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. Basic Health Care [14000 - 14199.87] *(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)*

ARTICLE 3.1. Medi-Cal Provider Payment Increases and Investments Act [14124.160 - 14124.168] *(Article 3.1 added by Stats. 2024, Ch. 40, Sec. 63.)*

14124.160. (a) This article shall be known, and may be cited, as the Medi-Cal Provider Payment Increases and Investments (PPI) Act.

(b) The implementation of the act, as set forth in this article and the PPI Terms and Conditions, shall support all of the following goals:

(1) Improve access to high-quality care for Medi-Cal members, especially in underserved areas.

(2) Promote provider participation in the Medi-Cal program.

(3) Strengthen the Medi-Cal program's foundation through reimbursement methodologies that are more competitive with other payors and, where applicable, allow for periodic adjustments to keep pace with health care cost inflation.

(Added by Stats. 2024, Ch. 40, Sec. 63. (SB 159) Effective June 29, 2024. Conditionally repealed as of January 1, 2025, pursuant to Sec. 14124.168.)

14124.161. For purposes of this article, and elsewhere in law where specified, the following definitions shall apply:

(a) "PPI" means the respective components of the Medi-Cal Provider Payment Increases and Investments Act authorized by this article or other sections of law amended by the act that added this subdivision, and, as applicable, approved by the federal Centers for Medicare and Medicaid Services in the PPI Terms and Conditions.

(b) "PPI Terms and Conditions" means those terms and conditions issued and approved by the federal Centers for Medicare and Medicaid Services, including any attachments, appendices, or similar documents, and subsequent amendments thereto, that govern implementation of the respective components of PPI pursuant to this article or other sections of law amended by the act that added this subdivision. PPI Terms and Conditions shall include, at a minimum, any terms and conditions specified in the following:

(1) Any Medi-Cal Demonstration approved by the federal Centers for Medicare and Medicaid Services pursuant to Section 1315 of Title 42 of the United States Code that are necessary to implement a PPI component.

(2) Any Medicaid Waivers as approved by the federal Centers for Medicare and Medicaid Services pursuant to Section 1396n of Title 42 of the United States Code that are necessary to implement a PPI component.

(3) Any associated Medi-Cal State Plan amendments approved by the federal Centers for Medicare and Medicaid Services that are necessary to implement a PPI component.

(4) Any provision of a comprehensive risk contract, nonrisk contract, or other similar managed care arrangement, including an intergovernmental agreement or directed payment authorized pursuant to Section 438.6(c) of Title 42 of the Code of Federal Regulations, approved by the federal Centers for Medicare and Medicaid Services to implement this article, or the authorities described in paragraph (1), (2), or (3).

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

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

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

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

(g) “Nonrisk contract” has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(Added by Stats. 2024, Ch. 40, Sec. 63. (SB 159) Effective June 29, 2024. Conditionally repealed as of January 1, 2025, pursuant to Sec. 14124.168.)

14124.162. (a) Consistent with federal law, the department shall seek federal approval for, and implement PPI, including, but not limited to, all of the following components:

(1) Reimbursement increases for professional services described in Section 14124.163.

(2) Reimbursement increases for ground emergency medical transport services described in Section 14124.164.

(3) Reimbursement increases for abortion services described in Section 14124.165.

(4) Reimbursement increases for family planning services described in Section 14124.166.

(5) Reimbursement increases for services described in Section 14124.167.

(6) Updating the reimbursement methodology for optional hearing aid benefits, as described in Section 14131.05.

(7) Elimination of certain rate reductions as described in paragraph (16) of subdivision (h) of Section 14105.192.

(8) Implementation of increases to the amount of directed payments for qualifying nonhospital 340B community clinics pursuant to paragraph (2) of subdivision (a) of Section 14105.468.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this article, other sections of law amended by the act that added this subdivision, the PPI Terms and Conditions, or any appertaining Medi-Cal reimbursement methodologies in whole or in part, by means of all-county letters, plan letters, provider bulletins, information notices, or other similar instructions, without taking any further regulatory action.

