys and federal funds received under Title XX of the federal Social Security Act for all aged, blind, and disabled persons receiving in-home supportive services pursuant to Article 7 (commencing with Section 12300) of Chapter 3, in the 2000–01 fiscal year or in any subsequent fiscal year, are expected to exceed the General Fund appropriation and the federal appropriation received under Title XX of the federal Social Security Act for expenditures for all aged, blind, and disabled persons receiving in-home supportive services provided in the 1999–2000 fiscal year pursuant to Article 7 (commencing with Section 12300) of Chapter 3, as it read on June 30, 1998, as adjusted for caseload growth or as changed in the Budget Act or by statute or

regulation, then this subdivision shall cease to be operative on the first day of the month that begins after the expiration of a period of 30 days subsequent to a notification in writing by the Director of the Department of Finance to the chairperson of the committee in each house that considers appropriations, the chairpersons of the committees and the appropriate subcommittees in each house that consider the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(4) Solely for purposes of paragraph (3), caseload growth means an adjustment factor determined by the department based on:

(A) Growth in the number of persons eligible for benefits under Chapter 3 (commencing with Section 12000) on the basis of their disability.

(B) The average increase in the number of hours in the program established pursuant to Article 7 (commencing with Section 12300) of Chapter 3 in the 1994–95 to 1998–99 fiscal years, inclusive, due to the level of impairment.

(C) Any increase in program cost that is required by an increase in hourly costs pursuant to the Budget Act or statute.

(5) In the event of a final judicial determination by any court of appellate jurisdiction or a final determination by the Administrator of the federal Centers for Medicare and Medicaid Services that personal care services must be provided to any medically needy person who is not aged, blind, or disabled, then this subdivision shall cease to be operative on the first day of the first month that begins after the expiration of a period of 30 days subsequent to a notification in writing by the Director of Finance to the chairperson of the committee in each house that considers appropriations, the chairpersons of the committees and the appropriate subcommittees in each house that consider the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(6) If this subdivision ceases to be operative, all aged, blind, and disabled persons who would have been eligible to receive services under this section shall be immediately eligible for services under the IHSS Plus waiver authorized pursuant to Section 14132.951, if otherwise eligible, upon this section becoming inoperative. If this section becomes inoperative and a person is ineligible for the IHSS Plus waiver, then eligibility shall be determined under the In-Home Supportive Services program pursuant to Article 7 (commencing with Section 12300) of Chapter 3.

SEC. 147. Section 14132.99 of the Welfare and Institutions Code is amended to read:

14132.99. (a) For the purposes of this section, “facility residents” means individuals who are currently residing in a nursing facility and whose care is paid for by Medi-Cal either with or without a long-term care patient liability. The term “facility residents” also includes individuals who are hospitalized and who are or will be waiting for transfer to a nursing facility.

(b) For those patients who are in acute care hospitals and who are pending placement in a nursing facility, the department shall expedite the processing of waiver applications in order to divert hospital discharges from nursing facilities into the community.

(c) The Nursing Facility/Acute Hospital Transition and Diversion Waiver shall include the following services:

(1) One-time community transition services as defined and allowed by the federal Centers for Medicare and Medicaid Services, including, but not limited to, security deposits that are required to obtain a lease on an apartment or home, essential furnishings, and moving expenses required to occupy and use a community domicile, set-up fees, or deposits for utility or service access, including, but not limited to, telephone, electricity, and heating, and health and safety assurances, including, but not limited to, pest eradication, allergen control, or one-time cleaning prior to occupancy. These costs shall not exceed five thousand dollars ($5,000).

(2) Habilitation services, as defined in Section 1915(c)(5) of the federal Social Security Act (42 U.S.C. Sec. 1396n(c)(5)), and in attachment 3-d to the July 25, 2003, State Medicaid Directors Letter re Olmstead Update No. 3, to mean services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home- and community-based settings.

(d) (1) (A) Notwithstanding paragraphs (1) and (2) of subdivision (d) of Section 12300.4, the department shall grant an exemption, as described in paragraph (2), to a provider of an applicant or participant of the Nursing Facility/Acute Hospital Transition and Diversion Waiver or the In-Home Operations Waiver, or their successors, who was enrolled in either waiver on January 31, 2016, and whose medical or behavioral needs require that the services to the applicant or participant be provided by the requested provider, if any of the following circumstances exists:

(i) The provider lives in the same home as the waiver applicant or participant, even if the provider is not a family member.

(ii) The provider currently provides care to the waiver participant, and has done so for two or more years continuously.

(iii) The waiver applicant or participant is unable to find a local caregiver who speaks the same language as the applicant or participant, resulting in the applicant or participant being unable to direct their own care.

(B) For a waiver participant who enrolls in either waiver after January 31, 2016, the department shall grant a provider an exemption from the workweek requirements described in paragraphs (1) and (2) of subdivision (d) of Section 12300.4 on a case-by-case basis pursuant to paragraph (5).

(2) A provider of in-home supportive services or waiver personal care services who is granted an exemption pursuant to paragraph (1) may work up to a total of 12 hours per day, and up to 360 hours per month combined for the in-home supportive services and waiver personal care services that they provide, not to exceed each waiver participant’s monthly authorized hours.

(3) On a one-time basis upon implementation of this paragraph, the department shall mail an informational notice and an exemption request form to all providers who may be eligible for an exemption pursuant to this subdivision and to the waiver participants to whom the providers provide services.

(4) At the time of initial application, and at least annually, the department shall inform all waiver applicants or participants whose providers may be eligible for an exemption pursuant to this subdivision and their providers about the exemptions and the application process.

(5) (A) The department shall review the requests for consideration for an exemption described in subparagraph (B) of paragraph (1) pursuant to a process developed by the department with input from stakeholders. The department shall consider whether the waiver applicant or participant meets the criteria described in subparagraph (A) of paragraph (1) in making its determination.

(B) Within 30 days of receiving an application for an exemption described in subparagraph (B) of paragraph (1) from a provider and from a waiver applicant or participant on behalf of a provider, the department shall mail a written notification letter to the provider and the waiver applicant or participant for whom the provider provides services of its approval or denial of the exemption. If the department denies the exemption, the department shall also explain in the notification letter the reason for the denial. The department shall use a standardized notification letter, developed by the department in consultation with stakeholders, for purposes of providing the notification letter that is required by this subparagraph.

(6) The department shall record the number of requests for exemptions that are received and the number of requests approved or denied. These numbers shall be posted no later than every three months on the department's internet website.

(e) The department shall implement this section only to the extent it can demonstrate fiscal neutrality within the overall department budget, and federal fiscal neutrality as required under the terms of the federal waiver, and only if the department has obtained the necessary approvals and receives federal financial participation from the federal Centers for Medicare and Medicaid Services.

SEC. 148. Section 14146 of the Welfare and Institutions Code is amended to read:

14146. (a) (1) The department shall work with identified stakeholders to conduct a study to identify current requirements for medical interpretation services as well as education, training, and licensure requirements, analyze other state Medicaid programs, and make recommendations on strategies that may be employed regarding the provision of medical interpretation services for Medi-Cal beneficiaries who are limited English proficient (LEP), in compliance with applicable state and federal requirements.

(2) The study also shall assess and make recommendations based on pilot projects, studies, and available data that would further the objectives of this article, including funding for those activities and the allowable use of federal funding.

(b) (1) The department shall work with identified stakeholders to establish a pilot project concurrent with the study.

(2) A pilot project shall include up to four separate sites to evaluate the provision of medical interpretation services for LEP Medi-Cal beneficiaries

enrolled in Medi-Cal managed care plans and in fee-for-service Medi-Cal. In identifying sites, the department shall take into account the need for those services, the availability of a pool of medical interpreters that meet the language needs of the Medi-Cal population for use by providers and managed care plans, and the studies and available data identified under paragraph (2) of subdivision (a).

(c) (1) The department may use or contract with an external vendor, vendors, or other contracted subject matter experts to implement the activities described in this section, including the pilot project. However, the vendor for the study shall not be used for the pilot project. The department shall consult with identified stakeholders regarding the draft initial scope of work that shall be used to seek and evaluate proposals pursuant to this section.

(2) At a minimum, the pilot project shall be designed to evaluate all of the following:

(A) Whether Medi-Cal beneficiary satisfaction is greater than for those beneficiaries without access to in-person medical interpretation.

(B) Whether the satisfaction of physicians and surgeons, nurse practitioners, physician assistants, and other health professionals acting within their scope of practice increases.

(C) Whether noncompliance with treatment regimens or avoidable medical errors are reduced.

(D) Whether disparities in care are reduced, with respect to LEP Medi-Cal beneficiaries compared with Medi-Cal beneficiaries who are proficient in English.

(E) Whether the Medi-Cal managed care plans identify improvements in quality of care.

(F) The utilization of medical interpreters by providers and Medi-Cal managed care plans.

(d) (1) Each year, commencing in 2017, during the annual state budget process, the department shall provide an update to the budget committees of the Legislature on the implementation of this article.

