**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 6.3. Medi-Cal Managed Care Plans [14197 - 14197.9]** *( Article 6.3 added by Stats. 2017, Ch. 738, Sec. 7. )*

**14197.** (a) It is the intent of the Legislature that the department implement and monitor compliance with the time or distance requirements set forth in Sections 438.68, 438.206, and 438.207 of Title 42 of the Code of Federal Regulations and this section, to ensure that all Medi-Cal managed care covered services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as those standards were enacted in May 2016.

(b) Commencing January 1, 2018, for covered benefits under its contract, as applicable, a Medi-Cal managed care plan shall maintain a network of providers that are located within the following time or distance standards for the following services:

(1) For primary care, both adult and pediatric, 10 miles or 30 minutes from the beneficiary's place of residence.

(2) For hospitals, 15 miles or 30 minutes from the beneficiary's place of residence.

(3) For dental services provided by a Medi-Cal managed care plan, 10 miles or 30 minutes from the beneficiary's place of residence.

(4) For obstetrics and gynecology primary care, 10 miles or 30 minutes from the beneficiary's place of residence.

(c) Commencing July 1, 2018, for the covered benefits under its contracts, as applicable, a Medi-Cal managed care plan shall maintain a network of providers that are located within the following time or distance standards for the following services:

(1) For specialists, as defined in subdivision (i), adult and pediatric, including obstetric and gynecology specialty care, as follows:

(A) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(B) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(C) Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(D) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(2) For pharmacy services, 10 miles or 30 minutes from the beneficiary's place of residence.

(3) For outpatient mental health services, as follows:

(A) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(B) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(C) Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(D) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(4) (A) For outpatient substance use disorder services other than opioid treatment programs, as follows:

(i) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(ii) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(iii) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Monterey, Mono, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba.

(B) For opioid treatment programs, as follows:

(i) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(ii) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(iii) Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(iv) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(d) (1) (A) A Medi-Cal managed care plan shall comply with the appointment time standards developed pursuant to Section 1367.03 of the Health and Safety Code, Section 1300.67.2.2 of Title 28 of the California Code of Regulations, subject to any authorized exceptions in Section 1300.67.2.2 of Title 28 of the California Code of Regulations, and the standards set forth in contracts entered into between the department and Medi-Cal managed care plans.

(B) Commencing July 1, 2018, subparagraph (A) applies to Medi-Cal managed care plans that are not, as of January 1, 2018, subject to the appointment time standards described in subparagraph (A).

(2) A Medi-Cal managed care plan shall comply with the following availability standards for skilled nursing facility services and intermediate care facility services, as follows:

(A) Within five business days of the request for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(B) Within seven business days of the request for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(C) Within 14 calendar days of the request for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(D) Within 14 calendar days of the request for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(3) A county Drug Medi-Cal organized delivery system shall provide an appointment within three business days to an opioid treatment program.

(4) A dental managed care plan shall provide an appointment within four weeks of a request for routine pediatric dental services and within 30 calendar days of a request for specialist pediatric dental services.

(e) The department may authorize a Medi-Cal managed care plan to use clinically appropriate video synchronous interaction, as defined in paragraph (5) of subdivision (a) of Section 2290.5 of the Business and Professions Code, as a means of demonstrating compliance with the time or distance standards established pursuant to this section, as defined by the department.

(f) (1) The department may develop policies for granting credit in the determination of compliance with time or distance standards established pursuant to this section when Medi-Cal managed care plans contract with specified providers to use clinically appropriate video synchronous interaction, as defined in paragraph (5) of subdivision (a) of Section 2290.5 of the Business and Professions Code.

(2) The department, upon request of a Medi-Cal managed care plan, may authorize alternative access standards for the time or distance standards established under this section if either of the following occur:

(A) The requesting Medi-Cal managed care plan has exhausted all other reasonable options to obtain providers to meet the applicable standard.

(B) The department determines that the requesting Medi-Cal managed care plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.

(3) (A) If a Medi-Cal managed care plan cannot meet the time or distance standards set forth in this section, the Medi-Cal managed care plan shall submit a request for alternative access standards to the department, in the form and manner specified by the department.

(B) An alternative access standard request may be submitted at the same time as the Medi-Cal managed care plan submits its annual demonstration of compliance with time or distance standards, if known at that time and at any time the Medi-Cal managed care plan is unable to meet time or distance standards.

(C) A Medi-Cal managed care plan is not required to submit a previously approved alternative access standard request to the department for review and approval on an annual basis, unless the Medi-Cal managed care plan requires modifications to its previously approved request. However, the Medi-Cal managed care plan shall submit this previously approved alternative access standard request to the department at least every three years for review and approval when the plan is required to demonstrate compliance with time or distance standards.

(D) A Medi-Cal managed care plan shall close out any corrective action plan deficiencies in a timely manner to ensure beneficiary access is adequate and shall continually work to improve access in its provider network.

(4) A request for alternative access standards shall be approved or denied on a ZIP Code and provider type, including specialty type, basis by the department within 90 days of submission of the request. The Medi-Cal managed care plan shall also include a description of the reasons justifying the alternative access standards based on those facts and circumstances. Effective no sooner than contract periods commencing on or after July 1, 2020, the Medi-Cal managed care plan shall include a description on how the Medi-Cal managed care plan intends to arrange for beneficiaries to access covered services if the health care provider is located outside of the time or distance standards specified in subdivision (c). The department may stop the 90-day timeframe, on one or more occasions as necessary, in the event of an incomplete submission or to obtain additional information from the Medi-Cal managed care plan requesting the alternative access standards. Upon submission of sufficient additional information to the department, the 90-day timeframe shall resume at the same point in time it was previously stopped, except if there is less than 30 days remaining in which case the department shall approve or deny the request within 30 days of submission of sufficient additional information. If the department rejects the Medi-Cal managed care plan's proposal, the department shall inform the Medi-Cal managed care plan of the department's reason for rejecting the proposal. The department shall post any approved alternative access standards on its internet website.

(5) As part of the department's evaluation of a request submitted by a Medi-Cal managed care plan to utilize an alternative access standard pursuant to this subdivision, the department shall evaluate and determine whether the resulting time or distance is reasonable to expect a beneficiary to travel to receive care.

(6) The department may authorize a Medi-Cal managed care plan to use clinically appropriate video synchronous interaction, as defined in paragraph (5) of subdivision (a) of Section 2290.5 of the Business and Professions Code, as part of an alternative access standard request.

(g) (1) Effective for contract periods commencing on or after July 1, 2018, a Medi-Cal managed care plan shall, on an annual basis and when requested by the department, demonstrate to the department the Medi-Cal managed care plan's compliance with the time or distance and appointment time standards developed pursuant to this section. The report shall measure compliance separately for adult and pediatric services for primary care, behavioral health, and core specialist services.

(2) Effective for contract periods commencing on or after July 1, 2020, the Medi-Cal managed care plan shall demonstrate, on an annual basis, and when requested by the department, to the department how the Medi-Cal managed care plan arranged for the delivery of Medi-Cal covered services to Medi-Cal enrollees, such as through the use of either Medi-Cal covered transportation or clinically appropriate video synchronous interaction, as specified in paragraph(6) of subdivision (f), if the enrollees of a Medi-Cal managed care plan needed to obtain health care services from a health care provider or a facility located outside of the time or distance standards, as specified in subdivision (c).

The report shall measure compliance separately for adult and pediatric services for primary care, behavioral health, and core specialist services.

(3) Effective for contract periods commencing on or after July 1, 2018, the department shall evaluate on an annual basis a Medi-Cal managed care plan's compliance with the time or distance and appointment time standards implemented pursuant to this section. This evaluation may include, but need not be limited to, annual and random surveys, investigation of complaints, grievances, or other indicia of noncompliance. Nothing in this subdivision shall be construed to limit the appeal rights of a Medi-Cal managed care plan under its contracts with the department.

(4) The department shall publish annually on its internet website a report that details the department's findings in evaluating a Medi-Cal managed care plan's compliance under paragraph (2). At a minimum, the department shall specify in this report those Medi-Cal managed care plans, if any, that were subject to a corrective action plan due to noncompliance with the time or distance and appointment time standards implemented pursuant to this section during the applicable year and the basis for the department's finding of noncompliance. The report shall include a Medi-Cal managed care plan's response to the corrective plan, if available.

(h) The department shall consult with Medi-Cal managed care plans, including dental managed care plans, mental health plans, and Drug Medi-Cal Organized Delivery System programs, health care providers, consumers, providers and consumers of long-term services and supports, and organizations representing Medi-Cal beneficiaries in the implementation of the requirements of this section.

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

(1) "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(A) Article 2.7 (commencing with Section 14087.3), including dental managed care programs developed pursuant to Section 14087.46.

(B) Article 2.8 (commencing with Section 14087.5).

(C) Article 2.81 (commencing with Section 14087.96).

(D) Article 2.82 (commencing with Section 14087.98).

(E) Article 2.9 (commencing with Section 14088).

(F) Article 2.91 (commencing with Section 14089).

(G) Chapter 8 (commencing with Section 14200), including dental managed care plans.

(H) Chapter 8.9 (commencing with Section 14700).

(I) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration pursuant to Article 5.5 (commencing with Section 14184) or a successor demonstration or waiver, as applicable.

(2) "Specialist" means any of the following:

(A) Cardiology/interventional cardiology.

(B) Nephrology.

(C) Dermatology.

(D) Neurology.

(E) Endocrinology.

(F) Ophthalmology.

(G) Ear, nose, and throat/otolaryngology.

(H) Orthopedic surgery.

(I) Gastroenterology.

(J) Physical medicine and rehabilitation.

(K) General surgery.

(L) Psychiatry.

(M) Hematology.

(N) Oncology.

(O) Pulmonology.

(P) HIV/AIDS specialists/infectious diseases.

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

(k) The department shall seek any federal approvals it deems necessary to implement this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(l) This section shall remain in effect only until January 1, 2026, and as of that date is repealed, unless a later enacted statute that is enacted before January 1, 2026, deletes or extends that date.

*(Amended by Stats. 2022, Ch. 47, Sec. 132. (SB 184) Effective June 30, 2022. Repealed as of January 1, 2026, by its own provisions.)*

**14197.04.** (a) (1) A Medi-Cal managed care plan that has received approval from the department to utilize an alternative access standard pursuant to subdivision (f) of Section 14197, upon the request of an enrollee who is required to travel farther than the time or distance standards, as established in subdivision (c) of Section 14197, shall assist that enrollee in obtaining an appointment with an appropriate specialist provider within the time or distance standards established pursuant to subdivision (c) of Section 14197 and the appointment time standards established pursuant to subdivision (d) of Section 14197.

(2) For purposes of complying with the requirement to assist an enrollee, as specified in paragraph (1), a Medi-Cal managed care plan shall do either of the following:

(A) Make its best effort to establish a member-specific case agreement, at the Medi-Cal fee-for-service rate or a rate mutually agreed upon by the specialist provider and the plan, with an appropriate specialist provider within the time or distance standards established pursuant to subdivision (c) of Section 14197 and the appointment time standards established pursuant to subdivision (d) of Section 14197.

(B) Arrange for an appointment with a network specialist provider within the time or distance standards established pursuant to subdivision (c) of Section 14197, and the appointment time standards established pursuant to subdivision (d) of Section 14197.

(3) The requirements of paragraph (1) shall not apply if there is not a specialist provider with an office location within the applicable time or distance standards in relation to the area within which the enrollee resides or the Medi-Cal managed care plan has attempted to establish a member-specific case agreement with the specialist provider for any enrollee pursuant to subparagraph (A) of paragraph (2) in the most recent fiscal year and the provider refused to enter into a member-specific case agreement.

(b) If a specialist provider is unavailable to render necessary health care services pursuant to subdivision (a) to an enrollee within the time or distance standards established pursuant to subdivision (c) of Section 14197 and the appointment time standards established pursuant to subdivision (d) of Section 14197, as specified in subdivision (a), the Medi-Cal managed care plan or the Medi-Cal fee-for-service program, as determined appropriate by the department, shall arrange for Medi-Cal covered transportation for an enrollee to obtain covered Medi-Cal services pursuant to Section 14132.

(c) A Medi-Cal managed care plan that has received approval from the department to utilize an alternative access standard pursuant to subdivision (f) of Section 14197 shall inform its affected members of the approved alternative access standards in a manner and timeframe, as determined by the department.

(d) (1) “Medi-Cal managed care plan” means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(A) Article 2.7 (commencing with Section 14087.3), including dental managed care programs developed pursuant to Section 14087.46.

(B) Article 2.8 (commencing with Section 14087.5).

(C) Article 2.81 (commencing with Section 14087.96).

(D) Article 2.82 (commencing with Section 14087.98).

(E) Article 2.91 (commencing with Section 14089).

(F) Chapter 8 (commencing with Section 14200), including dental managed care plans.