(c) For purposes of implementing this article, other sections of law amended by the act that added this subdivision, or the PPI Terms and Conditions, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis, and may implement changes to existing information technology systems. Notwithstanding any other law, contracts entered into or amended, or changes to existing information technology systems, pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(d) The department shall seek any federal approvals it deems necessary to implement PPI under this article and other provisions of law amended by the act that added this subdivision. This shall include, but need not be limited to, approval of any amendment, addition, or technical correction to the PPI Terms and Conditions, as the department deems necessary. Except those portions of this article related to abortion services, this article shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(e) To the extent that there is a later enacted statute that restricts the availability of the moneys in, restricts transfers of moneys into, or transfers moneys out of the Medi-Cal Provider Payment Reserve Fund, or restricts the availability or use of managed care organization provider tax revenues derived from the taxes imposed pursuant to Article 7.1 (commencing with Section 14199.80) or any subsequent continuation of the managed care organization provider tax, the department shall only implement this article or other sections of law amended by the act that added this section to the extent that the department determines the provisions of this article remain feasible with or without making modifications pursuant to subdivision (f).

(f) (1) Consistent with subdivisions (d) and (e), the director may modify any methodology or parameter specified in this article or other sections of law amended by the act that added this subdivision, to the extent necessary to do any of the following:

(A) To comply with federal law or the PPI Terms and Conditions, to obtain or maintain federal approval, or to ensure federal financial participation is available and not otherwise jeopardized.

(B) To conform with any later enacted statute that restricts the availability of the moneys in, restricts transfers of moneys into, or transfers moneys out of the Medi-Cal Provider Payment Reserve Fund, or restricts the availability or use of managed care organization provider tax revenues derived from the taxes imposed pursuant to Article 7.1 (commencing with Section 14199.80) or any subsequent continuation of the managed care organization provider tax.

(2) Any modification must be consistent with the goals set forth in this article and its individual components. Modifications may include, but are not limited to, implementing PPI components on a time-limited basis or modifying the targeted funding amounts or applicable percentages without exceeding amounts appropriated in the state budget for these purposes.

(3) Prior to proposing a modification pursuant to this subdivision, the director shall consult with affected stakeholders. Upon approval by the Department of Finance, any modification made pursuant to this subdivision shall take effect no sooner than 30 days after the director provides public notice of the proposed modification and provides notification to the chairpersons of the committees in each house of the Legislature that consider health policy, chairpersons of the committees in each house of the Legislature that consider appropriations, the chairpersons of the committees and appropriate subcommittees that consider the State Budget, and the Chairperson of the Joint Legislative Budget Committee, or not sooner than whatever lesser time the chairperson of the joint committee, or the chairperson's designee, may determine. The public notice shall include a description of the projected fiscal impact of the proposed modification on each PPI component. Submission of the semiannual Medi-Cal estimate provided to the Legislature in January and May shall be considered meeting the notification requirement of this provision if the required information is included in the estimate.

(g) The payment methodologies, investments, and parameters developed and implemented pursuant to this article, the PPI Terms and Conditions, or other sections of law amended by the act that added this subdivision shall supersede any conflicting law or regulation, shall, as applicable, supersede and replace any other applicable payment methodology, and shall be implemented notwithstanding any other law.

(h) (1) The payments implemented pursuant to this article, other sections of law amended by the act that added this subdivision, or the PPI Terms and Conditions shall be supported by managed care organization provider tax revenue, either pursuant to Article 7.1 (commencing with Section 14199.80) or any subsequent continuation of the managed care organization provider tax, or other state funds appropriated by the Legislature to the department as the state's share for this purpose, including, but not limited to, funds transferred to the Medi-Cal Provider Payment Reserve Fund in accordance with Sections 14105.200 and 14199.82, and to the Healthcare Treatment Fund in accordance with subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

(2) Notwithstanding any other law, the Legislature finds and declares increases to fee-for-service reimbursement rates and managed care capitation payments that are made pursuant to this article, other sections of law amended by the act that added this subdivision, or the PPI Terms and Conditions constitute increases in accordance with subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

(3) Notwithstanding any other law, increases to fee-for-service reimbursement rates, managed care capitation payments, or other investments that are made pursuant to this article, other sections of law amended by the act that added this section, or the PPI Terms and Conditions constitute increased reimbursement rates in accordance with statutory requirements imposed on the use of funds generated by the managed care organization provider tax, pursuant to Article 7.1 (commencing with Section 14199.80) or any subsequent statute that continues the managed care organization provider tax.

(i) The department may require Medi-Cal providers, Medi-Cal managed care plans, and other persons or entities pertaining to the Medi-Cal delivery system to submit information the department deems necessary to implement and monitor compliance with this article, other sections of law amended by the act that added this section, or the PPI Terms and Conditions, at the times and in the form and manner specified by the department.

