WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000 - 18999.98] *(Division 9 added by Stats. 1965, Ch. 1784.)*

PART 3. AID AND MEDICAL ASSISTANCE [11000 - 15771] *(Part 3 added by Stats. 1965, Ch. 1784.)*

CHAPTER 7.5. Protect Access to Health Care Act of 2024 [14199.100 - 14199.136] *(Chapter 7.5 added November 5, 2024, by initiative Proposition 35, Sec. 1.)*

ARTICLE 7. Definitions [14199.128- 14199.128.] *(Article 7 added November 5, 2024, by initiative Proposition 35, Sec. 1.)*

14199.128. Definitions

For purposes of this chapter, as used in both the singular and plural form, the following definitions shall apply:

(a) “Abortion” has the same meaning as set forth in subdivision (a) of Section 123464 of the Health and Safety Code.

(b) “Acute psychiatric hospital” has the same meaning as set forth in subdivision (b) of Section 1250 of the Health and Safety Code.

(c) “Advanced practice clinicians and allied health care professionals” shall be defined by the department, subject to the stakeholder input requirements of Section 14199.121, to include appropriate health profession careers.

(d) “Article 7.1” means Article 7.1 (commencing with Section 14199.80) of Chapter 7, as added by Chapter 13 of the Statutes of 2023.

(e) “Base data source” means the most recent available quarterly financial statement filings or annual enrollment data submitted by health plans to the Department of Managed Health Care for that updated base year, retrieved by the department, and supplemented by, as necessary, Medi-Cal enrollment data for the updated base year as maintained by the department, and as modified by the department to account for known or anticipated contracting changes that will affect Medi-Cal enrollment.

(f) “Base year” means a 12-month period running from January 1 through December 31 of a calendar year selected by the department. The department may elect to update the base year to the extent it deems necessary to meet the requirements of federal statute or regulations, to obtain or maintain federal approval, or to ensure federal financial participation is available or is not otherwise jeopardized.

(g) “Bona fide labor-management cooperation committee” or “bona fide LMCC” means a joint labor-management committee that is established pursuant to the federal Labor Management Cooperation Act of 1978 (29 U.S.C. Sec. 175a) and meets the following criteria:

(1) The bona fide LMCC is not involved in the governance of a health care entity but exists to promote worker training, workforce expansion, and support for workers during training.

(2) The bona fide LMCC has the following composition:

(A) Fifty percent of the committee consists of representatives of organized labor unions that represent health workers in the state.

(B) Fifty percent of the committee consists of representatives of health care employers that primarily serve Medi-Cal patients located in the state.

(h) “CalHealthCares Program” means the Medi-Cal Physicians and Dentists Loan Repayment Program Act established pursuant to Section 14114.

(i) “California Affordable Drug Manufacturing Act of 2020” means the program established pursuant to Chapter 10 (commencing with Section 127690) of Part 2 of Division 107 of the Health and Safety Code.

(j) “Clinic” means any of the following:

(1) Federally qualified health centers (FQHC), including FQHC look-alike clinics designated by the federal Health Resources and Services Administration as meeting FQHC program requirements as set forth in Sections 1395x(aa)(4)(B) and 1396d(1)(2)(B) of Title 42 of the United States Code.

(2) Rural health clinics (RHC) meeting the definition set forth in Section 1396d(l)(1) of Title 42 of the United States Code.

(3) Clinics licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code.

(4) Tribal clinics exempt from licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code.

(5) Intermittent clinics exempt from licensure pursuant to subdivision (h) of Section 1206 of the Health and Safety Code.

(6) Clinics exempt from licensure pursuant to subdivision (b) of Section 1206 of the Health and Safety Code. If clinics exempt from licensure pursuant to subdivision (b) of Section 1206 of the Health and Safety Code choose to participate in a directed payment program described in Section 14199.120.5, the directed payment program will use the “classes of provider” functionality at a minimum to create a tier for those clinics and allow for payments to those clinics to be based on an amount allocated to their class’s pool.

(7) Indian health clinics that provide services in California pursuant to the Indian Health Program, as set forth in Chapter 4 (commencing with Section 124575) of Part 4 of Division 106 of the Health and Safety Code.

(k) “Committee” or “stakeholder advisory committee” means the Protect Access to Health Care Act Stakeholder Advisory Committee established pursuant to Section 14199.129.

(l) “Community-based organization” means a nonprofit organization of demonstrated effectiveness that is representative of a community or significant segments of a community and promotes access to, or provides physical or mental health or related services to, individuals in the community.

(m) “Community health worker” shall have the same meaning as defined in paragraph (1) of subdivision (b) of Section 14132.36.

(n) “Community provider” means a holder of a certificate described in Section 2050 of the Business and Professions Code who serves Medi-Cal patients.

(o) “Comprehensive clinical family planning services” means the services set forth in subdivision (aa) of Section 14132.

(p) “Countable enrollee” means an individual enrolled in a health plan during a month of the base year according to the base data source. “Countable enrollee” does not include an individual enrolled in a Medicare plan, a plan-to-plan enrollee, or an individual enrolled in a health plan pursuant to the Federal Employees Health Benefits Act of 1959 (Public Law 86-382) to the extent the imposition of the tax under Article 6 (commencing with Section 14199.123) of this chapter or Article 7.1 (commencing with Section 14199.80) of Chapter 7 is preempted pursuant to Section 8909(f) of Title 5 of the United States Code.