(G) Chapter 8.9 (commencing with Section 14700).

(H) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration pursuant to Article 5.5 (commencing with Section 14184) or a successor demonstration or waiver, as applicable.

(2) “Specialist provider” has the same meaning as “specialist” as defined in paragraph (2) of subdivision (i) of Section 14197.

*(Amended by Stats. 2022, Ch. 47, Sec. 133. (SB 184) Effective June 30, 2022.)*

**14197.05.** (a) As part of the federally required external quality review organization (EQRO) review of Medi-Cal managed care plans in the annual detailed technical report required by Section 438.364 of Title 42 of the Code of Federal Regulations, effective for contract periods commencing on or after July 1, 2018, the EQRO designated by the department shall compile the data described in subdivision (b), by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197.

(b) (1) The information compiled by the EQRO shall include all of the following:

(A) Number of requests for alternative access standards in the plan service area for time and distance, categorized by provider types, including specialists, and by adult and pediatric.

(B) Number of allowable exceptions for the appointment time standard, if known, categorized by provider types, including specialists, and by adult and pediatric.

(C) Distance and driving time between the nearest network provider and ZIP Code of the beneficiary furthest from that provider for requests for alternative access standards.

(D) Approximate number of beneficiaries impacted by alternative access standards or allowable exceptions.

(E) Percentage of providers in the plan service area, by provider and specialty type, that are under a contract with a Medi-Cal managed care plan.

(F) The number of requests for alternative access standards approved or denied by ZIP Code and provider and specialty type, and the reasons for the approval or denial of the request for alternative access standards. If an approval is authorized, the reasons for approval shall identify whether the approval was granted for either of the following reasons:

(i) A provider was not located in the requested ZIP Code.

(ii) The Medi-Cal managed care plan was unable to enter into a contract with a provider or providers in the requested ZIP Code.

(G) The process of ensuring out-of-network access.

(H) Descriptions of contracting efforts and explanation for why a contract was not executed.

(I) Timeframe for approval or denial of a request for alternative access standards by the department.

(J) Consumer complaints, if any.

(2) The information described in paragraph (1) shall be presented in a chart format to enable comparison among counties, provider types, and plans.

(c) The EQRO shall develop a methodology to assess information that will help inform the experience of individuals placed in a skilled nursing facility or intermediate care facility and the distance that they are placed from their place of residence. The EQRO shall report the results from the use of this methodology in the EQRO annual Medi-Cal managed care plan technical report.

(d) The department shall comply with the requirements of subsection (c) of Section 438.364 of Title 42 of the Code of Federal Regulations in making the information described in this section publicly available.

*(Amended by Stats. 2019, Ch. 465, Sec. 5. (AB 1642) Effective January 1, 2020.)*

**14197.07.** (a) A Medi-Cal managed care plan shall ensure access to care for latent tuberculosis infection and active tuberculosis disease and coordination with local health department tuberculosis control programs for plan enrollees with active tuberculosis disease, including, but not limited to, both of the following:

(1) Arranging for and coordinating outpatient diagnostic and treatment services to all plan enrollees with suspected or active tuberculosis disease to minimize delays in initiating isolation and treatment of infectious patients. These outpatient services shall include physical examination, drug therapy, laboratory testing, and radiology.

(2) Consulting with local health departments to assess the risk of noncompliance with drug therapy for each plan enrollee who requires placement on antituberculosis drug therapy, in accordance with the plan's existing contract with the department.

(b) For purposes of this section, "Medi-Cal managed care plan" has the same meaning as set forth in Section 14197.08.

*(Added by Stats. 2024, Ch. 951, Sec. 3. (AB 2132) Effective January 1, 2025.)*

**14197.08.** (a) A contract between the department and a Medi-Cal managed care plan shall require the Medi-Cal managed care plan to do both of the following:

(1) Identify, on a quarterly basis, every enrollee who is a child without a record of completing the blood lead screening tests required pursuant to Chapter 9 (commencing with Section 37100) of Division 1 of Title 17 of the California Code of Regulations.

(2) On a quarterly basis, remind the contracting network provider who is a health care provider responsible for performing the periodic health assessment of the child enrollee pursuant to Section 37100 of Title 17 of the California Code of Regulations of the requirement to perform required blood lead screening tests for that child, and the requirement to provide oral or written anticipatory guidance to a parent or guardian of the child, including at a minimum, the information that children may be harmed by exposure to lead.

(b) The department shall develop and implement procedures, and may impose sanctions pursuant to Section 14197.7, to ensure that a Medi-Cal managed care plan is compliant with the requirements specified in subdivision (a).

(1) As part of these procedures, the department shall require a Medi-Cal managed care plan to maintain a record of all child enrollees six years of age or younger who have missed a required blood lead screening and identify the age at which the required blood lead screenings were missed, including which children are without any record of a completed blood lead screening at each age, and provide that record to the department annually and upon request for auditing and compliance purposes.

(2) If the child enrollee, or the child enrollee's parent, guardian, or authorized representative refuses a required blood lead screening test, the Medi-Cal managed care plan shall ensure a statement of voluntary refusal is signed by the child enrollee, if an emancipated minor, or by the child enrollee's parent, guardian, or authorized representative, and is documented in the child enrollee's medical record. If the refusing party declines to sign the statement of voluntary refusal, it shall be noted in the child enrollee's medical record. Documented unsuccessful attempts to provide the blood lead screening tests shall be considered evidence of the Medi-Cal managed care plan meeting the requirements in subdivision (a).

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

(1) "Medi-Cal managed care plan" means an individual, organization, or entity that enters into a contract with the department to provide general health care services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(A) Chapter 3 (commencing with Section 101675) of Part 4 of Division 101 of the Health and Safety Code.

(B) Article 2.7 (commencing with Section 14087.3), excluding dental managed care programs developed pursuant to Section 14087.46.

(C) Article 2.8 (commencing with Section 14087.5).

(D) Article 2.81 (commencing with Section 14087.96).

(E) Article 2.82 (commencing with Section 14087.98).

(F) Article 2.9 (commencing with Section 14088).

(G) Article 2.91 (commencing with Section 14089).

(H) Chapter 8 (commencing with Section 14200), excluding dental managed care programs developed pursuant to Section 14087.46.

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

(d) Notwithstanding Chapter 3.5 (commencing Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions, without taking any further regulatory action.

*(Added by Stats. 2020, Ch. 216, Sec. 3. (AB 2276) Effective January 1, 2021.)*

**14197.09.** (a) (1) No later than 12 months after the working group develops its recommendations for curriculum pursuant to subdivision (b) of Section 150950 of the Health and Safety Code, and no later than March 1, 2025, a Medi-Cal managed care plan shall require all of its subcontractors, downstream subcontractors, and all of its managed care plan staff who are in direct contact with beneficiaries in the delivery of care or beneficiary services to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or intersex (TGI).

(2) An evidence-based cultural competency training implemented pursuant to paragraph (1) shall include all of the following:

(A) Information about the effects, including, but not limited to, ongoing personal effects, of historical and contemporary exclusion and oppression of TGI communities.

(B) Information about communicating more effectively across gender identities, including TGI-inclusive terminology, using people’s correct names and pronouns, even when they are not reflected in records or legal documents; avoiding language, whether verbal or nonverbal, that demeans, ridicules, or condemns TGI individuals; and avoiding making assumptions about gender identity by using gender-neutral language and avoiding language that presumes all individuals are heterosexual, cisgender or gender conforming, or nonintersex.

(C) Discussion on health inequities within the TGI community, including family and community acceptance.

(D) Perspectives of diverse, local constituency groups and TGI-serving organizations, including, but not limited to, the California Transgender Advisory Council.

(E) Recognition of the difference between personal values and professional responsibilities with regard to serving TGI people.

(F) Facilitation by TGI-serving organizations.

(3) Cultural competency training implemented by a Medi-Cal managed care plan that includes TGI components, as required by its managed care plan contract with the department, shall meet this requirement. This cultural competency training shall consider recommendations made by the working group pursuant to Section 150950 of the Health and Safety Code.

(4) Use of any training curricula for purposes of implementing paragraph (1) shall be subject to approval by the department, following stakeholder engagement with local constituency groups and TGI-serving organizations, including, but not limited to, the California Transgender Advisory Council.

(5) After first-time completion of the evidence-based cultural competency training, in the form of initial basic training, an individual described in paragraph (1) shall complete a refresher course if a complaint has been filed, and a decision has been made in favor of the complainant, against that individual for not providing trans-inclusive health care, or on a more frequent basis if deemed necessary by the Medi-Cal managed care plan or the department for purposes of providing trans-inclusive health care.

(b) (1) No later than 12 months after the working group develops its recommendations for curriculum pursuant to subdivision (b) of Section 150950 of the Health and Safety Code, and no later than March 1, 2025, the department shall develop and implement procedures, and may impose sanctions pursuant to Section 14197.7, to ensure that a Medi-Cal managed care plan is compliant with the requirements described in subdivision (a).

(2) The department shall track and monitor complaints received by the department related to trans-inclusive health care and publicly report this data with other complaint data on its website or with other public reports containing complaint data.

(c) No later than 12 months after the working group develops its recommendations for curriculum pursuant to subdivision (b) of Section 150950 of the Health and Safety Code, and no later than March 1, 2025, a Medi-Cal managed care plan shall include information within or accessible from the plan's provider directory, and accessible through the plan's call center, that identifies which of the Medi-Cal managed care plan's in-network providers have affirmed that they offer and have provided gender-affirming services, including, but not limited to, feminizing mammoplasty, male chest reconstruction, mastectomy, gender-confirming facial surgery, hysterectomy, oophorectomy, penectomy, orchiectomy, feminizing genitoplasty, metoidioplasty, phalloplasty, scrotoplasty, voice masculinization or feminization, hormone therapy related to gender dysphoria or intersex conditions, gender-affirming gynecological care, or voice therapy related to gender dysphoria or intersex conditions. This information shall be updated when an in-network provider requests its inclusion or exclusion as a provider that offers and provides gender-affirming services. Nothing in this act alters any business establishment's obligation to provide full and equal services to customers or patients regardless of their sex and other protected characteristics, pursuant to the Unruh Civil Rights Act (Section 51 of the Civil Code) and other applicable law.

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

(1) "Medi-Cal managed care plan" means an individual, organization, or entity that enters into a contract with the department to provide general health care services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(A) Article 2.7 (commencing with Section 14087.3), excluding dental managed care programs developed pursuant to Section 14087.46.

(B) Article 2.8 (commencing with Section 14087.5).

(C) Article 2.81 (commencing with Section 14087.96).

(D) Article 2.82 (commencing with Section 14087.98).

(E) Article 2.9 (commencing with Section 14088).

(F) Article 2.91 (commencing with Section 14089).

(G) Chapter 8 (commencing with Section 14200), excluding dental managed care plans.

(H) Chapter 8.9 (commencing with Section 14700).

(I) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration pursuant to Article 5.5 (commencing with Section 14184), the California Advancing and Innovating Medi-Cal Demonstration pursuant to Section 14184.401, or a successor demonstration or waiver, as applicable.

(2) The requirements described in this section that are imposed on a "Medi-Cal managed care plan" also apply to a Program of All-Inclusive Care for the Elderly (PACE) organization operating pursuant to Chapter 8.75 (commencing with Section 14591). The sanctions described in subdivision (b) also apply to a PACE organization, which may be imposed by the department or the State Department of Public Health pursuant to Section 14592 or any other provisions applicable to PACE organizations.

(3) "TGI" means transgender, gender diverse, or intersex.

(4) "TGI-serving organization" has the same meaning as set forth in paragraph (2) of subdivision (f) of Section 150900 of the Health and Safety Code.

(5) "Trans-inclusive health care" means comprehensive health care that is consistent with the standards of care for individuals who identify as TGI, honors an individual's personal bodily autonomy, does not make assumptions about an individual's gender, accepts gender fluidity and nontraditional gender presentation, and treats everyone with compassion, understanding, and respect.

(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 for purposes of this section by July 1, 2027, 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.

*(Added by Stats. 2022, Ch. 822, Sec. 7. (SB 923) Effective January 1, 2023.)*

**14197.1.** (a) The department shall ensure that all covered mental health benefits and substance use disorder benefits, as those terms are defined in Section 438.900 of Title 42 of the Code of Federal Regulations, are provided in compliance with Parts 438, 440, 456, and 457 of Title 42 of the Code of Federal Regulations, as amended March 30, 2016, as published in the Federal Register (81

Fed. Reg. 18390), and any subsequent amendment to those regulations, and any associated federal policy guidance issued by the federal Centers for Medicare and Medicaid Services.

(b) 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. In doing so, the director shall consult with managed care plans and consumer advocates. By July 1, 2022, the department shall adopt regulations, where appropriate, 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) The department shall make any findings of noncompliance and corrective action plans available on its Internet Web site.