(2) Any report submitted under this subdivision shall be submitted in compliance with Section 9795 of the Government Code.

(e) (1) For activities under this section, the department may expend up to three million dollars ($3,000,000) under Provision 14 of Item 4260-101-0001 of Section 2.00 of the Budget Act of 2016 (Chapter 23 of the Statutes of 2016) for the support of activities related to a medical interpreters pilot project, study, or both. In addition, the department shall expend up to five million dollars ($5,000,000) for the pilot project under Provision 15 of Item 4260-101-0001 of Section 2.00 of the Budget Act of 2019 (Chapter 23 of the Statutes of 2019), which shall be available for expenditure until June 30, 2025.

(2) The department may seek any available federal funding for support of activities relating to medical interpretation services as provided under this section.

(3) Expenditure or encumbrance of the funds described in this subdivision is contingent upon approval by the Department of Finance.

SEC. 149. Section 14146.5 of the Welfare and Institutions Code is amended to read:

14146.5. This article shall become inoperative on July 1, 2025, and, as of January 1, 2026, is repealed.

SEC. 150. Section 14148.04 of the Welfare and Institutions Code is amended to read:

14148.04. (a) The department shall adopt, as specified in this section, an electronic process for families to enroll a deemed eligible newborn in the Medi-Cal program from hospitals that have elected to participate in the process. The electronic enrollment process adopted pursuant to this section shall be known as the Newborn Hospital Gateway.

(b) With respect to the enrollment of a child under one year of age who is deemed to have applied and is deemed eligible for Medi-Cal benefits under Section 1396a(e)(4) of Title 42 of the United States Code, the enrollment procedures of the Newborn Hospital Gateway shall specifically include procedures for confirming the eligibility of, and issuing a Medi-Cal card to, that child.

(c) In developing the Newborn Hospital Gateway required by this section, the department shall consult with consumer, provider, county, and health plan representatives.

(d) The Newborn Hospital Gateway may not be adopted until both of the following occur:

(1) Sufficient moneys have been deposited in the Special Funds Account of the Gateway Fund to defray the costs of developing the Newborn Hospital Gateway.

(2) Sufficient new staff, not to exceed a total of three personnel years, is available at the department for the purposes of this section and Section 14148.03 and is funded through nonstate General Fund sources. Notwithstanding any other provision of law, the department may hire staff necessary to implement this section.

(e) The department shall implement the Newborn Hospital Gateway within 12 months after the date upon which both of the conditions required under subdivision (d) have occurred.

(f) To implement this section, the department may contract with public or private entities, or utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary, only if services provided under the program are specifically identified and reimbursed in a manner that appropriately claims federal financial reimbursement. Contracts, including the Medi-Cal fiscal intermediary contract for the Child Health and Disability Prevention Program and including any contract amendment, any system change pursuant to a change order, and any project or systems development notice shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, and any policies, procedures, or regulations authorized by these laws.

(g) This section shall become inoperative on 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, and shall be repealed on January 1 directly following that date.

SEC. 151. Section 14148.04 is added to the Welfare and Institutions Code, to read:

14148.04. (a) The department shall adopt, as specified in this section, an electronic process for families to enroll a deemed eligible newborn in the Medi-Cal program from hospitals that have elected to participate in the process. The electronic enrollment process adopted pursuant to this section shall be known as the Newborn Hospital Gateway and shall be accessed through existing presumptive eligibility portals.

(b) All qualified Medi-Cal providers participating in presumptive eligibility programs shall use the Newborn Hospital Gateway system to report a Medi-Cal eligible newborn born in their facilities, including hospitals, birthing centers, or other birthing settings, within 72 hours after birth, or one business day after discharge, whichever is sooner.

(c) With respect to the enrollment of a child under one year of age who is deemed to have applied and is deemed eligible for Medi-Cal benefits under Section 1396a(e)(4) of Title 42 of the United States Code, the enrollment procedures of the Newborn Hospital Gateway shall specifically include procedures for confirming the eligibility of, and issuing a Medi-Cal card to, that child.

(d) In developing the Newborn Hospital Gateway required by this section, the department shall consult with consumer, provider, county, and health plan representatives.

(e) To implement this section, the department may contract with public or private entities, or utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary, only if services provided under the program are specifically identified and reimbursed in a manner that appropriately claims federal financial reimbursement. Contracts, including the Medi-Cal fiscal intermediary contract for presumptive eligibility programs and including any contract amendment, any system change pursuant to a change order, and any project or systems development notice shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, and any policies, procedures, or regulations authorized by these laws.

(f) This section shall become operative on 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.

SEC. 152. Section 14148.5 of the Welfare and Institutions Code is amended to read:

14148.5. (a) State-funded perinatal services shall be provided under the Medi-Cal program to pregnant persons and state-funded medical services to infants up to one year of age in families with incomes above 185 percent, but not more than 208 percent, of the federal poverty level, in the same manner that these services are being provided to the Medi-Cal population, including eligibility requirements and integration of eligibility determinations

and payment of claims. When determining eligibility under this section, an applicant's or beneficiary's income and resources shall be determined, counted, and valued in accordance with the methodology set forth in Section 14005.64.

(b) Services provided under this section shall not be subject to any spend down of excess income requirements.

(c) (1) The department, in implementing the Medi-Cal program and public health programs, in coordination with the Managed Risk Medical Insurance Board's Access for Infants and Mothers component, may provide for outreach activities in order to enhance participation and access to perinatal services. Funding received pursuant to the federal provisions shall be used to expand perinatal outreach activities. These outreach activities shall be implemented if funding is provided for this purpose by an appropriation in the annual Budget Act or other statute.

(2) Those outreach activities authorized by paragraph (1) shall be targeted toward both Medi-Cal and non-Medi-Cal eligible high risk or uninsured pregnant persons and infants. Outreach activities may include, but not be limited to, all of the following:

(A) Education of the targeted persons on the availability and importance of early prenatal care and referral to Medi-Cal and other programs.

(B) Information provided through toll-free telephone numbers.

(C) Recruitment and retention of perinatal providers.

(d) Notwithstanding any other law, contracts required to implement the provisions of this section shall be exempt from the approval of the Director of General Services and from the provisions of the Public Contract Code.

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

SEC. 153. Section 14148.5 is added to the Welfare and Institutions Code, to read:

14148.5. (a) State-funded perinatal services shall be provided under the Medi-Cal program to pregnant persons and state-funded medical services to infants up to one year of age in families with incomes above 185 percent, but not more than 208 percent, of the federal poverty level, in the same manner that these services are being provided to the Medi-Cal population, including eligibility requirements and integration of eligibility determinations and payment of claims. When determining eligibility under this section, an applicant's or beneficiary's income shall be determined, counted, and valued in accordance with the methodology set forth in Section 14005.64.

(b) Services provided under this section shall not be subject to any spend down of excess income requirements.

(c) (1) The department, in implementing the Medi-Cal program and public health programs, may provide for outreach activities in order to enhance participation and access to perinatal services. Funding received pursuant to the federal provisions shall be used to expand perinatal outreach activities. These outreach activities shall be implemented if funding is provided for this purpose by an appropriation in the annual Budget Act or other statute.

(2) Those outreach activities authorized by paragraph (1) shall be targeted toward both Medi-Cal and non-Medi-Cal eligible high risk or uninsured pregnant persons and infants. Outreach activities may include, but not be limited to, all of the following:

(A) Education of the targeted persons on the availability and importance of early prenatal care and referral to Medi-Cal and other programs.

(B) Information provided through toll-free telephone numbers.

(C) Recruitment and retention of perinatal providers.

(d) Notwithstanding any other law, contracts required to implement this section shall be exempt from the approval of the Director of General Services and from the Public Contract Code.

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

SEC. 154. Section 14154.5 of the Welfare and Institutions Code is amended to read:

14154.5. (a) Each county shall work, on a routine basis, any error alert from the department's Medi-Cal Eligibility Data System (MEDS). Any alert that affects eligibility or the spend down of excess income that is received by the 10th working day of the month shall be processed in time for the change to be effective the beginning of the following month. Any alert that affects eligibility or the spend down of excess income that is received after the 10th working day of the month shall be processed in time for the change to be effective the beginning of the month after the following month. The department shall consult with the County Welfare Directors Association to define those alerts that affect eligibility or the spend down of excess income.

(b) The county shall submit reconciliation files of its Medi-Cal eligible population to the department every three months, based upon a schedule determined by the department and in a format prescribed by the department, to identify any discrepancies between eligibility files in the county records and eligibility as reflected in MEDS. Counties shall be notified of any changes to the standard format for submitting reconciliation files sufficiently in advance to allow for budgeting, scheduling, development, testing, and implementation of any required change in county automated eligibility systems.

(c) For those records that are on the county's files, but not on MEDS, the county shall receive worker alerts from the department that identify these cases, and the county shall fix any data discrepancies. Any worker alert received by the 10th working day of the month shall be processed in time for the change to be effective the beginning of the following month. Any worker alert received after the 10th working day of the month shall be processed in time for the change to be effective the beginning of the month after the following month.