(j) (1) The department may direct Medi-Cal managed care plans to reimburse eligible providers furnishing the services subject to PPI in accordance with one or more directed payment methodologies pursuant to subsection (c) of Section 438.6 of Title 42 of the Code of Federal Regulations, and as set forth by other sections of law amended by the act that added this section and by the department in guidance issued pursuant to subdivision (b).

(2) Commencing with the first managed care rating period for which the department documents in the annual rate certification that the base period data submitted and attested to by Medi-Cal managed care plans that is used by the department for the development of capitation rates for the Medi-Cal managed care delivery system reflects the increased reimbursement levels for a service subject to PPI, the department may, following consultation with affected stakeholders, elect to discontinue any directed payment methodologies implemented for that service.

(k) The department, as appropriate and to the extent practicable, shall consult with interested stakeholders regarding implementation of applicable components of PPI in which they will participate.

(Added by Stats. 2024, Ch. 40, Sec. 63. (SB 159) Effective June 29, 2024. Conditionally repealed as of January 1, 2025, pursuant to Sec. 14124.168.)

14124.163. (a) For the purposes of this section:

(1) “Eligible providers” means physicians, physician assistants, nurse practitioners, podiatrists, certified nurse midwives, licensed midwives, doula providers, psychologists, licensed professional clinical counselors, licensed clinical social workers, licensed marriage and family therapists, optometrists, audiologists, and community health workers.

(2) “Applicable professional services” means:

(A) Evaluation and management services associated with primary care and specialist office visits, preventative care services, and care management services.

(B) Maternal care services, including obstetric care services and doula services.

(C) Outpatient behavioral health services that are not the financial responsibility of county mental health plans operating pursuant to Chapter 8.9 (commencing with Section 14700).

(D) Vaccine administration services, as specified by the department.

(E) Vision services.

(F) Community health worker services, as described in the approved Medi-Cal State Plan.

(G) Evaluation and management services associated with emergency physician services.

(H) Other services commonly provided by primary care, specialist, and hospital-based emergency physician and non-physician health professionals as determined by the department.

(I) Hearing aids and audiological services.

(3) “Applicable professional services” do not include:

(A) Abortion and family planning services.

(B) Other allied health services, clinical laboratory services, radiology, and durable medical equipment.

(C) Outpatient hospital facility services other than services described in subparagraphs (B) and (C) of paragraph (2).

(4) “Applicable percentage” means:

(A) With respect to the applicable services listed in subparagraphs (A) and (B) of paragraph (2), 95 percent.

(B) With respect to the applicable services listed in subparagraphs (C) to (E), inclusive, of paragraph (2), 87.5 percent.

(C) With respect to the applicable services listed in subparagraph (F) of paragraph (2), 100 percent.

(D) With respect to the applicable services listed in subparagraph (G) of paragraph (2), 90 percent.

(E) With respect to the applicable services listed in subparagraphs (H) and (I) of paragraph (2), 80 percent.

(b) Notwithstanding any other law, for dates of service no sooner than January 1, 2026, or on the effective date of any necessary federal approvals as required by subdivision (d) of Section 14124.162, whichever is later, the department shall establish a geographically adjusted fee schedule for applicable services rendered by eligible providers consistent with the geographic localities utilized by the federal Medicare Program.

(c) (1) (A) Notwithstanding any other law, for dates of service no sooner than January 1, 2025, or on the effective date of any necessary federal approvals as required by subdivision (d) of Section 14124.162, whichever is later, the reimbursement rates for eligible providers rendering the services described in subparagraph (G) of paragraph (2) of subdivision (a) shall be no less than the applicable percentage of the lowest maximum allowance established by the federal Medicare Program for the same or similar services in effect as of January 1 of the calendar year prior to the implementation of this subparagraph.

(B) Notwithstanding any other law, for dates of service no sooner than January 1, 2026, or on the effective date of any necessary federal approvals as required by subdivision (d) of Section 14124.162, whichever is later, the reimbursement rates for eligible providers rendering the applicable professional services shall be no less than the applicable percentage of the applicable, geographically adjusted, maximum allowance established by the federal Medicare Program for the same or similar services in effect as of January 1 of the calendar year prior to the implementation of this subdivision for each geographic locality established by the Medicare Program.

(2) The department shall develop and implement a methodology for establishing reimbursement rates or payments for services for which there is no maximum allowable rate established by the federal Medicare Program. The department shall review this methodology annually and may, in its sole discretion, modify the methodology on a prospective basis.