(d) For purposes of this section, “Medi-Cal managed care plan” means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(1) Article 2.7 (commencing with Section 14087.3), excluding dental managed care programs developed pursuant to Section 14087.46.

(2) Article 2.8 (commencing with Section 14087.5).

(3) Article 2.81 (commencing with Section 14087.96).

(4) Article 2.82 (commencing with Section 14087.98).

(5) Article 2.91 (commencing with Section 14089).

(6) Chapter 8 (commencing with Section 14200), excluding dental managed care plans.

(7) Chapter 8.9 (commencing with Section 14700).

(8) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services and described in the Special Terms and Conditions. For purposes of this subdivision, “Special Terms and Conditions” shall have the same meaning as set forth in subdivision (o) of Section 14184.10.

*(Added by Stats. 2017, Ch. 768, Sec. 3. (SB 171) Effective January 1, 2018.)*

**14197.11.** (a) Notwithstanding any other law, subject to subdivisions (e) and (g), the department may enter into one or more comprehensive risk contracts with an alternate health care service plan (AHCSP) to serve as a primary Medi-Cal managed care plan for eligible beneficiaries described in subdivision (b) in geographic regions that are designated by the department pursuant to subdivision (c) and that are regions in which the AHCSP already provides commercial coverage in the individual, small group, or large group market.

(b) The following beneficiary populations enrolling in Medi-Cal managed care shall be eligible to enroll, or choose to maintain their enrollment, in an AHCSP contracted with the department pursuant to subdivision (a):

(1) A beneficiary who was previously a member of the AHCSP as their Medi-Cal managed care plan at any point from January 1, 2023, to December 31, 2023, inclusive.

(2) An existing member of the AHCSP who is transitioning into Medi-Cal managed care.

(3) A beneficiary who was a member of the AHCSP at any time during the 12 months preceding the effective date of the beneficiary’s Medi-Cal eligibility.

(4) A beneficiary with an AHCSP family linkage.

(5) A beneficiary who was previously enrolled in a primary Medi-Cal managed care plan other than the AHCSP at any point from January 1, 2023, to December 31, 2023, inclusive, but who was assigned to, and made the responsibility of, the AHCSP under a subcontract with the Medi-Cal managed care plan.

(6) A dual eligible beneficiary residing in a geographic region approved by the department for purposes of this subdivision and for which the department has contracted with the AHCSP pursuant to subdivision (a).

(7) A beneficiary who is in foster care in this state or is otherwise eligible on the basis of their receipt of services through a child welfare agency pursuant to Section 300 or a former foster youth eligible pursuant to Section 14005.28 residing in a geographic region for which the department has contracted with the AHCSP pursuant to subdivision (a). A beneficiary who was previously

enrolled in the AHCSP as their primary Medi-Cal managed care plan under this paragraph may remain in the AHCSP even if the beneficiary is no longer receiving services through a child welfare agency pursuant to Section 300.

(8) (A) A beneficiary not listed in paragraphs (1) to (7), inclusive, who resides in a geographic region for which the department has contracted with the AHCSP pursuant to subdivision (a) and is assigned to the AHCSP according to the department's default enrollment process for beneficiaries that fail to elect a Medi-Cal managed care plan in accordance with Section 14016.5. The department shall annually determine the rate of default enrollment for beneficiaries into the AHCSP in each applicable county or geographic region based on the AHCSP's projected capacity.

(B) If the default enrollment into the AHCSP described in subparagraph (A) results in a default rate of 20 percent or higher for two consecutive months in an applicable county or counties as described in subdivision (c) of Section 14016.55, the department may elect not to conduct a one-time beneficiary survey, notwithstanding the requirement of subdivision (c) of Section 14016.55.

(c) Notwithstanding any other law, the department may contract with an AHCSP as a Medi-Cal managed care plan in any geographic region of the state for which federal approval is available and received pursuant to subdivision (g), for which the AHCSP maintains appropriate licensure or an approved exemption from the Department of Managed Health Care, and in which the AHCSP already provides commercial coverage in the individual, small group, or large group market. To the extent permissible under federal law, the department may enter into either a single comprehensive risk contract for all geographic areas where the AHCSP is approved to operate as a Medi-Cal managed care plan or multiple contracts to serve the different geographic areas. If the department enters into a single comprehensive risk contract, capitation rates shall be determined on a county or regional basis.

(1) The AHCSP shall not deny enrollment to any individual eligible pursuant to subdivision (b) unless the department or the Department of Managed Health Care has ordered the AHCSP to cease enrollment in an applicable service area.

(2) (A) The AHCSP shall not, on its own, disenroll any eligible beneficiary described in subdivision (b).

(B) The Health Care Options Program shall disenroll any member of an AHCSP if the member meets any one of the reasons for disenrollment enumerated in Section 53891 of Title 22 of the California Code of Regulations, except that the Health Care Options Program shall not disenroll a member who meets the conditions described in subdivision (f) of Section 53845 of Title 22 of the California Code of Regulations. The Health Care Options Program shall follow the disenrollment process described in Section 53889 of Title 22 of the California Code of Regulations.

(3) Except for those standards and requirements relating to beneficiary enrollment that the department determines are inapplicable to the AHCSP, the comprehensive risk contract or contracts with the AHCSP pursuant to this section shall include the same standards and requirements as those for other Medi-Cal managed care plans, including any requirements imposed by the CalAIM Terms and Conditions, as the term is defined in subdivision (c) of Section 14184.101, and any terms and conditions imposed by a successor federal waiver or demonstration project and the same standards and requirements as for other Medi-Cal managed care plans in effect at that time.

(4) (A) In addition to the comprehensive risk contract or contracts described in this section, the AHCSP shall enter into a memorandum of understanding with the department to memorialize any standards or requirements that are in addition to, or different than, those imposed on other Medi-Cal managed care plans as described in paragraph (3). Upon execution, the department shall post the memorandum of understanding on its internet website.

(B) The memorandum of understanding entered into pursuant to subparagraph (A) shall include, but need not be limited to, the AHCSP's commitment to increase enrollment of new Medi-Cal members over the course of the relevant contract terms and any requirements related to the AHCSP's collaboration with, and support of, applicable safety net providers, including federally qualified health centers (FQHCs), as follows:

(i) The AHCSP shall work with FQHCs in AHCSP service areas selected by the AHCSP and the department, at the request of the FQHC, to provide assistance with population health management and clinical transformation.

(ii) The department and the AHCSP shall identify the highest need specialties and geographic areas where the AHCSP will provide, using the AHCSP's physicians, outpatient specialty care and services to address related needs, including, but not limited to, diagnostic testing and outpatient procedures for Medi-Cal beneficiaries who are not enrollees of the AHCSP.

(C) Within six months after the end of each applicable rating period for which the department contracts with the AHCSP pursuant to this section, commencing with the 2024 calendar year, the department shall publish a report describing the implementation of those standards and requirements imposed by the memorandum of understanding for the applicable rating period and post the report on its internet website.

(5) During the relevant terms of the contracts entered into pursuant to subdivision (a), the AHCSP shall periodically consult with counties and other affected local stakeholders in those geographic regions in which the AHCSP operates, in a form and manner as

directed by the department. The AHCSP shall enter into memoranda of understanding with local agencies pursuant to Medi-Cal managed care contract requirements.

(d) It is the intent of the Legislature that Medi-Cal beneficiaries enrolled in the AHCSP be assigned to a primary care physician who is contracted with the AHCSP through its exclusive contracts with a single medical group subject to the limitations imposed by federal law.

(e) Except when an AHCSP was already contracted with the department as a Medi-Cal managed care plan as of January 1, 2022, contracts entered into pursuant to subdivision (a) shall be effective no sooner than January 1, 2024.

(f) Before the initial effective date of a contract entered into pursuant to this section, the department shall conduct an assessment of the AHCSP's readiness to meet behavioral health network adequacy requirements pursuant to Medi-Cal managed care contract requirements and Section 14197 and shall post those findings on the department's internet website, including any corrective action plan imposed due to noncompliance and the department's basis for that finding of noncompliance, if any.

(g) The department shall seek any federal approvals it deems necessary to implement this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(h) The capitation rates established for contracts entered into pursuant to subdivision (a) shall be set annually in accordance with Section 14301.1. It is the intent of the Legislature that all Medi-Cal managed care plans be paid in an actuarially sound manner according to the projected acuity of the populations they serve under contract with the department.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of plan letters or other similar instructions, without taking any further regulatory action.

(j) Notwithstanding any other law, 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, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

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

(1) "Alternate health care service plan" means a nonprofit health care service plan with at least 4,000,000 enrollees statewide that owns or operates pharmacies and provides professional medical services to enrollees in specific geographic regions through an exclusive contract with a single medical group in each specific geographic region in which it is licensed pursuant to 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). If the AHCSP cannot comply with any terms of the Knox-Keene Health Care Service Plan Act, it shall request a modification of its license from the Department of Managed Health Care pursuant to Section 1352 of the Health and Safety Code, including regulations promulgated thereunder, or request an exemption from the Department of Managed Health Care pursuant to subdivision (b) of Section 1343 of the Health and Safety Code.

(2) "AHCSP family linkage" includes when any of the following individuals are current AHCSP members on the effective date of the beneficiary's Medi-Cal eligibility.

(A) A beneficiary's spouse or domestic partner.

(B) A beneficiary's dependent child, foster child, or stepchild under 26 years of age.

(C) A beneficiary's dependent who is disabled and over 21 years of age.

(D) A parent or stepparent of a beneficiary under 26 years of age.

(E) A beneficiary's grandparent, guardian, foster parent, or other relative of a beneficiary under 26 years of age with appropriate documentation of familial relationship, as determined by the department.

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

(4) "Dual eligible beneficiary" has the same meaning as set forth in paragraph (1) of subdivision (f) of Section 14184.200.

(5) "Medi-Cal managed care plan" has the same meaning as set forth in subdivision (j) of Section 14184.101.

(6) "Member" means an enrollee of the AHCSP. A beneficiary is not an enrollee solely by virtue of receiving a service through an AHCSP provider or AHCSP-contracted provider.

(l) In 2026, the department shall report to the health and fiscal committees of the Legislature to provide an update on the implementation of this section.

*(Added by Stats. 2022, Ch. 73, Sec. 4. (AB 2724) Effective January 1, 2023.)*

**14197.2.** (a) This section implements the state option in subsection (j) of Section 438.8 of Title 42 of the Code of Federal Regulations.

(b) Commencing July 1, 2019, a Medi-Cal managed care plan shall comply with a minimum 85 percent medical loss ratio (MLR) consistent with Section 438.8 of Title 42 of the Code of Federal Regulations. The ratio shall be calculated and reported for each MLR reporting year by the Medi-Cal managed care plan consistent with Section 438.8 of Title 42 of the Code of Federal Regulations.

(c) (1) Effective for contract rating periods commencing on or after July 1, 2023, a Medi-Cal managed care plan shall provide a remittance for an MLR reporting year if the ratio for that MLR reporting year does not meet the minimum MLR standard of 85 percent. The department shall determine the remittance amount on a plan-specific basis for each rating region of the plan and shall calculate the federal and nonfederal share amounts associated with each remittance.

(2) After the department returns the requisite federal share amounts associated with any remittance funds collected in any applicable fiscal year to the federal Centers for Medicare and Medicaid Services, the remaining amounts remitted by a Medi-Cal managed care plan pursuant to this section shall be transferred to the Medi-Cal Loan Repayment Program Special Fund for the purposes of the Medi-Cal Physicians and Dentists Loan Repayment Program as described in Section 14114.

(d) Except as otherwise required under this section, and until June 30, 2022, the requirements under this section do not apply to a health care service plan under a subcontract with a Medi-Cal managed care plan to provide covered health care services to Medi-Cal beneficiaries enrolled in the Medi-Cal managed care plan. This subdivision shall be inoperative on July 1, 2022.

(e) The department shall post on its internet website all of the following information:

(1) The aggregate MLR of all Medi-Cal managed care plans.

(2) The MLR of each Medi-Cal managed care plan, and, as applicable, the MLR of each subcontractor plan or other delegated entity, under contract with the Medi-Cal managed care plan, that is required to report an MLR pursuant to the CalAIM Terms and Conditions.

(3) Any required remittances owed by each Medi-Cal managed care plan, and, as applicable, any required remittances owed by each subcontractor plan or other delegated entity to that Medi-Cal managed care plan pursuant to the CalAIM Terms and Conditions.

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

(1) “Medical loss ratio (MLR) reporting year” shall have the same meaning as that term is defined in Section 438.8 of Title 42 of the Code of Federal Regulations.

(2) (A) “Medi-Cal managed care plan” means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(i) Article 2.7 (commencing with Section 14087.3).

(ii) Article 2.8 (commencing with Section 14087.5).

(iii) Article 2.81 (commencing with Section 14087.96).

(iv) Article 2.82 (commencing with Section 14087.98).

(v) Article 2.91 (commencing with Section 14089).

