AB-133 Health. (2021-2022)

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Assembly Bill No. 133

CHAPTER 143

An act to add Section 502 to, and to repeal Sections 2717, 2852.5, 3518.1, 3770.1, and 4506 of, the Business and Professions Code, to amend Section 100504 of, and to add Sections 100503.5 and 100520.5 to, the Government Code, to amend Sections 38074, 102430, 120511, 120780.2, 120956, 120972, 127000, 127005, 127010, 127280, 127285, 127345, 127346, 127350, 127360, 127400, 127435, 127450, 127671, 127671.1, 127672, 127672.8, 127672.9, 127673, 127673.1, 127673.2, 127673.3, 127673.4, 127673.5, 127673.6, 127673.7, 127673.8, 127673.81, 127673.82, 127673.83, 127673.84, 127674, 127674.1, 127675, 127677, 127679, 127681, 127683, 127685, 127885, 127900, 127940, 127985, 127995, 128000, 128005, 128020, 128030, 128035, 128040, 128050, 128051, 128052, 128130, 128135, 128140, 128155, 128165, 128170, 128175, 128180, 128190, 128195, 128205, 128215, 128220, 128230, 128235, 128330, 128345, 128350, 128355, 128365, 128370, 128371, 128375, 128385, 128401, 128454, 128458, 128485, 128550, 128551, 128552, 128553, 128555, 128556, 128690, 128700, 128705, 128730, 128734, 128735, 128736, 128737, 128738, 128740, 128745, 128747, 128748, 128750, 128755, 128760, 128765, 128766, 128770, 128775, 128782, 128785, 128790, 128795, 128800, 128805, 128810, 129010, 129015, 129020, 129022, 129030, 129035, 129040, 129045, 129049, 129050, 129051, 129052, 129055, 129065, 129070, 129075, 129080, 129085, 129087, 129090, 129092, 129095, 129100, 129105, 129110, 129125, 129130, 129135, 129140, 129145, 129150, 129152, 129155, 129160, 129165, 129170, 129172, 129173, 129174, 129174.1, 129175, 129180, 129185, 129200, 129205, 129210, 129220, 129221, 129230, 129295, 129330, 129335, 129355, 129680, 129715, 129730, 129740, 129750, 129760, 129761, 129765, 129770, 129775, 129785, 129787, 129790, 129795, 129800, 129805, 129810, 129812, 129820, 129825, 129830, 129835, 129840, 129850, 129851, 129853, 129855, 129856, 129875, 129875.1, 129880, 129885, 129890, 129895, 129900, 129905, 129925, 129930, 129940, 129950, 129975, 129980, 129985, 129990, 130000, 130005, 130010, 130020, 130025, 130050, 130055, 130060, 130061, 130061.5, 130062, 130063, 130063.1, 130064, 130065, 130066, 130070, and 131300 of, to amend the heading of Part 1 (commencing with Section 127000) of Division 107 of, to amend the heading of Division 107 (commencing with Section 127000) of, to amend the heading of Article 5 (commencing with Section 128050) of Chapter 2 of Part 3 of Division 107 of, to amend the heading of Article 1 (commencing with Section 128125) of Chapter 3 of Part 3 of Division 107 of, to amend the heading of Article 1 (commencing with Section 128330) of Chapter 5 of Part 3 of Division 107) of, and to amend the heading of Chapter 5 (commencing with Section 128330) of Part 3 of Division 107 of, to amend and repeal Section 128335 of, to add3 Sections 1374.722, 120972.1, 122445, 127002, 128337, and 128338 to, to add Article 11.9 (commencing with Section 1399.870 to Chapter 2.2 of Division 2 of, to add Chapter 14 (commencing with Section 1860) to Division 2.5 of, to add Chapter 13.8 (commencing with Section 121295) to Part 4 of Division 105 of, to add Chapter 1.5 (commencing with Section 127825) to Part 3 of Division 107 of, and to add Division 109.7 (commencing with Section 130290) to, to add and repeal Chapter 1.7 (commencing with Section 103871) of Part 2 of Division 102 of, to repeal Sections 103870.2,

125075, 127015, 127020, 127025, 127030, 127035, 127040, 127045, 127050, 127125, 127130, 127135, 127140, 127145, 127150, 127155, 127160, 127165, 127170, 127175, 127180, 127185, 127190, 127195, 127200, 127205, 127210, 127215, 127220, 127225, 127230, 127235, 127240, 127245, 127250, 127255, 127260, 127265, 127270, 127275, 127290, 127295, 127300,128207, 128224, 128240, 128240.1 128241, 128340, 128395, 128456, 128495, 128554, 128557, and 128681 of, to repeal the heading of Article 1 of Chapter 2 of Part 2 of Division 107 of, to repeal the heading of Article 3 of Chapter 4 of Part 3 of Division 107 of, to repeal the heading of Chapter 2 of Part 5 of Division 107 of, to repeal the heading of Chapter 3 of Part 5 of Division 107 of, to repeal the heading of Chapter 2 of Part 7 of Division 107 of, to repeal Article 1 (commencing with Section 127750) of Chapter 1 of Part 3 of Division 107 of, to repeal Article 2.5 (commencing with Section 127925) of Chapter 2 of Part 3 of Division 107 of, to repeal Article 2 (commencing with Section 128198) of Chapter 3 of Part 3 of Division 107 of, to repeal Article 2 (commencing with Section 128250) of Chapter 4 of Part 3 of Division 107 of, to repeal Article 3 (commencing with Section 128425) of Chapter 5 of Part 3 of Division 107 of, to repeal Article 6 (commencing with Section 128560) of Chapter 5 of Part 3 of Division 107 of, to repeal Part 4 (commencing with Section 128600) of Division 107, to repeal Chapter 3 (commencing with Section 127575) of Part 2 of Division 107 of, Chapter 4 (commencing with Section 127620) of Part 2 of Division 107 of, and Chapter 8 (commencing with Section 127670) of Part 2 of Division 107 of, to repeal Chapter 2 (commencing with Section 129375) of Part 6 of Division 107 of, and to repeal Chapter 2 of Part 7 of Division 107 of, and to repeal and add Sections 128225 and 128360 of, the Health and Safety Code, to add Section 10144.53 to the Insurance Code, to amend Sections 1370, 1370.01, 1372, and 4011.11 of the Penal Code, to add Section 30130.59 to the Revenue and Taxation Code, to amend Sections 4100, 4122, 4361, 5886, 7275, 7276, 7277.1, 7278, 7282, 14005.18, 14007.8, 14011.10, 14042.1, 14043.15, 14059.5, 14087.46, 14105.075, 14105.192, 14105.22, 14105.48, 14124.12, 14124.89, 14127.6, 14131.10, 14132.968, 14184.10, 14184.30, 14184.40, 14188.1, 14196.2, 14196.4, 14196.5, 14197.4, 14301.1, 15840, and 17601 of, to amend and repeal Sections 14132.275, 14132.276, 14132.277, 14182.16, 14182.17, 14182.18, 14186, 14186.1, 14186.2, 14186.3, and 14186.4 of, to amend, repeal, and add Section 14132 of, to add Chapter 6.7 (commencing with Section 4361.5) to Part 3 of Division 4 of, to add Part 7 (commencing with Section 5960) to Division 5 of, to add Article 5.51 (commencing with Section 14184.100) to Chapter 7 of Part 3 of Division 9 of, to add Sections 4147, 4335.2, 14000.6, 14005.185, 14005.62, 14043.51, 14105.194, 14105.222, 14126.029, 14132.755, 14132.85, 14132.969, and 14197.9 to, to repeal Chapter 1 (commencing with Section 5960) of Part 7 of Division 5 of, to repeal Sections 14021.37 and 14105.485 of, and to repeal and add Sections 14124.90 and 14188.4 of, the Welfare and Institutions Code, to repeal Section 69 of Chapter 12 of the Statutes of 2020, and to amend Items 4265-001-0001 and 4265-111-0001 of Section 2.00 of the Budget Act of 2019 (Chapters 23 and 55 of the Statutes of 2019), relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.

[Approved by Governor July 27, 2021. Filed with Secretary of State July 27, 2021.]

LEGISLATIVE COUNSEL'S DIGEST

AB 133, Committee on Budget. Health.

(1) Existing law establishes the Office of Statewide Health Planning and Development (OSHPD), under the control of an executive officer known as the Director of Statewide Health Planning and Development. The office is vested with all the duties, powers, purposes, and responsibilities of the State Department of Public Health relating to health planning and research development. Existing law creates the health care workforce clearinghouse to serve as the central source of health care workforce and education data in the state to collect data regarding health care workers, including the supply of health care workers and current and forecasted demand for health care workers.

This bill would rename the Office of Statewide Health Planning and Development as the Department of Health Care Access and Information. The bill would repeal numerous duties and programs currently carried out by the OSHPD, including, among others, rural health care transition oversight, the Steven M. Thompson Medical School Scholarship Program, and the Postsurgical Care Demonstration Project.

This bill would eliminate the health care workforce clearinghouse and establish the California Health Workforce Research and Data Center to serve as the state’s central source of health care workforce and education data and to inform state policy regarding health care workforce issues. The bill would establish uniform requirements for the reporting and collection of workforce data from health care-related licensing boards to the data center and make related conforming changes. The bill would require

the department to maintain the confidentiality of licensee information collected pursuant to these provisions and would only authorize the department to release the information in aggregate form.

Existing law makes the office responsible for administering various programs with respect to the health care professions. Existing law establishes various programs to facilitate the expansion of the health care workforce in rural and underserved communities, including, but not limited to, the Health Professions Career Opportunity Program and the California Registered Nurse Education Program. Existing law requires the office to establish a nonprofit public benefit corporation known as the Health Professions Education Foundation to perform various duties with respect to implementing health professions scholarship and loan programs. Existing law also establishes the California Healthcare Workforce Policy Commission to, among other things, identify specific areas of the state where unmet priority needs for primary care family physicians and registered nurses exist and to make recommendations to the Director of Statewide Health Planning and Development with regard to the funding of specific programs.

This bill would dissolve the Health Professions Education Foundation, but would authorize the department to continue various foundation programs, such as the California Registered Nurse Education Program. The bill would also eliminate the California Healthcare Workforce Policy Commission and replace it with the California Health Workforce Education and Training Council to plan and coordinate California's approach to health workforce education and training in order to develop a health workforce to meet statewide health care needs. The bill would change the composition of the membership of the council and would authorize the council, among other things, to make recommendations to the department regarding the use of health care education and training funds and advocate for additional funds and additional sources of funds to stimulate graduate medical education expansion in California. The bill would make related conforming changes to existing provisions.

This bill would require the Health Professions Career Opportunity Program to be implemented at colleges and universities, as specified, with priority given to campuses in medically underserved areas or with students from groups underrepresented in medicine, demonstrated commitment to diversity and associated institutional change, a track record of providing tailored student support, and strong health professions school partnerships, as specified.

Existing law authorizes the office to oversee various aspects of the health care market, including oversight of hospital facilities and community benefit plans. Existing law also requires the office to adopt and enforce regulations prescribing building standards for the adequacy and safety of health facility physical plants.

This bill would make necessary conforming changes to these provisions to reflect the reorganization of the office to the Department of Health Care Access and Information.

(2) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime.

This bill would require the department, on or before March 1, 2022, to convene a Health Equity and Quality Committee to make recommendations to the department for standard health equity and quality measures, including annual benchmark standards for assessing equity and quality in health care delivery. The bill would require the department to consider the committee's recommendations and to establish standard measures and annual benchmarks for equity and quality in health care delivery. The bill would require a health care service plan, including a Medi-Cal managed care plan not licensed by the department, to annually submit to the department a report containing equity and quality data and information. The bill would require the department to review a health care service plan's equity and quality report to determine the plan's compliance with the health equity and quality standard measures and annual benchmarks established by the department. The bill would authorize the department to take certain actions against a health care service plan that does not demonstrate compliance with the requirements of the bill, including requiring a health care service plan to implement corrective action to achieve and demonstrate compliance with the standard measures and annual benchmarks, monitoring a corrective action plan, and assessing administrative penalties, as provided. The bill would require the department, commencing in 2025, and annually thereafter, to publish on its internet website a Health Equity and Quality Compliance Report. The bill would authorize the department to implement the bill by means of all-plan letters or similar instructions, without taking regulatory action until January 1, 2027. The bill would require a health care service plan, but not a Medi-Cal managed care plan, to be accredited by the National Committee for Quality Assurance on or before January 1, 2026. Because a willful violation of the bill's provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

(3) Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Under existing law, the schedule of benefits includes the purchase of prescribed drugs, subject to the Medi-Cal List of Contract Drugs and utilization controls. Existing law excludes nonlegend cough, cold, and acetaminophen-containing products from the schedule of benefits, with prescribed exceptions, such as children's acetaminophen-containing products.

This bill would expand, on July 1, 2021, the Medi-Cal schedule of benefits to include nonlegend cough, cold, and acetaminophen-containing products.

(4) Existing law establishes that the Medi-Cal program covers specified health care services, including substance use disorder treatment, pursuant to a state plan. Under existing law, the Director of Health Care Services has those powers and duties to conform to requirements for securing approval of a state plan under federal law, and, pursuant to this authority, the director secured approval for the state plan to include clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force, including adult Alcohol Misuse Screening and Behavioral Counseling Interventions in Primary Care, such as screening for misuse of opioids and other illicit drugs. Existing law requires the department to seek federal approval to expand the Medi-Cal benefit for adult Alcohol Misuse Screening and Behavioral Counseling Interventions in Primary Care to include screening for misuse of opioids and other illicit drugs, and suspends the implementation of these provisions on December 31, 2021, unless specified circumstances apply.

This bill would repeal obsolete law on the department's obligation to seek federal approval to expand the above-specified benefit and the suspension of the implementation of those provisions.

(5) Under existing law governing the Medi-Cal program, health care services are rendered by enrolled Medi-Cal providers, who are subject to specified requirements relating to provider enrollment. Existing federal law requires a state Medicaid program to implement electronic visit verification for prescribed Medicaid services, including personal care services and home health services that require an in-home visit by a provider.

This bill would authorize the department to undertake action to implement an electronic visit verification system for purposes of obtaining and maintaining federal approval or ensuring federal financial participation is available or not otherwise jeopardized, and to partner and contract with specified governmental entities, including the State Department of Social Services, to comply with federal requirements on electronic visit verification. If a provider renders Medi-Cal services that are subject to electronic visit verification, the bill would require the provider to comply with requirements on electronic visit verification, as established by the department and its partners, and would authorize the department and its partners to take prescribed action, such as requiring an approved correction action plan, to address a provider's noncompliance of those requirements. The bill would authorize the department and its partners to enter into contracts to implement these provisions, and to implement these provisions by various means, including provider bulletins.

(6) Under existing federal and state law, Medi-Cal is required to be the payer of last resort if a Medi-Cal beneficiary has other health coverage in addition to Medi-Cal. To assess overlapping or duplicate health coverage, existing law requires specified other health coverage entities to maintain a centralized file with specified information about their subscribers, enrollees, or policyholders, and to make this information available to the department upon reasonable request by the department.

Under existing law, other health coverage entities that are legally responsible for payment of a claim for a health care item or service are required to provide specified information to the department, at the department's request, upon certification by the department that the information requested is pertaining to an individual that is an applicant for, recipient of, or legally responsible person for an applicant for, or recipient of, Medi-Cal services. Existing law requires the department to enter into cooperative agreements with other health coverage entities to establish mutually agreeable procedures for requesting and furnishing specified information to the department about a beneficiary's other health coverage and provides for the reimbursement, as specified, of other health coverage entities for complying with these provisions.

This bill would add to the list of other health coverage entities subject to these provisions all health entities licensed by the Department of Insurance, third-party administrators, and union trusts. The bill would also add new categories of information that the other health coverage entities are required to maintain about a subscriber, policyholder, enrollee, or insured. The bill would require other health coverage entities to enter into a cooperative agreement with the department for the provision of specified information, rather than placing this requirement on the department. The bill would require that the information provided pursuant to these cooperative agreements be provided to the department within 90 days of the department's request for the information, at no cost to the department, eliminating the existing reimbursement provisions.

The bill would require that the subscriber, policyholder, enrollee, or insured information required to be maintained in the centralized file be provided to the department, at least once a month, in a format specified by the department. The bill would also require this information be provided to the department's agents and Medi-Cal managed care plans upon reasonable request. The bill would require the specified entities to provide the department with real-time, electronic eligibility verification, at no cost, and in a form and manner specified by the department. The bill would also authorize the department to implement these requirements by means of policy letter, information notice, or other similar instruction, without taking any further regulatory action.

(7) Existing law excludes specified optional services from coverage in the Medi-Cal program, including audiology services, optometric services, podiatric services, and incontinence creams and washes, among others. Notwithstanding this exclusion, existing law restores coverage for specified optional benefits, including audiology services, optometric services, podiatric

services, and incontinence creams and washes. Existing law suspends these optional benefits on December 31, 2021, unless specified conditions occur.

This bill would delete the provisions suspending these optional benefits.

(8) Under existing law, an individual is eligible for Medi-Cal benefits, to the extent required by federal law, as though the individual was pregnant, for all pregnancy-related and postpartum services for a 60-day period beginning on the last day of pregnancy. Existing law, subject to an appropriation in the annual Budget Act, extends Medi-Cal eligibility for a pregnant individual who receives health care coverage under the Medi-Cal program, or another related program, and who has been diagnosed with a maternal mental health condition, for a period of one year following the last day of the individual's pregnancy if the individual complies with certain requirements. Existing law suspends implementation of these provisions on December 31, 2021, unless specified circumstances apply.

This bill would remove the conditional suspension of the above Medi-Cal eligibility extension. The bill would make those provisions on eligibility extension inoperative upon implementation of the extended eligibility provisions described below, and would restore their operation if the provisions below are no longer implemented. The bill would require the department to determine the implementation status of the provisions below and to post, on its internet website, notice of its determination.

The bill would instead extend eligibility for full-scope Medi-Cal benefits for a pregnant individual or targeted low-income child who is eligible for and is receiving health care coverage under the Medi-Cal program, or another related program, for the duration of the pregnancy and for a period of one year following the last day of the individual's pregnancy, without conditioning the extended eligibility to a diagnosis of a maternal mental health condition.

The bill would require the department to seek any necessary federal approvals for these purposes. Coverage under these provisions would commence on April 1, 2022, or the effective date or dates reflected in any necessary federal approvals obtained by the department, whichever is later. The bill would make implementation of these provisions subject to an appropriation, receipt of any necessary federal approvals, except as specified, and the availability of federal financial participation.

The bill would make conforming changes to related provisions.

Because counties are required to make eligibility determinations, and this bill would expand Medi-Cal eligibility, the bill would impose a state-mandated local program.

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

This bill would, contingent upon a reduction in allocations to the state dental program, backfill the reduced amount by continuously appropriating moneys from the General Fund in an amount equivalent to the required reduction, so that the total funding for the state dental program remains at $30,000,000 annually. By continuously appropriating moneys from the General Fund, this bill would make an appropriation.

(10) Existing law allocates a specified percentage of those revenues to the department to increase funding for the Medi-Cal program, in a manner that, among other things, ensures timely access, limits specific geographic shortages of services, or ensures quality care. Existing law establishes the Healthcare Treatment Fund for this purpose.

Existing law authorizes the department to use those funds to make supplemental payments or rate increases for specified service categories, including physician services, dental services, and home health providers, and programs, including value-based payment (VBP) programs. Existing law suspends the department's ability to make those supplemental payments and rate increases after July 1, 2021, unless specified conditions apply, including that the estimates of General Fund revenue and expenditures for the 2021–22 and 2022–23 fiscal years contain estimated annual General Fund revenues that exceed estimated annual General Fund expenditures for those fiscal years by an amount equal to or greater than the sum total of all General Fund appropriations for other specified programs subject to suspension.

This bill would repeal these provisions imposing the suspension.

Existing law requires the department to develop, using moneys appropriated in the Budget Act for this purpose from the Healthcare Treatment Fund, VBP programs that require designated Medi-Cal managed care plans to make incentive payments to qualified network providers in behavioral health integration (BHI), prenatal and postpartum care, and chronic disease management for prescribed purposes. Existing law makes the VBP programs inoperative on July 1, 2021, if the department's ability to make those supplemental payments and rate increases is suspended, as specified above.

With respect to VBP programs aimed at improving BHI in Medi-Cal managed care, existing law requires designated Medi-Cal managed care plans to make incentive payments to qualified network providers, as prescribed, and authorizes qualified network providers to be eligible for different levels of incentive payments depending on the level of integration.