(d) In regard to any record that is on MEDS but not on the county's file, the county shall either correct the county record or MEDS, whichever is appropriate, within the same timeframes specified in subdivision (c).

(e) The department shall terminate a MEDS-eligible record if the person is not eligible on the county's file when there has been no eligibility update on the MEDS record for six months.

(f) (1) If the department finds that a county is not performing all of the following activities, the county shall, within 60 days, submit a corrective action plan to the department for approval:

(A) Conducting reconciliations as required in subdivision (b).

(B) Processing 95 percent of worker alerts referred to in subdivisions (c) and (d), within the timeframes specified.

(C) Processing 90 percent of the error alerts referred to in subdivision (a) that affect eligibility or the spend down of excess income, within the timeframes specified.

(2) The corrective action plan shall, at a minimum, include steps that the county shall take to improve its performance on the requirements 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 sanctions.

(g) (1) If the county does not meet the interim benchmarks for improvement standards, the department may, in 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.

(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.

(h) The department, in consultation with the County Welfare Directors Association, shall investigate features that could be installed in MEDS to reduce the number of alerts and streamline the reconciliation process.

(i) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, provider bulletins, or similar instructions. Thereafter, the department may adopt regulations in

accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 155. Section 14169.81 of the Welfare and Institutions Code is amended to read:

14169.81. (a) Notwithstanding Sections 14105.191 and 14105.192, reimbursement for services provided by skilled nursing facilities that are distinct parts of general acute care hospitals shall be determined, for dates of service on or after October 1, 2013, without application of the reductions and limitations set forth in Sections 14105.191 and 14105.192.

(b) For dates of service on or after January 1, 2024, the department shall adopt a rate year based on the calendar year for skilled nursing facilities that are distinct parts of general acute care hospitals, including subacute care units.

(c) In implementing this section, the department shall seek any federal approvals it deems necessary. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of provider bulletins or notices, policy letters, or other similar instructions, without taking regulatory action.

SEC. 156. Section 14184.102 of the Welfare and Institutions Code is amended to read:

14184.102. (a) Consistent with federal law, the department shall seek federal approval for, and implement, the CalAIM initiative, including, but not limited to, all of the following components:

(1) Continuation of the Medi-Cal Managed Care program, described in part in Sections 14184.200 to 14184.208, inclusive, and, elsewhere in this chapter and Chapter 8 (commencing with Section 14200), and which includes any comprehensive risk contract between the department and an individual, organization, or entity 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).

(2) Continuation of the Global Payment Program, described in Section 14184.40, as amended by the act that added this section, and Section 14184.300.

(3) Continuation of the Medi-Cal Specialty Mental Health Services Program, as described in part in Section 14184.400.

(4) Continuation of the Drug Medi-Cal organized delivery system program, as described in part in Section 14184.401.

(5) Behavioral Health Medical Necessity Changes, Payment Reform, Administrative Simplification, and Behavioral Health Quality Improvement Program, as described in Sections 14184.402, 14184.403, 14184.404, and 14184.405.

(6) The State Plan Dental Improvement Program, as described in Section 14184.500.

(7) Enhancing County Oversight and Monitoring, as described in Section 14184.600.

(8) Providing Access and Transforming Health (PATH) Supports, as described in Section 14184.700.

(9) Targeted Pre-Release Medi-Cal Benefits for Qualified Inmates, as described in Section 14184.800.

(b) The department shall report to the Legislature any conflicts between this article and the CalAIM Terms and Conditions, including identification of the specific conflicts and recommendations for conforming language.

(c) The department, as appropriate and to the extent practicable, shall consult with interested stakeholders with regard to implementation of applicable components of CalAIM under subdivision (a) in which they will participate, including, but not limited to, the issuance of departmental guidance pursuant to subdivision (d). Interested stakeholders may include, but need not be limited to, designated public hospitals, district and municipal public hospitals, other local governmental agencies, consumer representatives, and Medi-Cal managed care plans.

(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 article or the CalAIM Terms and Conditions, 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. The department shall make use of appropriate processes to ensure that affected stakeholders 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 related to the applicable CalAIM component are finalized.

(e) For purposes of implementing this article or the CalAIM 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.

(f) The department shall seek any federal approvals it deems necessary to implement CalAIM 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 CalAIM Terms and Conditions, as the department deems necessary. This article shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(g) Consistent with subdivision (b), the director shall report to the Legislature on any recommended amendments to any provision, process, or methodology specified in this article, Article 5.4 (commencing with Section 14180), Article 5.5 (commencing with Section 14184), or other sections of law amended by the act that added this subdivision, to the extent necessary to comply with federal law or the CalAIM Terms and Conditions, to obtain or maintain federal approval, or to ensure federal financial participation is available and not otherwise jeopardized, if the amendment is consistent with the goals set forth in this article and its individual components, and does not significantly alter the relative level of support for participating entities. If the director, after consulting with those entities participating in the applicable CalAIM component and that would be affected by that amendment, determines that the potential amendment would be consistent with the goals set forth in this article and would not significantly alter the relative level of support for affected participating entities, the amendment shall be submitted to the Legislature for its consideration.

(h) During the course of the CalAIM term, the department may develop and implement successor payment methodologies or programs to continue to support entities participating in one or more components of CalAIM following the expiration of the CalAIM term and that further the goals set forth in this article. The department shall consult with the entities participating in the payment methodologies or program components under CalAIM, affected stakeholders, and the Legislature in the development of any successor payment methodologies or program components pursuant to this subdivision.

(i) The department may seek to extend the payment methodologies or programs described in this article, or in the CalAIM Terms and Conditions, including modification thereto, through the CalAIM term or to subsequent time periods by way of amendment or extension of the relevant CalAIM Terms and Conditions, amendment to the Medi-Cal State Plan, or any combination thereof, consistent with the applicable federal requirements. This subdivision shall only be implemented after consultation with the entities participating in, or affected by, those methodologies or programs, and only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(j) Notwithstanding any other state or local law, including, but not limited to, Section 5328 of this code, and Sections 11812 and 11845.5 of the Health and Safety Code, the sharing of health, social services, housing, and criminal justice information, records, and other data with and among the department, other state departments, including the State Department of Public Health and the State Department of Social Services, Medi-Cal managed care plans, Medi-Cal behavioral health delivery systems, counties, health care providers, social services organizations, care coordination and case management teams, and other authorized provider or plan entities, and contractors of all of those entities, shall be permitted to the extent necessary to implement applicable CalAIM components described in this article and the CalAIM Terms and Conditions, and to the extent consistent with federal law. The department

shall issue guidance identifying permissible data-sharing arrangements to implement CalAIM.

(k) (1) Notwithstanding any other law, and to the extent authorized by the CalAIM Terms and Conditions, the department may claim federal financial participation for expenditures associated with the designated state health programs identified in the CalAIM Terms and Conditions for use solely by the department as specified in this subdivision.

(2) Any federal financial participation claimed pursuant to paragraph (1) shall be used to offset applicable General Fund expenditures. These amounts are hereby appropriated to the department and shall be available for transfer to the General Fund for this purpose.

(3) An amount of General Fund moneys equal to the federal financial participation that may be claimed pursuant to paragraph (1) is hereby appropriated to the Health Care Deposit Fund for use by the department for purposes of implementing this article.

(4) (A) Notwithstanding any other law, the department shall maintain reimbursement rates in the Medi-Cal program for primary care, obstetric care, and behavioral health services, and shall increase reimbursement rates for those service codes, as necessary to meet federally imposed minimum requirements specified in the CalAIM Terms and Conditions for dates of service on or after January 1, 2024, to the extent required by the federal Centers for Medicare and Medicaid Services as a condition of claiming federal financial participation for designated state health programs as described in this subdivision.

(B) To the extent required by the CalAIM Terms and Conditions, subparagraph (A) shall apply to claims for the identified codes paid by the department in fee-for-service and to claims paid by a Medi-Cal managed care plan.

SEC. 157. Section 14184.200 of the Welfare and Institutions Code is amended to read:

14184.200. (a) Notwithstanding any other law, the department may standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, subject to a Medi-Cal managed care plan readiness, continuity of care transition plan, and disenrollment process developed in consultation with stakeholders, in accordance with the CalAIM Terms and Conditions and as described in this section.

(1) (A) The department shall ensure the Medi-Cal managed care plan's readiness for network adequacy includes a geographic access review of rural ZIP Codes to ensure time or distance standards are met, or alternative access standard requests are approved, as applicable, and the plan's ability to meet existing federal and state mandatory provider type requirements, where available.

(B) The department shall not require a population to enroll in managed care if Medi-Cal managed care plans fail to meet the Medi-Cal managed care plan readiness requirements detailed in this paragraph for that population.

(2) The Medi-Cal managed care plan shall comply with the continuity of care requirements in Section 1373.96 of the Health and Safety Code and shall be consistent with and no more restrictive than existing or future policy and guidance issued by the department, including All Plan Letter 22-032, any superseding all plan letter, and related guidance.