(vi) Article 1 (commencing with Section 14200) of Chapter 8.

(vii) Article 7 (commencing with Section 14490) of Chapter 8.

(B) For purposes of the remittance requirement described in subdivision (c), “Medi-Cal managed care plan” does not include dental managed care plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200). This subparagraph shall be inoperative on January 1, 2024.

(3) “CalAIM Terms and Conditions” shall have the same meaning as that term is defined in subdivision (c) of Section 14184.101.

(g) The department shall seek any federal approvals it deems necessary to implement this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(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 plan letters, plan or provider bulletins, or similar instructions, without taking any further regulatory action.

*(Amended by Stats. 2022, Ch. 738, Sec. 18. (AB 204) Effective September 29, 2022.)*

**14197.3.** (a) A Medi-Cal managed care plan shall give a beneficiary timely and adequate notice of an adverse benefit determination in writing consistent with the requirements in Sections 438.404, 438.408, and 438.10 of Title 42 of the Code of Federal Regulations. For purposes of this subdivision, “adverse benefit determination” means either of the following:

(1) Any action described in Section 10950.

(2) Any health care service eligible for coverage and payment under a Medi-Cal managed care plan contract that has been denied, modified, or delayed by a decision of the Medi-Cal managed care plan, or by one of its contracting providers.

(b) Except as provided in subdivision (c), a Medi-Cal managed care plan shall resolve an appeal no more than 30 calendar days from the day the Medi-Cal managed care plan receives the appeal.

(c) A Medi-Cal managed care plan shall resolve an expedited appeal no longer than 72 hours after the Medi-Cal managed care plan receives the appeal. A Medi-Cal managed care plan shall establish and maintain an expedited review process for a beneficiary or the beneficiary’s provider to request an expedited resolution of an appeal based on either of the following circumstances:

(1) If the Medi-Cal managed care plan determines, for a request from the beneficiary, or the provider indicates, in making the request on the beneficiary’s behalf or supporting the beneficiary’s request, that taking the time for a standard resolution under the timeframe described in subdivision (b) could seriously jeopardize the beneficiary’s life, physical or mental health, or ability to attain, or regain, maximum function.

(2) When the beneficiary’s condition is such that the beneficiary faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the timeframe described in subdivision (b) would be detrimental to the beneficiary’s life or health or could jeopardize the beneficiary’s ability to regain maximum function.

(d) For purposes of this section, “Medi-Cal managed care plan” means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(1) Article 2.7 (commencing with Section 14087.3), including dental managed care programs developed pursuant to Section 14087.46.

(2) Article 2.8 (commencing with Section 14087.5).

(3) Article 2.81 (commencing with Section 14087.96).

(4) Article 2.82 (commencing with Section 14087.98).

(5) Article 2.9 (commencing with Section 14088).

(6) Article 2.91 (commencing with Section 14089).

(7) Chapter 8 (commencing with Section 14200), including dental managed care plans.

(8) Chapter 8.9 (commencing with Section 14700).

(9) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services and described in the Special Terms and Conditions. For purposes of this subdivision, “Special Terms and Conditions” shall have the same meaning as set forth in subdivision (o) of Section 14184.10.

*(Added by Stats. 2017, Ch. 738, Sec. 7. (AB 205) Effective January 1, 2018.)*

**14197.4.** (a) The Legislature finds and declares all of the following:

(1) Designated public hospital systems play an essential role in the Medi-Cal program, providing high-quality care to a disproportionate number of low-income Medi-Cal and uninsured populations in the state. Because Medi-Cal covers approximately one-third of the state's population, the strength of these essential public health care systems is of critical importance to the health and welfare of the people of California.

(2) Designated public hospital systems provide comprehensive health care services to low-income patients and lifesaving trauma, burn, and disaster-response services for entire communities, and train the next generation of doctors and other health care professionals, such as nurses and paramedical professionals, who are critical to new team-based care models that achieve more efficient and patient-centered care.

(3) The Legislature intends to continue to provide levels of support for designated public hospital systems in light of their reliance on Medi-Cal funding to provide quality care to everyone, regardless of insurance status, ability to pay, or other circumstance, the significant proportion of Medi-Cal services provided under managed care by these public hospital systems, and federal requirements related to Medicaid managed care.

(4) It is the intent of the Legislature that Medi-Cal managed care plans and designated public hospital systems that may enter into contracts to provide services for Medi-Cal beneficiaries shall in good faith negotiate for, and implement, contract rates, the provision and arrangement of services and member assignment that are sufficient to ensure continued participation by Medi-Cal managed care plans and designated public hospital systems and to maintain access to services for Medi-Cal managed care beneficiaries and other low-income patients.

(5) It is the intent of the Legislature that, in order to ensure both the financial viability of Medi-Cal managed care plans and support the participation of designated public hospital systems in Medi-Cal managed care, the department shall provide Medi-Cal managed care plans actuarially sound rates reflecting the directed contract services payments implemented to comply with federal requirements relating to Medicaid managed care.

(b) Commencing with the 2017–18 state fiscal year for designated public hospital systems, and commencing with the 2023 calendar year for district and municipal public hospitals, and for each state fiscal year or rate year, as applicable, thereafter, and notwithstanding any other law, the department shall require each Medi-Cal managed care plan to increase contract services payments to the designated public hospital systems and to district and municipal public hospitals by amounts determined under a directed payment methodology that meets federal requirements and as described in this subdivision. The directed payments may be determined and applied as distributions from directed payment pools, as uniform dollar or percentage increases, or on other bases, and may incorporate acuity adjustments or other factors.

(1) The directed payments may separately account for inpatient hospital services and noninpatient hospital services. The directed payments shall be developed and applied separately for classes of designated public hospital systems and district and municipal public hospitals. The department, in consultation with the designated public hospital systems and district and municipal public hospitals, as applicable, shall establish the classes of designated public hospital systems and district and municipal public hospitals, as applicable, consistent with the objectives set forth in subdivisions (a) and (d) and that take into account differences in services provided, service delivery systems, and the level of risk assumed from Medi-Cal managed care plans. For designated public hospital systems, the factors to be considered shall include, but are not limited to, operation by the University of California, designated public hospital systems comprised of multiple acute care hospitals, level 1 or level 2 trauma designation, and the assumption of risk for the provision of inpatient hospital services.

(2) To the extent permitted by federal law and to meet the objectives identified in subdivisions (a) and (d), the department shall develop and implement the directed payment program in consultation with designated public hospital systems and district and municipal public hospitals or Medi-Cal managed care plans, or all, as follows:

(A) The department, in consultation with the designated public hospital systems and district and municipal public hospitals, as applicable, shall annually determine on a prospective basis the aggregate amount of payments that will be directed to each class of designated public hospital systems and district and municipal public hospitals pursuant to this subdivision and the classification of each designated public hospital system and district and municipal public hospital. Once the department determines the classification for each designated public hospital system and district and municipal public hospital for a particular state fiscal year or rate year, that classification shall not be eligible to change until no sooner than the subsequent year. For state fiscal years or rate years following the 2017–18 state fiscal year, the aggregate amounts of payments to a class of designated public hospital systems shall account for trend adjustments to the aggregate amounts available during the prior year, subject to any modifications to account for changes in the classification of designated public hospital systems, changes

required by federal law, changes to account for the size of the payments made pursuant to subdivision (c), or other material changes.

(B) The department, in consultation with the designated public hospital systems and district and municipal public hospitals, as applicable, shall develop the methodologies for determining the required directed payments for each designated public hospital system and district and municipal public hospital.

(C) To the extent necessary to meet the objectives identified in subdivisions (a) and (d) or to comply with federal requirements, the department may, in consultation with the designated public hospital systems and district and municipal public hospitals, as applicable, adjust or modify the amounts of the aggregate directed payments for any class of designated public hospital systems and district and municipal public hospitals, the method for determining the distribution of the directed payment amounts within any class of designated public hospital systems and district and municipal public hospitals, and may modify, consolidate, or subdivide the classes of designated public hospital systems and district and municipal public hospitals established pursuant to paragraph (1).

(D) After the aggregate amounts and the distribution methodology of directed payments for each designated public hospital system and district and municipal public hospital class have been established, the department shall consult with the designated public hospital systems, district and municipal public hospitals, and each affected Medi-Cal managed care plan with regard to the impact on the Medi-Cal managed care plan capitation ratesetting process and implementation of the directed payment requirements, including applicable interim and final payment processes, to ensure that 100 percent of the aggregate amounts are paid to the applicable designated public hospital system and district and municipal public hospital.

(3) The required directed payment amounts shall be paid by the Medi-Cal managed care plans as adjustments, in a form and manner specified by the department, to the total amounts of contract services payments otherwise paid to the designated public hospital systems and district and municipal public hospitals.

(4) The directed payments required under this subdivision shall be implemented and documented by each Medi-Cal managed care plan, designated public hospital system, and district and municipal public hospital, as applicable, in accordance with all of the following parameters and any guidance issued by the department:

(A) A Medi-Cal managed care plan and the designated public hospital systems and district and municipal public hospitals shall determine the manner, timing, and amount of payment for contract services, including through fee-for-service, capitation, or other permissible manner. The rates of payment for contract services agreed upon by the Medi-Cal managed care plan and the designated public hospital system and district and municipal public hospital, as applicable, shall be established and documented without regard to the directed payments and quality incentive payments required by this section.

(B) The required directed payment enhancements provided pursuant to this subdivision shall not supplant amounts that would otherwise be payable by a Medi-Cal managed care plan to a designated public hospital system or district and municipal public hospital for an applicable state fiscal year or rate year, and the Medi-Cal managed care plan shall not impose a fee or retention amount that would result in a direct or indirect reduction to the amounts required under this subdivision.

(C) A contract between a Medi-Cal managed care plan and a designated public hospital system or district and municipal public hospital shall not be terminated by either party for the specific purpose of circumventing or otherwise impacting the payment obligations implemented pursuant to this subdivision.

(D) If a Medi-Cal managed care plan subcontracts or delegates responsibility to a separate entity for either or both the arrangement or payment of services, the Medi-Cal managed care plan shall be responsible for paying the designated public hospital system and district and municipal public hospital, as applicable, the directed payment described in this subdivision with respect to the services it provides that are covered by that arrangement. The designated public hospital system or district and municipal public hospital, as applicable, and the applicable subcontractor or delegated entity shall work together with the Medi-Cal managed care plan to provide the information necessary to facilitate the Medi-Cal managed care plan’s compliance with the payment requirements under this subdivision.

(5) Each state fiscal year, a Medi-Cal managed care plan shall provide to the department, at the times and in the form and manner specified by the department, an accounting of amounts paid or payable to the designated public hospital systems and district and municipal public hospitals with which it contracts, including both contract rates and the directed payments, to demonstrate compliance with this subdivision. To the extent that the department determines that a Medi-Cal managed care plan is not in compliance with the requirements of this subdivision, or is otherwise circumventing the purposes thereof, to the material detriment of an applicable designated public hospital system, the department may, after providing notice of its determination to the affected Medi-Cal managed care plan and allowing a reasonable period for the Medi-Cal managed care plan to cure the specified deficiencies, reduce the default assignment into the Medi-Cal managed care plan with respect to all Medi-Cal managed care beneficiaries by up to 25 percent in the applicable county, so long as the other Medi-Cal managed care plan or Medi-Cal managed

care plans in the applicable county have the capacity to receive the additional default membership. The department's determination whether to exercise discretion under this paragraph shall not be subject to judicial review, except that a Medi-Cal managed care plan that has its default assignment reduced pursuant to this paragraph may bring a writ of mandate under Section 1085 of the Code of Civil Procedure to rectify an abuse of discretion by the department under this paragraph. Nothing in this paragraph shall be construed to preclude or otherwise limit the right of any Medi-Cal managed care plan or designated public hospital system to pursue a breach of contract action, or any other available remedy as appropriate, in connection with the requirements of this subdivision.

(6) Capitation rates paid by the department to a Medi-Cal managed care plan shall be actuarially sound and account for the Medi-Cal managed care plan's obligation to pay the directed payments to designated public hospital systems and district and municipal public hospitals in accordance with this subdivision. The department may require Medi-Cal managed care plans and the designated public hospital systems and district and municipal public hospitals to submit information regarding contract rates and expected or actual utilization of services, at the times and in the form and manner specified by the department. To the extent consistent with federal law and actuarial standards of practice, the department shall utilize the most recently available data and reasonable projections, as determined by the department, when accounting for the directed payments required under this subdivision, and shall account for additional clinics, practices, or other health care providers added to a designated public hospital system or district and municipal public hospital. In implementing the requirements of this section, including the Medi-Cal managed care plan ratesetting process, the department may additionally account for material adjustments, as appropriate under federal law and actuarial standards, as described above, and as determined by the department, to contracts entered into between a Medi-Cal managed care plan or applicable subcontracted or delegated entity and a designated public hospital system or district and municipal public hospital, as applicable.