For VBP programs aimed at improving BHI in Medi-Cal managed care, this bill would instead authorize designated Medi-Cal managed care plans to earn incentive payments for achieving milestones and measures through partnerships with qualified network providers, and would provide that different levels of incentive payments may be available depending on the level of integration. For VBP programs, the bill would delete the provisions making those programs inoperative on July 1, 2021, and would require the department to implement payments under VBP programs for a service period during a state fiscal year subject to appropriation by the Legislature for that state fiscal year.

(11) Existing law, the Medi-Cal 2020 Demonstration Project Act, requires the department to implement specified components of a Medi-Cal demonstration project, including the Global Payment Program (GPP), the Dental Transformation Initiative, and the Whole Person Care pilot program, consistent with the Special Terms and Conditions approved by the federal Centers for Medicare and Medicaid Services. Pursuant to existing law, the department has created a multiyear initiative, the California Advancing and Innovating Medi-Cal (CalAIM) initiative, to build upon the outcomes of various Medi-Cal pilots and demonstration projects, including the Medi-Cal 2020 Demonstration Project Act.

This bill would establish the CalAIM initiative in statute to support the stated goals of identifying and managing the risk and needs of Medi-Cal beneficiaries, transitioning and transforming the Medi-Cal program to a more consistent and seamless system, and improving quality outcomes. The bill would require the department to seek federal approval for the CalAIM initiative, and would condition its implementation on receipt of federal approvals and availability of federal financial participation. For implementation purposes, the bill would authorize the department to enter into exclusive or nonexclusive contracts, or amend existing contracts. The bill would require the department to issue guidance identifying permissible data-sharing arrangements to implement CalAIM. To the extent authorized by the CalAIM Terms and Conditions, the bill would authorize the department to claim federal financial participation for expenditures associated with the designated state health care programs identified in the CalAIM Terms and Conditions for use solely by the department, and would appropriate both federal and General Fund moneys to the Health Care Deposit Fund in an amount equal to the federal financial participation that may be claimed under these provisions.

This bill would authorize the department to make incentive payments, grants, or other financial support available to qualified entities or providers, as specified, under the Providing Access and Transforming Health (PATH) program to support services, infrastructure, and capacity building in advancing and complimenting select goals and components of CalAIM. The bill would require the department to establish the methodologies, parameters, and eligibility criteria for PATH payments.

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

This bill would authorize the department to standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, subject to a Medi-Cal managed care plan readiness, continuity of care transition plan, and disenrollment process developed in consultation with stakeholders, in accordance with specified requirements and the CalAIM Terms and Conditions.

Under the CalAIM initiative, this bill would require the department to implement an enhanced care management (ECM) benefit designed to address the clinical and nonclinical needs on a whole-person-care basis for certain target populations of Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans, as specified. The bill would require Medi-Cal managed care plans to consult and collaborate with county mental health plans for the delivery of ECM services for beneficiaries with certain health conditions, including serious mental illness, to maximize federal reimbursement and minimize duplication of services. The bill would require the department to require those plans to report specified information related to the ECM benefit and would require the department to annually publicly report on the utilization of ECM in a manner that allows for an analysis of demographic populations, as specified.

As part of the CalAIM initiative, and commencing January 1, 2022, this bill would require the department to authorize Medi-Cal managed care plans to elect to cover those services or settings approved by the department as cost effective and medically appropriate in the comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. The bill would provide that in lieu of services include specified services, such as housing transition navigation services, recuperative care, and asthma

remediation. The bill would require the department to establish metrics for, and conduct an annual evaluation of, the utilization and effectiveness of in lieu of services, and to publicly report the evaluation, as specified.

This bill would reorganize or repeal some of those provisions relating to the Medi-Cal 2020 Demonstration Project Act under the CalAIM initiative, and would continue other components of the Medi-Cal 2020 Demonstration Project Act, including the GPP, Medi-Cal dental efforts, such as the state plan dental improvement program, and enhancement of county oversight and monitoring, as components of the CalAIM initiative. Under the CalAIM initiative, the bill would make various changes to the Medi-Cal managed care system, including requiring prescribed accreditation by the National Committee for Quality Assurance or an alternative entity and providing incentive payments to plans.

As part of the CalAIM initiative, this bill would make various changes to the Medi-Cal behavioral health delivery system. The bill would set forth requirements for coverage of certain nonspecialty mental health services by a Medi-Cal managed care plan or the Medi-Cal fee-for-service delivery system, and coverage of specialty mental health services by a county mental health plan, as specified. The bill would prohibit a dispute between a county mental health plan and a Medi-Cal managed care plan from delaying the provision of medically necessary services by either of those plans. The bill would also set forth requirements for covered services provided under a Drug Medi-Cal Treatment Program or a Drug Medi-Cal organized delivery system, including the use of certain professional criteria and coverage of all medically necessary substance use disorder services for an individual under 21 years of age, as specified. The bill would require the department to develop standardized screening tools, statewide transition tools, and documentation standards related to care transitions in the behavioral health delivery system, as specified. The bill would also require the design of an intergovernmental transfer-based reimbursement methodology. The bill would require the department to establish, implement, and administer the Behavioral Health Quality Improvement Program to provide grants to qualified Medi-Cal behavioral health delivery systems to prepare those entities and their contracting health care providers for implementation of CalAIM behavioral health components, and would impose requirements on the department relating to the behavioral health delivery system, such as determining the eligibility criteria. Commencing January 1, 2027, the bill would require an individual county, or counties acting jointly, to provide and administer covered behavioral health Medi-Cal benefits under a single Medi-Cal behavioral health delivery system contract.

Subject to federal approval, and under the CalAIM initiative, this bill would require the department to implement the State Plan Dental Improvement Program to further improving accessibility of Medi-Cal dental services and oral health outcomes for targeted populations, as specified.

As a component of the CalAIM initiative, on and after July 1, 2022, this bill would require the department, in consultation with representatives of county welfare departments and other affected stakeholders, to develop and make publicly available a dashboard that reflects each county's performance in meeting existing County Administrative Cost Control Plan measures. During the CalAIM term, the bill would require the department to develop and implement specified initiatives to enhance oversight and monitoring of county administration of the California Children's Services (CCS) program and would require the department to convene a workgroup consisting of counties and other stakeholders to develop and implement one or more initiatives designed to improve the collection and use of beneficiary demographic and contact information in administering the Medi-Cal program and other public assistance programs.

Commencing January 1, 2023, the bill would require the department to implement the Population Health Management Program under the Medi-Cal managed care delivery system to improve health outcomes, care coordination, and efficiency through application of standardized health management requirements. The bill would require the department to require each Medi-Cal managed care plan to develop and maintain a beneficiary-centered population health management program that meets specified standards, including identifying and mitigating social determinants of health and reducing health disparities or inequities. The bill would require the department to consult with specified stakeholders, including the State Department of Public Health, to establish requirements for the population health management program, as specified, and, beginning January 1, 2024, would require the department to annually post an analysis of the Population Health Management Program on its internet website.

As part of the CalAIM initiative, this bill would authorize the department to establish capitation rates to contracted health plans on a regional basis in lieu of health plan and county-specific rates, and would require the department to consult with and provide a briefing to affected entities and individuals, as specified. Before the implementation of a regional-based capitation rate, the bill would require the department to report to the Legislature on specified matters, including how these rates are to be established. The bill would require the department to publish on its public internet website a description of the rate methodology, data used for rate development, and core actuarial assumptions and adjustments in each year that the department develops these rates. The bill would authorize the department to develop and implement appropriate actuarial methods to prevent significant overpayments or significant underpayments, as specified.

(12) Existing federal law provides for the federal Medicare program, which is a public health insurance program for persons who are 65 years of age or older and specified persons with disabilities who are under 65 years of age. Under existing law, a demonstration project known as the Coordinated Care Initiative (CCI) enables beneficiaries who are dually eligible for the Medi-

Cal program and the Medicare Program to receive a continuum of services that maximizes access to, and coordination of, benefits between these programs.

As a component of the CalAIM initiative, this bill would make CCI operative only through December 31, 2022, as specified, and would repeal its provisions on January 1, 2025. The bill would require Medi-Cal managed care plans to operate, or continue to operate, a Medicare Advantage Dual Special Needs Plan, commencing January 1, 2023, in CCI counties, and, commencing January 1, 2026, in all other counties.

(13) Existing law authorizes the department to create the Health Home Program for Medi-Cal enrollees with chronic conditions, subject to federal approval and the availability of federal financial participation. Existing law generally conditions the implementation of the program on no additional General Fund moneys being used to fund the administration and costs of services.

Commencing with the 2021–22 state fiscal year, this bill would authorize program implementation using General Funds moneys upon appropriation by the Legislature. The bill would require the department to cease implementing the program on January 1, 2022, or as specified, and would repeal the program's provisions on January 1, 2023.

(14) Existing law authorizes the board of supervisors in each county to designate an entity or entities to assist county jail inmates to apply for a health insurance affordability program, as defined, consistent with federal requirements.

Commencing January 1, 2023, this bill would instead require the board of supervisors, in consultation with the county sheriff, to designate an entity or entities to assist both county jail inmates and juvenile inmates with the application process. The bill would make conforming changes to provisions relating to the coordination duties of jail administrators. By creating new duties for local officials, including boards of supervisors and jail administrators, the bill would impose a state-mandated local program.

No sooner than January 1, 2023, the bill would require the department to develop and implement a mandatory process for county jails and county juvenile facilities to coordinate with Medi-Cal managed care plans and Medi-Cal behavioral health delivery systems to facilitate continued behavioral health treatment in the community for inmates. The bill would authorize the sharing of certain information, including health records, with and among counties and other specified entities, as determined necessary by the department.

(15) Existing law provides for the suspension of Medi-Cal benefits to an inmate of a public institution, and requires county welfare departments to notify the department within 10 days of receiving information that an individual who is receiving Medi-Cal is or will be an inmate of a public institution. Existing law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their eligibility for Medi-Cal benefits.

This bill would, beginning no sooner than January 1, 2023, require that a qualifying inmate of a public institution be eligible to receive targeted Medi-Cal services approved in the CalAIM Terms and Conditions for 90 days, or the number of days approved in the CalAIM Terms and Conditions if fewer than 90 days, prior to the date they are released from a public institution, if otherwise eligible for the services. The bill would, to the extent federal approval is obtained for this purpose, require the department to arrange for an independent, third-party evaluation of the hypotheses and outcomes associated with providing targeted Medi-Cal services to qualifying inmates as described in the CalAIM Terms and Conditions. The bill would require the department to post the evaluation report on its internet website following submission to the federal Centers for Medicare and Medicaid Services. The bill would also, commencing no sooner than July 1, 2021, require the department, in consultation with specified stakeholders, to initiate the planning process to prioritize the automation of Medi-Cal suspensions for incarcerated individuals into the California Healthcare Eligibility, Enrollment, and Retention System, as specified.

(16) For purposes of the programs and services described in paragraphs (11) to (15), inclusive, this bill would make conforming changes to provisions relating to the adoption of regulations or issuance of all-county letters by the department.

(17) Existing law includes coverage for specified pharmacist services under the Medi-Cal program, subject to federal approval, the availability of federal financial participation, department protocols, and utilization controls.

This bill would add medication therapy management (MTM) pharmacist services, provided in conjunction with the dispensing of qualified specialty drugs, to the list of covered pharmacist services under the Medi-Cal program, subject to the above conditions. The bill would define MTM and specialty drugs for purposes of these provisions.

Existing law requires that the rate of reimbursement for pharmacist services be at 85% of the fee schedule for physician services under the Medi-Cal program.

This bill would make an exception for the above MTM pharmacist services and would, subject to an annual appropriation, require the department to implement an MTM reimbursement methodology for covered pharmacist services related to the dispensing of

qualified specialty drugs by an eligible pharmacy contracted with the department. The bill would require the department to establish and maintain protocols and utilization controls, a list of covered specialty drug therapy categories, rates of reimbursement, and eligibility criteria and conditions for receipt of MTM pharmacist services reimbursement, as specified.

(18) Existing federal law establishes the Money Follows the Person Rebalancing Demonstration, which is designed to achieve various objectives with respect to institutional and home- and community-based long-term care services provided under state Medicaid programs. Under the Money Follows the Person Rebalancing Demonstration, an eligible individual is required to meet prescribed qualifications, including that they have resided in an inpatient facility for a period of not less than 60 consecutive days.

Existing law requires the department to provide services consistent with the Money Follows the Person Rebalancing Demonstration for transitioning eligible individuals out of an inpatient facility. Existing law defines “eligible individual” for these purposes as a person who meets certain requirements, including the prescribed qualifications set forth under federal law, except that the person is not required to have resided for at least 90 consecutive days in an inpatient facility. Existing law requires the department to cease providing those services on January 1, 2024, and repeals these provisions on January 1, 2025.

This bill would delete the 90 consecutive day residence period, and would instead provide that the eligible individual is not required to have resided for at least 60 consecutive days in an inpatient facility. The bill would make other conforming changes.

(19) Existing law requires, for the duration of the COVID-19 emergency period, the State Department of Health Care Services to implement any federal Medicaid program waiver or flexibility approved by the federal Centers for Medicare and Medicaid Services related to that emergency.

This bill would require the department to seek any federal approvals it deems necessary to extend the approved waiver or flexibility implemented pursuant to those provisions as of July 1, 2021, that are related to the delivery and reimbursement of services via telehealth modalities in the Medi-Cal program, and, subject to approval by the Department of Finance, would require the department to implement those extended waivers or flexibilities for which federal approval is obtained for a specified period of time ending December 31, 2022. The bill would also require the department to convene an advisory group to provide recommendations to inform the department in establishing and adopting billing and utilization management protocols for telehealth modalities to increase access and equity and reduce disparities in the Medi-Cal program. The bill would authorize the department to enter into contracts, or amend existing contracts, for the purposes of implementing these provisions and would exempt those contracts or amendments from specified provisions of law.

(20) The Long-Term Care, Health, Safety, and Security Act of 1973 generally requires the State Department of Public Health to license and regulate long-term health care facilities and to establish an inspection and reporting system to ensure that long-term health care facilities are in compliance with state statutes and regulations. The term “long-term health care facility” includes, among other types of facilities, a skilled nursing facility and intermediate care facility. Existing law provides that it is the intent of the Legislature to expressly set forth fundamental human rights which patients are entitled to in a skilled nursing facility, intermediate care facility, or hospice facility, and to ensure that patients in those facilities are advised of their fundamental human rights, including rights relating to transfers and discharges, and the obligations of the facilities.

Existing law, the Medi-Cal Long-Term Care Reimbursement Act, requires, among other things, the State Department of Health Care Services to implement a facility-specific reimbursement ratesetting system for certain skilled nursing facilities. Under the act, existing law requires nursing facilities to meet the residents’ discharge planning and referral needs, or make referrals to a designated local contact agency, as determined by the department.

This bill would require a long-term health care facility, as defined, to timely comply with a hearing decision, as issued by the department’s Office of Administrative Hearings and Appeals, that finds that the facility improperly transferred, discharged, or refused to readmit a resident. If a facility fails to timely comply with a hearing decision, the bill would authorize the department to assess penalties of $750 for each calendar day the facility fails to comply with the hearing decision. To demonstrate compliance with a hearing decision, the bill would require a facility to file a specified certification of compliance with the department, would require the department to make a certificate of compliance available on its internet website, and would provide that the facility’s failure to provide the certification of compliance would subject the facility to the prescribed penalties, except as specified. The bill would authorize the department to deduct the penalties from Medi-Cal payments to the facility if the department provides prior written notice to the facility and takes into account the financial condition of the facility. If there is a merger, acquisition, or change of ownership involving a facility that has outstanding penalties, the bill would require the successor long-term health care facility to be responsible for paying to the department the amount of outstanding penalties attributable to the facility for which it was assessed. The bill would authorize the department to waive assessed penalties if that facility petitions for a waiver and the department makes a determination that the facility meets certain requirements, including that the facility has taken corrective action to remediate its improper conduct. The bill would provide that the assessed penalties are appealable only to the superior court of the county where the facility is located and would require the department to refund any penalties paid by a long-term health care facility if the hearing decision is reversed on appeal. The bill would require collected penalties to be deposited into the General Fund, and, upon appropriation by the Legislature, to be used for particular purposes, including to improve the quality of

long-term care services under the Medi-Cal program, would authorize the department to implement these provisions by various means, including provider bulletins, and would require the department to seek federal approvals, as necessary, to implement these provisions. The bill would condition the implementation of these provisions to the extent that necessary federal approvals are obtained and federal financial participation is not jeopardized.

(21) Existing law requires the State Department of Health Care Services to establish a Medically Tailored Meals Pilot Program in specified counties to provide medically tailored meals, as defined, to Medi-Cal participants with specified health conditions, such as cancer and renal disease. Existing law requires the department to evaluate, at the conclusion of the program, the impact of the pilot program on specified matters related to participants, including hospital readmission and emergency room utilization rates, and to send a report on the evaluation to the Legislature.

For the 2021–22 fiscal year, this bill would require the department to implement the Short-Term Medically Tailored Meals Intervention Services Program to award funds to qualified entities providing medically tailored meals intervention services to eligible Medi-Cal beneficiaries with certain health conditions, such as cancer and congestive heart failure, who reside in specified counties. To the extent funding is available, the bill would require an eligible Medi-Cal beneficiary to receive medically tailored meals intervention services, as prescribed, for a period of 12 to 52 weeks, depending on the medical diagnosis and need. The bill would authorize the department to implement additional eligibility requirements for individuals to receive these services, and to use data from the Medi-Cal program to identify eligible Medi-Cal beneficiaries who may receive services under the Short-Term Medically Tailored Meals Intervention Services Program. The bill would require providers that are awarded funding to monitor and document the impacts of this program, including health outcomes, and to provide that information to the department. The bill would require the department to develop a methodology for reimbursing contractors or other entities for services and would require the department to allocate 5% of the funds allocated for purposes of the program to a nonprofit organization fiscal sponsor to coordinate the program, as specified.

Existing law makes the provisions of the Medically Tailored Meals Pilot Program inoperative on the earlier of the date the department submits its report to the Legislature or 12 months after the end of that program.

This bill would instead make these provisions inoperative on the date the department submits its report to the Legislature or 12 months after the end of the Medically Tailored Meals Pilot Program or the Short-Term Medically Tailored Meals Intervention Services Program, whichever occurs last.

(22) The federal Medicaid program provisions prohibit payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

Existing law requires individuals under 19 years of age enrolled in restricted-scope Medi-Cal benefits at the time the Director of Health Care Services makes a determination that systems have been programmed for implementation of these provisions to be enrolled in the full scope of Medi-Cal benefits, if otherwise eligible, pursuant to an eligibility and enrollment plan, and extends eligibility for full-scope Medi-Cal benefits to individuals who are under 25 years of age, and who are otherwise eligible for those benefits but for their immigration status. Existing law makes the effective date of enrollment for those individuals the same day that systems are operational to begin processing new applications pursuant to the director's determination. Existing law requires an individual eligible for Medi-Cal under these provisions to enroll in a Medi-Cal managed care health plan. Existing law provides that Medi-Cal benefits for individuals who are 65 years of age or older, and who do not have satisfactory immigration status or are unable to establish satisfactory immigration status, as specified, are to be prioritized in the annual Budget Act for the upcoming fiscal year if the Department of Finance projects a positive ending balance in the Special Fund for Economic Uncertainties for the upcoming fiscal year and each of the ensuing 3 fiscal years that exceeds the cost of providing those individuals with full-scope Medi-Cal benefits.

The bill would delete the above-specified provisions regarding individuals who are under 19 or 25 years of age, or 65 years of age or older, and delay implementation until the director makes the determination described above. The bill would instead make an individual who is 25 years of age or younger, and who does not have satisfactory immigration status or is unable to establish satisfactory immigration status, as specified, eligible for the full scope of Medi-Cal benefits if they are otherwise eligible for those benefits, would delete obsolete provisions, and would make conforming changes.