(3) The disenrollment process for an enrollee in any county shall be consistent with and no more restrictive than existing federal and state statutes and regulations, including Section 53889 and subdivision (c) of Section 53891 of Title 22 of the California Code of Regulations. The beneficiary may request a medical exemption from mandatory enrollment in a Medi-Cal managed care plan in accordance with Section 53887 of Title 22 of the California Code of Regulations and may disenroll or be exempted from mandatory enrollment under the limited circumstances set forth in subdivision (c) of Section 53891 of Title 22 of the California Code of Regulations. That disenrollment or exemption from mandatory enrollment in a Medi-Cal managed care plan shall be consistent with subsection (c) of Section 438.56 of Title 42 of the Code of Federal Regulations and applicable state law.

(b) (1) Notwithstanding any other law, if the department standardizes those populations subject to mandatory enrollment in a Medi-Cal managed care plan pursuant to subdivision (a), commencing January 1, 2022, and subject to subdivision (f) of Section 14184.102, a non-dual-eligible beneficiary, except a beneficiary identified in paragraph (2), shall be required to enroll, or shall continue to be required to enroll, in a Medi-Cal managed care plan for purposes of their receipt of covered Medi-Cal benefits.

(2) Notwithstanding any other law, if the department standardizes those populations subject to mandatory enrollment in a Medi-Cal managed care plan pursuant to subdivision (a), commencing January 1, 2022, subject to subdivision (f) of Section 14184.102, the following dual and non-dual beneficiary groups, as identified by the department, shall be exempt from mandatory enrollment in a Medi-Cal managed care plan:

(A) A beneficiary eligible for only restricted-scope Medi-Cal benefits, as described in subdivision (d) of Section 14007.5.

(B) A beneficiary made eligible on the basis of a share of cost, including, but not limited to, a non-dual-eligible beneficiary residing in a county that is authorized to operate a county organized health system (COHS), as described in Article 2.8 (commencing with Section 14087.5), except for a non-dual-eligible beneficiary that is eligible on the basis of their need for long-term care services with a share of cost, as identified by the department.

(C) A beneficiary made eligible on the basis of a federally approved Medi-Cal Presumptive Eligibility program, as determined by the department, but only during the relevant period of presumptive eligibility.

(D) An eligible beneficiary who is an inmate of a public institution, or who is released pursuant to Section 26605.6 or 26605.7 of the Government Code.

(E) A beneficiary with satisfactory immigration status, including a noncitizen that is lawfully present, who is eligible for only pregnancy-related

Medi-Cal coverage and who received services through the Medi-Cal fee-for-service delivery system prior to January 1, 2022, as identified by the department, but only through the end of the postpartum period.

(F) A beneficiary without satisfactory immigration status or who is unable to establish satisfactory immigration status as required by Section 14011.2, who is eligible for only pregnancy-related Medi-Cal coverage, excluding a beneficiary enrolled in the Medi-Cal Access Program described in Chapter 2 (commencing Section 15810) of Part 3.3.

(G) A non-dual-eligible beneficiary who is an Indian, as defined in subdivision (a) of Section 438.14 of Title 42 of the Code of Federal Regulations, and who elects to forego voluntary enrollment in a Medi-Cal managed care plan.

(H) A non-dual-eligible beneficiary eligible on the basis of their receipt of services through a state foster care program, or eligible pursuant to Section 14005.28, who elects to forego voluntary enrollment in a Medi-Cal managed care plan, except for a non-dual beneficiary described in this subparagraph who resides in a county that is authorized to operate COHS, as described in Article 2.8 (commencing with Section 14087.5), or, effective January 1, 2025, in a county operating a Single Plan model of managed care established under Article 2.7 (commencing with Section 14087.3) and Article 2.8 (commencing with Section 14087.5). For the purpose of this subdivision, the following requirements shall apply to non-dual-eligible beneficiaries eligible on the basis of their receipt of services through a state foster care program, or eligible pursuant to Section 14005.28, who are transitioning to mandatory enrollment in a Medi-Cal managed care plan in a county operating a Single Plan model of managed care:

(i) Medi-Cal managed care plans shall comply with the access requirements in Section 14197 and in accordance with All Plan Letter 23-001, any superseding all plan letter, and any related guidance.

(ii) The department shall use the Intercounty Transfer process as outlined in All County Welfare Directors Letter 18-02E to provide for immediate access to care and treatment services in the month of enrollment when a beneficiary moves from one county to another.

(iii) The department shall issue guidance with input from stakeholders, including county child welfare departments.

(I) A non-dual-eligible beneficiary enrolled with an entity with a contract with the department pursuant to the Program of All-Inclusive Care for the Elderly (PACE), as described in Chapter 8.75 (commencing with Section 14591).

(J) Any other non-dual-eligible beneficiary, as identified by the department, for whom federal law prohibits mandatory enrollment in a Medi-Cal managed care plan.

(K) A beneficiary residing in one of the Veterans' Homes of California, as described in Chapter 1 (commencing with Section 1010) of Division 5 of the Military and Veterans Code.

(c) (1) Notwithstanding any other law, if the department standardizes those populations subject to mandatory enrollment in a Medi-Cal managed

care plan pursuant to subdivision (a), commencing January 1, 2023, and subject to subdivision (f) of Section 14184.102, a dual eligible beneficiary, except as provided in paragraph (2) of subdivision (b) or paragraph (2) of this subdivision, shall be required to enroll, or shall continue to be required to enroll, in a Medi-Cal managed care plan for purposes of their receipt of covered Medi-Cal benefits.

(2) The following dual eligible beneficiary groups, as identified by the department, shall be exempt from mandatory enrollment in Medi-Cal managed care as described in paragraph (1):

(A) A dual eligible beneficiary made eligible on the basis of a share of cost, including, but not limited to, a dual eligible beneficiary residing in a county that is authorized to operate COHS, as described in Article 2.8 (commencing with Section 14087.5), except for a dual eligible beneficiary who is eligible on the basis of their need for long-term care services with a share of cost, as determined by the department.

(B) A dual eligible beneficiary enrolled with an entity with a contract with the department pursuant to PACE as described in Chapter 8.75 (commencing with Section 14591).

(C) A dual eligible beneficiary enrolled with an entity with a Senior Care Action Network (SCAN) contract with the department.

(D) A dual eligible beneficiary who is an Indian, as defined in subsection (a) of Section 438.14 of Title 42 of the Code of Federal Regulations, and who elects to forego voluntary enrollment in a Medi-Cal managed care plan.

(E) A dual eligible beneficiary with HIV/AIDS who elects to forego voluntary enrollment in a Medi-Cal managed care plan.

(F) A dual eligible beneficiary eligible on the basis of their receipt of services through a state foster care program, or eligible pursuant to Section 14005.28, who elects to forego voluntary enrollment in a Medi-Cal managed care plan, except for a dual beneficiary described in this subparagraph who resides in a county that is authorized to operate COHS, as described in Article 2.8 (commencing with Section 14087.5), or, effective January 1, 2025, in a county operating a Single Plan model of managed care established under Article 2.7 (commencing with Section 14087.3) and Article 2.8 (commencing with Section 14087.5). For the purpose of this subdivision, the following requirements shall apply to non-dual-eligible beneficiaries eligible on the basis of their receipt of services through a state foster care program, or eligible pursuant to Section 14005.28, who are transitioning to mandatory enrollment in a Medi-Cal managed care plan in a county operating a Single Plan model of managed care:

(i) Medi-Cal managed care plans shall comply with the access requirements in Section 14197 and in accordance with All Plan Letter 23-001, any superseding all plan letter, and any related guidance.

(ii) The department shall use the Intercounty Transfer process as outlined in All County Welfare Directors Letter 18-02E to provide for immediate access to care and treatment services in the month of enrollment when a beneficiary moves from one county to another.

(iii) The department shall issue guidance with input from stakeholders, including county child welfare departments.

(G) A dual eligible beneficiary residing in one of the Veterans' Homes of California, as described in Chapter 1 (commencing with Section 1010) of Division 5 of the Military and Veterans Code.

(H) Any other dual eligible beneficiary, as identified by the department, for whom federal law prohibits mandatory enrollment in a Medi-Cal managed care plan.

(d) (1) This section shall not prohibit a Medi-Cal beneficiary from receiving covered benefits on a temporary basis through the Medi-Cal fee-for-service delivery system pending enrollment into an individual Medi-Cal managed care plan in accordance with this section and the CalAIM Terms and Conditions.

(2) This section shall not prohibit certain Medi-Cal beneficiaries eligible for full-scope benefits under the Medi-Cal State plan, as identified by the department, from voluntarily enrolling in a Medi-Cal managed care plan, in accordance with the CalAIM Terms and Conditions.