(c) Commencing with the 2017–18 state fiscal year for designated public hospital systems, and commencing with the 2020–21 state fiscal year for district and municipal public hospitals, and for each state fiscal year or rate year, as applicable, thereafter, the department, in consultation with the designated public hospital systems, district and municipal public hospitals, and applicable Medi-Cal managed care plans, as applicable, shall establish and implement a program or programs under which a designated public hospital system or a district and municipal public hospital may earn performance-based quality incentive payments from the Medi-Cal managed care plan with which they contract in accordance with this subdivision.

(1) Payments shall be earned by each designated public hospital system based on its performance in achieving identified targets for quality of care.

(A) The department, in consultation with the designated public hospital systems and applicable Medi-Cal managed care plans, shall establish and provide a method for updating uniform performance measures for the performance-based quality incentive payment program and parameters for the designated public hospital systems to select the applicable measures. The performance measures shall advance at least one goal identified in the state's Medicaid quality strategy. Through and until June 30, 2020, performance measures pursuant to this subdivision shall not duplicate measures utilized in the PRIME program established pursuant to Section 14184.50.

(B) Each designated public hospital system shall submit reports to the department containing information required to evaluate its performance on all applicable performance measures, at the times and in the form and manner specified by the department. A Medi-Cal managed care plan shall assist a designated public hospital system in collecting and distributing information necessary for these reports.

(2) The department, in consultation with each designated public hospital system, shall determine a maximum amount that each class established pursuant to paragraph (1) of subdivision (b) may earn in quality incentive payments for the state fiscal year or rate year.

(3) The department shall calculate the amount earned by each designated public hospital system based on its performance score established pursuant to paragraph (1).

(A) This amount shall be paid to the designated public hospital system by each of its contracted Medi-Cal managed care plans. If a designated public hospital system contracts with multiple Medi-Cal managed care plans, the department shall identify each Medi-Cal managed care plan's proportionate amount of the designated public hospital system's payment. The timing and amount of the distributions and any related reporting requirements for interim payments shall be established and agreed to by the designated public hospital system and each of the applicable Medi-Cal managed care plans.

(B) A contract between a Medi-Cal managed care plan and designated public hospital system shall not be terminated by either party for the specific purpose of circumventing or otherwise impacting the payment obligations implemented pursuant to this subdivision.

(C) Each Medi-Cal managed care plan shall be responsible for payment of the quality incentive payments described in this subdivision, subject to funding by the department pursuant to paragraph (5).

(4) Commencing with the 2020–21 state fiscal year, payments under this paragraph shall be earned by a district and municipal public hospital based on its performance in achieving identified targets for quality of care.

(A) The department, in consultation with district and municipal public hospitals, shall establish a class of district and municipal public hospitals, or multiple classes to the extent federal approval is available, for purposes of payments under this paragraph.

(B) The department, in consultation with district and municipal public hospitals, shall determine a maximum amount that the class, or classes, of district and municipal public hospitals established pursuant to subparagraph (A) may earn in quality incentive payments for an applicable state fiscal year or rate year.

(C) The department, in consultation with district and municipal public hospitals and applicable Medi-Cal managed care plans, shall establish and provide a method for updating uniform performance measures for the performance-based quality incentive payments and parameters for district and municipal public hospitals to select the applicable measures. The performance measures shall advance at least one goal identified in the state's Medicaid quality strategy.

(D) Each district and municipal public hospital shall submit reports to the department containing information required to evaluate its performance on all applicable performance measures, at the time and in the form and manner specified by the department. Medi-Cal managed care plans shall assist a district and municipal public hospital in collecting and distributing information necessary for these reports.

(E) The department shall calculate the amount earned by each district and municipal public hospital based on its performance score established pursuant to subparagraphs (C) and (D). This amount shall be paid to the district and municipal public hospital by each of its contracted Medi-Cal managed care plans. If a district and municipal public hospital contracts with multiple Medi-Cal managed care plans, the department shall identify each Medi-Cal managed care plan's proportionate amount of the district and municipal public hospital's payment. The timing and amount of the distributions and any related reporting requirements for interim payments shall be established and agreed to by the district and municipal public hospital and each of the applicable Medi-Cal managed care plans.

(F) A contract between a Medi-Cal managed care plan and district and municipal public hospital shall not be terminated by either party for the specific purpose of circumventing or otherwise impacting the payment obligations implemented pursuant to this paragraph.

(G) Each Medi-Cal managed care plan shall be responsible for payment of the quality incentive payments described in this paragraph, subject to funding by the department pursuant to paragraph (5).

(5) The department shall provide appropriate funding to each Medi-Cal managed care plan, to account for and to enable them to make the quality incentive payments described in this subdivision, through the incorporation into actuarially sound capitation rates or any other federally permissible method. The amounts designated by the department for the quality incentive payments made pursuant to this subdivision shall be reserved for the purposes of the performance-based quality incentive payment program.

(d) (1) In determining the amount of the required directed payments described in paragraph (2) of subdivision (b), and the aggregate size of the quality incentive payment program described in paragraph (2) of subdivision (c), the department shall consult with designated public hospital systems to establish levels for these payments that, in combination with one another, are projected to result in aggregate payments that will advance the quality and access objectives reflected in prior payment enhancement mechanisms for designated public hospital systems. To the extent necessary to meet these objectives or to comply with any federal requirements, the department may, in consultation with the designated public hospital systems, adjust or modify either or both the directed payments or quality incentive payment program. Once these payment levels are established, the department shall consult with the designated public hospital systems and the Medi-Cal managed care plans in the development of the Medi-Cal managed care rates needed for the directed payments and the structure of the quality incentive payment program.

(2) (A) For the 2017–18 state fiscal year, the department shall, as soon as practicable after receipt of necessary federal approvals pursuant to paragraph (1) of subdivision (g), provide written notice of the directed payment and quality incentive payment amounts established pursuant to this section. A Medi-Cal managed care plan's obligation to pay the directed payments and quality incentive payments required under subdivisions (b) and (c), respectively, to a designated public hospital system for the 2017–18 state fiscal year shall be contingent on the receipt of the written notice described in this subparagraph.

(B) For each annual determination, commencing with the 2018–19 state fiscal year and each state fiscal year or rate year thereafter, the department shall provide written notice, as soon as practicable, to each affected Medi-Cal managed care plan, designated public hospital system, and, commencing with the 2020–21 state fiscal year, each district and municipal public hospital of the applicable Medi-Cal managed care plan's directed payment amounts, the classification of designated public hospital systems and district and municipal public hospitals, as applicable, quality incentive payment amounts, and any other information deemed necessary for the Medi-Cal managed care plan to fulfill its payment obligations under subdivisions (b) and (c), as applicable, for the subject state fiscal year or rate year. If the modification of either or both directed payment amounts or

quality incentive payment amounts is necessary after receipt of the written notification, the department shall notify the Medi-Cal managed care plan, designated public hospital system, and district and municipal public hospital, as applicable, in writing of the revised amounts before implementation of the revised amounts.

(e) (1) The provisions of paragraphs (3), (4), and (5) of subdivision (a), paragraphs (3) and (4) of subdivision (b), paragraphs (3) and (5) of subdivision (c), and paragraph (2) of subdivision (d) shall be deemed incorporated into each contract between a designated public hospital system and a Medi-Cal managed care plan, and its subcontractor or designee, as applicable, and any claim for breach of those provisions may be brought by the designated public hospital system or the Medi-Cal managed care plan directly in a court of competent jurisdiction.

(2) Commencing with the 2020–21 state fiscal year, the provisions of paragraph (4) of subdivision (c) and paragraph (2) of subdivision (d) shall be deemed incorporated into each contract between a district and municipal public hospital and a Medi-Cal managed care plan, and its subcontractor or designee, as applicable, and any claim for breach of those provisions may be brought by the district and municipal public hospital or the Medi-Cal managed care plan directly in a court of competent jurisdiction.

(f) (1) (A) The nonfederal share of the portion of the capitation rates specifically associated with directed payments required under subdivision (b) and the quality incentive payments established pursuant to subdivision (c) may consist of voluntary intergovernmental transfers of funds provided by designated public hospitals or district and municipal public hospitals and their affiliated governmental entities, or other public entities, pursuant to Section 14164. Upon providing any intergovernmental transfer of funds, each transferring entity shall certify that the transferred funds qualify for federal financial participation pursuant to applicable federal Medicaid laws, and in the form and manner specified by the department. Any intergovernmental transfer of funds made pursuant to this section shall be considered voluntary for purposes of all federal laws.

(B) Notwithstanding any other law, commencing with the 2025 calendar year, the department may, upon acceptance of the voluntary intergovernmental transfers described in subparagraph (A), assess a fee not to exceed 5 percent on intergovernmental transfers pursuant to this section to reimburse the department for the administrative costs of operating the programs pursuant to this section and for the support of the Medi-Cal program.

(2) (A) When applicable for voluntary intergovernmental transfers described in paragraph (1) that are associated with payments to designated public hospital systems, the department, in consultation with the designated public hospital systems, shall develop and maintain a protocol to determine the available funding for the nonfederal share associated with payments for each applicable state fiscal year or rate year pursuant to this section. The protocol developed and maintained pursuant to this paragraph shall account for any applicable contributions made by public entities to the nonfederal share of Medi-Cal managed care expenditures, including, but not limited to, contributions previously made by those specific public entities for the 2015–16 state fiscal year pursuant to Section 14182.15 or 14199.2, but excluding any contributions made pursuant to Sections 14301.4 and 14301.5. Nothing in this section shall be construed to limit or otherwise alter any existing authority of the department to accept intergovernmental transfers for purposes of funding the nonfederal share of Medi-Cal managed care expenditures.

(B) When applicable for voluntary intergovernmental transfers described in paragraph (1) that are associated with payments to district and municipal public hospital systems, the department, in consultation with district and municipal public hospital systems, shall develop and maintain a protocol to determine the available funding for the nonfederal share associated with payments for each applicable state fiscal year or rate year pursuant to this section. Nothing in this section shall be construed to limit or otherwise alter any existing authority of the department to accept intergovernmental transfers for purposes of funding the nonfederal share of Medi-Cal managed care expenditures.

(g) (1) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(2) For any state fiscal year in which this section is implemented, in whole or in part, and notwithstanding any other law, the department or a Medi-Cal managed care plan shall not be required to make any payment pursuant to Section 14182.15, 14199.2, or 14301.5. Nothing in this section shall be construed to preclude or otherwise impose limitations on payment amounts or arrangements that may be negotiated and agreed to between the relevant parties, including, but not limited to, the continuation of existing or the creation of new quality incentive or pay-for-performance programs in addition to the quality incentive payment program described in subdivision (c) and contract services payments that may be in excess of the directed payment amounts required under subdivision (b).

(h) (1) The department shall seek any necessary federal approvals for the directed payments and the quality incentive payments set forth in this section.

(2) The department shall consult with the designated public hospital systems and district and municipal public hospitals with regard to the development of the directed payment levels established pursuant to subdivisions (b) and (c) of this section, as applicable, and shall consult with designated public hospital systems, district and municipal public hospitals, and Medi-Cal managed care plans with regards to the implementation of payments under this section.

(3) The director, after consultation with the designated public hospital systems, district and municipal public hospitals, and Medi-Cal managed care plans, may modify the requirements set forth in this section to the extent necessary to meet federal requirements or to maximize available federal financial participation. If federal approval is only available with significant limitations or modifications, or if there are changes to the federal Medicaid program that result in a loss of funding currently available to the designated public hospital systems or to the district and municipal public hospitals, the department shall consult with the designated public hospitals systems, the district and municipal public hospitals, and Medi-Cal managed care plans, as applicable, to consider alternative methodologies.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, provider bulletins, or other similar instructions, without taking regulatory action. The department shall make use of appropriate processes to ensure that affected designated public hospital systems, the district and municipal public hospitals, and Medi-Cal managed care plans, as applicable, are timely informed of, and have access to, applicable guidance issued pursuant to this authority, and that this guidance remains publicly available until all payments made pursuant to this section are finalized.

(j) (1) (A) Directed payments and quality incentive payments to designated public hospital systems pursuant to subdivisions (b) and (c) shall cease to be operative on the first day of the state fiscal year or rate year beginning on or after the date the department determines, after consultation with the designated public hospital systems, that implementation of this section is no longer financially or programmatically supportive of the Medi-Cal program. This determination shall be based solely on the following factors:

(i) The projected amount of nonfederal share funds available is insufficient to support implementation of the payments to designated public hospital systems pursuant to subdivisions (b) and (c) in the subject state fiscal year or rate year.

(ii) The degree to which the payment arrangements for designated public hospital systems will no longer materially advance the goals and objectives reflected in this section and in the department's managed care quality strategy drafted and implemented pursuant to Section 438.340 of Title 42 of the Code of Federal Regulations in the subject state fiscal year or rate year.