After the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of these purposes, but no sooner than May 1, 2022, this bill would extend Medi-Cal eligibility for the full scope of Medi-Cal benefits to an individual who is 50 years of age or older, and who does not have satisfactory immigrant status or is unable to establish satisfactory immigration status, as specified, if they are otherwise eligible for those benefits. The bill would make the effective date of enrollment for those individuals the same day that systems are operational to begin processing new applications pursuant to the director's determination. The bill would provide that a person enrolled in the Medi-Cal program under these provisions is not required to file a new application for the Medi-Cal program, would require the enrollment to be conducted pursuant to a prescribed eligibility and enrollment plan, and would require the department to provide monthly updates to the Legislature, as specified. Because counties are required to make Medi-Cal eligibility

determinations and this bill would expand Medi-Cal eligibility to specified individuals who are 50 years of age and older, the bill would impose a state-mandated local program.

(23) Existing law authorizes the department to provide health care services to beneficiaries through models of managed care, including geographic managed care and prepaid health plans, and requires the department to implement a dental managed care program. Dental services are provided under geographic managed care in the County of Sacramento and prepaid health plans in the County of Los Angeles.

This bill would require the department to extend dental managed care contracts to December 31, 2022, and to secure the extensions on a sole source basis, as specified. The bill would authorize the department to implement provisions on the Medi-Cal dental managed care program by prescribed means, including information notices, without taking any further regulatory action.

(24) Existing federal law provides for the federal Medicare program, which is a public health insurance program for persons who are 65 years of age or older and specified persons with disabilities who are under 65 years of age. Under existing law, a demonstration project known as the Coordinated Care Initiative (CCI) enables beneficiaries who are dually eligible for the Medi-Cal program and the Medicare program to receive a continuum of services that maximizes access to, and coordination of, benefits between these programs.

This bill would establish the Office of Medi-Cal Innovation and Integration in the department. The duties of the department would include, among others, to provide focused leadership and expertise on innovative models for Medicare beneficiaries in California, as specified, and to develop innovative approaches to integrated models of care and coordinated access to long-term services and supports for Medicare-only beneficiaries and dually eligible beneficiaries.

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

This bill would require the department to seek federal approval to implement specified disregards in nonexempt property for applicants or beneficiaries whose eligibility is not determined using the MAGI-based financial methods, and would condition the implementation of this provision on the Director of Health Care Services determining that systems have been programmed and they communicate that determination in writing to the Department of Finance, and no sooner than July 1, 2022.

This bill would prohibit the use of resources, including property or other assets, to determine Medi-Cal eligibility for applicants or beneficiaries whose eligibility is not determined using the MAGI-based financial methods, and would require the department to seek federal authority to disregard all resources as authorized by the flexibilities provided pursuant to federal law.

The bill would authorize the department to implement these provisions by various means, including provider bulletins, without taking regulatory authority. The bill would require the department to adopt, amend, or repeal regulations on the prohibition, and to update its notices and forms to delete any reference to limitations on resources or assets, as specified. The bill would condition the implementation of the bill's provisions to the extent consistent with federal law, upon the department obtaining any necessary federal approvals, and to the extent federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.

Because counties are required to make Medi-Cal eligibility determinations, and this bill would expand Medi-Cal eligibility, the bill would impose a state-mandated local program.

(26) The Budget Act of 2018 appropriates $2,000,000 for the Whole Genome Sequencing Pilot Project, and requires the department to provide a grant to a state nonprofit organization for the execution of a one-time pilot project to investigate the potential clinical and programmatic value of utilizing clinical Whole Genome Sequencing in the Medi-Cal program.

This bill would, no sooner than January 1, 2022, expand the Medi-Cal schedule of benefits to include rapid Whole Genome Sequencing, as specified, for any Medi-Cal beneficiary who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit. The bill would authorize the department to implement this provision by various means without taking regulatory action.

(27) Existing law requires the department to develop, subject to federal approval, reimbursement rates for clinical or laboratory services according to specified standards, including requiring that reimbursement to providers for those services not exceed the lowest of enumerated criteria, including 80% of the lowest maximum allowance established by the federal Medicare program for the same or similar services.

For dates of service on or after July 1, 2022, this bill would raise the above-described standard to 100% of the lowest maximum allowance established by the federal Medicare program for the same or similar services. For dates of service from July 1, 2021, to June 30, 2022, inclusive, the bill would require the department to establish the reimbursement rates for clinical laboratory or laboratory services at the rates in effect and approved in the Medi-Cal State Plan as of December 31, 2019. The bill would prohibit the department from retroactively implementing reimbursement reductions and from recouping overpayments for clinical laboratory or laboratory services, as specified.

(28) Existing law authorizes the department to adopt regulations for the certification of each applicant and each provider in the Medi-Cal program. Existing law requires a provider that is not currently enrolled at a location where the provider intends to provide services, goods, supplies, or merchandise to a Medi-Cal beneficiary to submit a complete application package for enrollment at a new location or a change in location. Existing law exempts an applicant, a provider operated by a licensed primary care clinic, or an affiliated mobile health care unit from this requirement and from a requirement to enroll in the Medi-Cal program as a separate provider, if a licensed primary care clinic operating the applicant, provider clinic, or mobile health care unit notifies the department of its separate locations.

This bill would, to the extent permissible under federal law, authorize a mobile optometric office that meets certain requirements to be enrolled in the Medi-Cal program as either a mobile optometric office or within any other provider category for which the applicant or provider qualifies.

(29) Under existing law, durable medical equipment, which includes custom rehabilitation equipment and custom rehabilitation technology services, is a covered Medi-Cal benefit, subject to utilization controls.

Existing law requires a provider of custom rehabilitation equipment and custom rehabilitation technology services to have a qualified rehabilitation professional on staff, as specified, and requires a medical provider to conduct a physical examination of an individual before prescribing a motorized wheelchair or scooter for a Medi-Cal beneficiary.

This bill would repeal and recast those provisions to apply to complex rehabilitation technology (CRT), defined as items classified within the federal Medicare Program as of January 1, 2021, as durable medical equipment that are individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living identified as medically necessary. The bill would impose certain accreditation, staffing, supply, and other types of requirements for CRT providers. The bill would maintain the above-described requirement concerning physical examinations by medical providers.

The bill would recast qualified rehabilitation professionals as qualified health care professionals and qualified rehabilitation technology professionals, as defined, with certain changes to certification requirements. The bill would make a conforming change to a related provision. The bill would require both types of professionals to be involved in the evaluation of complex needs patients, as defined, who receive a complex rehabilitation manual wheelchair, power wheelchair, or seating component. The bill would authorize the department to adopt utilization controls, including a specialty evaluation by a qualified health care professional.

The bill would require the department to seek any necessary federal approvals for the implementation of these provisions, and would condition their implementation to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

Existing law requires, except as otherwise provided, Medi-Cal provider payments and payments for specified non-Medi-Cal programs to be reduced by 10% for dates of service on and after June 1, 2011, and conditions the implementation of these provisions on the department securing federal approval.

For dates of service on and after January 1, 2022, or the effective date of any necessary federal approvals, whichever is later, this bill would exempt providers of CRT and CRT services from the above-described provider payment reduction.

(30) Existing law authorizes the State Department of Public Health to establish the Office of Suicide Prevention within the department, and requires the office to perform specified duties, including providing information and technical assistance to statewide and regional partners regarding best practices on suicide prevention policies and programs and reporting on progress to reduce rates of suicide, and to authorize the office to apply for and use federal, state, and foundation grants.

This bill would remove the limitation that, should the office be established, all duties and responsibilities of the office be carried out using existing staff and resources.

(31) Existing law authorizes the Director of Public Health to establish and administer a program within the State Department of Public Health's Office of AIDS to subsidize certain costs of medications for the prevention of human immunodeficiency virus (HIV) infection and other related medical services to residents of California who are at least 18 years of age, who are HIV negative, have been prescribed medications listed on the AIDS Drug Assistance Program (ADAP) formula, and meet specified financial

eligibility requirements. Existing law also authorizes the program to subsidize, without regard to eligibility and for the prevention of HIV infection, up to 30 days of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) medications.

This bill would expand eligibility for subsidized medications under this program to include individuals who have the specified medication dispensed or otherwise furnished.

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

This bill would, to the extent that funds are available for these purposes, authorize the office to allocate funds to local health departments and community-based organizations to support PrEP and PEP navigation and retention coordinators and related services for the purpose of increasing PrEP and PEP initiation and retention among individuals most vulnerable to HIV. The bill would require the office to establish a simple application process for funding to support these PrEP and PEP navigation and retention services. The bill would establish eligibility criteria for applicants to receive these funds. The bill would require funded local health departments and community-based organizations to collaborate with the office to conduct outcome and process evaluation of PrEP and PEP navigation and retention services, and would require the office to establish performance metrics to ensure that funding is used efficiently and to measure program success. The bill would authorize the office to use a portion of funds to contract with a third-party entity to provide training, program technical assistance, and capacity building to funded local health departments and community-based organizations. The bill would, to the extent allowable under federal law, and upon availability of funds, authorize the office to expend funding from the AIDS Drug Assistance Program Rebate Fund, a continuously appropriated fund, for these activities. Because the bill would authorize a new purpose for a continuously appropriated fund, the bill would create an appropriation.

(33) Existing law requires a licensed physician and surgeon or other person attending a newborn infant diagnosed as having had rhesus (Rh) isoimmunization hemolytic disease to report the condition to the State Department of Public Health on report forms prescribed by the department.

This bill would repeal that reporting requirement.

(34) Existing law authorizes the State Department of State Hospitals, subject to appropriation by the Legislature, to solicit proposals from, and to contract with, a county to help fund the development or expansion of pretrial diversion for individuals with serious mental disorders who may otherwise be found incompetent to stand trial and committed to the department for restoration of competency. Existing law requires participants to meet specified criteria, including, among others, that they suffer from certain mental disorders and have felony charges, and that there is a significant relationship between the serious mental disorders and the charged offense or between the individual's conditions of homelessness and the charged offense.

This bill would, beginning July 1, 2021, and upon appropriation from the Legislature, permit the department to amend a contract with a county to fund the expansion of an existing department-funded pretrial diversion. The bill would permit expansion of existing department-funded pretrial diversion programs for participants that have been found incompetent to stand trial on a felony charge and suffer from a mental disorder, except as specified. The bill would specify that a county expanding its programs under this section will not be required to meet any additional match funding requirements.

(35) Existing law specifies a process for declaring a defendant who is charged with a felony to be mentally incompetent to stand trial. Existing law requires the court to order that the mentally incompetent defendant be delivered by the sheriff to a State Department of State Hospitals facility or to any other available public or private treatment facility that meets stated specifications, or placed on outpatient status.

This bill would authorize the State Department of State Hospitals to conduct a reevaluation, as defined, in person or by video telehealth, of a defendant in county custody if the defendant has been committed to and awaiting admission to the department for 60 days or more, as specified. The bill would require the county jails to provide the department confidential access to the defendant for evaluation, including establishing and maintaining remote access capabilities at the jail for this purpose. By imposing additional duties on county jails, this bill would create a state-mandated local program. The bill would require the department to provide funding at a rate set by the department for reimbursement of information technology support and a portion of staff time used to facilitate telehealth interviews and evaluations of felony defendants.

This bill would also require the California Health and Human Services Agency, along with the State Department of State Hospitals, to convene an Incompetent to Stand Trial Solutions Workgroup to identify solutions to advance alternatives to placing defendants at a State Department of State Hospitals facility who are found incompetent to stand trial. The bill would require the workgroup to submit recommendations to the agency and the Department of Finance on or before November 30, 2021, for short-term, medium-term, and long-term solutions that can be accomplished on or before specified dates. Until December 31, 2024, if the recommendations cannot be completed, as specified, or if other described conditions are not met, the bill would authorize the

State Department of State Hospitals, upon specified approval, to discontinue admissions for specified patients, impose patient reduction targets, and charge 150% of the daily bed rate for counties for specified patients that are above the patient reduction targets.

(36) Existing law prohibits a person who is mentally incompetent, as specified, from being tried or sentenced for a criminal offense. Existing law requires the court, upon a finding that a criminal defendant is mentally incompetent to stand trial, to order that defendant to be committed to a facility of the State Department of State Hospitals (DSH), or other available facility, for restoration of competence.

Existing law requires the medical director of the facility, within 90 days after commitment, to make a report of the defendant's progress to the court, as specified. If that report indicates that there is no substantial likelihood of the defendant regaining mental competence in the foreseeable future, or if, after a specified interval of treatment, the defendant is not restored to mental competence, existing law requires the defendant to be returned to the court for further proceedings.

This bill would prohibit a person from being admitted to a state hospital under these provisions.

This bill would require a mentally incompetent defendant in the custody of a DSH facility, for whom there is no substantial likelihood of restoration of competency or who, after a specified interval of treatment, has not been restored to mental competence, to be returned to the custody of the county, as specified.

The bill would also authorize DSH to charge a county that fails to take custody of such a defendant a daily rate, as specified, for any time that the defendant remains in DSH custody.

The bill would make other conforming changes.

By requiring counties to take, or pay for, the custody of these defendants, this bill would impose a state-mandated local program.

(37) Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. If a qualified health plan covers abortion services for which federal funding is prohibited, PPACA requires the plan to deposit the premium amounts that equal the actuarial value of the coverage of those services into a separate account. PPACA prohibits the actuarial value of that abortion services coverage from being estimated at a cost of less than $1 per enrollee per month.

This bill would require the Exchange, upon appropriation by the Legislature and beginning on or after January 1, 2022, to make payments to qualified health plan issuers that equal the cost of providing abortion services for which federal funding is prohibited to individuals enrolled in a qualified health plan through the Exchange in the individual market. The bill would prohibit the payments from being less than $1 per enrollee per month.

(38) Under existing state law, Covered California is governed by an executive board that facilitates the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law specifies the powers and duties of the board governing the Exchange, and requires the board to facilitate the purchase of qualified health plans by qualified individuals and qualified small employers. Existing law establishes the California Health Trust Fund and continuously appropriates moneys in the fund for these purposes.

This bill would establish the Health Care Affordability Reserve Fund, and would authorize the Controller to use funds in the Health Care Affordability Reserve Fund for cashflow loans to the General Fund. Upon the enactment of the Budget Act of 2021, and upon order of the Director of Finance, the bill would require the Controller to transfer $333,439,000 from the General Fund to the Health Care Affordability Reserve Fund, and, upon appropriation by the Legislature, the bill would require that fund to be utilized for the purpose of health care affordability programs operated by the California Health Benefit Exchange. The bill would also require the Exchange, in consultation with stakeholders and the Legislature, to develop options for providing cost sharing reduction subsidies to reduce cost sharing for low- and middle-income Californians, and would require the Exchange to report the developed options to the Legislature, Governor, and the Healthy California for All Commission for consideration in the 2022–23 budget process and to post the report on its internet website.

(39) Existing law authorizes the executive board of Covered California to adopt necessary rules and regulations by emergency regulations until January 1, 2022, with the exception of regulations implementing prescribed provisions relating to criminal background history checks for persons with access to confidential, personal, or financial information. Existing law authorizes the Office of Administrative Law to approve more than 2 readoptions of emergency regulations until January 1, 2027. Existing law provides that these extensions apply to a regulation adopted before January 1, 2019.

This bill would instead extend the authority of the board to adopt those necessary rules and regulations by emergency regulations to January 1, 2025, and would extend the authority of the Office of Administrative Law to approve more than 2 readoptions of emergency regulations until January 1, 2030. The bill would provide that these prescribed time extensions apply to a regulation adopted before January 1, 2022.

(40) Existing law requires the Office of Statewide Health Planning and Development to be the single state agency designated to collect certain health facility or clinic data for use by all state agencies. Existing law requires hospitals to file with the office certain information regarding patients that is reported through a Hospital Discharge Abstract Data Record, an Emergency Care Data Record, and an Ambulatory Surgery Data Record, as applicable.

Existing law requires that the above-described collected health information be made available to the State Department of Health Care Services and the State Department of Public Health. Existing law requires the departments to ensure that the patient's rights to confidentiality are not violated in any manner and to comply with all applicable policies and requirements involving review and oversight by the State Committee for the Protection of Human Subjects.

This bill would additionally require that the health information be made available to the California Health Benefit Exchange and would extend the above requirements for the departments to the Exchange. The bill would require the Exchange to report to the Governor and the Legislature on or before August 1, 2023, regarding the impact of these requirements on the Exchange.

(41) Under existing law, a Physician Orders for Life Sustaining Treatment (POLST) form is a request regarding resuscitative measures that directs a health care provider regarding resuscitative and life-sustaining measures. Existing law requires a health care provider to treat an individual in accordance with their POLST form.

Existing law establishes the Advance Health Care Directive Registry, allowing individuals to register a written advance health care directive with the Secretary of State. Existing law distinguishes a request regarding resuscitative measures from an advance health care directive.

The bill would enact the California POLST eRegistry Act, which would require the Emergency Medical Services Authority to establish a statewide electronic POLST registry system for the purpose of collecting a patient's POLST information and disseminating that information to an authorized user. The bill would require the authority to promulgate regulations necessary for the operation of the POLST eRegistry. The bill would require the agency to incorporate the Advance Health Care Directive Registry into the POLST eRegistry. The bill would appropriate $10,000,000 from the General Fund for the 2021–22 fiscal year to support the planning, development, and implementation of the POLST eRegistry, and would continuously appropriate $750,000 from the General Fund annually thereafter to prepare for and support the POLST eRegistry. By appropriating money from the General Fund, the bill would make an appropriation.

(42) Existing law establishes the Richard Paul Hemann Parkinson's Disease Program, which, among other things, requires the State Department of Public Health to collect data on the incidence of Parkinson's disease in California, as specified. Existing law requires a hospital, facility, physician and surgeon, or other health care provider diagnosing or providing treatment to Parkinson's disease patients to report each case of Parkinson's disease to the department, as prescribed. Existing law conditions the implementation of the program on the availability of funds and repeals the program on January 1, 2022.

This bill would extend the Richard Paul Hemann Parkinson's Disease Program indefinitely.

The bill would also create the California Neurodegenerative Disease Registry Program, which would, among other things, require the department to collect data on the incidence of neurodegenerative disease, as defined, in California. The bill would require a hospital, facility, physician and surgeon, or other health care provider diagnosing or providing treatment to a patient for a neurodegenerative disease to report each case of a neurodegenerative disease to the department, as prescribed.

This bill would repeal these provisions on January 1, 2028.

(43) Existing law, the State Department of Health Services Cooperative Agreement Act, provides for the establishment of cooperative agreements between the State Department of Public Health and other public and private entities for the purposes of, among other things, simplifying the administration of public health programs by the department. The act requires cooperative agreements to be subject to review and approval by the Department of General Services with certain exceptions. Existing law requires that cooperative agreements be procured by means of a request for application, as defined, or a request for proposal, unless the amount of the agreement is less than $50,000 annually or less than $200,000 a year and from a program that awards 5 or fewer grants per year.

This bill would additionally authorize a cooperative agreement to be procured without a request for application or a request for proposal if the department is awarding a cooperative agreement under the California Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to an entity or organization that currently has an executed agreement with the specific WIC local agency. Under these circumstances, the bill would authorize the cooperative agreement to be procured by means of

subvention. The bill would require cooperative agreements for new or additional WIC local agencies to be procured by means of a process that complies with applicable federal and state laws and the department's state plan for operation of WIC.

(44) Under existing law, various programs provide behavioral health services to children and youth, such as the School-based Early Mental Health Intervention and Prevention Services for Children Act of 1991, which authorizes the Director of Health Care Services, in consultation with the Superintendent of Public Instruction, to award grants to local educational agencies to pay specified costs of providing school-based early mental health intervention and prevention services to eligible pupils at schoolsites. Existing law also establishes the Mental Health Student Services Act as a mental health partnership competitive grant program for the purpose of establishing mental health partnerships between a county's mental health or behavioral health departments and school districts, charter schools, and the county office of education within the county, as provided.

This bill would establish the Children and Youth Behavioral Health Initiative (initiative), which would be administered by the California Health and Human Services Agency and its departments. The bill would declare the purpose of the initiative to be to transform the state's behavioral health system into an innovative ecosystem in which all children and youth 25 years of age and younger, regardless of payer, are screened, supported, and served for emerging and existing behavioral health needs.

The bill would require the State Department of Health Care Services to, among other things, procure and oversee a vendor to establish and maintain a behavioral health services and supports virtual platform to integrate behavioral health screenings, application-based supports, and direct behavioral health services, as specified. The bill would also require the department, or a contracted vendor, to provide competitive grants to qualified entities to build partnerships, capacity, and infrastructure supporting ongoing school-linked behavioral health services for children and youth 25 years of age and younger, among other purposes. The bill would require the Office of Statewide Health Planning and Development to award competitive grants to qualified entities and individuals to expand the supply of behavioral health counselors, coaches, peer supports, and other allied health care providers serving children and youth, including those at schoolsites.