(3) The department shall annually review and, subject to appropriation by the Legislature, revise the reimbursement rates established in accordance with this subdivision based on changes to the applicable maximum allowable rate established by the federal Medicare Program for the same or similar services. Any revisions to the reimbursement rates shall be considered as part of the annual budget development process and subject to the provisions of subdivision (d) of Section 14124.162 and take effect beginning no sooner than January 1, 2026, and thereafter on each subsequent January 1 of the calendar year following the department's annual review.

(d) Notwithstanding subdivision (b) of Section 14105.201, the following shall apply:

(1) For contract periods during which subdivision (c) is implemented, each Medi-Cal managed care plan shall reimburse a network provider furnishing the services subject to subdivision (c) at least the amount the network provider would be paid for those services in the Medi-Cal fee-for-service delivery system, as set forth by the department in the approved Medi-Cal State Plan and guidance issued pursuant to subdivision (b) of Section 14124.162.

(2) In any instance where a Medi-Cal managed care plan and network provider furnishing the services subject to subdivision (c) mutually agree to reimbursement on a basis other than per-service reimbursement, the Medi-Cal managed care plan shall account for the reimbursement amount required pursuant to paragraph (1) in determining the negotiated level of reimbursement and disclose to the network provider the value of any reimbursement increases associated with the changes to Medi-Cal managed care program described in this section.

(3) (A) For the 2026 calendar year, the department shall require Medi-Cal managed care plans to demonstrate compliance with the requirements of paragraphs (1) and (2) in a form and manner specified by the department.

(B) Subsequent to the 2026 calendar year, and subject to paragraph (2) of subdivision (j) of Section 14124.162, the department shall require Medi-Cal managed care plans to redemonstrate compliance with the requirements of paragraphs (1) and (2), in a form and manner specified by the department, no less than once every four years, or more frequently as deemed necessary by the department.

(C) This paragraph does not limit the department’s authority to audit, monitor, or oversee a Medi-Cal managed care plan’s compliance with applicable contractual, statutory, or other requirements.

(Added by Stats. 2024, Ch. 40, Sec. 63. (SB 159) Effective June 29, 2024. Conditionally repealed as of January 1, 2025, pursuant to Sec. 14124.168.)

14124.164. (a) (1) Notwithstanding Section 51527 of Title 22 of the California Code of Regulations or any other law, for dates of service no sooner than January 1, 2025, or on the effective date of any necessary federal approvals as required by subdivision (d) of Section 14124.162, whichever is later, the department shall increase reimbursement for eligible providers rendering ground emergency medical transport services.

(2) The department may implement the reimbursement increases described in paragraph (1) solely with respect to the per-transport rate, with respect to both the per-transport and the mileage rates, or in any other manner as deemed appropriate by the department.

(3) This subdivision shall not apply to an eligible provider as defined in paragraph (1) of subdivision (a) of Section 14105.945.

(b) Notwithstanding Section 51527 of Title 22 of the California Code of Regulations or any other law, for dates of service no sooner than January 1, 2025, or on the effective date of any necessary federal approvals as required by subdivision (d) of Section 14124.162, whichever is later, the department may vary the reimbursement increases described in subdivision (a), or reimbursement rates for ground emergency medical transport services, based on complexity or the geographic localities utilized by the federal Medicare Program, may categorize localities into rural tiers, and may vary the amount of the rural adjustment per tier from those utilized by the Medicare Program to reflect a California-specific index of localities and adjustment factors. Nothing in this subdivision shall be construed to require the department to reimburse providers rendering ground emergency medical transport services the

rates utilized by the Medicare Program or to replicate the rural adjustment factors, or any other factors, utilized by the Medicare Program.

(c) Each applicable Medi-Cal managed care health plan shall satisfy its obligation under Section 438.114(c) of Title 42 of the Code of Federal Regulations for emergency medical transports and shall provide payment to noncontract emergency medical transport providers consistent with Section 1396u-2(b)(2)(D) of Title 42 of the United States Code. Effective upon implementation of this section, and for each state fiscal year thereafter for which this section is operative, the amounts a noncontract emergency medical transport provider could collect if the beneficiary received medical assistance other than through enrollment in a Medi-Cal managed care health plan pursuant to Section 1396u-2(b)(2)(D) of Title 42 of the United States Code shall be the resulting fee-for-service payment schedule amounts after the application of this section.

(d) The department shall implement the reimbursement increases specified in subdivision (a) in amounts that are designed to target increased state fund expenditures of equal to the annualized amount set forth in the state fiscal year 2024–25 budget for the first year of implementation in aggregate across both the Medi-Cal fee-for-service and managed care delivery systems. The reimbursement increases established pursuant to this methodology shall continue at these levels for each year thereafter, subject to subdivision (e).