(B) In making its determination, the department shall consider all reasonable options for mitigating the circumstances set forth in subparagraph (A), including, but not limited to, options for curing projected funding shortfalls and options for program revisions and strategy updates to better coordinate payment requirements with the goals and objectives of this section and the managed care quality strategy.

(C) The department shall post notice of the determination on its internet website, and shall provide written notice of the determination to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(2) (A) Directed payments and quality incentive payments to district and municipal public hospitals pursuant to subdivisions (b) and (c) shall cease to be operative on the first day of the state fiscal year or rate year beginning on or after the date the department determines, after consultation with the district and municipal public hospitals, that implementation of this section is no longer financially or programmatically supportive of the Medi-Cal program. This determination shall be based solely on the following factors:

(i) The projected amount of nonfederal share funds available is insufficient to support implementation of the payments to district and municipal hospitals pursuant to subdivisions (b) and (c) in the subject state fiscal year or rate year.

(ii) The degree to which the payment arrangement for district and municipal hospitals will no longer materially advance the goals and objectives reflected in this section and in the department's managed care quality strategy drafted and implemented pursuant to Section 438.340 of Title 42 of the Code of Federal Regulations in the subject state fiscal year or rate year.

(B) In making its determination, the department shall consider all reasonable options for mitigating the circumstances set forth in subparagraph (A), including, but not limited to, options for curing projected funding shortfalls and options for program revisions and strategy updates to better coordinate payment requirements with the goals and objectives of this section and the managed care quality strategy.

(C) The department shall post notice of the determination on its internet website, and shall provide written notice of the determination to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(k) The department, in consultation with the designated public hospital systems and the Medi-Cal managed care plans, shall provide the Legislature with the federally approved evaluation plan required in Section 438.6(c)(2)(i)(D) of Title 42 of the Code of Federal Regulations to measure the degree to which the payments authorized under this section advance at least one of the goals and objectives of the department's managed care quality strategy. The department, in consultation with the designated public hospital

systems and the Medi-Cal managed care plans, shall report to the Legislature the results of this evaluation once the department determines that the evaluation is finalized and complete according to the terms of any applicable federal approval and no earlier than January 1, 2021.

(l) (1) The department may, after consultation with the designated public hospital systems, the district and municipal public hospitals, and Medi-Cal managed care plans, as applicable, exclude certain Medi-Cal managed care enrollee categories of aid, or subcategories thereof, or certain categories of medical assistance provided under a Medi-Cal managed care plan, or subcategories thereof, from the definition of "contract services payments" for purposes of the directed payment requirements described in subdivision (b).

(2) The department shall seek federal approval to implement this subdivision.

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

(1) "Contract services payments" means the amount paid or payable to a designated public hospital system, including amounts paid or payable under fee-for-service, capitation amounts before any adjustments for service payment withholds or deductions, or payments made on any other basis, under a network provider contract with a Medi-Cal managed care plan for medically necessary and covered services, drugs, supplies, or other items provided to an eligible Medi-Cal beneficiary enrolled in the Medi-Cal managed care plan, excluding services provided to individuals who are dually eligible for both the Medicare and Medi-Cal programs and any additional exclusions that are approved pursuant to subdivision (l). Contract services includes all covered services, drugs, supplies, or other items the designated public hospital system provides, or is responsible for providing, or arranging or paying for, pursuant to a network provider contract entered into with a Medi-Cal managed care plan. If a Medi-Cal managed care plan subcontracts or delegates responsibility to a separate entity for either or both the arrangement or payment of services, "contract services payments" also include amounts paid or payable for the services provided by, or otherwise the responsibility of, the designated public hospital system that are within the scope of services of the subcontracted or delegated arrangement so long as the designated public hospital system holds a network provider contract with the primary Medi-Cal managed care plan.

(2) "Designated public hospital" has the same meaning as set forth in subdivision (f) of Section 14184.10.

(3) "Designated public hospital system" means a designated public hospital and its affiliated government entity clinics, practices, and other health care providers, including the respective affiliated hospital authority and county government entities described in Chapter 5 (commencing with Section 101850) and Chapter 5.5 (commencing with Section 101852), of Part 4 of Division 101 of the Health and Safety Code.

(4) (A) "Medi-Cal managed care plan" means an applicable organization or entity that enters into a contract with the department pursuant to any of the following:

(i) Article 2.7 (commencing with Section 14087.3).

(ii) Article 2.8 (commencing with Section 14087.5).

(iii) Article 2.81 (commencing with Section 14087.96).

(iv) Article 2.82 (commencing with Section 14087.98).

(v) Article 2.91 (commencing with Section 14089).

(vi) Chapter 8 (commencing with Section 14200).

(B) "Medi-Cal managed care plan" does not include any of the following:

(i) A mental health plan contracting to provide mental health care for Medi-Cal beneficiaries pursuant to Chapter 8.9 (commencing with Section 14700).

(ii) A plan not covering inpatient services, such as primary care case management plans, operating pursuant to Section 14088.85.

(iii) A Program of All-Inclusive Care for the Elderly organization operating pursuant to Chapter 8.75 (commencing with Section 14591).

(5) "Network provider" has the same meaning as that term is defined in Section 438.2 of Title 42 of the Code of Federal Regulations, and does not include arrangements where a designated public hospital system or a district and municipal public hospital provides or arranges for services under an agreement intended to cover a specific range of services for a single identified patient for a single inpatient admission, including any directly related followup care, outpatient visit or service, or other similar

patient specific nonnetwork contractual arrangement, such as a letter of agreement or single case agreement, with a Medi-Cal managed care plan or subcontractor of a Medi-Cal managed care plan.

(6) “District and municipal public hospital” means a nondesignated public hospital, as defined in subdivision (k) of Section 14184.10, that is a contracted network provider of one or more Medi-Cal managed care plans, and that had an approved project plan under the PRIME program established pursuant to Section 14184.50 or is otherwise authorized to participate in a quality incentive directed payment program pursuant to the applicable terms of federal approval obtained by the department pursuant to paragraph (1) of subdivision (h).

*(Amended by Stats. 2024, Ch. 40, Sec. 68. (SB 159) Effective June 29, 2024.)*

**14197.45.** (a) Notwithstanding any other law, for covered benefits under its contract, as applicable, a Medi-Cal managed care plan shall comply with all of the following:

(1) Make a good faith effort to contract with at least one National Cancer Institute (NCI)-designated comprehensive cancer center, site affiliated with the NCI Community Oncology Research Program (NCORP), or qualifying academic cancer center, within its contracted provider network and its subcontracted provider network, if applicable, within each county in which the Medi-Cal managed care plan operates, for provision of services to any eligible enrollee diagnosed with a complex cancer diagnosis. For purposes of this paragraph, the NCI-designated comprehensive cancer center, NCORP-affiliated site, or qualifying academic cancer center shall enroll in the Medi-Cal program if there is a state-level enrollment pathway, or the Medi-Cal managed care plan shall vet the qualifications of the facility to ensure they can meet the standards of participation required to contract with a Medi-Cal managed care plan.

(2) (A) Allow any eligible enrollee diagnosed with a complex cancer diagnosis to request a referral to receive medically necessary services through any of the following in-network providers unless the enrollee chooses a different cancer treatment provider:

(i) An NCI-designated comprehensive cancer center.

(ii) An NCORP-affiliated site.

(iii) A qualifying academic cancer center.

(B) (i) If the Medi-Cal managed care plan is unsuccessful in its good faith contracting efforts pursuant to paragraph (1), the Medi-Cal managed care plan shall allow an enrollee to request a referral to receive medically necessary services through an out-of-network NCI-designated comprehensive cancer center, out-of-network NCORP-affiliated site, or out-of-network qualifying academic cancer center, unless the enrollee chooses a different cancer treatment provider.

(ii) Clause (i) shall only apply if the Medi-Cal managed care plan and the out-of-network NCI-designated comprehensive cancer center, out-of-network NCORP-affiliated site, or out-of-network qualifying academic cancer center come to agreement with respect to payment.

(3) (A) After approving a referral request pursuant to paragraph (2), allow an eligible enrollee diagnosed with a complex cancer diagnosis to access oncology, hematology, or other relevant specialists through a contracted NCI-designated comprehensive cancer center, a contracted NCORP-affiliated site, or a contracted qualifying academic cancer center, for the enrollee’s condition and identified needs as medically necessary.

(B) If the NCI-designated comprehensive cancer center, NCORP-affiliated site, or qualifying academic cancer center refers an enrollee with a complex cancer condition to an out-of-network specialist pursuant to subparagraph (B) of paragraph (2), this paragraph shall only apply if the Medi-Cal managed care plan and the out-of-network specialist come to an agreement with respect to payment.

(4) A denial of an enrollee’s referral request shall be based upon a determination by the treating provider that the request to receive services at an NCI–designated comprehensive cancer center, or an NCORP-affiliated site, or a qualifying academic cancer center is not medically necessary, the requested services are not available at, or not applicable to the enrollee’s cancer diagnosis at, the requested NCI-designated comprehensive cancer center, NCORP-affiliated site, or qualifying academic cancer center, or the NCI-designated comprehensive cancer center, NCORP-affiliated site, or qualifying academic cancer center is an out-of-network provider and the Medi-Cal managed care plan and the out-of-network NCI-designated comprehensive cancer center, NCORP-affiliated site, or qualifying academic cancer center are unable to come to agreement with the respect to payment.

(5) Ensure that the services of an NCI-designated comprehensive cancer center, NCORP-affiliated site, or qualifying academic cancer center available to an eligible enrollee are sufficient in amount, duration, and scope as medically necessary for the

treatment of the enrollee's condition.

(6) Refrain from arbitrarily denying or reducing the amount, duration, or scope of required services solely because of diagnosis, type of illness, or condition of the enrollee.

(b) A Medi-Cal managed care plan shall notify all enrollees of their right to request a referral to access care through an NCI-designated comprehensive cancer center, NCORP-affiliated site, or qualifying academic cancer center, if they are diagnosed with a complex cancer diagnosis.

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

(1) (A) "Complex cancer diagnosis" means a diagnosis for which there is no standard FDA-approved treatment or for which known highly effective therapy for metastatic cancer has failed and any of the following diagnoses: hematological malignancies, acute leukemia, advanced, relapsed, refractory non-Hodgkin lymphoma and multiple myeloma, including BPDCN and T-cell leukemias and lymphomas, and advanced stage, relapsed solid tumors refractory to standard FDA-approved treatment options, advanced stage rare solid tumors for which there is no known effective standard treatment options, or any other condition as determined pursuant to paragraph (2) of subdivision (d). "Advanced stage" cancer means stage IV metastatic cancer.

(B) The department is authorized to periodically update and further define "complex cancer diagnosis" pursuant to the process outlined in subdivision (d).

(2) "Eligible enrollee" means an individual enrolled with a particular Medi-Cal managed care plan who receives a complex cancer diagnosis.

(3) "National Cancer Institute (NCI) Community Oncology Research Program (NCORP)-affiliated site" is a cancer center that has received an approved grant from NCI through NCORP that provides cancer clinical trials and care delivery studies.

(4) "NCI-designated comprehensive cancer center" is a cancer center that meets ongoing standards for cancer prevention, clinical services, and research, as determined by regular reviews and evaluations by NCI.

(5) "Qualifying academic cancer center" is a research and clinical cancer center that meets all the following criteria:

(A) It is an institution with a medical oncology or hematology subspecialty expertise in each of the diagnoses included in paragraph (1).

(B) It has a portfolio of phases 1, 2, and 3 clinical trials available for eligible enrollees.

(C) It provides fellowship programs in medical oncology, hematology or hematological oncology, radiation oncology, or a surgical oncology specialty.

(D) It provides inpatient and outpatient supportive care services.

(E) It covers clinical, anatomic, and molecular pathology with subspecialty expertise for each of the cancer types included in paragraph (1).

(F) It provides a program accredited by the American College of Surgeons (ACS) Commission on Cancer (CoC).

(G) It has accreditation for the main campus by the Foundation for the Accreditation of Cellular Therapy.

(d) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of all-county letters, plan letters, provider bulletins, information notices, or other similar guidance, without taking further regulatory action.

(2) The department, in consultation with stakeholders, shall develop a process for updating and further defining a "complex cancer diagnosis" on a periodic basis.

(e) The department shall seek any federal approvals it deems necessary to implement this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(f) For purposes of implementing this section, the department may enter into an exclusive or nonexclusive contract, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this section shall be exempt from 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.

*(Amended by Stats. 2023, Ch. 131, Sec. 232. (AB 1754) Effective January 1, 2024.)*

**14197.5.** (a) Notwithstanding any other law, but no sooner than July 1, 2019, the Cost-Based Reimbursement Clinic Directed Payment Program shall be in operation.

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

(1) “Cost-based reimbursement clinics” or “CBRCs” have the same meaning as the providers described in subdivision (a) of Section 14105.24.