This bill would authorize the State Department of Health Care Services to, subject to an appropriation, establish a Behavioral Health Continuum Infrastructure Program to award grants as specified for the construction, acquisition, and rehabilitation of behavioral health treatment resources, as described.

The bill would require a health care service plan contract or disability insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, that is required to provide coverage for medically necessary treatment of mental health and substance use disorders to cover the provision of specified services when delivered at schoolsites, regardless of the network status of the local educational agency, institution of higher education, or health care provider. The bill would require the plan or insurer to reimburse the entity that provided the services, as specified. The bill would require the services to be provided without prior authorization or cost sharing. Because a violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The bill would require, no sooner than July 1, 2022, and subject to federal approval, that dyadic behavioral visits be a covered Medi-Cal benefit. The bill would require the dyadic visits to include screening for, among other things, behavioral health problems, interpersonal safety, and social determinants of health, as specified.

(45) Existing law establishes the California Health and Human Services Agency (CHHSA), which includes departments charged with administration of health, social, and human services. Existing law makes legislative findings and declarations on health information technology, including that there is a need to promote secure electronic health data exchange among specified individuals, such as health care providers and consumers of health care.

This bill would require, on or before July 1, 2022, subject to an appropriation in the annual Budget Act, CHHSA, in consultation with stakeholders and local partners, to establish the California Health and Human Services Data Exchange Framework that includes a single data sharing agreement and common set of policies and procedures that will govern and require the exchange of health information among health care entities and government agencies in California. The bill would require specified entities to execute the framework data sharing agreement on or before January 31, 2023. The bill would require, on or before January 31, 2024, that specified entities, including general acute care hospitals and skilled nursing facilities, exchange health information, as defined, in real time. The bill would require other specified entities, including physician practices of fewer than 25 physicians and rehabilitation hospitals, to meet this standard on January 31, 2026. The bill would require CHHSA to convene a stakeholder advisory group no later than September 1, 2021, to advise on the development and implementation of the framework and would require, no later than April 1, 2022, CHHSA to submit an update to the Legislature based on the input received from the stakeholder advisory group. The bill would require, on or before January 31, 2023, that CHHSA work with the California State Association of Counties to encourage the inclusion of county health, public health, and social services in the California Health and Human Services Data Exchange Framework.

(46) Existing law authorizes a public entity, as defined, that receives General Fund money from the State Department of Public Health for human immunodeficiency virus prevention and education to use that money to support clean needle and syringe

exchange projects authorized by the public entity. Existing law authorizes the department to purchase and provide to the programs sterile hypodermic needles, syringes, and other supplies.

This bill would additionally authorize the department to support any costs associated with the distribution of those supplies.

(47) Existing law establishes the Mental Health Student Services Act, administered by the Mental Health Services Oversight and Accountability Commission. Existing law requires the commission to award grants to county mental health or behavioral health departments and to fund partnerships between educational and county mental health entities.

This bill, subject to an appropriation and commencing with the 2021–22 fiscal year, would require the commission to award grants to a county mental health or behavioral health department or another lead agency, as identified by the partnership within each county that meets the requirements of the program. The bill would authorize the commission to redistribute those funds to other eligible grantees if the commission is unable to provide a grant to a partnership in a county because of a lack of applicants or because no applicants met the minimum requirements within the established timeframes. The bill, for the 2021–22 fiscal year, would require the commission to take into consideration any previous funding the grantee received under this program.

(48) Existing law requires the State Department of Public Health to develop and review plans and participate in a program for the prevention and control of venereal disease.

This bill would require the department, contingent upon a specific appropriation in the annual Budget Act, to allocate grants to local health jurisdictions for sexually transmitted disease control and prevention activities, as prescribed.

(49)Existing law provides for programs relating to treatment of persons with human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS). Under existing law, the Office of AIDS, in the State Department of Public Health, is the lead agency within the state responsible for coordinating state programs, services, and activities relating to HIV and AIDS and AIDS-related conditions.

This bill would require the department, in consultation with the California Department of Aging, to establish a program for up to 5 demonstration projects to operate for a period of up to 3 years, to allow for innovative, evidence-informed approaches to improve the health and well-being of older people living with HIV, as specified. The bill would require the department to establish a process to request applications, and award funding on a competitive basis, for eligible entities to operate a demonstration project. The bill would require applicants to demonstrate experience and expertise in providing culturally appropriate services to the most vulnerable and underserved older people living with HIV and to demonstrate the capacity to ensure that the multidisciplinary clinical and nonclinical needs of older people living with HIV are assessed and addressed, as specified.

(50) Existing law, the California Healthcare, Research and Prevention Tobacco Tax Act of 2016, an initiative measure approved as Proposition 56 at the November 8, 2016, statewide general election, increases taxes imposed on distributors of cigarettes and tobacco products and requires all revenues to be deposited into the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund, a continuously appropriated fund. Proposition 56 requires the Controller to transfer 82% of those revenues to the Healthcare Treatment Fund, to be used by the department to increase funding for the Medi-Cal program and other specified health care programs and services in a way that, among other things, ensures timely access, limits geographic shortages of services, and ensures quality care.

For intermediate care facilities for individuals with developmental disabilities, facilities providing continuous skilled nursing care to individuals with developmental disabilities, and freestanding pediatric subacute care units, and for dates of service on or after August 1, 2021, this bill would require the Medi-Cal reimbursement rate to exclude prescribed rate reductions, limitations, or increases. For dates of service on or after August 1, 2021, and for each rate year thereafter, the bill would require the department to calculate and publish the reimbursement rates for these providers. For the 2021–22 fiscal year, and for each fiscal year thereafter, the bill would require the reimbursement rates for these providers to account for, and be inclusive of, Proposition 56 supplemental payments if the Budget Act of that fiscal year appropriates funds from the Healthcare Treatment Fund to the department to make those supplemental payments to these providers. With respect to intermediate care facilities for the developmentally disabled or facilities providing continuous skilled nursing care to developmentally disabled individuals, for dates of service on or after August 1, 2021, to July 31, 2022, inclusive, the rates would be the greater of the amount determined above, or the approved Medi-Cal State Plan reimbursement rate, inclusive of the temporary increased Medicaid payments associated with the COVID-19 Public Health Emergency, plus the Proposition 56 supplemental payment amount, in effect for that facility, as specified.

The bill would require the department to seek federal approvals to implement these provisions, and would condition the implementation of these provisions on the department securing federal approval and the availability of federal financial participation. The bill would authorize the department to implement these provisions by various means, including provider bulletins, and to modify methodology and specified provisions under prescribed circumstances.

(51) Existing law requires the State Department of Public Health to allocate funds to local health jurisdictions to provide hepatitis C virus (HCV) activities, including, but not limited to, monitoring, prevention, testing, and linkage to, and retention in, care activities for the most vulnerable and underserved individuals living with, or at high risk for, HCV infection.

This bill, in order to ensure that the most vulnerable Californians are informed of their HCV status and are linked to care and a cure, would require the State Department of Public Health's Office of Viral Hepatitis Prevention to purchase HCV test kits and associated materials and supplies for distribution to community-based organizations and local health departments. The bill would also authorize the office to allocate funding to train personnel, as specified, to conduct HCV testing, human immunodeficiency virus (HIV) testing, and sexually transmitted infection (STI) testing and related activities. The bill would authorize the office to use a portion of the funds allocated for purposes of the bill to hire necessary staff to successfully implement and evaluate the activities authorized by the bill.

(52) Existing law establishes state hospitals for the care, treatment, and education of mentally disordered persons, and provides the State Department of State Hospitals with jurisdiction over specified facilities, including state hospitals and county jail treatment facilities under contract with the department to provide competency restoration services.

Existing law authorizes the department to transfer patients of a state institution under its jurisdiction to another institution, and requires the transfer of a conservatee to be made only with the consent of the conservator.

This bill would delete the requirement of consent to the transfer of a conservatee.

Subject to an appropriation by the Legislature, this bill would authorize the department to contract for subacute bed capacity, including institutions for mental disease, mental health rehabilitation centers, skilled nursing facilities, or any other treatment options, such as community-based restoration of competency services, to address the increasing number of patient referrals to the department, and would expand the jurisdiction of the department to include these contracted facilities. The bill would authorize contracted funds to include certain expenses, such as program implementation costs and one-time purchases of patient and staff furnishings. The bill would exempt these contracts from specified contracting requirements, including the State Administrative Manual, and from approval by the Department of General Services. The bill would authorize the department to implement these provisions by specified means, including departmental letters.

(53) Existing law establishes the State Department of State Hospitals within the California Health and Human Services Agency and provides the department with jurisdiction over specified facilities for the care and treatment of persons with mental health disorders. Under existing law, specified relatives of a patient in a state hospital are liable for their costs of care, support, and maintenance of the patient. Existing law requires the department to investigate to determine if a patient has a relative responsible for the patient's costs and if they are financially able to pay those costs. Under existing law, reports regarding these investigations, and investigations into the patient's moneys, properties, and interests in property, are records of the department and may be inspected at any time by interested relatives, their agents, or representatives. Existing law authorizes the Director of State Hospitals to reduce, cancel, or remit the amount a relative owes.

This bill would delete the above-described provisions, thus eliminating a relative's financial liability for a patient in a state hospital and their authorization to inspect specified investigative reports at any time.

(54) The Budget Act of 2019 made appropriations for the support of state government for the 2019–20 fiscal year.

This bill would amend the Budget Act of 2019 by revising items of appropriation.

This bill would declare that it is to take effect immediately as a Budget Bill.

(55) This bill would make its provisions severable and would make other legislative findings and declarations.

(56) This bill would declare that it is to take effect immediately as a bill providing for appropriations related to the Budget Bill.

(57) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

(58) Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.
Vote: majority Appropriation: yes Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares all of the following with respect to Division 109.7 (commencing with Section 130290) of the Health and Safety Code, as added by this act:

(a) While parts of California's health care system rely on coordinated, interoperable electronic systems, other parts rely on decentralized, manual, and siloed systems of clinical and administrative data exchange that is voluntary in many situations. This voluntary patchwork imposes burdens on providers and patients, limits the health care ecosystem from making material advances in equity and quality, and functionally inhibits patient access to personalized, longitudinal health records. Further, a lack of clear policies and requirements to share data between payers, providers, hospitals, and public health systems is a significant hindrance to addressing public health crises, as demonstrated by challenges inherent to the COVID-19 pandemic.

(b) Despite the widespread availability of secure electronic data transfer, a small but important minority of Californians' medical information is stored or shared on paper. When that medical information is shared between providers, much of it happens by mail, fax, or, most likely, by the patients themselves, who frequently carry their records from appointment to appointment. While electronic health information exchange cannot replace provider-patient communication, it can greatly improve the completeness of patient records, which has a significant effect on health and wellness outcomes, as past history, current medications, and other information are jointly reviewed during appointments.

(c) Social and economic factors distinct from medical care are powerful predictors of health outcomes and disease burden throughout a person's life. From a population health perspective, this means that evidence-based policies that affect the broader conditions in which people are born, grow, and live can exert a powerful influence on health and well-being. From an operational perspective, data-driven efforts to better coordinate human and social supports with the medical and health care sectors provide opportunities to deliver services that are more client centered, efficient, effective, and tailored.

SEC. 2. The Legislature finds and declares all of the following with respect to Part 7 (commencing with Section 5960) of Division 5 of the Welfare and Institutions Code, as added by this act:

(a) The COVID-19 public health emergency has impacted every aspect of life as social distancing became a necessity, businesses closed, schools transitioned to remote education, and millions of Americans lost their jobs. The pandemic's impacts on behavioral health, including the toll of pandemic-related stress, have increased the need for behavioral health resources.

(b) In particular, the pandemic has exacerbated behavioral health conditions for children and youth. Increases in economic hardship, material insecurity, and parental stress and behavioral health challenges all raise the risk of long-term harm.

(c) The pandemic has also exacerbated the need to build new capacity or expand existing capacity for the continuum of behavioral health treatment resources in less restrictive, community-based, residential settings of care.

(d) It is the intent of the Legislature to establish an innovative and prevention-focused behavioral health system where all children and youth are routinely screened, supported, and served for emerging and existing behavioral health needs due to the pandemic.

(e) It is the intent of the Legislature to provide competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets to support the community continuum of behavioral health treatment resource needs due to the pandemic.

SEC. 3. The Legislature finds and declares all of the following with respect to Section 14000.6 of the Welfare and Institutions Code, as added by this act:

(a) Individuals with multiple chronic conditions or functional limitations, people with disabilities, and residents of nursing facilities are often dually eligible for the Medicare and Medi-Cal programs. These individuals tend to experience high rates of chronic illness, with many having long-term care needs and social risk factors. In addition, dually eligible individuals are more likely to be from systematically and historically disadvantaged populations.

(b) For dually eligible individuals, the Medicare and Medi-Cal programs operate independently and under different funding streams. California has implemented a time-limited federal demonstration and other health care delivery system models to promote integrated care for dually eligible individuals and to improve health care outcomes, quality, and cost effectiveness. Under the California Advancing and Innovating Medi-Cal (CalAIM) Initiative, the number of dually eligible individuals enrolled in integrated care will increase, through aligned enrollment in affiliated Medicare health plans and Medi-Cal managed care plans.

(c) The number of Medicare-only beneficiaries is rapidly growing in California. California's population of residents over 60 years of age is projected to grow faster than any other age group, and is projected to be one quarter of the state's population by 2030.

This population is also becoming more diverse, with increased numbers of older adults being single or childless and living alone, thus increasing the need for additional external supports.

(d) Long-term services and supports may be unaffordable for some middle-income Medicare-only beneficiaries who are not eligible for the Medi-Cal program. This places them at greater risk of having unmet needs, and may increase the likelihood of unnecessary institutionalization or spending down assets to qualify for the Medi-Cal program.

(e) All older adults, and those with disabilities, should be provided with meaningful choice and access to coordinated and client-friendly services and supports in their communities.

(f) Both paid and unpaid caregivers to Medicare-only and dually eligible beneficiaries should be supported in the provision of their essential care for older adults and those with disabilities, especially with the growing demand for that care.

SEC. 4. Section 502 is added to the Business and Professions Code, to read:

502. (a) Notwithstanding any other law, both of the following apply:

(1) The Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians of the State of California, the Physician Assistant Board, and the Respiratory Care Board of California shall collect workforce data from their respective licensees and registrants as specified in subdivision (b) for future workforce planning at least biennially. The data shall be collected at the time of electronic license or registration renewal for those boards that utilize electronic renewals for licensees or registrants.

(2) All other boards that are not listed in paragraph (1) that regulate healing arts licensees or registrants under this division shall request workforce data from their respective licensees and registrants as specified in subdivision (b) for future workforce planning at least biennially. The data shall be requested at the time of electronic license or registration renewal for those boards that utilize electronic renewals for licensees or registrants.

(b) In conformance with specifications under subdivision (d), the workforce data collected or requested by each board about its licensees and registrants shall include, at a minimum, all of the following information:

(1) Anticipated year of retirement.

(2) Area of practice or specialty.

(3) City, county, and ZIP Code of practice.

(4) Date of birth.

(5) Educational background and the highest level attained at time of licensure or registration.

(6) Gender or gender identity.

(7) Hours spent in direct patient care, including telehealth hours as a subcategory, training, research, and administration.

(8) Languages spoken.

(9) National Provider Identifier.

(10) Race or ethnicity.

(11) Type of employer or classification of primary practice site among the types of practice sites specified by the board, including, but not limited to, clinic, hospital, managed care organization, or private practice.

(12) Work hours.

(13) Sexual orientation.

(14) Disability status.

(c) Each board shall maintain the confidentiality of the information it receives from licensees and registrants under this section and shall only release information in an aggregate form that cannot be used to identify an individual other than as specified in subdivision (e).

(d) The Department of Consumer Affairs, in consultation with the Department of Health Care Access and Information, shall specify for each board subject to this section the specific information and data that will be collected or requested pursuant to subdivision (b). The Department of Consumer Affairs' identification and specification of this information and data shall be exempt

until June 30, 2023, from the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(e) Each board, or the Department of Consumer Affairs on its behalf, shall, beginning on July 1, 2022, and quarterly thereafter, provide the individual licensee and registrant data it collects pursuant to this section to the Department of Health Care Access and Information in a manner directed by the Department of Health Care Access and Information, including license or registration number and associated license or registration information. The Department of Health Care Access and Information shall maintain the confidentiality of the licensee and registrant information it receives and shall only release information in an aggregate form that cannot be used to identify an individual.

(f) A licensee or registrant shall not be required to provide the information listed in subdivision (b) as a condition for license or registration renewal, and licensees or registrants shall not be subject to discipline for not providing the information listed in subdivision (b).

(g) This section does not alter or affect mandatory reporting requirements for licensees or registrants established pursuant to this division, including, but not limited to, Sections 1715.5, 1902.2, 2425.3, and 2455.2.

SEC. 5. Section 2717 of the Business and Professions Code is repealed.

SEC. 6. Section 2852.5 of the Business and Professions Code is repealed.

SEC. 7. Section 3518.1 of the Business and Professions Code is repealed.

SEC. 8. Section 3770.1 of the Business and Professions Code is repealed.

SEC. 9. Section 4506 of the Business and Professions Code is repealed.

SEC. 10. Section 100503.5 is added to the Government Code, to read:

100503.5. (a) The Exchange shall provide payments equaling the cost of providing coverage of services described in Section 18023(b)(1)(B)(i) of Title 42 of the United States Code to individuals enrolled in a qualified health plan through the Exchange in the individual market. The payments shall not be less than one dollar ($1) per enrollee per month.

(b) The Exchange shall make the payments required under subdivision (a) directly to the qualified health plan issuers on behalf of the enrollees.

(c) The payments required under subdivision (a) shall be made upon appropriation by the Legislature. The payments shall not be made from the California Health Trust Fund established by Section 100520.

(d) Subject to appropriation, the payments shall be made for months beginning on or after January 1, 2022.

(e) For purposes of this section, “qualified health plan” does not include a qualified dental plan offered through the Exchange.

(f) This section does not create an entitlement program of any kind, appropriate any funds, require the Legislature to appropriate any funds, or increase or decrease taxes owed by a taxpayer.

SEC. 11. Section 100504 of the Government Code is amended to read:

100504. (a) The board may do the following:

(1) With respect to individual coverage made available in the Exchange, collect premiums and assist in the administration of subsidies.

(2) Enter into contracts.

(3) Sue and be sued.

(4) Receive and accept gifts, grants, or donations of moneys from an agency of the United States, an agency of the state, and a municipality, county, or other political subdivision of the state.

(5) Receive and accept gifts, grants, or donations from individuals, associations, private foundations, and corporations, in compliance with the conflict of interest provisions to be adopted by the board at a public meeting.

(6) (A) Adopt rules and regulations, as necessary. Until January 1, 2025, necessary rules and regulations, except those implementing Section 1043, may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2). The adoption of emergency regulations

pursuant to this section shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2, including subdivisions (e) and (h) of Section 11346.1, an emergency regulation adopted pursuant to this section shall be repealed by operation of law unless the adoption, amendment, or repeal of the regulation is promulgated by the board pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 within five years of the initial adoption of the emergency regulation. A rule or regulation adopted pursuant to this section shall be discussed by the board during at least one properly noticed board meeting before the board meeting at which the board adopts the rule or regulation. Notwithstanding subdivision (h) of Section 11346.1, until January 1, 2030, the Office of Administrative Law may approve more than two readoptions of an emergency regulation adopted pursuant to this section.

(B) The amendments made to this paragraph by the act that added this subparagraph also shall apply to a regulation adopted pursuant to this section before January 1, 2022.

(7) Collaborate with the State Department of Health Care Services and the Managed Risk Medical Insurance Board, to the extent possible, to allow an individual the option to remain enrolled with the individual's carrier and provider network if the individual experiences a loss of eligibility of premium tax credits and becomes eligible for the Medi-Cal program, or loses eligibility for the Medi-Cal program and becomes eligible for premium tax credits through the Exchange.

(8) Share information with relevant state departments, consistent with the confidentiality provisions in Section 1411 of the federal act, necessary for the administration of the Exchange.