(e) (1) No later than January 1, 2023, in all non-County Organized Health System counties, in areas where a PACE plan is available, the PACE plan shall be presented as an enrollment option, included in enrollment materials, and made available to an applicable beneficiary whenever enrollment choices and options are presented. Outreach and enrollment materials shall enable a Medi-Cal beneficiary to understand what PACE provides, that, if eligible, they may be assessed for PACE eligibility and enroll in PACE, and how they can receive additional information and request to be assessed for PACE eligibility. A person meeting the age qualifications for PACE and who chooses PACE shall not be assigned to a Medi-Cal managed care plan for the lesser of 60 days or until they are assessed for eligibility for PACE and determined not to be eligible for PACE. A person enrolled in a PACE plan shall receive all Medicare and Medi-Cal services from the PACE plan pursuant to the three-way agreement between the PACE plan, the department, and the federal Centers for Medicare and Medicaid Services.

(2) In areas of the state where a presentation on Medi-Cal managed care plan enrollment options is unavailable, the department, or its contracted vendor, shall provide informational, outreach, and enrollment materials about the PACE program.

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

(1) "Dual eligible beneficiary" means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or both, and is eligible for medical assistance under the Medi-Cal State Plan. For purposes of this article, "dual eligible beneficiary" shall include both a "full-benefit dual eligible beneficiary" and a "partial-benefit dual eligible beneficiary," as those terms are defined in this subdivision.

(2) "Full-benefit dual eligible beneficiary" means an individual 21 years or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.), Medicare Part B (42 U.S.C. Sec. 1395j et seq.), and Medicare

Part D (42 U.S.C. Sec. 1395w-101), and is eligible for medical assistance under the Medi-Cal State Plan.

(3) "Non-dual-eligible beneficiary" means an individual eligible for medical assistance under the Medi-Cal State plan, as determined by the department, that is not eligible for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.).

(4) "Partial-benefit dual eligible beneficiary" means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.), but not Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or who is enrolled for Medicare Part B (42 U.S.C. Sec. 1395j et seq.), but not Medicare Part A (42 U.S.C. Sec. 1395c et seq.), and is eligible for medical assistance under the Medi-Cal State Plan.

SEC. 158. Section 14184.201 of the Welfare and Institutions Code is amended to read:

14184.201. (a) Notwithstanding any other law, the department shall standardize those applicable covered Medi-Cal benefits provided by Medi-Cal managed care plans under comprehensive risk contracts with the department on a statewide basis and across all models of Medi-Cal managed care in accordance with this section and the CalAIM Terms and Conditions.

(b) (1) Notwithstanding any other law, commencing January 1, 2023, subject to subdivision (f) of Section 14184.102, the department shall include, or continue to include, skilled nursing facility services as capitated benefits in the comprehensive risk contract with each Medi-Cal managed care plan.

(2) For contract periods from January 1, 2023, to December 31, 2025, inclusive, during which paragraph (1) is implemented, each Medi-Cal managed care plan shall reimburse a network provider furnishing skilled nursing facility services to a Medi-Cal beneficiary enrolled in that plan, and each network provider of skilled nursing facility services shall accept the payment amount the network provider of skilled nursing facility services would be paid for those services in the Medi-Cal fee-for-service delivery system, as defined by the department in the Medi-Cal State Plan and guidance issued pursuant to subdivision (d) of Section 14184.102. For contract periods commencing on or after January 1, 2026, during which paragraph (1) is implemented, the department may elect to continue the payment requirement described in this paragraph, subject to subdivision (f) of Section 14184.102.

(3) For contract periods during which paragraph (1) is implemented, capitation rates paid by the department to a Medi-Cal managed care plan shall be actuarially sound and shall account for the payment levels described in paragraph (2) as applicable. The department may require Medi-Cal managed care plans and network providers of skilled nursing facility services to submit information the department deems necessary to implement this subdivision, at the times and in the form and manner specified by the department.

(c) (1) Notwithstanding any other law, commencing January 1, 2024, subject to subdivision (f) of Section 14184.102, the department shall include, or continue to include, institutional long-term care services not described

in subdivision (b) as capitated benefits in the comprehensive risk contract with each Medi-Cal managed care plan.

(2) For contract periods from January 1, 2024, to December 31, 2025, inclusive, during which paragraph (1) is implemented, each Medi-Cal managed care plan shall reimburse a network provider furnishing institutional long-term care services not described in subdivision (b) to a Medi-Cal beneficiary enrolled in that plan, and each network provider of institutional long-term care services not described in subdivision (b) shall accept the payment amount the network provider of institutional long-term care services would be paid for those services in the Medi-Cal fee-for-service delivery system, as defined by the department in the Medi-Cal State Plan and guidance issued pursuant to subdivision (d) of Section 14184.102. For contract periods commencing on or after January 1, 2026, during which paragraph (1) is implemented, the department may elect to continue the payment requirement described in this paragraph, subject to subdivision (f) of Section 14184.102.

(3) For contract periods during which paragraph (1) is implemented, capitation rates paid by the department to a Medi-Cal managed care plan shall be actuarially sound and shall account for the payment levels described in paragraph (2), as applicable. The department may require Medi-Cal managed care plans and network providers of institutional long-term care services to submit information the department deems necessary to implement this subdivision, at the times and in the form and manner specified by the department.

(4) The department shall convene, in collaboration with the State Department of Developmental Services (DDS), a workgroup to address transition of intermediate care facility/developmentally disabled (ICF/DD) facilities, and Intermediate Care Facility for the Developmentally Disabled-Nursing (ICF/DD-N) and Intermediate Care Facility for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes from the Medi-Cal fee-for-service delivery system to the Medi-Cal managed care delivery system to ensure a smooth transition to CalAIM.

(d) (1) Notwithstanding any other law, commencing January 1, 2022, the department shall include donor and recipient organ transplant surgeries, as described in Section 14132.69 and in the CalAIM Terms and Conditions, and donor and recipient bone marrow transplants, as described in Section 14133.8 and in the CalAIM Terms and Conditions, as capitated benefits in the comprehensive risk contract with each Medi-Cal managed care plan.

(2) For contract periods from January 1, 2022, to December 31, 2024, inclusive, during which paragraph (1) is implemented, each applicable Medi-Cal managed care plan shall reimburse a provider furnishing organ or bone marrow transplant surgeries to a Medi-Cal beneficiary enrolled in that plan, and each provider of organ or bone marrow transplant surgeries shall accept the payment amount the provider of organ or bone marrow transplant surgeries would be paid for those services in the Medi-Cal fee-for-service delivery system, as defined by the department in the Medi-Cal State Plan and guidance issued pursuant to subdivision (d) of Section

14184.102. For contract periods commencing on or after January 1, 2025, during which paragraph (1) is implemented, the department may elect to continue the payment requirement described in this paragraph, subject to subdivision (f) of Section 14184.102.

(3) For contract periods during which paragraph (1) is implemented, capitation rates paid by the department to a Medi-Cal managed care plan shall be actuarially sound and shall account for the payment levels described in paragraph (2) as applicable. The department may require Medi-Cal managed care plans and providers of organ or bone marrow transplant surgeries to submit information the department deems necessary to implement this subdivision, at the times and in the form and manner specified by the department.

(e) (1) Notwithstanding any other law, commencing January 1, 2022, Community-Based Adult Services (CBAS), as described in Section 14186.3, shall continue to be available as a capitated benefit for a qualified Medi-Cal beneficiary under a comprehensive risk contract with an applicable Medi-Cal managed care plan, in accordance with the CalAIM Terms and Conditions.

(2) CBAS shall only be available as a covered Medi-Cal benefit for a qualified Medi-Cal beneficiary under a comprehensive risk contract with an applicable Medi-Cal managed care plan. Medi-Cal beneficiaries who are eligible for CBAS shall enroll in an applicable Medi-Cal managed care plan in order to receive those services, except for beneficiaries exempt from mandatory enrollment in a Medi-Cal managed care plan pursuant to the CalAIM Terms and Conditions and Section 14184.200.

(3) CBAS shall be delivered in accordance with applicable state and federal law, including, but not limited to, the federal home and community-based settings regulations set forth in Sections 441.301(c)(4), 441.530(a)(1), and 441.710(a)(1) of Title 42 of the Code of Federal Regulations, and related subregulatory guidance and any amendment issued thereto.

(4) For contract periods during which paragraph (1) is implemented, each applicable Medi-Cal managed care plan shall reimburse a network provider furnishing CBAS to a Medi-Cal beneficiary enrolled in that plan, and each network provider of CBAS shall accept the payment amount the network provider of CBAS would be paid for the service in the Medi-Cal fee-for-service delivery system, as defined by the department in guidance issued pursuant to subdivision (d) of Section 14184.102, unless the Medi-Cal managed plan and network provider mutually agree to reimbursement in a different amount.

(5) For contract periods during which paragraph (1) is implemented, capitation rates paid by the department to an applicable Medi-Cal managed care plan shall be actuarially sound and shall account for the payment levels described in paragraph (4) as applicable. The department may require applicable Medi-Cal managed care plans and network providers of CBAS to submit information the department deems necessary to implement this subdivision, at the times and in the form and manner specified by the department.