(2) “Cost-Based Reimbursement Clinic Directed Payment Program” or “CBRC DPP” or “program,” means a directed payment initiative implemented pursuant to subsection (c) of Section 438.6 of Title 42 of the Code of Federal Regulations or other applicable federal authority that requires affected Medi-Cal managed care plans to compensate CBRCs that are network providers for all network contract services provided to enrollees of the applicable Medi-Cal managed care plan as those clinics would be reimbursed according to the Medi-Cal cost-based, fee-for-service methodology as described in Section 14105.24. Services provided to enrollees who are dually eligible for both the Medicare and Medi-Cal programs are excluded for purposes of this program.

(3) “Medi-Cal managed care plan” or “plan” has the same meaning as described in paragraph (4) of subdivision (m) of Section 14197.4.

(4) “Network provider” has the same meaning as that term is defined in paragraph (5) of subdivision (m) of Section 14197.4.

(c) (1) The department shall increase the capitation amounts paid to affected plans in each fiscal year by the amount the department deems necessary for the plan to comply with the requirements of this section, subject to the availability of nonfederal share funding described in subdivision (d).

(2) The directed payment amounts paid under this section shall not supplant amounts that would otherwise be payable by a plan to a CBRC for an applicable fiscal year, and the plan shall not impose a fee or retention amount that would result in a direct or indirect reduction to the amounts required under this section.

(d) The nonfederal share of the increases described in subdivision (c) may be funded through voluntary, intergovernmental transfers from affected counties or other public entities pursuant to Section 14164. Subject to an appropriation in the annual Budget Act, the first thirty million dollars ($30,000,000) of nonfederal share in each fiscal year, or any lesser amount as determined by the department pursuant to paragraph (2) of subdivision (e), shall be financed by other state funds appropriated to the department for this purpose. Upon providing any intergovernmental transfer of funds, each transferring entity shall certify, in the form and manner specified by the department, that the transferred funds qualify for federal financial participation pursuant to applicable Medicaid laws. Any intergovernmental transfer of funds made pursuant to this section shall be considered voluntary for purposes of all federal laws. Notwithstanding any other law, the department shall not assess the fee described in subdivision (d) of Section 14301.4 nor any other similar fee.

(e) (1) The department shall consult with the affected counties on a periodic basis, as determined appropriate by the department, to assess the extent to which implementation of the directed payments under this section in a particular fiscal year is likely to be federally approved and remains financially and programmatically supportive of the Medi-Cal program.

(2) After consulting with the affected counties pursuant to paragraph (1), the department may do either of the following:

(A) Reduce the total size of CBRC DPP payments to be made in that applicable fiscal year. If the department elects to reduce the total size of payments, the amount of state funding required to be provided first as nonfederal share for an applicable fiscal year pursuant to subdivision (d) shall be reduced as calculated and determined by the department.

(B) Elect to not implement CBRC DPP payments for an applicable fiscal year or years.

(f) Notwithstanding any other law, for any fiscal year in which the department implements the CBRC DPP payments, the amount of state funding provided as described in subdivision (d) shall not be included in the total revenues as defined in paragraph (7) of subdivision (b) of Section 17612.5.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of plan letters, provider bulletins, or other similar instructions, without taking regulatory action.

(h) 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.

*(Added by Stats. 2018, Ch. 34, Sec. 32. (AB 1810) Effective June 27, 2018.)*

**14197.6.** (a) For purposes of this section, the following definitions apply:

(1) “Children’s hospital” has the same meaning as that term is defined in Section 10727.

(2) “Medi-Cal managed care plan” has the same meaning as that term is defined in subdivision (j) of Section 14184.101.

(b) Notwithstanding any other law, for dates of service no sooner than July 1, 2024, the department shall establish a directed payment reimbursement methodology, or revise one or more existing directed payment reimbursement methodologies, applicable to children’s hospitals. Medi-Cal managed care plans shall reimburse children’s hospitals in accordance with the requirements of the directed payment arrangement established by the department pursuant to this section and guidance issued pursuant to subdivision (e).

(c) The department shall establish the form and manner of the directed payments authorized pursuant to this section, in consultation with representatives of children’s hospitals and in accordance with the requirements for directed payment arrangements described in Section 438.6(c) of Title 42 of the Code of Federal Regulations and any associated federal guidance.

(d) In implementing this section, the department shall seek any federal approvals that it deems necessary. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(e) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section, in whole or in part, by means of all-county letters, plan letters, provider bulletins, information notices, or other similar instructions, without taking any further regulatory action.

(f) The department shall develop the methodologies and parameters for the payments implemented pursuant to subdivisions (b) and (c) and may revise the methodologies and parameters for purposes, including, but not limited to, obtaining or maintaining any necessary federal approvals as required by subdivision (d).

(g) Commencing no sooner than July 1, 2024, and notwithstanding Section 13340 of the Government Code, one hundred fifteen million dollars ($115,000,000) annually shall be continuously appropriated to the department from the General Fund to support the payments implemented pursuant to this section, except that such amount may be adjusted pursuant to subdivision (h).

(h) If the Protect Access to Healthcare Act of 2024 (A.G. No. 23-0024) is approved by the voters, and if children’s hospitals receive increased reimbursement rates or payments pursuant to Section 14199.108, 14199.108.3, 14199.112, or 14199.116, or if children’s hospitals receive increased reimbursement rates or payments funded pursuant to subdivision (c) of Section 14105.200, then the amount available for directed payments to children’s hospitals as specified in subdivision (g) and the amount directed pursuant to subdivision (c) may be reduced by the estimated total amount of such increases, as determined by the Department of Health Care Services, in an amount not to exceed seventy-five million dollars ($75,000,000) annually.

(i) It is the intent of the Legislature that the payments implemented pursuant to this section are to augment amounts that would otherwise be payable to children’s hospitals by a Medi-Cal managed plan or the department. It is not the intent of the Legislature that the payments implemented pursuant to this section replace amounts that would otherwise be payable by a Medi-Cal managed care plan or the department to children’s hospitals.

*(Added by Stats. 2024, Ch. 40, Sec. 69. (SB 159) Effective June 29, 2024.)*

**14197.7.** (a) (1) Notwithstanding any other law, if the director finds that an entity that contracts with the department for the delivery of health care services (contractor), including a Medi-Cal managed care plan or a prepaid health plan, fails to comply with contract requirements, state or federal law or regulations, or the state plan or approved waivers, or for other good cause, the director may terminate the contract or impose sanctions as set forth in this section.

(2) Good cause includes, but is not limited to, a finding of deficiency that results in improper denial or delay in the delivery of health care services, potential endangerment to patient care, disruption in the contractor’s provider network, failure to approve continuity of care, that claims accrued or to accrue have not or will not be recompensed, or a delay in required contractor reporting to the department.

(b) The director may identify findings of noncompliance or good cause through any means, including, but not limited to, findings in audits, investigations, contract compliance reviews, quality improvement system monitoring, routine monitoring, facility site surveys, encounter and provider data submissions, grievances and appeals, network adequacy reviews, assessments of timely access requirements, reviews of utilization data, health plan rating systems, fair hearing decisions, complaints from beneficiaries and other stakeholders, whistleblowers, and contractor self-disclosures.

(c) (1) Except when the director determines there is an immediate threat to the health of Medi-Cal beneficiaries receiving health care services from the contractor, at the request of the contractor, the department shall hold a public hearing to commence 30 days after notice of intent to terminate the contract has been received by the contractor.

(2) The department shall present evidence at the hearing showing good cause for the termination.

(3) The department shall assign an administrative law judge who shall provide a written recommendation to the department on the termination of the contract within 30 days after conclusion of the hearing.

(4) (A) Reasonable notice of the hearing shall be given to the contractor, Medi-Cal beneficiaries receiving services through the contractor, and other interested parties, including any other person and organization the director may deem necessary.

(B) The notice shall state the effective date of, and the reason for, the termination.

(d) In lieu of contract termination, the director shall have the power and authority to require or impose a plan of correction and issue one or more of the following sanctions against a contractor for findings of noncompliance or good cause, including, but not limited to, those specified in subdivision (a):

(1) Temporarily or permanently suspend enrollment and marketing activities.

(2) Require the contractor to suspend or terminate contractor personnel or subcontractors.

(3) Issue one or more of the temporary suspension orders set forth in subdivision (j).

(4) Impose temporary management consistent with the requirements specified in Section 438.706 of Title 42 of the Code of Federal Regulations.

(5) Suspend default enrollment of enrollees who do not select a contractor for the delivery of health care services.

(6) Impose civil monetary sanctions consistent with the dollar amounts and violations specified in Section 438.704 of Title 42 of the Code of Federal Regulations, as follows:

(A) A limit of twenty-five thousand dollars ($25,000) for each determination of the following:

(i) The contractor fails to provide medically necessary services that the contractor is required to provide, under law or under its contract with the department, to an enrollee covered under the contract.

(ii) The contractor misrepresents or falsifies information to an enrollee, potential enrollee, or health care provider.

(iii) The contractor distributes directly, or indirectly through an agent or independent contractor, marketing materials that have not been approved by the state or that contain false or materially misleading information.

(B) A limit of one hundred thousand dollars ($100,000) for each determination of the following:

(i) The contractor conducts an act of discrimination against an enrollee on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or a practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.

(ii) The contractor misrepresents or falsifies information that it furnishes to the federal Centers for Medicare and Medicaid Services or to the department.

(C) A limit of fifteen thousand dollars ($15,000) for each beneficiary the director determines was not enrolled because of a discriminatory practice under clause (i) of subparagraph (B). This sanction is subject to the overall limit of one hundred thousand dollars ($100,000) under subparagraph (B).

(e) Notwithstanding the monetary sanctions imposed for the violations set forth in paragraph (6) of subdivision (d), the director may impose monetary sanctions in accordance with this section based on any of the following:

(1) The contractor violates a federal or state statute or regulation.

(2) The contractor violates a provision of its contract with the department.

(3) The contractor violates a provision of the state plan or approved waivers.

(4) The contractor fails to meet quality metrics or benchmarks established by the department. Any changes to the minimum quality metrics or benchmarks made by the department that are effective on or after January 1, 2020, shall be established in advance of the applicable reporting or performance measurement period, unless required by the federal government.

(5) The contractor fails to demonstrate that it has an adequate network to meet anticipated utilization in its service area.

(6) The contractor fails to comply with network adequacy standards, including, but not limited to, time and distance, timely access, and provider-to-beneficiary ratio requirements pursuant to standards and formulae that are set forth in federal or state law, regulation, state plan, or contract and that are posted in advance to the department’s internet website.

(7) The contractor fails to comply with the requirements of a corrective action plan.

(8) The contractor fails to submit timely and accurate network provider data.

(9) The director identifies deficiencies in the contractor's delivery of health care services.

(10) The director identifies deficiencies in the contractor's operations, including the timely payment of claims.

(11) The contractor fails to comply with reporting requirements, including, but not limited to, those set forth in Section 53862 of Title 22 of the California Code of Regulations.

(12) The contractor fails to timely and accurately process grievances or appeals.

(f) (1) Monetary sanctions imposed pursuant to subdivision (e) may be separately and independently assessed and may also be assessed for each day the contractor fails to correct an identified deficiency. For a deficiency that impacts beneficiaries, each beneficiary impacted constitutes a separate violation. Monetary sanctions shall be assessed in the following amounts:

(A) Up to twenty-five thousand dollars ($25,000) for a first violation.

(B) Up to fifty thousand dollars ($50,000) for a second violation.

(C) Up to one hundred thousand dollars ($100,000) for each subsequent violation.

(2) For monetary sanctions imposed on a contractor that is funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive, of subdivision (n), the department shall calculate a percentage of the funds attributable to the contractor to be offset per month pursuant to paragraphs (2) to (4), inclusive, of subdivision (n) until the amount offset equals the amount of the penalty imposed pursuant to paragraph (1).

(g) When assessing sanctions pursuant to this section, the director shall determine the appropriate amount of the penalty for each violation based upon one or more of the following nonexclusive factors:

(1) The nature, scope, and gravity of the violation, including the potential harm or impact on beneficiaries.

(2) The good or bad faith of the contractor.

(3) The contractor's history of violations.

(4) The willfulness of the violation.

(5) The nature and extent to which the contractor cooperated with the department's investigation.

(6) The nature and extent to which the contractor aggravated or mitigated any injury or damage caused by the violation.

(7) The nature and extent to which the contractor has taken corrective action to ensure the violation will not recur.

(8) The financial status of the contractor, including whether the sanction will affect the ability of the contractor to come into compliance.

(9) The financial cost of the health care service that was denied, delayed, or modified.

(10) Whether the violation is an isolated incident.

(11) The amount of the penalty necessary to deter similar violations in the future.

(12) Other mitigating factors presented by the contractor.