(9) Require carriers participating in the Exchange to make available to the Exchange and regularly update an electronic directory of contracting health care providers so that individuals seeking coverage through the Exchange can search by health care provider name to determine which health plans in the Exchange include that health care provider in their network. The board may also require a carrier to provide regularly updated information to the Exchange as to whether a health care provider is accepting new patients for a particular health plan. The Exchange may provide an integrated and uniform consumer directory of health care providers indicating which carriers the providers contract with and whether the providers are currently accepting new patients. The Exchange may also establish methods by which health care providers may transmit relevant information directly to the Exchange, rather than through a carrier.

(10) Make available supplemental coverage for enrollees of the Exchange to the extent permitted by the federal act, provided that General Fund money is not used to pay the cost of that coverage. Supplemental coverage offered in the Exchange shall be subject to the charge imposed under subdivision (n) of Section 100503.

(b) The Exchange shall only collect information from individuals or designees of individuals necessary to administer the Exchange and consistent with the federal act.

(c) (1) The board shall have the authority to standardize products to be offered through the Exchange. A product standardized by the board pursuant to this subdivision shall be discussed by the board during at least one properly noticed board meeting before the board meeting at which the board adopts the standardized products to be offered through the Exchange.

(2) The adoption, amendment, or repeal of a regulation by the board to implement this subdivision is exempt from the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2).

SEC. 12. Section 100520.5 is added to the Government Code, immediately following Section 100520, to read:

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

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

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

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

(e) (1) The California Health Benefit Exchange shall, in consultation with stakeholders and the Legislature, develop options for providing cost sharing reduction subsidies to reduce cost sharing for low- and middle-income Californians. On or before January 1, 2022, the Exchange shall report those developed options to the Legislature, Governor, and the Healthy California for All

Commission, established pursuant to Section 1001 of the Health and Safety Code, for consideration in the 2022–23 budget process.

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

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

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

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

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

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

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

SEC. 13. Section 1374.722 is added to the Health and Safety Code, to read:

1374.722. (a) (1) A health care service plan contract issued, amended, renewed or delivered on or after January 1, 2024, that is required to provide coverage for medically necessary treatment of mental health and substance use disorders pursuant to Sections 1374.72, 1374.721, and 1374.73 shall cover the provision of the services identified in the fee-for-service reimbursement schedule published by the State Department of Health Care Services, as described in subparagraph (B) of paragraph (5) of subdivision (c), when those services are delivered at schoolsites pursuant to this section, regardless of the network status of the local educational agency, institution of higher education, or health care provider.

(2) This section does not relieve a local educational agency or institution of higher education from requirements to accommodate or provide services to students with disabilities pursuant to any applicable state and federal law, including, but not limited to, the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.), Part 30 (commencing with Section 56000) of Division 4 of Title 2 of the Education Code, Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code, and Chapter 3 (commencing with Section 3000) of Division 1 of Title 5 of the California Code of Regulations.

(b) The following definitions apply for purposes of this section:

(1) “Health care provider” has the same meaning as defined in paragraph (4) of subdivision (a) of Section 1374.72 and paragraph (5) of subdivision (c) of Section 1374.73.

(2) “Institution of higher education” means the California Community Colleges, the California State University, or the University of California.

(3) “Local educational agency” means a school district, county office of education, charter school, the California Schools for the Deaf, and the California School for the Blind.

(4) “Medically necessary treatment of a mental health or substance use disorder” has the same meaning as defined in paragraph (3) of subdivision (a) of Section 1374.72.

(5) “Mental health and substance use disorder” has the same meaning as defined in paragraph (2) of subdivision (a) of Section 1374.72.

(6) “School site” means a facility or location used for public kindergarten, elementary, secondary, or postsecondary purposes. “School site” also includes a location not owned or operated by a public school, or public school district, if the school or school district provides or arranges for the provision of medically necessary treatment of a mental health or substance use disorder to its students at that location, including off-campus clinics, mobile counseling services, and similar locations.

(7) “Utilization review” has the same meaning as defined in paragraph (3) of subdivision (f) of Section 1374.721.

(c) When a local educational agency or institution of higher education provides or arranges for the provision of treatment of a mental health or substance use disorder services subject to this section by a health care provider for an individual 25 years of age or younger at a school site, the student’s health care service plan shall reimburse the local educational agency or institution of higher education for those services.

(1) A health care service plan shall not require prior authorization for services provided pursuant to this section.

(2) A health care service plan may conduct a postclaim review to determine appropriate payment of the claim. Payment for services subject to this section may be denied only if the health care service plan reasonably determines that the services were provided to a student not enrolled in the health plan, were never performed, or were not provided by a health care provider appropriately licensed or authorized to provide the services.

(3) Notwithstanding paragraph (1), a health plan may require prior authorization for services as authorized by the department pursuant to subdivision (d).

(4) A local educational agency, community college district, the California State University system, or the Regents of the University of California may consolidate claims for purposes of submitting the claims to a health care service plan.

(5) A health care service plan shall provide reimbursement for services provided to students pursuant to this section at the greater of either of the following amounts:

(A) The health plan's contracted rate with the local educational agency, institution of higher education, or health care provider, if any.

(B) The fee-for-service reimbursement rate published by the State Department of Health Care Services for the same or similar services provided in an outpatient setting, pursuant to Section 5961.4 of the Welfare and Institutions Code.

(6) A health care service plan shall provide reimbursement for services provided pursuant to this section in compliance with the requirements for timely payment of claims, as required by this chapter.

(7) Services provided pursuant to this section shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing.

(8) An individual or entity shall not bill the enrollee or subscriber, nor seek reimbursement from the enrollee or subscriber, for services provided pursuant to this section.

(d) No later than December 31, 2023, the director shall issue guidance to health care service plans regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Any guidance issued pursuant to this subdivision shall be effective only until the director adopts regulations pursuant to the Administrative Procedure Act.

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

SEC. 14. Article 11.9 (commencing with Section 1399.870) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 11.9. Health Equity and Quality

1399.870. (a) (1) On or before March 1, 2022, the department shall convene a Health Equity and Quality Committee to make recommendations to the department for standard health equity and quality measures, including annual benchmark standards for assessing equity and quality in health care delivery. The department may contract with consultants to assist the committee with the implementation and administration of its duties.

(2) The committee shall provide initial recommendations, as well as recommendations on updating and revising standard health equity and quality measures and annual benchmark standards, consistent with this article. These recommendations shall consider the interaction of multiple characteristics in determining where disparate outcomes exist, including, but not limited to, race, ethnicity, gender, sexual orientation, language, age, income, and disability.

(3) Meetings of the committee shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

(4) The department may contract with consultants to assist the committee with the implementation and administration of its duties.

(b) In appointing members to the committee, the director shall consider all of the following:

(1) The expertise of each committee member so that the committee's composition reflects a diversity of relevant expertise.

(2) The racial, cultural, ethnic, sexual orientation, gender, economic, linguistic, age, disability, and geographical diversity of the state so that the committee's composition reflects the communities of California.

(3) The expertise of representatives from other state agencies that are engaged in the work of setting quality and equity goals or standards for health care entities.

(4) The representation of consumer stakeholders that serve diverse populations.

(5) Inclusion of experts, researchers, and community members who are engaged in the development of alternative approaches to measuring health equity, consumer experience, and health outcomes.

(c) On or before September 30, 2022, the committee shall provide the recommendations described in subdivision (a), which may consider and may include all of the following:

(1) Quality measures, including, but not limited to, Healthcare Effectiveness Data and Information Set (HEDIS) measures and the federal Centers for Medicare and Medicaid Services Child and Adult Core Set measures.

(2) Surveys or other measures to assess consumer experience and satisfaction, including alternative approaches that take into account cultural competence, health literacy, exposure to discrimination, and social and cultural connectedness, such as connection to community, identity, traditions, and spirituality.

(3) Other child and adult quality or outcome measures that the committee determines are appropriate, including establishing new measures for patient-reported outcomes.

(4) Effective ways to measure health outcomes in the absence of quality measures, including both of the following:

(A) Demographic data or other data related to race, ethnicity, or socioeconomic variables that are currently collected by health care service plans.

(B) Other data sources, including the Health Care Payments Data Program established pursuant to Section 127671.1, the health evidence initiative of Covered California for the individual and small group markets, and other statistically valid and reliable sources of data.

(5) Approaches to stratifying reporting of results by factors, including, but not limited to, age, sex, geographic region, race, ethnicity, language, sexual orientation, gender identity, and income to the extent health plans or public programs have data on these factors and that the results are statistically valid and reliable.

(6) Alternative methods to measure health outcomes that permit sufficient stratification to determine impacts on health equity and quality that are not subject to the methodological limitations of current measurement approaches.

(7) Alternative methods to measure physical and behavioral health outcomes, including, but not limited to, measures to assess social and cultural connectedness, such as connection to community, identity, traditions, and spirituality. The department shall consult with the Office of Health Equity in identifying these alternative methods.

(8) Measures of social determinants of health, such as housing security, food insecurity, caregiving, and other nonmedical determinants of health.

(d) The committee's recommendations shall include setting annual health equity and quality benchmarks.

(e) The department shall consider the committee's recommendations in establishing the standard measures and annual benchmarks pursuant to Section 1399.871. The department shall enforce the established set of standard health equity and quality measures and applicable annual benchmarks consistent with Section 1399.872.

(f) The department shall reconvene the committee following the establishment of the standard measures and annual benchmarks pursuant to Section 1399.871 for the purpose of reviewing or revisiting the standard measures and annual benchmarks after the department has received data from health care service plans pursuant to Section 1399.872.

(g) Contracts entered into pursuant to this article are exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, and are exempt from the review or approval of any division of the Department of General Services, until January 1, 2024.

1399.871. (a) (1) The department shall establish standard measures and annual benchmarks for equity and quality in health care delivery.

(2) A standard measure or annual benchmark shall not be adopted, updated, or revised in any manner without being discussed during at least one public meeting of the Health Equity and Quality Committee before the meeting in which the committee makes recommendations to the director.

(3) Standard measures and annual benchmarks shall sunset at most every five years from the date the department establishes standard measures and annual benchmarks pursuant to paragraph (1). To continue the standard measures and annual benchmarks, the department shall conduct a public assessment, at least one year before the sunset, of whether the measures and benchmarks are improving quality and equity, consistent with this article.

(b) In establishing the standard measures and annual benchmarks pursuant to subdivision (a), the department shall consider the recommendations made by the Health Equity and Quality Committee pursuant to Section 1399.870, as well as stakeholder comments on draft standards and benchmarks.

(c) After the department establishes the standard measures and benchmarks pursuant to subdivision (a), a health care service plan shall comply with the annual benchmarks and shall demonstrate compliance in reports submitted to the department pursuant to Section 1399.872.

(d) (1) On or before January 1, 2026, a health care service plan and its subcontracted health care service plans shall have and maintain National Committee for Quality Assurance (NCQA) accreditation.

(2) This subdivision does not apply to a health care service plan that contracts with the State Department of Health Care Services to provide health care services to Medi-Cal beneficiaries. NCQA accreditation for these plans shall be in accordance with Section 14184.203 of the Welfare and Institutions Code.

(e) Throughout the development, implementation, and updating of the standard measures and annual benchmarks pursuant to this section, the department shall coordinate with the State Department of Health Care Services, the Office of Statewide Health Planning and Development, the California Health Benefit Exchange, CalPERS, and the State Department of Public Health.

1399.872. (a) Upon the department's establishment or updating of standard measures and annual benchmarks pursuant to Section 1399.871, a health care service plan shall annually submit to the department, at the time and in a manner specified by the department, a report containing health equity and quality data and information. A health care service plan shall implement the policies, procedures, and systems necessary for compliance with this article and shall, in a manner specified by the department, disclose substantiating documentation to the department demonstrating how the health care service plan shall achieve that compliance.

(b) The department shall review a health care service plan's equity and quality report submitted pursuant to this section for compliance with the health equity and quality standard measures and annual benchmarks established pursuant to Section 1399.871. The department may also review and use other credible sources of information and data, including, but not limited to, relevant data provided by other state agencies, to determine a health care service plan's compliance with the equity and quality standard measures and annual benchmarks.

(c) The department shall determine a health care service plan's compliance with the health equity and quality standard measures and annual benchmarks and issue a report of its findings to the health care service plan, which shall also be made publicly available on the department's internet website.

(d) If a health care service plan does not demonstrate compliance with this article, the department may take the following actions, which may be progressive, as appropriate:

(1) Require the health care service plan to implement corrective action to achieve and demonstrate compliance with the health equity and quality standard measures and annual benchmarks.

(2) Monitor a health care service plan's corrective action plan and improvement efforts.

(3) Investigate and require supplemental reporting by the health care service plan.

(4) Assess an administrative penalty in an amount that is initially commensurate with the failure to meet the requirements of this article, and assess additional penalties, in escalating amounts for repeated or continuing failure to meet the requirements. The director may assess administrative penalties under this paragraph if a health care service plan engages in any of the following conduct:

(A) Fails to report complete and accurate data required by this article.

(B) Neglects to file a required corrective action plan with the department.

(C) Fails to file an acceptable required corrective action plan with the department.

(D) Fails to implement or monitor a required corrective action plan.

(E) Fails to provide information required by this article to the department.

(F) Falsifies information required by this section.

(G) Fails to meet the health equity and quality standard measures and annual benchmarks established pursuant to Section 1399.871.

(5) Take other disciplinary or other enforcement action, as determined necessary and appropriate by the director.

(6) If the department assesses an administrative penalty or takes other disciplinary action, the department shall inform the California Health Benefit Exchange, the Office of Statewide Health Planning and Development, CalPERS, and the State Department of Health Care Services, each of which shall consider appropriate action.

(e) (1) For the measurement years 2023 and 2024, the department's enforcement activities pursuant to subdivision (d) shall address deficiencies in procedural data collection, reporting, corrective action plan implementation, or monitoring requirements pursuant to this article.

(2) Commencing with measurement year 2025, and for each following measurement year, the department's enforcement activities shall address deficiencies in meeting the requirements under paragraph (1), compliance with the standard measures and annual benchmarks, and all other requirements pursuant to this article.

(3) For the purpose of this subdivision, "measurement year" means the time period within which a health care service plan shall collect the required information for the report required by this section.

(f) Commencing in 2025, and annually thereafter, the department shall publish on its internet website a Health Equity and Quality Compliance Report.

(g) The department shall coordinate with the State Department of Health Care Services to support the review of, and any compliance action taken with respect to, Medi-Cal managed care plans consistent with this article, to maintain consistency with the applicable federal and state Medicaid requirements governing those plans.

1399.873. (a) Except as provided by any other law, the requirements of this article apply to health care service plans that cover hospital, medical, or surgical expenses, including a health care service plan that contracts with the State Department of Health Care Services to provide health care services to Medi-Cal beneficiaries, and specialized health care service plans that provide behavioral health care.

(b) The obligation of a health care service plan to comply with this article is not waived if the health care service plan delegates any services or functions to its medical groups, independent practice associations, or other contracting entities.

1399.874. (a) This article does not restrict the director's enforcement authority under this chapter.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this article by means of all-plan letters, methodologies, rules, policies, forms, or similar instructions, without taking regulatory action, until January 1, 2027.

SEC. 15. Chapter 14 (commencing with Section 1860) is added to Division 2.5 of the Health and Safety Code, to read:

CHAPTER 14. California POLST eRegistry Act

1860. This chapter shall be known, and may be cited, as the California POLST eRegistry Act.

1861. For purposes of this chapter:

(a) "Authorized user" means a person authorized by the authority to submit information to, or to receive information from, the POLST eRegistry, including health care providers, as defined in Section 4781 of the Probate Code, and their designees.

(b) "CEDRS" means the California Emergency Medical Services Data Resource System.

(c) "POLST" means a Physician Orders for Life Sustaining Treatment form that fulfills the requirements, in any format, of Section 4780 of the Probate Code.

(d) “POLST eRegistry” means the registry established pursuant to this chapter to make electronic, in addition to other modes of submission and transmission, POLST information available to authorized users in conjunction with, and as a part of, CEDRS.

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

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

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

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

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

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

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

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

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

(3) The authority shall incorporate the Advance Health Care Directive Registry, established pursuant to Part 5 (commencing with Section 4800) of Division 4.7 of the Probate Code, into the POLST eRegistry.

1863. (a) For the 2021–22 fiscal year, the sum of ten million dollars ($10,000,000) is hereby appropriated from the General Fund to the Emergency Medical Services Authority to support the planning, development, and implementation of a statewide POLST eRegistry to be included with the CEDRS system. The ten million dollars ($10,000,000) for the 2021–22 fiscal year to support these efforts shall not fully fund the POLST eRegistry’s implementation or maintenance and operations costs. These costs will be determined through the California Department of Technology planning process, known as the Project Approval Life Cycle (PAL). The authority shall only utilize funds for development and implementation of the POLST eRegistry after it obtains full PAL approval.

(b) For the 2022–23 fiscal year, and annually thereafter, the sum of seven hundred fifty thousand dollars ($750,000) is hereby appropriated annually from the General Fund to the Emergency Medical Services Authority for state operations to prepare for and support the POLST eRegistry. State operations costs may include, but are not limited to, promotion of POLST quality, such as ongoing education and training of health care professionals, community education, and outreach, and adherence to quality standards. The authority may contract for these activities as necessary.

SEC. 16. Section 38074 of the Health and Safety Code is amended to read:

38074. (a) Cooperative agreements shall be procured by means of a request for application or a request for proposal, whichever is applicable, as determined by the department.

(b) A procurement by a request for application is one where the department has funds, regardless of the source, that it seeks to distribute to those entities or organizations specified in Section 38072, that meet the criteria and standards stated in the request for application. A distinguishing feature of a request for application is that, unlike a request for proposal, a request for application is a request where multiple awards are to be made based on the information provided in the application and evaluated against the methodology and criteria specified in the request for application.

(c) All request for proposal cooperative agreement awards shall comply with the requirements of Section 10344 of the Public Contract Code.

(d) A cooperative agreement shall be for a period of up to three years.

(e) A cooperative agreement for a one-year period may provide for up to two annual extensions.

(f) A cooperative agreement may be procured without a request for application or a request for proposal under any of the following circumstances:

(1) If the amount of the cooperative agreement is less than fifty thousand dollars ($50,000) annually. A nonprofit organization shall receive only one of these awards during each fiscal year.

(2) If the amount of the cooperative agreement is less than two hundred thousand dollars ($200,000) a year and from a program that awards five or fewer grants per year.

(3) If the department is awarding a cooperative agreement under the California Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to an entity or organization that currently has an executed agreement with the specific WIC local agency. A cooperative agreement described in this paragraph may be awarded by means of subvention. Cooperative agreements for new or additional WIC local agencies shall be procured by means of a process that complies with applicable federal and state laws and the department's state plan for operation of WIC.

SEC. 17. Section 102430 of the Health and Safety Code is amended to read:

102430. (a) The second section of the certificate of live birth as specified in subdivision (b) of Section 102425, the electronic file of birth information collected pursuant to subparagraphs (B) to (H), inclusive, of paragraph (2) of subdivision (a) of Section 102426, the birth mother linkage collected pursuant to Section 102425.2, and the second section of the certificate of fetal death as specified in Section 103025, are confidential. Access to the confidential portion of any certificate of live birth or fetal death, the electronic file of birth information collected pursuant to subparagraphs (B) to (H), inclusive, of paragraph (2) of subdivision (a) of Section 102426, and the birth mother linkage collected pursuant to Section 102425.2 shall be limited to the following:

(1) Department staff.

(2) Local registrar's staff and local health department staff when approved by the local registrar or local health officer, respectively.

(3) The county coroner.

(4) Persons with a valid scientific interest as determined by the State Registrar, who are engaged in demographic, epidemiological, or other similar studies related to health, and who agree to maintain confidentiality as prescribed by this part and by regulation of the State Registrar.

(5) The parent who signed the certificate or, if no parent signed the certificate, the mother.

(6) The person named on the certificate.

(7) A person who has petitioned to adopt the person named on the certificate of live birth, subject to Section 102705 of the Health and Safety Code and Sections 9200 and 9203 of the Family Code.

(8) The following state government departments requesting the information for official government business purposes as deemed appropriate by the State Registrar, that agree to maintain confidentiality as prescribed by this part:

(A) The State Department of Public Health.

(B) The State Department of Health Care Services.

(C) The Department of Finance. This section shall not be construed as a limitation of the authority granted to the Department of Finance in Sections 13073 to 13073.5, inclusive, of the Government Code.

(D) The Scholarshare Investment Board, for the purpose of implementing the California Kids Investment and Development Savings Program pursuant to Article 19.5 (commencing with Section 69996) of Chapter 2 of Part 42 of Division 5 of Title 3 of the Education Code, as long as the California Kids Investment and Development Savings Program is operational and actively opening new KIDS accounts, as defined in subdivision (g) of Section 69996.2 of the Education Code, for eligible children.