(q) “County mental health plan” means an entity or local agency that contracts with the department to provide covered specialty mental health services pursuant to Section 14184.400 and Chapter 8.9 (commencing with Section 14700).

(r) “Department” means the State Department of Health Care Services.

(s) “Designated public hospital system” means a designated public hospital as defined in paragraph (1) of subdivision (f) of Section 14184.10 and its affiliated governmental providers and contracted governmental and nongovernmental entities that constitute a hospital and health care system. A single designated public hospital system may include multiple designated public hospitals under common government ownership.

(t) (1) “Directed payment” means a payment arrangement whereby the department directs certain expenditures made by a Medi-Cal managed care plan that is approved by the federal Centers for Medicare and Medicaid Services as described in Section 438(c) of Title 42 of the Code of Federal Regulations, established pursuant to Section 438(c) of Title 42 of the Code of Federal Regulations, or otherwise required by the Medi-Cal managed care plan contract, and documented in a rate certification approved by the federal Centers for Medicare and Medicaid Services as applicable.

(2) References in this subdivision to Section 438(c) of Title 42 of the Code of Federal Regulations shall include any subsequent amendments thereto.

(u) “Director” means the director of the State Department of Health Care Services.

(v) “Emergency air ambulance transport” means emergency medical transportation by air, as described in paragraph (1) of subdivision (c) of Section 51323 of Title 22 of the California Code of Regulations, by air ambulance, as defined in Section 100280 of Title 22 of the California Code of Regulations.

(w) “Family PACT” means the Family Planning, Access, Care, and Treatment Program established pursuant to subdivision (aa) of Section 14132.

(x) “Family planning services and family planning-related services in the Medi-Cal program” means the services covered by the Medi-Cal program pursuant to subdivision (n) of Section 14132.

(y) “Family planning services in the State-Only Family Planning Program” means the services covered by that program pursuant to Division 24 (commencing with Section 24000).

(z) “Fund” means the Protect Access to Health Care Fund established in the State Treasury pursuant to Section 14199.103.

(aa) “General acute care hospital” has the same meaning as in subdivision (a) of Section 1250 of the Health and Safety Code.

(ab) “Ground emergency medical transports” means emergency medical transports, as defined in Section 14129, that originate from a 911 call center or equivalent public safety answering point.

(ac) “Health care service plan” or “health plan” means a health care service plan, other than a plan that provides only specialized or discount services, that is licensed by the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) or a Medi-Cal managed care plan contracted with the department to provide full-scope Medi-Cal services.

(ad) “Medi-Cal patient” means a Medi-Cal beneficiary as defined in Section 14252.

(ae) “Medi-Cal enrollee” means an individual enrolled in a health plan, as defined in subdivision (ac), who is a Medi-Cal patient for whom the department directly pays the health plan a capitated payment.

(af) “Medi-Cal managed care plan” means any individual, organization, or entity that enters into a comprehensive risk contract with the department to provide covered full-scope health care services to enrolled Medi-Cal patients pursuant to this chapter or Chapter 8 (commencing with Section 14200).

(ag) “Medi-Cal per enrollee tax amount” means the amount of tax assessed per countable Medi-Cal enrollee within a Medi-Cal taxing tier.

(ah) “Medi-Cal taxing tier” means a range of cumulative enrollment of countable Medi-Cal enrollees for the base year.

(ai) “Net reimbursement” or “net reimbursement levels” means the total payments to Medi-Cal providers for the applicable services and procedures received as of January 1, 2024, less any amounts financed by Medi-Cal providers as the nonfederal share of those payments via provider taxes or fees, certified public expenditures, or intergovernmental transfers.

(aj) “Network provider” has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(ak) “Other enrollee” means an individual enrolled in a health plan who is not a Medi-Cal enrollee.

(al) “Other per enrollee tax amount” means the amount of tax assessed per countable other enrollee within an other taxing tier.

(am) “Other taxing tier” means a range of cumulative enrollment of countable other enrollees for the base year.

(an) “Plan-to-plan enrollee” means an individual who receives their health care services through a health plan pursuant to a subcontract from another health plan.

(ao) “Primary care” has the same meaning as in Section 51170.5 of Title 22 of the California Code of Regulations.

(ap) “Private ground emergency medical transport provider” means a provider of ground emergency medical transports that does not meet the definition of paragraph (1) of subdivision (a) of Section 14105.945.

(aq) “Qualified family planning provider” means a Medi-Cal provider that meets all of the following conditions:

(1) Is a community clinic licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code.

(2) Is enrolled in the Family PACT program, as described in subdivision (aa) of Section 14132.

(3) Provides both abortion and contraception services.

(ar) “Specialist” means a physician or surgeon or other licensee pursuant to the Medical Practice Act (Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code) or the Osteopathic Act (Chapter 8 (commencing with Section 3600) of Division 2 of the Business and Professions Code) who delivers to Medi-Cal patients health care services, treatment, or procedures at least some of which do not qualify as primary care.

(as) “Specialty care” means health care services provided by a specialist.

(at) “State-Only Family Planning Program” means the program established pursuant to Division 24 (commencing with Section 24000).

(au) “Tax period” means a period of not more than 12 months for which the tax imposed pursuant to Article 6 (commencing with Section 14199.123) is assessed.

(Amended by Stats. 2025, Ch. 21, Sec. 114. (AB 116) Effective June 30, 2025.)