(f) Notwithstanding any other law, including, but not limited to, subdivision (a), the department may not transfer responsibility for specialty mental health services in the Counties of Sacramento and Solano from the Medi-Cal managed care plan responsible for those services on July 1, 2022, in those counties until no sooner than all of the following requirements have been met:

(1) The requirements of Section 14184.403 have been implemented.

(2) Each county and Medi-Cal managed care plan has submitted to the department a transition plan that contains provisions for continuity of care or the transfer of care.

(3) Notice has been provided to affected beneficiaries, including the ability of beneficiaries to request continuity of care pursuant to mental health and substance use disorder information notices issued by the department.

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

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

(2) "Institutional long-term care services" has the same meaning as set forth in the CalAIM Terms and Conditions and, subject to subdivision (f) of Section 14184.102, includes at a minimum all of the following:

(A) Skilled nursing facility services.

(B) Subacute facility services.

(C) Pediatric subacute facility services.

(D) Intermediate care facility services.

(3) "Network provider" has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

SEC. 159. Section 14184.403 of the Welfare and Institutions Code is amended to read:

14184.403. (a) Notwithstanding any other law, commencing no sooner than July 1, 2022, subject to subdivision (f) of Section 14184.102, each Medi-Cal behavioral health delivery system shall comply with the behavioral health payment reform provisions approved in the CalAIM Terms and Conditions and any associated instruction issued by the department pursuant to subdivision (d) of Section 14184.102.

(b) As a component of Behavioral Health Payment Reform under CalAIM, the department shall, at a minimum, design and implement an intergovernmental transfer-based reimbursement methodology to replace the use of certified public expenditures for claims associated with covered Specialty Mental Health and Drug Medi-Cal services provided through Medi-Cal behavioral health delivery systems.

(c) Notwithstanding any other law, commencing no sooner than July 1, 2022, the nonfederal share of any payments associated with each Medi-Cal behavioral health delivery system shall consist of voluntary intergovernmental transfers of funds provided by eligible governmental agencies or public entities associated with a respective Medi-Cal behavioral health delivery system. Upon providing any intergovernmental transfer of funds, each transferring entity shall certify that the transferred funds qualify for federal financial participation pursuant to Section 433.51 of Title 42 of

the Code of Federal Regulations, any other applicable federal Medicaid laws, and the CalAIM Terms and Conditions, 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 state and federal laws. Notwithstanding any other law, the department shall not assess the fee described in subdivision (d) of Section 14301.4 or any other similar fee on the intergovernmental transfers made pursuant to this section. The total intergovernmental transfer-funded payment amount, which includes the federal and nonfederal share, paid to a Medi-Cal behavioral health delivery system shall be for the support of behavioral health-related services and activities that benefit patients served by the Medi-Cal behavioral health delivery system, consistent with federal law.

(d) (1) The department shall establish and implement prospective reimbursement rate methodologies utilizing past county cost experience for covered Specialty Mental Health and Drug Medi-Cal services provided by Medi-Cal behavioral health delivery systems. Those methodologies shall make use of peer groups whereby counties are grouped according to past cost experience, where the department determines appropriate. The department shall determine the frequency of payments and intergovernmental transfers made pursuant to this section. The department shall consult with the representatives of Medi-Cal behavioral health delivery systems in the development of the rate methodologies, peer groups, and the payment schedule.

(2) The department, in consultation with the representatives of Medi-Cal behavioral health delivery systems, shall review and may modify the methodologies annually, including, but not limited to, adjustments to the peer groups or to rates.

(e) (1) The Medi-Cal County Behavioral Health Fund is hereby created in the State Treasury.

(2) The nonfederal moneys collected by the department pursuant to this section shall be deposited in the Medi-Cal County Behavioral Health Fund.

(3) Notwithstanding Section 13340 of the Government Code, the moneys deposited in the Medi-Cal County Behavioral Health Fund are continuously appropriated, without regard to fiscal year, to the department for purposes of implementing this section.

(4) (A) Notwithstanding any other law, for counties that elect to participate in the offset and transfer of funds pursuant to this paragraph, moneys from the following sources shall be offset and transferred by the Controller into the Medi-Cal County Behavioral Health Fund pursuant to schedules, in accordance with subparagraph (C), provided by the department and created in consultation with the Department of Finance and applicable counties:

(i) The Behavioral Health Subaccount in the Support Services Account in the Local Revenue Fund 2011 established pursuant to subparagraph (B) of paragraph (2) of subdivision (b) of Section 30025 of the Government Code.

(ii) The Mental Health Subaccount in the Sales Tax Account in the Local Revenue Fund established pursuant to paragraph (1) of subdivision (b) of Section 17600.

(iii) The Mental Health Services Fund established pursuant to Section 5890.

(B) To the extent that funds are offset and transferred from the subaccounts or fund listed in subparagraph (A), the use of the funds shall be consistent with, and in furtherance of, the purposes for which they were previously deposited to the subaccounts or fund, as applicable.

(C) (i) If the department prepares monthly schedules, it shall provide the schedules to the Controller by the first day of each month. If the department prepares quarterly schedules, it shall provide the schedules to the Controller detailing offsets for each month in that quarter by the first day of each quarter as agreed upon by the department, the Department of Finance, and the Controller.

(ii) The department shall provide notifications to the Controller to start, stop, or resume offsetting funds by the first day of the month for changes expected to take effect in the current month. Notifications received by the Controller after the first day of the month shall be processed in the subsequent month.

(5) Notwithstanding Section 16305.7 of the Government Code, the Medi-Cal County Behavioral Health Fund shall contain all interest and dividends earned on moneys in the fund and shall be used only for the purpose of implementing this section.

SEC. 160. Section 14717.1 of the Welfare and Institutions Code is amended to read:

14717.1. (a) (1) For purposes of this section, “foster child” or “foster children” means a Medi-Cal eligible child or children younger than 21 years of age who have been placed into foster care by a county child welfare agency or a county probation department.

(2) It is the intent of the Legislature to ensure that foster children who are placed outside of their county of original jurisdiction are able to access specialty mental health services in a timely manner, consistent with their individual strengths and needs and the requirements of federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

(3) It is the further intent of the Legislature to overcome any barriers to care that may result when responsibility for providing or arranging for specialty mental health services to foster children who are placed outside of their county of original jurisdiction is retained by the county of original jurisdiction.

(b) In order to facilitate the receipt of medically necessary specialty mental health services by a foster child who is placed outside of their county of original jurisdiction, the California Health and Human Services Agency shall coordinate with the department and the State Department of Social Services to take all of the following actions on or before July 1, 2017:

(1) The department shall issue policy guidance on the conditions for, and exceptions to, presumptive transfer, as described in subdivisions (c) and

(d), in consultation with the State Department of Social Services and with the input of stakeholders that include the County Welfare Directors Association of California, the Chief Probation Officers of California, the County Behavioral Health Directors Association of California, provider representatives, and family and youth advocates.

(2) Policy guidance concerning the conditions for, and exceptions to, presumptive transfer shall ensure all of the following:

(A) The transfer of responsibility improves access to specialty mental health care services consistent with the mental health needs of the foster child.

(B) Presumptive transfer does not disrupt the continuity of care.

(C) Conditions and exceptions are applied consistently statewide, giving due consideration to the varying capabilities of small, medium, and large counties.

(D) Presumptive transfer can be waived only with an individualized determination that an exception applies.

(E) A party to the case who disagrees with the presumptive transfer individualized exception determination made by the county placing agency pursuant to subdivision (d) is afforded an opportunity to request judicial review before a transfer or exception being finalized.

(F) There is a procedure for expedited transfer within 48 hours of placement of the child outside of the county of original jurisdiction.

(c) For purposes of this section, "presumptive transfer" means that absent any exceptions as established pursuant to this section, responsibility for providing or arranging for specialty mental health services shall promptly transfer from the county of original jurisdiction to the county in which the foster child resides, under either of the following conditions:

(1) A foster child is placed in a county other than the county of original jurisdiction on or after July 1, 2017.

(2) A foster child who resides in a county other than the county of original jurisdiction after June 30, 2017, and is not receiving specialty mental health services consistent with their mental health needs, requests transfer of responsibility. A foster child who resided in a county other than the county of original jurisdiction after June 30, 2017, and who continues to reside outside the county of original jurisdiction after December 31, 2017, shall have jurisdiction transferred no later than the child's first regularly scheduled status review hearing conducted pursuant to Section 366 in the 2018 calendar year unless an exception described under subdivision (d) applies.

(d) (1) On a case-by-case basis, and when consistent with the medical rights of children in foster care, presumptive transfer may be waived and the responsibility for the provision of specialty mental health services shall remain with the county of original jurisdiction if any of the exceptions described in paragraph (5) exist.

(2) A request for waiver in a manner established by the department may be made by the foster child, the person or agency that is responsible for making mental health care decisions on behalf of the foster child, the county probation agency or the child welfare services agency with responsibility

for the care and placement of the child, or any other interested party who owes a legal duty to the child involving the child's health or welfare, as defined by the department.