(E) The Department of Health Care Access and Information.

(9) The birth hospital responsible for preparing and submitting a record of the birth or fetal death for purposes of reviewing and correcting birth or fetal death records. The birth hospital shall not further disclose the information nor use the information for

purposes other than allowed by this part.

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

(A) The name of the person authorizing access.

(B) The name, title, and organizational affiliation of persons given access.

(C) The dates of access.

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

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

(c) All research proposed to be conducted using the confidential medical and social information on the birth certificate or fetal death certificate shall first be reviewed by the appropriate committee constituted for the protection of human subjects that is approved by the federal Department of Health and Human Services and has a general assurance pursuant to Part 46 of Title 45 of the Code of Federal Regulations. Information shall not be released until the request for information has been reviewed by the Vital Statistics Advisory Committee and the committee has recommended to the State Registrar that the information shall be released.

SEC. 18. Section 120972 of the Health and Safety Code is amended to read:

120972. (a) To the extent that funds are available for these purposes, the director may establish and administer a program within the department's Office of AIDS to subsidize certain costs of medications for the prevention of HIV infection and other related medical services, as authorized by this section, to persons who meet all of the following requirements:

(1) Are residents of California who are at least 18 years of age, or who may consent to medical care related to the prevention of a sexually transmitted disease consistent with Section 6926 of the Family Code.

(2) Are HIV negative.

(3) Meet the financial eligibility requirements identified in Section 120960. Unemancipated minors between 12 and 17 years of age shall be considered a family size of one for purposes of determining financial eligibility for this program.

(4) Have been prescribed, dispensed, or otherwise furnished medication listed on the AIDS Drug Assistance Program (ADAP) formulary as provided in paragraph (2) of subdivision (a) of Section 120955.

(b) To the extent allowable under federal law, and upon available funds, the director may expend funding for this program from the AIDS Drug Assistance Program Rebate Fund as implemented pursuant to Section 120956.

(c) To the extent that funding is made available for this purpose, the program may subsidize all of the following costs of medication for the prevention of HIV infection and related medical services for eligible individuals:

(1) For uninsured individuals, the costs for both of the following:

(A) HIV pre-exposure prophylaxis (PrEP)-related and post-exposure prophylaxis (PEP)-related medical services for individuals who are enrolled, if eligible, in a drug manufacturer's medication assistance program.

(B) Medication for the prevention of HIV infection for individuals who are ineligible for a drug manufacturer's medication assistance program.

(2) For insured individuals, the costs for all of the following:

(A) Medication copays, coinsurance, and deductibles for the prevention of HIV infection after the individual's insurance is applied and, if eligible, after the drug manufacturer's medication assistance program's contributions are applied. Use of the drug manufacturer's medication assistance program is not required if it is not accepted by the health plan or pharmacy contracted with the health plan.

(B) Medical copays, coinsurance, and deductibles for PrEP-related and PEP-related medical services.

(C) Subsidizing premiums to purchase or maintain health insurance coverage for individuals using PrEP if the director makes a determination that it is feasible and would result in cost savings to the state.

(d) For the purposes of this program, an insured individual on a parent's or partner's health plan shall be considered uninsured if the individual is unable to use the individual's health insurance coverage for confidentiality or safety reasons.

(e) Notwithstanding the eligibility requirements in subdivision (a), the program may subsidize the costs of up to 30 days of PrEP and PEP medications for the prevention of HIV infection.

(f) If the director makes a formal determination that, in any fiscal year, funds appropriated for the program will be insufficient to provide medications for the prevention of HIV infection or related medical costs to existing eligible persons for the fiscal year and that a suspension of the implementation of the program is necessary, the director may suspend either of the following:

(1) The program.

(2) The eligibility determinations and enrollment in the program for the period of time necessary to meet the needs of existing eligible persons in the program.

(g) Reimbursement under the program shall not be made for any drugs or related services that are available to the recipient under any other private, state, or federal programs, or under any other contractual or legal entitlements, except as specified in this section. The director may authorize an exemption from this subdivision if it would result in cost savings to the state.

(h) If the department utilizes a contractor or subcontractor to administer any aspect of the program, the provisions of Section 120970, except subdivision (i) of that section, shall apply.

(i) All types of information, whether written or oral, concerning a client, made or maintained in connection with the administration of this program, shall be confidential, and shall not be used or disclosed except for any of the following:

(1) For purposes directly connected with the administration of the program.

(2) If disclosure is otherwise authorized by law.

(3) Pursuant to a written authorization by the person who is the subject of the record or, if the person is 18 years of age or older, by the person's guardian or conservator.

(j) For purposes of verifying financial eligibility for the program, the department shall verify the accuracy of the modified adjusted gross income reported by an applicant or recipient of the program, with data, if available, from the Franchise Tax Board. The Franchise Tax Board and the department are authorized to disclose personally identifiable data to one another, solely for this purpose, and in accordance with the data exchange process identified in Section 120962.

(k) Regulations adopted pursuant to subdivision (c), (d), or (e), are exempt from rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

SEC. 19. Section 103870.2 of the Health and Safety Code is repealed.

SEC. 20. Chapter 1.7 (commencing with Section 103871) is added to Part 2 of Division 102 of the Health and Safety Code, to read:

CHAPTER 1.7. California Neurodegenerative Disease Registry Program

103871. (a) Beginning January 1, 2023, the department shall collect data on the incidence of neurodegenerative disease, as defined in subdivision (i), in California.

(b) The department shall establish a system for the collection of information determining the incidence and prevalence of neurodegenerative diseases. The department shall designate the specified neurodegenerative diseases as a disease required to be reported in the state or any part of the state. All cases of neurodegenerative disease diagnosed or treated in California shall be reported to the department.

(c) The department shall provide notification of the mandatory reporting of neurodegenerative disease on its internet website and shall also provide that information to associations representing physicians and hospitals and directly to the Medical Board of California at least 90 days prior to requiring information be reported.

(d) Beginning July 1, 2023, a hospital, facility, physician and surgeon, or other health care provider diagnosing or providing treatment for a patient with a neurodegenerative disease shall report each case of a neurodegenerative disease to the department in a format prescribed by the department.

(e) If the hospital or other facility fails to report in a format prescribed by the department, the department's authorized representative may access the information from the hospital or the facility and report it in the appropriate format. In these cases, the hospital or other facility shall reimburse the department or the authorized representative for its costs to access and report the information.

(f) A physician and surgeon, hospital, outpatient clinic, and any other facility, individual, or agency providing diagnostic or treatment services to a patient with a neurodegenerative disease shall grant to the department or the authorized representative access to all records that would identify a case of a neurodegenerative disease or would establish characteristics of a neurodegenerative disease, treatment of a neurodegenerative disease, or medical status of any identified patient with a neurodegenerative disease. Willful failure to grant access to those records shall be punishable by a civil penalty of up to five hundred dollars ($500) each day access is refused. Any civil penalties collected pursuant to this subdivision shall be deposited by the department in the General Fund.

(g) Except as otherwise provided in this chapter, all information collected pursuant to this section shall be confidential. For purposes of this chapter, this information shall be referred to as “confidential information.”

(h) The program shall be under the direction of the director, who may enter into contracts, grants, or other agreements as are necessary for the conduct of the program. The award of these contracts, grants, or funding agreements shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code. This chapter shall be implemented only to the extent funds are made available for its purposes.

(i) For the purposes of this section, “neurodegenerative disease” may include, but need not be limited to, Alzheimer’s disease, multiple sclerosis, Huntington’s disease, and amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig’s disease.

103871.1. (a) A person with a valid scientific interest who is engaged in demographic, epidemiological, or other similar studies related to health who meets qualifications as determined by the department, and who agrees, in writing, to maintain confidentiality, may be authorized access to confidential information collected by the department pursuant to Section 103871.

(b) The department may enter into agreements to furnish confidential information to other states’ neurodegenerative disease registries, federal neurodegenerative disease control agencies, local health officers, or health researchers for the study of neurodegenerative diseases. Before confidential information is disclosed to those agencies, officers, researchers, or out-of-state registries, the requesting entity shall agree in writing to maintain the confidentiality of the information, and in the case of researchers, shall also do both of the following:

(1) Obtain approval of their committee for the protection of human subjects established in accordance with Part 46 (commencing with Section 46.101) of Title 45 of the Code of Federal Regulations.

(2) Provide documentation to the department that demonstrates to the department’s satisfaction that the entity has established the procedures and ability to maintain the confidentiality of the information.

(c) Notwithstanding any other law, a disclosure authorized by this section shall include only the information necessary for the stated purpose of the requested disclosure, used for the approved purpose, and not be further disclosed.

(d) The furnishing of confidential information to the department or its authorized representative in accordance with this section shall not expose any person, agency, or entity furnishing information to liability, and shall not be considered a waiver of any privilege or a violation of a confidential relationship.

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

(A) Name of the person authorizing access.

(B) Name, title, address, and organizational affiliation of persons given access.

(C) Dates of access.

(D) Specific purpose for which information is to be used.

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

(f) Notwithstanding any other law, the confidential information shall not be available for subpoena, shall not be disclosed, discoverable, or compelled to be produced in any civil or administrative proceeding, or other similar proceeding. The confidential information shall not be deemed admissible as evidence in any civil or administrative proceeding, or other similar tribunal or court for any reason.

(1) This subdivision does not prohibit the department from publishing reports and statistical compilations that do not identify individual cases or individual sources of information.

(2) Notwithstanding the restrictions in this subdivision, the individual to whom the information pertains shall have access to the individual’s own information in accordance with Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of

the Civil Code.

(g) This section does not preempt the authority of a facility or an individual providing diagnostic or treatment services to a patient with a neurodegenerative disease to maintain their own facility-based neurodegenerative disease registry.

103871.2. This chapter shall remain in effect only until January 1, 2028, and as of that date is repealed.

SEC. 21. Section 120511 of the Health and Safety Code is amended to read:

120511. (a) The department shall allocate funds to local health jurisdictions for sexually transmitted disease prevention and control activities in accordance, to the extent possible, with the following:

(1) Local health jurisdictions shall be prioritized based on population and incidence of sexually transmitted diseases.

(2) Funds shall be allocated to prioritized local health jurisdictions in a manner that balances the need to spread funding to as many local health jurisdictions, community-based organizations, and nonprofit health care providers as possible and the need to provide meaningful activities to each recipient. No less than 50 percent of the funds allocated to local health jurisdictions shall be provided to community-based organizations or nonprofit health care providers, provided that there are community-based organizations or nonprofit health care providers in the jurisdiction that can conduct the activities and provide these services consistent with this section.

(3) Each local health jurisdiction shall demonstrate to the department that the community-based organization or nonprofit health care provider that receives funding under this section has done all of the following:

(A) Identified priority target populations.

(B) Satisfactorily described its outreach protocols.

(C) Included community resources for prevention and control activities.

(D) Engaged representatives from impacted communities in the development of outreach activities.

(4) Local health jurisdiction shall use these funds to facilitate expanded access to sexually transmitted infection (STI) clinical services, including, but not limited to, LBGTQ+ populations, including those who face confidentiality barriers in using their health coverage to receive STI testing, treatment, and related care.

(5) The department shall develop measures for each local health jurisdiction funded pursuant to this section to demonstrate accountability.

(b) In awarding funds pursuant to subdivision (a), the department shall authorize local health jurisdictions to include innovative and impactful prevention and control activities, including, but not limited to, the following:

(1) Voluntary screening for sexually transmitted diseases among inmates and wards of county adult and juvenile correctional facilities. The department may provide assistance or guidance to the local health jurisdiction if necessary to secure participation by other county agencies.

(2) Technology, telehealth, and digital platforms and applications to enhance immediate access to screening, testing, and treatment, as well as partner activities in order to speed activities and to reduce administrative costs.

(3) State-of-the-art testing modalities that ensure swift and accurate screening for, and diagnosis of, sexually transmitted diseases.

(4) Community-based testing and disease investigation.

(c) The department shall monitor activities in funded local health jurisdictions, based on the accountability measures required under paragraph (4) of subdivision (a), in order to assess the effectiveness of prevention and control activities efforts.

(d) It is the intent of the Legislature that the activities identified in this section are to enhance the activities that are already provided. Therefore, nothing in this section shall be construed to require the department to replace existing activities with the activities provided for in subdivision (a) or to prevent the department from adding new activities as may be appropriate.

(e) This section shall be operative only if funds are explicitly appropriated in the annual Budget Act specifically for purposes of this section.

SEC. 22. Section 120780.2 of the Health and Safety Code is amended to read:

120780.2. In order to reduce the spread of HIV, hepatitis C, and other potentially deadly bloodborne pathogens, the State Department of Public Health may purchase sterile hypodermic needles and syringes, and other supplies, for distribution to syringe exchange programs authorized pursuant to law and support any costs associated with distribution of supplies. Supplies provided to programs, including those administered by local health departments, are not subject to the formulas and limits of Section 120780.1.

SEC. 23. Section 120956 of the Health and Safety Code is amended to read:

120956. (a) The AIDS Drug Assistance Program Rebate Fund is hereby created as a special fund in the State Treasury.

(b) All rebates collected from drug manufacturers on drugs purchased through the AIDS Drugs Assistance Program (ADAP) implemented pursuant to this chapter and, notwithstanding Section 16305.7 of the Government Code, interest earned on these moneys shall be deposited in the fund exclusively to cover costs related to the purchase of drugs and services provided through ADAP and the HIV prevention programs as described in Sections 120972 and 120972.1.

(c) Notwithstanding Section 13340 of the Government Code, moneys in the fund are continuously appropriated without regard to fiscal year to State Department of Public Health and available for expenditure for those purposes specified under this section.

SEC. 24. Section 120972.1 is added to the Health and Safety Code, to read:

120972.1. (a) To the extent that funds are available for these purposes, the State Department of Public Health, Office of AIDS may allocate funds to local health departments and community-based organizations to support HIV preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) navigation and retention coordinators and related services for the purpose of increasing PrEP and PEP initiation and retention among individuals most vulnerable to HIV.

(b) Navigation and retention services may include, but are not limited to, outreach and education, community messaging, assistance with applying for and retaining health coverage, assistance with enrollment in PrEP and PEP financial assistance programs, care coordination and adherence support, financial assistance for transportation costs, and linkage to behavioral health, substance use, housing, and other social service programs.

(c) The Office of AIDS shall establish a simple application process for local health departments and community-based organizations to receive funding to support PrEP and PEP navigation and retention coordinators and related services.

(d) Local health departments and community-based organizations in any county shall be eligible for funding if they meet all of the following requirements:

(1) Provide enrollment or clinical services for the HIV prevention program as outlined in Section 120972.

(2) Describe how funding for PrEP and PEP navigation and retention coordinators and related services will help to improve PrEP initiation and retention in their specific geographic area.

(3) Demonstrate the capacity to provide culturally appropriate PrEP and PEP navigation and retention services to one or more communities vulnerable to HIV, including, but not limited to, all of the following:

(A) Black, indigenous, and people of color.

(B) Lesbian, gay, bisexual, queer, and questioning individuals.

(C) Non-English-speaking individuals.

(D) Other populations that are difficult to reach, including those with transportation or technology challenges.

(E) People experiencing homelessness.

(F) People involved in the carceral system.

(G) People who use drugs.

(H) People engaged in sex work.

(I) Transgender and gender-nonconforming individuals.

(J) Undocumented individuals.

(K) Women.

(L) Youth.

(e) Local health departments and community-based organizations shall be eligible to apply for one or more PrEP navigation and retention coordinators based on need in the specific geographic area and organizational capacity to reach the target population or populations.

(f) Funded local health departments and community-based organizations shall collaborate with the Office of AIDS to conduct outcome and process evaluation of PrEP and PEP navigation and retention services. The Office of AIDS shall establish performance metrics to ensure that funding is used efficiently and measure program success.

(g) The Office of AIDS may use a portion of funds to contract with a third-party entity to provide training, program technical assistance, and capacity building to funded local health departments and community-based organizations.

(h) To the extent allowable under federal law, and upon availability of funds, the Office of AIDS may expend funding for the activities outlined in this section from the AIDS Drug Assistance Program Rebate Fund as implemented pursuant to Section 120956.

SEC. 25. Chapter 13.8 (commencing with Section 121295) is added to Part 4 of Division 105 of the Health and Safety Code, to read:

CHAPTER 13.8. HIV and Aging Demonstration Projects

121295. (a) The State Department of Public Health, in consultation with the California Department of Aging, shall establish a program for demonstration projects to allow for innovative, evidence-informed approaches to improve the health and well-being of older people living with HIV.

(b) The demonstration projects shall address the multidisciplinary clinical and nonclinical needs of older people living with HIV.

(c) The demonstration projects shall be responsive to the unique needs of older people living with HIV in the specific geographic area.

(d) The demonstration projects shall operate for a period of up to three years. The department shall implement up to five demonstration projects.

(e) The demonstration projects shall include an evaluation component and a plan for disseminating lessons learned in order to develop new programs and strengthen existing programs.

(f) (1) The department shall establish a process to request applications, and award funding on a competitive basis, for an eligible entity to operate a demonstration project pursuant to this chapter.

(2) An application to operate a demonstration project under this chapter shall be evaluated based on need in the geographic area, populations served, competency of the entity applying, and program design.

(g) The department shall determine the funding levels of each demonstration project based on the scope of the project and need in the specific geographic area.

(h) Any entity in any county shall be eligible to operate a demonstration project pursuant to this chapter if it meets both of the following requirements:

(1) Demonstrates experience and expertise in providing culturally appropriate services to the most vulnerable and underserved older people living with HIV, including, but not limited to, older people living with HIV who are Black, Indigenous, and people of color.

(2) Demonstrates the capacity to ensure that the multidisciplinary clinical and nonclinical needs of older people living with HIV are assessed and addressed. Services may be colocated or coordinated across different locations, including through referrals or partnerships with other entities.

SEC. 26. Section 122445 is added to the Health and Safety Code, to read:

122445. (a) In order to ensure that the most vulnerable Californians are informed of their hepatitis C virus (HCV) status and are linked to care and a cure, the State Department of Public Health's Office of Viral Hepatitis Prevention may purchase HCV test kits and associated materials and supplies for distribution to community-based organizations and local health departments.

(b) The Office of Viral Hepatitis Prevention may also allocate funding to train personnel associated with community-based organizations and local health departments to conduct HCV testing, human immunodeficiency virus (HIV) testing, and sexually transmitted infection (STI) testing and related activities.

(c) The Office of Viral Hepatitis Prevention may use a portion of the funds allocated for purposes of this section to hire necessary staff to successfully implement and evaluate the activities authorized by this section.

(d) The Office of Viral Hepatitis Prevention shall establish a simple application process for community-based organizations and local health departments to apply to receive HCV test kits and support for the activities authorized by this section.

(e) If the overall requests for HCV test kits and support exceeds the amount of funds allocated for this section, the Office of Viral Hepatitis Prevention may prioritize distribution of HCV test kits and support to community-based organizations and local health departments based on need in the specific geographic area and demonstrated capacity to provide culturally appropriate services to one or more of the communities most vulnerable to HCV.

SEC. 27. Section 125075 of the Health and Safety Code is repealed.

SEC. 28. The heading of Division 107 (commencing with Section 127000) of the Health and Safety Code is amended to read:

DIVISION 107. HEALTH CARE ACCESS AND INFORMATION

SEC. 29. The heading of Part 1 (commencing with Section 127000) of Division 107 of the Health and Safety Code is amended to read:

PART 1. DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION

SEC. 30. Section 127000 of the Health and Safety Code is amended to read:

127000. There is in the state government, in the Health and Welfare Agency, the Department of Health Care Access and Information.

SEC. 31. Section 127002 is added to the Health and Safety Code, to read:

127002. Any reference to the Office of Statewide Health Planning and Development shall be deemed a reference to the Department of Health Care Access and Information.

SEC. 32. Section 127005 of the Health and Safety Code is amended to read:

127005. The department is under the control of an executive officer known as the Director of the Department of Health Care Access and Information who shall be appointed by the Governor, subject to confirmation by the Senate, and hold office at the pleasure of the Governor. The Director shall receive the annual salary provided by Article 1 (commencing with Section 11550) of Chapter 6 of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 33. Section 127010 of the Health and Safety Code is amended to read:

127010. The director of the department shall have the powers of a head of the department pursuant to Chapter 2 (commencing with Section 11150) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 34. Section 127015 of the Health and Safety Code is repealed.