(e) The department may annually review and revise the reimbursement increases established in accordance with subdivision (a). Any revisions shall be subject to the provisions of subdivision (d) of Section 14124.162 and take effect beginning no sooner than January 1, 2026, and thereafter on each subsequent January 1 of the calendar year following the department's annual review.

(Added by Stats. 2024, Ch. 40, Sec. 63. (SB 159) Effective June 29, 2024. Conditionally repealed as of January 1, 2025, pursuant to Sec. 14124.168.)

14124.165. (a) (1) Notwithstanding any other law, for dates of service no sooner than January 1, 2025, the base reimbursement rates for eligible providers rendering Medi-Cal covered abortion services identified by the department, shall be increased in the fee-for-service delivery system such that, in combination with the projected actuarially equivalent impact on the managed care delivery system expenditures, the projected cost of the base reimbursement rate increases on an annualized basis is equal, as determined by the department, to the annualized amount set forth in the state fiscal year 2024–25 budget.

(2) The reimbursement rate increases described in paragraph (1) shall account for, and be inclusive of, the exemption of these services from payment reductions pursuant to Section 14105.192, and may be geographically adjusted as deemed appropriate by the department.

(b) For contract periods during which subdivision (a) is implemented, each Medi-Cal managed care plan shall reimburse eligible providers furnishing the services subject to subdivision (a) no less than the amounts established pursuant to subdivision (a) as directed by the department in guidance issued pursuant to subdivision (b) of Section 14124.162.

(Added by Stats. 2024, Ch. 40, Sec. 63. (SB 159) Effective June 29, 2024. Conditionally repealed as of January 1, 2025, pursuant to Sec. 14124.168.)

14124.166. (a) Beginning for dates of service no sooner than January 1, 2025, or on the effective date of any necessary federal approvals as required by subdivision (d) of Section 14124.162, whichever is later, the department may implement a supplemental payment program for services provided under the Family Planning, Access, Care, and Treatment program, as described in subdivision (aa) of Section 14132.

(b) The department shall develop, establish, and maintain the methodology, eligibility criteria, conditions, and payment amounts for the supplemental payments described in this section.

(Added by Stats. 2024, Ch. 40, Sec. 63. (SB 159) Effective June 29, 2024. Conditionally repealed as of January 1, 2025, pursuant to Sec. 14124.168.)

14124.167. (a) For the purposes of this section, the following definitions apply:

(1) Beginning for dates of service on or after January 1, 2025, “applicable services” means the following services:

(A) Emergency medical air transportation services as described in Section 76000.10 of the Government Code.

(B) Community-based adult services, as described in Section 14186.3 and as covered pursuant to subdivision (e) of Section 14184.201.

(C) Pediatric day health care, as described in Section 14132.10 and Section 1760.2 of the Health and Safety Code.

(D) Services provided in a congregate living health facility as defined in subdivision (i) of Section 1250 of the Health and Safety Code.

(2) Beginning for dates of service on or after January 1, 2026, “applicable services” means the following services:

(A) Services described in paragraph (1).

(B) Nonemergency medical transportation services as described in Section 51323 of Title 22 of the California Code of Regulations.

(C) Private duty nursing as described in Section 14105.13 and Section 1743.2 of the Health and Safety Code.

(b) Beginning for dates of service on or after January 1, 2025, or on the effective date of any necessary federal approvals as required by subdivision (d) of Section 14124.162, whichever is later, the department shall implement reimbursement increases for applicable services in the fee-for-service delivery system such that, in combination with the projected actuarially equivalent impact on the managed care delivery system expenditures, as applicable, the projected nonfederal share cost of the reimbursement increases on an annualized basis is equal, as determined by the department, to the annualized amount set forth in the state fiscal year 2024–25 budget.

(Added by Stats. 2024, Ch. 40, Sec. 63. (SB 159) Effective June 29, 2024. Conditionally repealed as of January 1, 2025, pursuant to Sec. 14124.168.)

14124.168. If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to this part at the November 5, 2024, statewide general election, this article shall be repealed as of January 1, 2025.

(Added by Stats. 2024, Ch. 40, Sec. 63. (SB 159) Effective June 29, 2024. Conditionally repealed as of January 1, 2025, by its own provisions. Note: Repeal affects Article 3.1, commencing with Sec. 14124.160)