(3) The county probation agency or the child welfare services agency with responsibility for the care and placement of the child, in consultation with the child and their parent, the child and family team, as defined in paragraph (4) of subdivision (a) of Section 16501, if one exists, and other professionals who serve the child as appropriate, is responsible for determining whether waiver of the presumptive transfer is appropriate pursuant to the conditions and exceptions established under this section. The person who requested the exception, along with any other parties to the case, shall receive notice of the county agency's determination.

(4) The individual who requested the exception or any other party to the case who disagrees with the determination made by the county agency pursuant to paragraph (3) may request judicial review before the county's determination becoming final. The court may set the matter for hearing and may confirm or deny the transfer of jurisdiction or application of an exception based on the best interest of the child.

(5) Presumptive transfer may be waived under any of the following exceptions:

(A) It is determined that the transfer would disrupt continuity of care or delay access to services provided to the foster child.

(B) It is determined that the transfer would interfere with family reunification efforts documented in the individual case plan.

(C) The foster child's placement in a county other than the county of original jurisdiction is expected to last less than six months.

(D) The foster child's residence is within 30 minutes of travel time to the child's established specialty mental health care provider in the county of original jurisdiction.

(6) A waiver processed based on an exception to presumptive transfer shall be contingent upon the mental health plan in the county of original jurisdiction demonstrating an existing contract with a specialty mental health care provider, or the ability to enter into a contract, single case agreement, or other service payment mechanism within 30 days of the waiver decision, and the ability to deliver timely specialty mental health services directly to the foster child. That information shall be documented in the child's case plan.

(7) A request for waiver, the exceptions claimed as the basis for the request, a determination whether a waiver is determined to be appropriate under this section, and any objections to the determination shall be documented in the foster child's case plan pursuant to Section 16501.1.

(e) If the mental health plan in the county of original jurisdiction has completed an assessment of needed services for the foster child, the mental health plan in the county in which the foster child resides shall accept that assessment. The mental health plan in the county in which the foster child resides may conduct additional assessments if the foster child's needs change

or an updated assessment is needed to determine the child's needs and identify the needed treatment and services to address those needs.

(f) (1) Upon presumptive transfer, the mental health plan in the county in which the foster child resides shall assume responsibility for the authorization and provision of specialty mental health services and payments for services. The foster child transferred to the mental health plan in the county in which the foster child resides shall be considered part of the county of residence caseload for claiming purposes from the Behavioral Health Subaccount and the Behavioral Health Services Growth Special Account, both created pursuant to Section 30025 of the Government Code.

(2) To support service delivery, continuity of care, and timely payment, the placing agency shall provide notification to the mental health plan that will be responsible for arranging and providing specialty mental health services for the foster child before placing a foster child out of county. The placing agency may complete these notifications through email. If notification before placement is not possible, the placing agency shall notify the appropriate mental health plan no later than three business days after making the out-of-county placement.

(g) The State Department of Social Services and the department shall adopt regulations by July 1, 2027, to implement this section. 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 State Department of Social Services and the department may implement and administer the changes made by this legislation through all-county letters, information notices, or similar written instructions until regulations are adopted.

(h) (1) If the department determines it is necessary, it shall seek approval from the United States Department of Health and Human Services, federal Centers for Medicare and Medicaid Services before implementing this section.

(2) If the department makes the determination that it is necessary to seek federal approval pursuant to paragraph (1), the department shall make an official request for approval from the federal government no later than January 1, 2017.

(i) This section shall be implemented only if, and to the extent that, federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is available and all necessary federal approvals have been obtained.

(j) Commencing July 1, 2024, in the case of placement of foster children in short-term residential therapeutic programs, community treatment facilities, or group homes, or in the case of admission of foster children to children's crisis residential programs, this section shall apply only if the circumstances described in paragraph (1) or (2) of subdivision (b) of Section 14717.2 exist.

SEC. 161. Section 14717.2 of the Welfare and Institutions Code is amended to read:

14717.2. (a) (1) For purposes of this section, "foster child" or "foster children" means a Medi-Cal eligible child or children younger than 21 years of age who have been placed into foster care by a county child welfare agency or a county probation department.

(2) It is the intent of the Legislature to ensure that foster children who are placed in community treatment facilities, group homes, or short-term residential therapeutic programs, or who are admitted to children's crisis residential programs, outside of their county of original jurisdiction, are able to access specialty mental health services in a timely manner, consistent with their individual strengths and needs and the requirements of federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

(3) The Legislature finds that because group home placements or short-term residential therapeutic program placements are intended to be short term, and because community treatment facility placements and children's crisis residential program admissions are intended to be time-limited based on medical necessity, the responsibility for the provision of or arrangement for specialty mental health services for a foster child throughout the short-term or time-limited placement or admission shall remain with the county of original jurisdiction.

(4) The Legislature intends that the placement of a foster child in a group home, community treatment facility, or short-term residential therapeutic program, or the admission of the child to a children's crisis residential program outside of the county of original jurisdiction should not disrupt continuity of care or adversely impact timely payment to the provider of specialty mental health services.

(b) Commencing July 1, 2024, a foster child's county of original jurisdiction shall retain responsibility to arrange and provide specialty mental health services if the foster child is placed out of the county of original jurisdiction in a community treatment facility, group home, or short-term residential therapeutic program, or is admitted to a children's crisis residential program, as these settings are defined in paragraph (8), (13), (18), or (21), respectively, of subdivision (a) of Section 1502 of the Health and Safety Code, unless either of the following circumstances exist:

(1) The case plan for the foster child specifies that the child will transition to a less restrictive placement in the same county as the facility in which the child has been placed.

(2) The placing agency determines, as informed by the child and family team, as defined in paragraph (4) of subdivision (a) of Section 16501, that the child will be negatively impacted if responsibility for providing or arranging for specialty mental health services is not transferred to the same county as the facility in which the child has been placed. The placing agency shall document the basis for making this determination in the child's case record and may include in a child and family team meeting the mental health plan of the receiving county where the facility is located. It is the intent of the Legislature to encourage local coordination with the receiving county mental health plan.

(c) If the circumstances in paragraph (1) or (2) of subdivision (b) exist, the process for presumptive transfer of responsibility for arranging and providing specialty mental health services set forth in Section 14717.1 shall apply.

(d) (1) To support service delivery, continuity of care, and timely payment, the placing agency shall provide notification to the mental health plan that will be responsible for arranging and providing specialty mental health services for the foster child before placing a foster child out of county in a community treatment facility, group home, or short-term residential therapeutic program, or admitting a foster child to a children's crisis residential program. The placing agency may complete these notifications through email. If notification before placement or admission is not possible, the placing agency shall notify the appropriate mental health plan no later than three business days after making the out-of-county placement.

(2) Upon accepting placement or admission of a foster child, a group home, short-term residential therapeutic program, community treatment facility, or children's crisis residential program may notify the mental health plan that will be responsible for arranging and providing specialty mental health services for the foster child that the foster child has been admitted to a children's crisis residential program or placed in a group home, short-term residential therapeutic program, or community treatment facility.

(e) If the circumstances in paragraph (1) or (2) of subdivision (b) exist at any point during the foster child's placement or admission out of county, Section 14717.1 shall apply.

(f) The placing agency shall document which mental health plan is responsible for providing or arranging for specialty mental health services.

(g) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department and the State Department of Social Services 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 similar written instructions, until regulations are adopted.

(2) By July 1, 2027, the department and the State Department of Social Services shall adopt regulations 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.

(h) (1) If the department determines it is necessary, it shall seek approval from the United States Department of Health and Human Services, federal Centers for Medicare and Medicaid Services before implementing this section.

(2) If the department makes the determination that it is necessary to seek federal approval pursuant to paragraph (1), the department shall make an official request for approval from the federal government no later than July 1, 2025.

(i) This section shall be implemented only if, and to the extent that, federal financial participation under Title XIX of the federal Social Security

Act (42 U.S.C. Sec. 1396 et seq.) is available and all necessary federal approvals have been obtained.

SEC. 162. Section 15832 of the Welfare and Institutions Code, as amended by Section 136 of Chapter 47 of the Statutes of 2022, is amended to read:

15832. (a) To be eligible to participate in the program, a person shall meet all of the requirements in either paragraph (1) or (2):

(1) (A) Be a woman who is pregnant or in her postpartum period as specified in Section 15840 and who is a resident of the state. A person who is a member of a federally recognized California Indian tribe is a resident of the state for these purposes.

(B) Have a household income that is above 208 percent of the official federal poverty level but does not exceed 317 percent of the official federal poverty level.

(C) Agree to the payment of the complete subscriber contribution. A federally recognized California Indian tribal government may make the subscriber contributions on behalf of a member of the tribe only if a contribution on behalf of members of federally recognized California Indian tribes does not limit or preclude federal financial participation under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.). If a federally recognized California Indian tribal government makes a contribution on behalf of a member of the tribe, the tribal government shall ensure that the subscriber is made aware of all the health care delivery options available in the county where the member resides.

(2) (A) Be a child under two years of age who is delivered by a mother enrolled in the program under this chapter. Except as stated in this section, these infants shall be automatically enrolled in the program.