SEC. 35. Section 127020 of the Health and Safety Code is repealed.

SEC. 36. Section 127025 of the Health and Safety Code is repealed.

SEC. 37. Section 127030 of the Health and Safety Code is repealed.

SEC. 38. Section 127035 of the Health and Safety Code is repealed.

SEC. 39. Section 127040 of the Health and Safety Code is repealed.

SEC. 40. Section 127045 of the Health and Safety Code is repealed.

SEC. 41. Section 127050 of the Health and Safety Code is repealed.

SEC. 42. Section 127125 of the Health and Safety Code is repealed.

SEC. 43. Section 127130 of the Health and Safety Code is repealed.

SEC. 44. Section 127135 of the Health and Safety Code is repealed.

SEC. 45. Section 127140 of the Health and Safety Code is repealed.

SEC. 46. Section 127145 of the Health and Safety Code is repealed.

SEC. 47. Section 127150 of the Health and Safety Code is repealed.

SEC. 48. Section 127155 of the Health and Safety Code is repealed.

SEC. 49. Section 127160 of the Health and Safety Code is repealed.

SEC. 50. Section 127165 of the Health and Safety Code is repealed.

SEC. 51. Section 127170 of the Health and Safety Code is repealed.

SEC. 52. Section 127175 of the Health and Safety Code is repealed.

SEC. 53. Section 127180 of the Health and Safety Code is repealed.

SEC. 54. Section 127185 of the Health and Safety Code is repealed.

SEC. 55. Section 127190 of the Health and Safety Code is repealed.

SEC. 56. Section 127195 of the Health and Safety Code is repealed.

SEC. 57. Section 127200 of the Health and Safety Code is repealed.

SEC. 58. Section 127205 of the Health and Safety Code is repealed.

SEC. 59. Section 127210 of the Health and Safety Code is repealed.

SEC. 60. Section 127215 of the Health and Safety Code is repealed.

SEC. 61. Section 127220 of the Health and Safety Code is repealed.

SEC. 62. Section 127225 of the Health and Safety Code is repealed.

SEC. 63. Section 127230 of the Health and Safety Code is repealed.

SEC. 64. Section 127235 of the Health and Safety Code is repealed.

SEC. 65. Section 127240 of the Health and Safety Code is repealed.

SEC. 66. Section 127245 of the Health and Safety Code is repealed.

SEC. 67. Section 127250 of the Health and Safety Code is repealed.

SEC. 68. Section 127255 of the Health and Safety Code is repealed.

SEC. 69. Section 127260 of the Health and Safety Code is repealed.

SEC. 70. Section 127265 of the Health and Safety Code is repealed.

SEC. 71. Section 127270 of the Health and Safety Code is repealed.

SEC. 72. Section 127275 of the Health and Safety Code is repealed.

SEC. 73. Section 127280 of the Health and Safety Code is amended to read:

127280. (a) Every health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, except a health facility owned and operated by the state, shall each year be charged a fee established by the department consistent with the requirements of this section.

(b) Commencing in calendar year 2004, every freestanding ambulatory surgery clinic as defined in Section 128700, shall each year be charged a fee established by the department consistent with the requirements of this section.

(c) The fee structure shall be established each year by the department to produce revenues equal to the appropriation made in the annual Budget Act or another statute to pay for the functions required to be performed by the department pursuant to this chapter, Article 2 (commencing with Section 127340) of Chapter 2, or Chapter 1 (commencing with Section 128675) of Part 5, and to pay for any other health-related programs administered by the department. The fee shall be due on July 1 and delinquent on July 31 of each year.

(d) The fee for a health facility that is not a hospital, as defined in subdivision (f) of Section 128700, shall be not more than 0.035 percent of the gross operating cost of the facility for the provision of health care services for its last fiscal year that ended on or before June 30 of the preceding calendar year.

(e) The fee for a hospital, as defined in subdivision (f) of Section 128700, shall be not more than 0.035 percent of the gross operating cost of the facility for the provision of health care services for its last fiscal year that ended on or before June 30 of the preceding calendar year.

(f) (1) The fee for a freestanding ambulatory surgery clinic shall be established at an amount equal to the number of ambulatory surgery data records submitted to the department pursuant to Section 128737 for encounters in the preceding calendar year multiplied by not more than fifty cents ($0.50).

(2) (A) For the calendar year 2004 only, a freestanding ambulatory surgery clinic shall estimate the number of records it will file pursuant to Section 128737 for the calendar year 2004 and shall report that number to the department by March 12, 2004. The estimate shall be as accurate as possible. The fee in the calendar year 2004 shall be established initially at an amount equal to the estimated number of records reported multiplied by fifty cents ($0.50) and shall be due on July 1 and delinquent on July 31, 2004.

(B) The department shall compare the actual number of records filed by each freestanding clinic for the calendar year 2004 pursuant to Section 128737 with the estimated number of records reported pursuant to subparagraph (A). If the actual number reported is less than the estimated number reported, the department shall reduce the fee of the clinic for calendar year 2005 by the amount of the difference multiplied by fifty cents ($0.50). If the actual number reported exceeds the estimated number reported, the department shall increase the fee of the clinic for calendar year 2005 by the amount of the difference multiplied by fifty cents ($0.50) unless the actual number reported is greater than 120 percent of the estimated number reported, in which case the department shall increase the fee of the clinic for calendar year 2005 by the amount of the difference, up to and including 120 percent of the estimated number, multiplied by fifty cents ($0.50), and by the amount of the difference in excess of 120 percent of the estimated number multiplied by one dollar ($1).

(g) There is hereby established the California Health Data and Planning Fund within the department for the purpose of receiving and expending fee revenues collected pursuant to this chapter.

(h) Any amounts raised by the collection of the special fees provided for by subdivisions (d), (e), and (f) that are not required to meet appropriations in the Budget Act for the current fiscal year shall remain in the California Health Data and Planning Fund and shall be available to the department in succeeding years when appropriated by the Legislature in the annual Budget Act or another statute, for expenditure under the provisions of this chapter, Article 2 (commencing with Section 127340) of Chapter 2, and Chapter 1 (commencing with Section 128675) of Part 5, or for any other health-related programs administered by the department, and shall reduce the amount of the special fees that the department is authorized to establish and charge. In no event, however, shall those amounts be used for programs administered by the department pursuant to Sections 127676, 127679, 127681, 127683, and 127685, that become effective on or after January 1, 2019.

(i) (1) No health facility liable for the payment of fees required by this section shall be issued a license or have an existing license renewed unless the fees are paid. A new, previously unlicensed, health facility shall be charged a pro rata fee to be established by the department during the first year of operation.

(2) The license of any health facility, against which the fees required by this section are charged, shall be revoked, after notice and hearing, if it is determined by the department that the fees required were not paid within the time prescribed by subdivision (c).

(j) This section shall become operative on January 1, 2002.

SEC. 74. Section 127285 of the Health and Safety Code is amended to read:

127285. (a) Health facilities and clinics, except for chronic dialysis clinics as defined in subdivision (b) of Section 1204, shall annually report to the department all of the following information on forms supplied by the department:

(1) A current inventory of beds and services.

(2) Utilization data by bed type and service.

(3) Acquisitions of diagnostic or therapeutic equipment during the reporting period with a value in excess of five hundred thousand dollars ($500,000).

(4) Commencement of projects during the reporting period that require a capital expenditure for the facility or clinic in excess of one million dollars ($1,000,000).

(b) With respect to chronic dialysis clinics, the department may annually obtain this information to the extent it is available from the Federal End Stage Renal Disease Network.

SEC. 75. Section 127290 of the Health and Safety Code is repealed.

SEC. 76. Section 127295 of the Health and Safety Code is repealed.

SEC. 77. Section 127300 of the Health and Safety Code is repealed.

SEC. 78. The heading of Article 1 of Chapter 2 of Part 2 of Division 107 of the Health and Safety Code is repealed.

SEC. 79. Section 127345 of the Health and Safety Code is amended to read:

127345. As used in this article, the following terms have the following meanings:

(a) "Charity care" means free health services provided without expectation of payment to persons who meet the organization's criteria for financial assistance and are unable to pay for all or a portion of the services. Charity care shall be reported at cost, as reported to the Department of Health Care Access and Information. Charity care does not include bad debt defined as uncollectible charges that the organization recorded as revenue but wrote off due to a patient's failure to pay.

(b) "Community benefits plan" means the written document prepared for annual submission to the Department of Health Care Access and Information that shall include, but shall not be limited to, a description of the activities that the hospital has undertaken in order to address identified community needs within its mission and financial capacity, and the process by which the hospital developed the plan in consultation with the community.

(c) "Community" means the service areas or patient populations for which the hospital provides health care services.

(d) (1) Solely for the planning and reporting purposes of this article, "community benefit" means a hospital's activities that are intended to address community needs and priorities primarily through disease prevention and improvement of health status, including, but not limited to, any of the following:

(A) Health care services, rendered to vulnerable populations, including, but not limited to, charity care and the unreimbursed cost of providing services to the uninsured, underinsured, and those eligible for Medi-Cal, Medicare, California Children's Services Program, or county indigent programs.

(B) The unreimbursed cost of services included in subdivision (d) of Section 127340.

(C) Financial or in-kind support of public health programs.

(D) Donation of funds, property, or other resources that contribute to a community priority.

(E) Health care cost containment.

(F) Enhancement of access to health care or related services that contribute to a healthier community.

(G) Services offered without regard to financial return because they meet a community need in the service area of the hospital, and other services including health promotion, health education, prevention, and social services.

(H) Food, shelter, clothing, education, transportation, and other goods or services that help maintain a person's health.

(2) "Community benefit" does not mean activities or programs that are provided primarily for marketing purposes or are more beneficial to the organization than to the community.

(e) "Community needs assessment" means the process by which the hospital identifies, for its primary service area as determined by the hospital, unmet community needs.

(f) "Community needs" means those requisites for improvement or maintenance of health status in the community.

(g) "Hospital" means a private not-for-profit acute hospital licensed under subdivision (a), (b), or (f) of Section 1250 and is owned by a corporation that has been determined to be exempt from taxation under the United States Internal Revenue Code. "Hospital" does not mean any of the following:

(1) Hospitals that are dedicated to serving children and that do not receive direct payment for services to any patient.

(2) Small and rural hospitals as defined in Section 124840, unless the hospital is part of a hospital system.

(3) A district hospital organized and governed pursuant to the Local Health Care District Law (Division 23 (commencing with Section 32000)) or a nonprofit corporation that is affiliated with the health care district hospital owner by means of the district's

status as the nonprofit corporation's sole corporate member pursuant to subparagraph (B) of paragraph (1) of subdivision (h) of Section 14169.31 of the Welfare and Institutions Code.

(h) "Mission statement" means a hospital's primary objectives for operation as adopted by its governing body.

(i) "Vulnerable populations" means any population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medi-Cal, Medicare, California Children's Services Program, or county indigent programs.

SEC. 80. Section 127346 of the Health and Safety Code is amended to read:

127346. (a) The Department of Healthcare Access and Information may impose a fine not to exceed five thousand dollars ($5,000) on hospitals for failure to adopt, update, or submit community benefit plans consistent with Section 127350.

(b) The department may grant a hospital an automatic 60-day extension for submitting annual community benefit plans.

(c) The department shall annually prepare, and post on its internet website, a report that includes all of the following:

(1) The amount each hospital spent on community benefits.

(2) The amount of community benefit spending attributable to charity care, the unpaid cost of government-sponsored health care programs, and community benefit programs and activities.

(3) A list of all hospitals that failed to report community benefits spending.

(d) The department shall make all community benefit plans submitted by hospitals pursuant to Section 127350 available to the public on its internet website.

SEC. 81. Section 127350 of the Health and Safety Code is amended to read:

127350. Each hospital shall do all of the following:

(a) By July 1, 1995, reaffirm its mission statement that requires its policies integrate and reflect the public interest in meeting its responsibilities as a not-for-profit organization.

(b) By January 1, 1996, complete, either alone, in conjunction with other health care providers, or through other organizational arrangements, a community needs assessment evaluating the health needs of the community serviced by the hospital, that includes, but is not limited to, a process for consulting with community groups and local government officials in the identification and prioritization of community needs that the hospital can address directly, in collaboration with others, or through other organizational arrangement. The community needs assessment shall be updated at least once every three years.

(c) By April 1, 1996, and annually thereafter adopt and update a community benefits plan for providing community benefits either alone, in conjunction with other health care providers, or through other organizational arrangements.

(d) (1) Annually submit its community benefits plan, including, but not limited to, the activities that the hospital has undertaken in order to address community needs within its mission and financial capacity to the Department of Health Care Access and Information. The hospital shall assign and report the economic value of community benefits provided in furtherance of its plan, and include a description of how needs identified in the assessment are being addressed and which needs are not being addressed, and why. Effective with hospital fiscal years, beginning on or after January 1, 1996, each hospital shall file a copy of the plan with the department not later than 150 days after the hospital's fiscal year ends.

(2) Hospitals under the common control of a single corporation or another entity may file a consolidated report if the report includes each hospital's community benefit financial data and describes the benefits provided to the communities in the hospitals' geographic area. Hospitals on a consolidated license may file a consolidated community benefit plan report if they serve the same geographic area.

(3) Each hospital's community benefit report shall contain an explanation of the methodology used to determine the hospital's costs, written in plain English.

(e) Annually post its community benefits plan on its internet website.

SEC. 82. Section 127360 of the Health and Safety Code is amended to read:

127360. Nothing in this article shall be used to justify the tax-exempt status of a hospital under state law. Nothing in this article shall preclude the department from requiring hospitals to directly report their charity activities.

SEC. 83. Section 127400 of the Health and Safety Code is amended to read:

127400. As used in this article, the following terms have the following meanings:

(a) “Allowance for financially qualified patient” means, with respect to services rendered to a financially qualified patient, an allowance that is applied after the hospital’s charges are imposed on the patient, due to the patient’s determined financial inability to pay the charges.

(b) “Federal poverty level” means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

(c) “Financially qualified patient” means a patient who is both of the following:

(1) A patient who is a self-pay patient, as defined in subdivision (f), or a patient with high medical costs, as defined in subdivision (g).

(2) A patient who has a family income that does not exceed 350 percent of the federal poverty level.

(d) “Hospital” means a facility that is required to be licensed under subdivision (a), (b), or (f) of Section 1250, except a facility operated by the State Department of State Hospitals or the Department of Corrections and Rehabilitation.

(e) “Department” means the Department of Health Care Access and Information.

(f) “Self-pay patient” means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers’ compensation, automobile insurance, or other insurance as determined and documented by the hospital. Self-pay patients may include charity care patients.

(g) “A patient with high medical costs” means a person whose family income does not exceed 350 percent of the federal poverty level, as defined in subdivision (b). For these purposes, “high medical costs” means any of the following:

(1) Annual out-of-pocket costs incurred by the individual at the hospital that exceed 10 percent of the patient’s family income in the prior 12 months.

(2) Annual out-of-pocket expenses that exceed 10 percent of the patient’s family income, if the patient provides documentation of the patient’s medical expenses paid by the patient or the patient’s family in the prior 12 months.

(3) A lower level determined by the hospital in accordance with the hospital’s charity care policy.

(h) “Patient’s family” means the following:

(1) For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not.

(2) For persons under 18 years of age, parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

(i) “Reasonable payment plan” means monthly payments that are not more than 10 percent of a patient’s family income for a month, excluding deductions for essential living expenses. “Essential living expenses” means, for purposes of this subdivision, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

SEC. 84. Section 127435 of the Health and Safety Code is amended to read:

127435. Each hospital shall provide to the department a copy of its discount payment policy, charity care policy, eligibility procedures for those policies, review process, and the application for charity care or discounted payment programs. The department may determine whether the information is to be provided electronically or in some other manner. The information shall be provided at least biennially on January 1, or when a significant change is made. If no significant change has been made by the hospital since the information was previously provided, notifying the department of the lack of change shall meet the requirements of this section. The department shall make this information available to the public.

SEC. 85. Section 127450 of the Health and Safety Code is amended to read:

127450. As used in this article, the following terms have the following meanings:

(a) “Allowance for financially qualified patient” means, with respect to emergency care rendered to a financially qualified patient, an allowance that is applied after the emergency physician’s charges are imposed on the patient, due to the patient’s determined financial inability to pay the charges.

(b) “Emergency care” means emergency medical services and care, as defined in Section 1317.1, that is provided by an emergency physician in the emergency department of a hospital.

(c) “Emergency physician” means a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code who is credentialed by a hospital and either employed or contracted by the hospital to provide emergency medical services in the emergency department of the hospital, except that an “emergency physician” shall not include a physician specialist who is called into the emergency department of a hospital or who is on staff or has privileges at the hospital outside of the emergency department.

(d) “Federal poverty level” means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

(e) “Financially qualified patient” means a patient who is both of the following:

(1) A patient who is a self-pay patient or a patient with high medical costs.

(2) A patient who has a family income that does not exceed 350 percent of the federal poverty level.

(f) “Hospital” means a facility that is required to be licensed under subdivision (a) of Section 1250, except a facility operated by the State Department of State Hospitals or the Department of Corrections and Rehabilitation.

(g) “Department” means the Department of Health Care Access and Information.

(h) “Self-pay patient” means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers’ compensation, automobile insurance, or other insurance as determined and documented by the emergency physician. Self-pay patients may include charity care patients.

(i) “A patient with high medical costs” means a person whose family income does not exceed 350 percent of the federal poverty level if that individual does not receive a discounted rate from the emergency physician as a result of their third-party coverage. For these purposes, “high medical costs” means any of the following:

(1) Annual out-of-pocket costs incurred by the individual at the hospital that provided emergency care that exceed 10 percent of the patient’s family income in the prior 12 months.

(2) Annual out-of-pocket expenses that exceed 10 percent of the patient’s family income, if the patient provides documentation of the patient’s medical expenses paid by the patient or the patient’s family in the prior 12 months. The emergency physician may waive the request for documentation.

(3) A lower level determined by the emergency physician in accordance with the emergency physician’s discounted payment policy.

(j) “Patient’s family” means the following:

(1) For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not.

(2) For persons under 18 years of age, parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

(k) “Reasonable payment formula” means monthly payments that are not more than 10 percent of a patient’s family income for a month, excluding deductions for essential living expenses. “Essential living expenses” means, for purposes of this subdivision, expenses for all of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

SEC. 86. Chapter 3 (commencing with Section 127575) of Part 2 of Division 107 of the Health and Safety Code is repealed.

SEC. 87. Chapter 4 (commencing with Section 127620) of Part 2 of Division 107 of the Health and Safety Code is repealed.

SEC. 88. Chapter 8 (commencing with Section 127670) of Part 2 of Division 107 of the Health and Safety Code is repealed.

SEC. 89. Section 127671 of the Health and Safety Code is amended to read:

127671. (a) The Legislature finds and declares that California has a substantial public interest in the price, cost, utilization, equity, and quality of health care services. California is a major purchaser of health coverage through the Public Employees' Retirement System, the State Department of Health Care Services, the Department of General Services, the Department of Corrections and Rehabilitation, the California Health Benefit Exchange, and other entities acting on behalf of a state purchaser. California also provides major tax expenditures through the tax exclusion of employer-sponsored coverage and tax deductibility of coverage purchased by individuals, as well as tax deductibility of excess health care costs for individuals and families.

(b) It is the intent of the Legislature in enacting this chapter to establish a system to collect information regarding health care costs, utilization, quality, and equity. Health care data is reported and collected through many disparate systems. Creating a process to aggregate and use this data will provide greater transparency regarding health care costs, utilization, quality, and equity, and the information may be used to inform policy decisions regarding the provision of quality health care, improving public health, reducing disparities, advancing health coverage, reducing health care costs, oversight of the health care system and health care companies, and providing public benefit for Californians and the state, while preserving consumer privacy.

(c) It is the intent of the Legislature to improve data transparency to achieve a sustainable health care system with more equitable access to affordable and quality health care for all.

(d) It is the intent of the Legislature in enacting this chapter to encourage state agencies, researchers, health care service plans, health insurers, providers, suppliers, and other stakeholders to use this data to develop innovative approaches, services, and programs that may have the potential to deliver health care that is both cost effective and responsive to the needs of enrollees, including recognizing the diversity of California and the impact of social determinants of health.

(e) It is the intent of the Legislature that the development of a Health Care Payments Data System be substantially completed no later than July 1, 2023, pursuant to this chapter.