(h) (1) Except in exigent circumstances in which there is an immediate risk to the health of beneficiaries, as determined by the department, the director shall give reasonable written notice to the contractor of the intention to impose any of the sanctions authorized by this section and others who may be directly interested, including any other persons and organizations the director may deem necessary.

(2) The notice shall include the effective date for, the duration of, and the reason for each sanction proposed by the director.

(3) A contractor may request the department to meet and confer with the contractor to discuss information and evidence that may impact the director's final decision to impose sanctions authorized by this section.

(4) The director shall grant a request to meet and confer prior to issuance of a final sanction if the contractor submits the request in writing to the department no later than two business days after the contractor's receipt of the director's notice of intention to impose sanctions.

(i) Notwithstanding subdivision (d), the director shall terminate a contract with a contractor that the United States Secretary of Health and Human Services has determined does not meet the requirements for participation in the Medicaid program contained in Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(j) (1) The department may make one or more of the following temporary suspension orders as an immediate sanction:

(A) Temporarily suspend enrollment activities.

(B) Temporarily suspend marketing activities.

(C) Require the contractor to temporarily suspend specified personnel of the contractor.

(D) Require the contractor to temporarily suspend participation by a specified subcontractor.

(2) The temporary suspension orders shall be effective no earlier than 20 days after the notice specified in subdivision (k).

(k) (1) Prior to issuing a temporary suspension order, or temporarily withholding funds pursuant to subdivision (o), the department shall provide the contractor with a written notice.

(2) The notice shall state the department's intent to impose a temporary suspension or temporary withhold and specify the nature and effective date of the temporary suspension or temporary withhold.

(3) The contractor shall have 30 calendar days from the date of receipt of the notice to file a written appeal with the department.

(4) Upon receipt of a written appeal filed by the contractor, the department shall, within 15 days, set the matter for hearing, which shall be held as soon as possible but not later than 30 days after receipt of the notice of hearing by the contractor.

(5) The hearing may be continued at the request of the contractor if a continuance is necessary to permit presentation of an adequate defense.

(6) The temporary suspension order shall remain in effect until the hearing is completed and the department has made a final determination on the merits. However, the temporary suspension order shall be deemed vacated if the director fails to make a final determination on the merits within 60 days of the close of the record for the matter.

(7) The department shall stay imposition of a temporary withhold, pursuant to subdivision (o), until the hearing is completed and the department has made a final determination on the merits within 60 days of the close of the record for the matter.

(l) (1) A contractor may request a hearing in connection with sanctions applied pursuant to subdivision (d) or (e) within 15 working days after the notice of the effective date of the sanctions has been given by sending a letter so stating to the address specified in the notice.

(2) The department shall stay collection of monetary sanctions upon receipt of the request for a hearing.

(3) Collection of the sanction shall remain stayed until the effective date of the final decision of the department.

(m) Except as otherwise provided in this section, all hearings to review the imposition of sanctions, including temporary suspension orders, the withholding or offsetting of funds pursuant to subdivision (n), or the temporary withholding of funds pursuant to subdivision (o) shall be held pursuant to the procedures set forth in Section 100171 of the Health and Safety Code.

(n) (1) If the director imposes monetary sanctions pursuant to this section on a contractor, except for a contractor described in paragraphs (2) to (5), inclusive, the amount of the sanction may be collected by withholding the amount from capitation or other associated payments owed to the contractor.

(2) If the director imposes monetary sanctions on a contractor that is funded from the Mental Health Subaccount, the Mental Health Equity Subaccount, the Vehicle License Collection Account of the Local Revenue Fund, or the Mental Health Account, the director may offset the monetary sanctions from the respective account. The offset is subject to paragraph (2) of subdivision (q).

(3) If the director imposes monetary sanctions on a contractor that is funded from the Behavioral Health Subaccount of the Local Revenue Fund 2011, the director may offset the monetary sanctions from that account from the distribution attributable to the applicable contractor. The offset is subject to paragraph (2) of subdivision (q).

(4) If the director imposes monetary sanctions on a contractor that is funded from another mental health or substance use disorder realignment fund from which the Controller is authorized to make distributions to the contractor, the director may offset the monetary sanctions from these funds if the funds described in paragraphs (2) and (3) are insufficient for the purposes described in this subdivision, as appropriate. The offset is subject to paragraph (2) of subdivision (q).

(5) (A) If the director imposes monetary sanctions pursuant to subdivision (e) of Section 5963.04, the director may offset the monetary sanctions from the Behavioral Health Services Fund from the distribution attributable to the applicable contractor.

(B) With respect to an individual contractor, the department shall not collect via offset more than 25 percent of the total amount of the funds distributed from the Behavioral Health Services Fund that are attributable to the contractor in a given month.

(C) If the department is not able to collect the full amount of monetary sanctions imposed on a contractor in a given month, the department shall continue to offset the amounts attributable to the contractor in subsequent months until the full amount of monetary sanctions has been collected. The offset is subject to paragraph (3) of subdivision (q).

(o) (1) (A) Whenever the department determines that a mental health plan or an entity that contracts with the department to provide Drug Medi-Cal services has violated state or federal law, a requirement of this chapter, Chapter 8 (commencing with Section 14200), Chapter 8.8 (commencing with Section 14600), or Chapter 8.9 (commencing with Section 14700), or any regulations, the state plan, a term or condition of an approved waiver, or a provision of its contract with the department, the department may temporarily withhold payments of federal financial participation and payments from the accounts listed in paragraphs (2) to (4), inclusive, of subdivision (n).

(B) The department shall temporarily withhold amounts it deems necessary to ensure the mental health plan or the entity that contracts with the department to provide Drug Medi-Cal services promptly corrects the violation.

(C) The department shall release the temporarily withheld funds when it determines the mental health plan or the entity that contracts with the department to provide Drug Medi-Cal services has come into compliance.

(2) (A) A mental health plan or an entity that contracts with the department to provide Drug Medi-Cal services may appeal the imposition of a temporary withhold pursuant to this subdivision in accordance with the procedures described in subdivisions (k) and (m).

(B) Imposition of a temporary withhold shall be stayed until the effective date of the final decision of the department.

(p) This section shall be read in conjunction with, and apply in addition to, any other applicable law that authorizes the department to impose sanctions or otherwise take remedial action upon contractors.

(q) (1) (A) Notwithstanding any other law, nonfederal moneys collected by the department pursuant to this section, except for moneys collected from a contractor funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive, of subdivision (n), shall be deposited into the General Fund for use and, upon appropriation by the Legislature, to address workforce issues in the Medi-Cal program and improve access to care in the Medi-Cal program.

(B) Beginning July 1, 2024, and continuing until June 30, 2027, unless otherwise specified in law, nonfederal moneys collected by the department pursuant to this section, except for moneys collected from a contractor funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive, of subdivision (n), shall be deposited into the General Fund for use and, upon appropriation by the Legislature, for the nonfederal share of Medi-Cal costs for health care services furnished to children, adults, seniors, and persons with disabilities, and persons dually eligible for the Medi-Cal program and the Medicare Program.

(2) (A) Monetary sanctions imposed via offset on a contractor that is funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive, of subdivision (n) shall be redeposited into the account from which the monetary sanctions were offset pursuant to paragraphs (2) to (4), inclusive, of subdivision (n).

(B) The department shall notify the Department of Finance of the percentage reduction for the affected county.

(C) The Department of Finance shall subsequently notify the Controller, and the Controller shall redistribute the monetary sanction amount to nonsanctioned counties based on each county's prorated share of the monthly base allocations from the realigned account.

(D) With respect to an individual contractor, the department shall not collect via offset more than 25 percent of the total amount of the funds distributed from the applicable account or accounts that are attributable to the contractor in a given month.

(E) If the department is not able to collect the full amount of monetary sanctions imposed on a contractor funded from one or more of the realigned accounts described in paragraphs (2) to (4), inclusive, of subdivision (n) in a given month, the department shall continue to offset the amounts attributable to the contractor in subsequent months until the full amount of monetary sanctions has been collected.

(3) Monetary sanctions imposed via offset on a contractor pursuant to subdivision (e) of Section 5963.04 shall be redeposited into the account from which the monetary sanctions were offset pursuant to paragraph (5) of subdivision (n).

(r) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions without taking any further regulatory action.

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

(t) For purposes of this section, “contractor” means an individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries or other individuals receiving behavioral health services, as applicable, pursuant to any of the following:

(1) Article 2.7 (commencing with Section 14087.3), including dental managed care programs developed pursuant to Section 14087.46.

(2) Article 2.8 (commencing with Section 14087.5).

(3) Article 2.81 (commencing with Section 14087.96).

(4) Article 2.82 (commencing with Section 14087.98).

(5) Article 2.9 (commencing with Section 14088).

(6) Article 2.91 (commencing with Section 14089).

(7) Chapter 8 (commencing with Section 14200), including dental managed care plans.

(8) Chapter 8.9 (commencing with Section 14700).

(9) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration pursuant to Article 5.5 (commencing with Section 14184) or a successor demonstration or waiver, as applicable.

(10) Chapter 2 (commencing with Section 5650) of Part 2 of Division 5, solely for purposes of imposition of corrective action plans, monetary sanctions, or temporary withholds pursuant to subdivision (e) of Section 5963.04.

(11) Section 12534 of the Government Code.

(12) The Home- and Community-Based Alternatives (HCBA) Waiver pursuant to state law and Section 1915(c) of the federal Social Security Act (42 U.S.C. Sec. 1396n(c)).

(13) The Program of All-Inclusive Care for the Elderly (PACE) pursuant to Chapter 8.75 (commencing with Section 14591).

(u) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

*(Amended by Stats. 2025, Ch. 21, Sec. 113. (AB 116) Effective June 30, 2025.)*

**14197.71.** (a) The department may, at its discretion, align relevant terms of its contract with a Medi-Cal behavioral health delivery system with the terms of its contract with a Medi-Cal managed care plan, as defined in subdivision (j) of Section 14184.101, for those requirements that apply to both entities. Requirements that apply to both entities include, but are not limited to, all of the following:

(1) Organization and administration of the plan, including key administrative staffing requirements.

(2) Financial information.

(3) Information systems.

(4) Quality improvement systems.

(5) Utilization management.

(6) Provider network.

(7) Provider compensation arrangements.

(8) Provider oversight and monitoring.

(9) Access and availability of services, including, but not limited to, reporting of waitlists for behavioral health services or attesting to no waitlists.

(10) Care coordination and data sharing.

(11) Member services.

(12) Member grievances and appeals data.

(13) Reporting requirements.

(14) Other contractual requirements determined by the department.

(b) The department shall establish minimum quality metrics to measure and evaluate the quality and efficacy of services and programs covered under Medi-Cal behavioral health delivery systems.

(c) (1) Each Medi-Cal behavioral health delivery system shall report annually to the county board of supervisors on utilization, quality, patient care expenditures, and other data as determined by the department.

(2) The board of supervisors shall annually submit an attestation to the department that the county is meeting its obligations to provide realigned programs and services pursuant to clauses (i), (iv), and (v) of subparagraph (B) of paragraph (16) of subdivision (f) of Section 30025 of the Government Code.

(d) (1) 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, as defined in subdivision (j) of Section 14184.101, Medi-Cal behavioral health delivery systems, as defined in subdivision (i) of Section 14184.101, 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 and consistent with federal law.

(2) The department shall issue guidance identifying permissible data-sharing arrangements.

(e) For purposes of this section, the term “Medi-Cal behavioral health delivery system” means an entity or local agency that contracts with the department to provide covered behavioral health Medi-Cal benefits pursuant to Section 14184.400 and Chapter 8.9 (commencing with Section 14700) or a county Drug Medi-Cal Organized Delivery System pilot authorized under the CalAIM Terms and Conditions and described in Section 14184.401 or authorized under the Medi-Cal 2020 Demonstration Project Act pursuant to Article 5.5 (commencing with Section 14184).

(f) This section shall be implemented only to the extent that necessary federal approvals have been obtained and federal financial participation is available and not otherwise jeopardized.

(g) The department shall implement this section no later than January 1, 2027.

*(Added by Stats. 2023, Ch. 790, Sec. 112. (SB 326) Effective April 17, 2024. Approved in Proposition 1 at the March 5, 2024, election. Operative January 1, 2025, pursuant to Sec. 117 of Proposition 1.)*

**14197.9.** (a) To the extent permitted under federal law, the department shall require a Medi-Cal managed care plan that is not licensed by the Department of Managed Health Care to comply with the applicable requirements in Article 11.9 (commencing with Section 1399.870) of Chapter 2.2 of Division 2 of the Health and Safety Code for the purpose of serving applicable Medi-Cal beneficiaries.

(b) For purposes of this section, “Medi-Cal managed care plan” means an 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 this chapter or Chapter 8 (commencing with Section 14200).

*(Added by Stats. 2021, Ch. 143, Sec. 415. (AB 133) Effective July 27, 2021.)*