(B) For the applicable month, not be enrolled in employer-sponsored health care coverage, or have been enrolled in that health care coverage in the prior three months or enrolled in full-scope Medi-Cal without a share of cost. Exceptions may be identified in regulations or other guidance and shall, at minimum, include all exceptions applicable to the Healthy Families Program on and after March 23, 2010.

(C) Be subject to subscriber contributions as determined by the department.

(3) For infants identified in paragraph (2), all of the following shall apply:

(A) Enrollment in the program shall cover the first 12 months of the infant's life unless the infant is determined eligible for Medi-Cal benefits under Section 14005.26. An infant shall be screened for eligibility under Section 14005.26 immediately after the infant is born. If the infant is eligible under Section 14005.26, the infant shall be automatically enrolled in the Medi-Cal program on that basis.

(B) (i) At the end of the 12 months, as a condition of continued eligibility, the subscriber shall provide income information. The infant shall be disenrolled from the program if the annual household income exceeds 317 percent of the federal poverty level, or if the infant is eligible for full-scope Medi-Cal with no share of cost.

(ii) Effective January 1, 2014, when determining eligibility for benefits under the program, income shall be determined, counted, and valued in accordance with the requirements of Section 1397bb(b)(1)(B) of Title 42 of the United States Code as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148) and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

(C) At the end of their first and second year in the program, infants shall be screened for eligibility for the Medi-Cal program.

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

(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) If the conditions described in paragraph (1) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2025, or the date certified by the department pursuant to paragraph (2) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

SEC. 163. Section 15832 of the Welfare and Institutions Code, as added by Section 137 of Chapter 47 of the Statutes of 2022, is amended to read:

15832. (a) To be eligible to participate in the program, a person shall meet all of the requirements in either paragraph (1) or (2):

(1) (A) Be a person who is pregnant or in the postpartum period as specified in Section 15840 and who is a resident of the state. A person who is a member of a federally recognized California Indian tribe is a resident of the state for these purposes.

(B) Have a household income that is above 208 percent of the official federal poverty level but does not exceed 317 percent of the official federal poverty level.

(C) Agree to the payment of the complete subscriber contribution. A federally recognized California Indian tribal government may make the subscriber contributions on behalf of a member of the tribe only if a contribution on behalf of members of federally recognized California Indian tribes does not limit or preclude federal financial participation under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.). If a federally recognized California Indian tribal government makes a contribution on behalf of a member of the tribe, the tribal government shall ensure that the subscriber is made aware of all the health care delivery options available in the county where the member resides.

(2) (A) Be a child under two years of age who is delivered by a mother enrolled in the program under this chapter. Except as stated in this section, these infants shall be automatically enrolled in the program.

(B) For the applicable month, not be enrolled in employer-sponsored health care coverage, or have been enrolled in that health care coverage in the prior three months or enrolled in full-scope Medi-Cal without a share of cost. Exceptions may be identified in regulations or other guidance and shall, at minimum, include all exceptions applicable to the Healthy Families Program on and after March 23, 2010.

(C) Be subject to subscriber contributions as determined by the department.

(3) For infants identified in paragraph (2), all of the following shall apply:

(A) Enrollment in the program shall cover the first 12 months of the infant's life unless the infant is determined eligible for Medi-Cal benefits under Section 14005.26. An infant shall be screened for eligibility under Section 14005.26 immediately after the infant is born. If the infant is eligible under Section 14005.26, the infant shall be automatically enrolled in the Medi-Cal program on that basis.

(B) (i) At the end of the 12 months, the infant shall remain continuously eligible for the Medi-Cal program until they are five years of age. A redetermination of Medi-Cal eligibility shall not be conducted before the child reaches five years of age, except as specified in Section 14005.255. This clause shall be implemented to the extent that any necessary federal approvals are obtained and federal financial participation is available. The department shall seek any necessary federal approvals to implement this clause.

(ii) Effective January 1, 2014, when determining eligibility for benefits under the program, income shall be determined, counted, and valued in accordance with the requirements of Section 1397bb(b)(1)(B) of Title 42 of the United States Code as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148) and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

(C) At the end of their first and second year in the program, and subsequent years, up to five years of age, the child shall be screened for eligibility for the Medi-Cal program.

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

(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) This section shall become operative on January 1, 2025, or the date certified by the department pursuant to paragraph (2) of subdivision (b), whichever is later.

SEC. 164. The Legislature finds and declares that the amendments made by this act to Section 14184.403 of the Welfare and Institutions Code are consistent with, and further the intent of, the Mental Health Services Act.

SEC. 165. 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. 166. (a) Notwithstanding any other law, the following amounts shall revert to the General Fund on June 30, 2023:

(1) Fifteen million dollars ($15,000,000) of the amount appropriated for Nursing Initiative Grants in Provision 5 of Item 4140-101-0001 of the Budget Act of 2022 (as amended by Ch. 45, Stats. 2022).

(2) Three million five hundred thousand dollars ($3,500,000) of the amount appropriated for the Social Work Initiative in Provision 5 of Item 4140-101-0001 of the Budget Act of 2022 (as amended by Ch. 45, Stats. 2022).

(3) Twenty-three million five hundred thousand dollars ($23,500,000) of the amount appropriated for Addiction Psychiatric/Medicine Fellowships in Provision 11 of Item 4140-101-0001 of the Budget Act of 2022 (as amended by Ch. 45, Stats. 2022).

(4) Twenty-six million dollars ($26,000,000) of the amount appropriated for University/College Behavioral Health Workforce grants in Provision 12 of Section 130 of Item 4140-101-0001 of the Budget Act of 2022 (as amended by Ch. 45, Stats. 2022).

(b) The total program funding allocations as follows are reflected in the General Fund and Mental Health Services Fund appropriations in the Budget Act of 2023, as allocated by the Department of Health Care Access and Information from the appropriate fund source for these services:

(1) Seventy million dollars ($70,000,000) for Nursing Initiative Grants.

(2) Fifteen million dollars ($15,000,000) for Community Health Workers Initiative Grants.

(3) Fifty-one million nine hundred thousand dollars ($51,900,000) for the Social Work Initiative.

(4) Forty-eight million five hundred thousand dollars ($48,500,000) for Addiction Psychiatric/Medicine Fellowships.

(5) Fifty-two million dollars ($52,000,000) for University/college Behavioral Health Workforce grants.

(6) Thirty million dollars ($30,000,000) for Masters in Social Work Slots at Public Universities/Colleges.

(7) Fifteen million dollars ($15,000,000) for Song-Brown Program Nurses.

(8) Seven million dollars ($7,000,000) for psychiatry local public behavioral health programs.

(9) Seven million dollars ($7,000,000) for psychiatry State Department of State Hospitals behavioral health programs.

(c) The Budget Act of 2023 provides fifty-seven million five hundred thousand dollars ($57,500,000) each year for the 2024–25 fiscal year and 2025–26 fiscal year for Community Health Workers Initiative Grants.

SEC. 167. (a) Notwithstanding any other law, the Director of Finance may authorize a loan from the General Fund, in a combined sum not to exceed two hundred million dollars ($200,000,000), through an allocation made pursuant to paragraphs (1) and (2), and subject to subdivision (b), for administration by the Department of Health Care Access and Information, and for use by qualified hospitals for the purpose of strengthening the foundation of the Medi-Cal program and supporting a robust health care delivery system.

(1) The Director of Finance may authorize a loan from the General Fund to the Distressed Hospital Loan Program Fund, as established in Section 129385 of the Health and Safety Code, in an amount not to exceed one hundred fifty million dollars ($150,000,000), as part of the combined sum, for the Distressed Hospital Loan Program.

(2) The Director of Finance may authorize a loan from the General Fund to the Small and Rural Hospital Relief Fund, as established in Section 130077 of the Health and Safety Code, in an amount not to exceed fifty million dollars ($50,000,000), as part of the combined sum, for the Small and Rural Hospital Relief Program.

(b) A loan authorized pursuant to subdivision (a) shall meet all of the following criteria, as applicable:

(1) The loan is to meet cash needs resulting from the delay in federal approval for the revised Managed Care Organization Provider Tax under Article 7.1 (commencing with Section 14199.80) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(2) The loan is short term and is repaid by June 30, 2024.

(3) Interest charges may be waived pursuant to subdivision (e) of Section 16314 of the Government Code.

(4) To expedite funds awarded to qualified hospitals and avoid potential delays, the Director of Finance shall notify the Joint Legislative Budget Committee within 10 business days prior to authorizing a loan.

(5) In the case of paragraph (1) of subdivision (a), the funds are used by the California Health Facilities Finance Authority to make loans to qualified hospitals pursuant to subdivision (c) of Section 129385 of the Health and Safety Code.

SEC. 168. Sections 55, 137, 139, 140, 141, and 167 of this bill shall become operative only if Assembly Bill 119 or Senate Bill 119 of the 2023–24 Regular Session is enacted and takes effect on or before July 1, 2023.

SEC. 169. 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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