(f) For purposes of this chapter:

(1) "Director" means the Director of the Department of Health Care Access and Information.

(2) "Fund" means the Health Care Payments Data Fund established pursuant to Section 127674.

(3) "Department" means the Department of Health Care Access and Information.

(4) "Program" means the Health Care Payments Data Program established pursuant to Section 127671.1.

(5) "Qualified applicants" includes state agencies, mandatory submitters, established nonprofit research institutions, the University of California, nonprofit educational institutions, providers, suppliers, labor unions, self-insured multiemployer plans that submit data to the system, and consumer organizations certified for the Consumer Participation Program administered by the Department of Managed Health Care pursuant to Section 1348.9 that have been awarded reasonable advocacy and witness fees in a proceeding or proceedings of the department.

(6) "Research" has the same meaning as defined in Section 164.501 of Title 45 of the Code of Federal Regulations.

(7) "System" means the Health Care Payments Data System.

SEC. 90. Section 127671.1 of the Health and Safety Code is amended to read:

127671.1. (a) The department shall establish, implement, and administer the Health Care Payments Data Program to implement and administer the system in accordance with this chapter.

(b) The system shall collect data on all California residents to the extent feasible and permissible subject to the state constitutional right to privacy and any other applicable state or federal law.

SEC. 91. Section 127672 of the Health and Safety Code is amended to read:

127672. (a) (1) The Department of Health Care Access and Information shall convene a Health Care Payments Data Program advisory committee, composed of health care stakeholders and experts, including, but not limited to, all of the following:

(A) Health care service plans, including specialized health care service plans.

(B) Insurers that have a certificate of authority from the Insurance Commissioner to provide health insurance, as defined in Section 106 of the Insurance Code.

(C) Suppliers, as defined in paragraph (3) of subdivision (b) of Section 1367.50.

(D) Providers, as defined in paragraph (2) of subdivision (b) of Section 1367.50.

(E) Self-insured employers.

(F) Multiemployer self-insured plans that are responsible for paying for health care services provided to beneficiaries or the trust administrator for a multiemployer self-insured plan.

(G) Businesses that purchase health care coverage for their employees.

(H) Organized labor.

(I) Organizations representing consumers.

(2) The advisory committee shall consist of no fewer than nine and no more than 11 persons.

(3) In addition to the members specified by paragraph (2), the director of the department, the director of the State Department of Health Care Services, and the executive director of the California Health Benefit Exchange, or their officially designated representatives, shall be nonvoting ex officio members of the advisory committee.

(4) Each appointed member shall serve a term of two years, except one-half of the initial appointments shall be for one year. Each appointed member shall serve at the discretion of the director and may be removed at any time.

(5) The chairperson of the advisory committee shall be an appointed member and shall be elected by a majority of the appointed members.

(6) The advisory committee shall meet at least quarterly or when requested by the director.

(7) The advisory committee shall assist and advise the director in formulating program policies regarding data collection, management, use, and access, and development of public information to meet the goals of the program. The advisory committee shall, through its meetings, provide a forum for stakeholder and public engagement. Upon request of the director, the advisory committee may assist and advise on the department's other data programs.

(8) On or before July 1, 2024, the advisory committee shall make recommendations to the department on how existing state public health data functions may be integrated into the system. The advisory committee shall also recommend options for state public health data integration. These recommendations shall be published on the department's internet website.

(9) The advisory committee shall not have decisionmaking authority related to the administration of the system and shall not have a financial interest, individually or through a family member, in the recommendations made to the department. The advisory committee shall hold public meetings with stakeholders, solicit input, and set its own meeting agendas. Meetings of the advisory committee are subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

(10) The members of the advisory committee appointed from outside government shall serve without compensation, but shall receive a per diem for each day's attendance at an advisory committee meeting. All members shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the committee.

(b) The department may convene other committees or workgroups as necessary to support effective operation of the system. These committees may be standing committees or time-limited workgroups, at the discretion of the director.

SEC. 92. Section 127672.8 of the Health and Safety Code is amended to read:

127672.8. The department shall ensure that the system can map to other datasets, including public health datasets on morbidity and mortality, and data regarding the social determinants of health.

SEC. 93. Section 127672.9 of the Health and Safety Code is amended to read:

127672.9. Until January 1, 2026, for purposes of implementing this chapter, including, but not limited to, hiring staff and consultants, facilitating and conducting meetings, conducting research and analysis, and developing the required reports, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis. Contracts entered into or amended pursuant to this section are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the

Government Code and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and are exempt from the review or approval of any division of the Department of General Services.

SEC. 94. Section 127673 of the Health and Safety Code is amended to read:

127673. (a) The department shall develop guidance to require data submission from the entities specified in this chapter. The guidance shall include a methodology for the collection, validation, refinement, analysis, comparison, review, and improvement of health care data to be submitted by entities specified in this chapter, including, but not limited to, data from fee-for-service, capitated, integrated delivery system, and other alternative, value-based, payment sources, and any other form of payment to health care providers and suppliers by health plans, health insurers, or other entities described in this chapter.

(b) Notwithstanding any other state law, for the purpose of providing information for inclusion in the system, mandatory submitters shall, and voluntary submitters may, provide health care data, including claim and encounter, member enrollment, provider and supplier information, nonclaims-based payments, premiums, and pharmacy rebate data, and provide all of the following to the department:

(1) Utilization data from the health care service plans' and insurers' medical payments or, in the case of entities that do not use payments data, including, but not limited to, integrated delivery systems, encounter data consistent with the core set of data elements for data submission proposed by the All-Payer Claims Database Council, the University of New Hampshire, and the National Association of Health Data Organizations.

(2) Pricing information for health care items, services, and medical and surgical episodes of care gathered from payments for covered health care items and services, including contracted rates, allowed amounts, fee schedules, and other information regarding the cost of care necessary to determine the amounts paid by health plans, health insurers, and public programs to health care providers, suppliers, and other entities. This shall include nonclaims-based payment information such as deductibles, copayments, and coinsurance and other information as needed to determine the total cost of care.

(3) Personally identifiable information that the mandatory submitter is otherwise required to collect, which may include detailed patient identifiers such as first and last name, address, date of birth, gender or gender identity, and Social Security Number or individual taxpayer identification number, in order to support analyses, including, but not limited to, longitudinal, public health impacts, and social determinants of health analyses. Personally identifiable information shall be subject to the privacy protections of this chapter and shall not be publicly available, except as specified in this chapter.

(4) Personal health information that the mandatory submitter is otherwise required to collect, which may include age, gender, gender identity, race, ethnicity, sexual orientation, health status, health condition, and any other data elements that constitute personal health information in this chapter.

(c) For purposes of this chapter, "mandatory submitters" include all of the following:

(1) A health care service plan, including a specialized health care service plan.

(2) An insurer licensed to provide health insurance, as defined in Section 106 of the Insurance Code, including dental-only insurance.

(3) A self-insured plan subject to Section 1349.2, or a state entity, city, county, or other political subdivision of the state, or a public joint labor management trust, that offers self-insured or multiemployer-insured plans that pay for or reimburse any part of the cost of health care services.

(4) The State Department of Health Care Services, for those enrolled in Medi-Cal and other insurance affordability programs, whether enrolled in Medi-Cal managed care, fee-for-service Medi-Cal, or any other payment arrangement.

(d) The department will accept, at its discretion, voluntarily submitted data. For purposes of this chapter, "voluntary submitters" include, but are not limited to:

(1) A self-insured employer that is not subject to Section 1349.2.

(2) A multiemployer self-insured plan that is responsible for paying for health care services provided to beneficiaries.

(3) The trust administrator for a multiemployer self-insured plan.

(4) A provider, as defined in paragraph (2) of subdivision (b) of Section 1367.50, that is a hospital or clinic.

(5) A supplier, as defined in paragraph (3) of subdivision (b) of Section 1367.50, that has an independent scope of practice and submits claims electronically.

(e) On or before December 31, 2021, the department shall adopt emergency regulations pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 to implement this chapter, including on all of the following:

(1) Plan size thresholds for submitters, with consideration given to implementation costs for both the submitter and the department. Thresholds shall not apply to qualified health plans offered by the California Health Benefit Exchange or submitters covering more than a total of 50,000 Californians through both Medicare Advantage plans and the private plans and insurance described in subdivision (b).

(2) Required and exempted lines of business.

(3) Coordination of submission in cases where submitters contract with other entities to administer health care benefits.

(4) The content, file formats, and timelines for data submission, and the methods of data collection. In the development of regulations, the department shall consider national, regional, and other all-payer claims databases' standards.

(5) Frequency of submission by health plans, insurers, and other mandatory submitters of all core data, including claims, encounters, eligibility, and provider files.

(6) Frequency of submission of nonclaims payment data files.

(f) The initial adoption, by the department, of regulations implementing subdivision (e) shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code. Any emergency regulation adopted pursuant to this section shall be repealed by operation of law unless the adoption, amendment, or repeal of the regulation is promulgated by the department pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code within two years of the initial adoption of the emergency regulation. After the adoption of the emergency regulation pursuant to subdivision (e), the department may thereafter establish regulations pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(g) (1) A qualified health plan shall submit information either directly or through the California Health Benefit Exchange, as determined by the exchange.

(2) The State Department of Health Care Services shall submit information for those enrolled in Medi-Cal and other insurance affordability programs, whether enrolled in Medi-Cal managed care, fee-for-service Medi-Cal, or any other payment arrangement.

(h) (1) In its initial implementation, the department shall seek data for the three years prior to the effective date of this chapter.

(2) In ongoing administration of the system, the department shall provide data for no less than three years and may seek data for longer time periods to support the intent of this chapter.

(i) To the extent possible, the department shall incorporate into the system any data collected by the department from providers and suppliers, including hospital discharge abstract data records and emergency care data records provided to the department by health facilities and ambulatory surgery data records provided to the department by ambulatory surgical centers.

(j) The department may accept and incorporate into the system any available information that will further the goals of the program.

(k) (1) On or before March 1, 2024, the department shall submit a report to the Legislature that includes all of the following:

(A) Claims data reported by mandatory submitters.

(B) Claims data reported by voluntary submitters.

(C) Data on the covered lives reported, percentage of the population for which the department has data, the number of self-insured plans, providers and suppliers who have voluntarily submitted data, variation of completeness of data across geographic regions, such as the California Health Benefit Exchange's rating regions, the extent of data submitted on hospitals, physicians, and physician groups, the extent to which mandatory and voluntary submitters are submitting data specified in subdivision (b), frequency of submission of all core data, including claims, encounters, eligibility, and provider files, frequency of submission of nonclaims payment data files, and any other information that is available to determine if hospital and physician data are captured.

(D) A cost estimate if providers and suppliers become mandatory submitters.

(E) The number of data requests from qualified applicants and their data uses.

(2) The department may request the data release committee established pursuant to Section 127673.84 to assist with the report.

(3) The report shall be submitted in compliance with Section 9795 of the Government Code.

(l) Entities regulated pursuant to Article 4.7 (commencing with Section 742.20) of Part 2 of Division 1 of the Insurance Code are exempt from this chapter.

(m) The program performs public health activities described in subdivision (b) of Section 164.512 of Title 45 of the Code of Federal Regulations. The information collected in accordance with this chapter is necessary to carry out projects with public health purposes.

(n) Article 8 (commencing with Section 1798.30) of Chapter 1 of Title 1.8 of Part 4 of Division 3 of the Civil Code shall not apply to records and personal information collected by the system pursuant to this section.

SEC. 95. Section 127673.1 of the Health and Safety Code is amended to read:

127673.1. (a) (1) The department shall report the information it receives pursuant to this chapter in a form that allows valid comparisons across care delivery systems.

(2) The department shall develop policies and procedures to outline the format and type of data to be submitted pursuant to this chapter.

(b) All entities submitting health care data are responsible for submitting complete and accurate data directly to the system and facilitating data submissions from data owners, including, but not limited to, data feeds from pharmacy benefit managers, behavioral health organizations, and any subsidiaries, affiliates, or subcontractors that a submitter has contracted with for services covered by this chapter.

SEC. 96. Section 127673.2 of the Health and Safety Code is amended to read:

127673.2. (a) In the development of the system, the department or its designee shall consult with state and federal entities, as necessary, to implement the program. State entities shall assist and provide to the department access to datasets needed to effectuate the intent of this chapter.

(b) The department shall seek data on Medicare enrollees from the federal Centers for Medicare and Medicaid Services and shall incorporate that data, to the extent possible.

(c) The department shall accept data from voluntary submitters if it is provided in a manner and format specified by the office.

SEC. 97. Section 127673.3 of the Health and Safety Code is amended to read:

127673.3. (a) The department shall develop and maintain a master person index, a master index of providers and suppliers, and a master payer index that will enable the matching of California residents longitudinally and across coverage sources, and will enable the matching of providers and suppliers across practice arrangements, payment sources, and regulators.

(b) The department shall supplement these indices with data from other public and private sources, such as the following:

(1) Other data maintained by the department.

(2) Vital statistics.

(3) Facility licensure data from the State Department of Public Health.

(4) Health professional licensure data from the Department of Consumer Affairs.

(5) Private sources of valid and reliable data, such as a provider and supplier directory utility if it is demonstrably accurate over time.

SEC. 98. Section 127673.4 of the Health and Safety Code is amended to read:

127673.4. (a) The department shall develop regulations on data quality and improvement processes and shall make these processes publicly available.

(b) Data quality processes shall be applied to each major phase of the system life cycle, including, but not limited to:

(1) Source data intake.

(2) Data conversion and processing.

(3) Data analysis, reporting, and release.

(4) Other data processes necessary for the system.

(c) The department shall provide, upon request of an interested party, to the interested party, and shall regularly report to the health care data policy advisory committee, information on data quality and data quality improvement processes, including, but not limited to, the following:

(1) Descriptions of processes and methodologies.

(2) Periodic updates on known issues and the implications of the issues for data quality and data availability.

(3) Other impediments to the functioning of the system.

SEC. 99. Section 127673.5 of the Health and Safety Code is amended to read:

127673.5. (a) (1) The purpose of the system is to learn about and seek to improve public health, population health, social determinants of health, and the health care system, not about individual patients.

(2) All policies and procedures developed in implementing this chapter shall ensure that the privacy, security, and confidentiality of consumers' individually identifiable health information is protected, consistent with state and federal privacy laws.

(b) The department shall develop policies regarding data aggregation and the protection of individual confidentiality, privacy, and security for individual consumers and patients.

SEC. 100. Section 127673.6 of the Health and Safety Code is amended to read:

127673.6. The department shall develop an information security program that uses existing state standards and complies with applicable state and federal laws.

SEC. 101. Section 127673.7 of the Health and Safety Code is amended to read:

127673.7. The department shall include in an annual analysis, such as, but not limited to, the following:

(a) Population and regional level data on prevention, screening, and wellness utilization.

(b) Population and regional level data on chronic conditions, management, and outcomes.

(c) Population and regional level data on trends in utilization of procedures for treatment of similar conditions to evaluate medical appropriateness.

(d) Regional variation in payment level for the treatment of identified chronic conditions.

(e) Data regarding hospital and nonhospital payments, including inpatient, outpatient, and emergency department payments and nonhospital ambulatory service data.

SEC. 102. Section 127673.8 of the Health and Safety Code is amended to read:

127673.8. (a) The department shall use the program data to produce publicly available information, including data products, summaries, analyses, studies, and other reports, to support the goals of the program. The department shall receive input on priorities for the public information portfolio from the advisory committee. The department may establish a pricing mechanism for data products.

(b) The department may establish a public liaison function through which individuals may submit requests for specific products or analyses. The department may establish a pricing mechanism for custom reports. The department shall maintain copies of custom reports as part of the program public information portfolio.

(c) The department may establish a research program to conduct research, as defined in Section 164.501 of Title 45 of the Code of Federal Regulations, to support program policy goals.

(d) Publicly available data products and reports shall protect patient and consumer privacy.

SEC. 103. Section 127673.81 of the Health and Safety Code is amended to read:

127673.81. (a) (1) All personal consumer information obtained or maintained by the program shall be confidential.

(2) Only deidentified aggregate patient or other consumer data shall be included in a publicly available analysis, data product, or research.

(b) All policies and procedures developed in implementing this chapter shall ensure that the privacy, security, and confidentiality of consumers' individually identifiable health information is protected, consistent with state and federal privacy laws, including the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)(Public Law 104-191) and the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code), and data shall not be disclosed until the department has developed a policy regarding the release of data.

(c) (1) The system and all program data shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), and shall not be made available except pursuant to this chapter.

(2) The department shall develop policies and procedures for the disclosure of information described in paragraph (2) of subdivision (a).

(d) Program data shall not be used for determinations regarding individual patient care or treatment and shall not be used for any individual eligibility or coverage decisions or similar purposes.

SEC. 104. Section 127673.82 of the Health and Safety Code is amended to read:

127673.82. (a) The department shall develop a comprehensive program for data use, access, and release that includes data use agreements that require data users to comply with this chapter. The purpose of the data use, access, and release program is to ensure that only aggregated, deidentified information is publicly accessible.

(b) Access to nonpublic data shall be governed by the data use, access, and release program.

(c) To meet the research and policy goals of the program, controlled access to nonpublic data by outside data analysts, researchers, and other qualified applicants is necessary.

(d) The department shall establish a secure research environment for access to potentially identifiable information. The environment shall include access controls sufficient to ensure that users access only the data specified in an approved data request and that personal information is protected from unapproved use.

(e) The department shall, with the advice of the advisory committee and data release committee, develop criteria, policies, and procedures for access to and release of nonpublic data. The policies shall be designed to recognize a patient's right of privacy and shall include at least the privacy protection standards specified in Section 127673.83.

(f) The department shall establish a pricing mechanism for the use of nonpublic data.

(g) The department shall maintain information about requests and the disposition of requests, and shall develop processes for the timely consideration and release of nonpublic data.

SEC. 105. Section 127673.83 of the Health and Safety Code is amended to read:

127673.83. (a) In accessing or obtaining nonpublic data through the secure environment, users shall only have access to the minimum amount of potentially identifiable data necessary for an approved project or access to a dataset designed for an approved purpose. Each person who accesses or obtains nonpublic personal data shall sign a data use agreement. Violation of a data use agreement shall be considered a violation of Section 1798.56 of the Civil Code and, if applicable, Section 1798.57 of the Civil Code.

(b) Access to data in the secure research environment shall be permissible as follows:

(1) If the data does not include any of the direct personal identifiers listed in Section 164.514(e) of Title 45 of the Code of Federal Regulations, access may be provided to qualified applicants for research and analysis purposes consistent with program goals.

(2) If the data includes any of the direct personal identifiers listed in Section 164.514(e) of Title 45 of the Code of Federal Regulations, access may be provided only to qualified applicants for research projects that offer significant opportunities to achieve program goals and meet all of the following criteria:

(A) Project approval has been recommended by the data release committee.

(B) The project has been approved by the Committee for the Protection of Human Subjects pursuant to subdivision (t) of Section 1798.24 of the Civil Code. Pursuant to that section, the department may release data to established nonprofit research institutions, the University of California, and other nonprofit educational institutions.

(C) The requester has documented expertise with privacy protection and with the analysis of large sets of confidential data.

(D) The research shall be made available to the department.

(c) The department's policies shall limit release or transmittal of personal information outside the secure environment.

(1) The department may develop standardized limited datasets that do not include any of the direct personal identifiers listed in Section 164.514(e) of Title 45 of the Code of Federal Regulations, and have the minimum necessary personal information for types of purposes specified by the department. Standardized datasets may be transmitted to qualified applicants if the requester has documented expertise with privacy protection and with the analysis of large sets of confidential data, data security will meet the standards that the department shall apply to personal data, and project approval has been recommended by the data release committee.

(2) Data described in paragraph (2) of subdivision (b) may be transmitted to an outside researcher only if the researcher meets all the criteria of that paragraph, the researcher has documented expertise with data security and the protection of large sets of confidential data, and data security will meet the standards that the department shall apply to personal data.

(d) Program data, including personal information, may be shared with other state agencies pursuant to subdivision (e) of Section 1798.24 of the Civil Code. For purposes of that section, personal information has been collected for the purposes specified in Section 127671, which include analyzing and improving state programs related to public health and the provision of health care or health care coverage.

SEC. 106. Section 127673.84 of the Health and Safety Code is amended to read:

127673.84. (a) The department shall establish a data release committee with a membership of at least 7 and no more than 11 members appointed by the director. Notwithstanding any other law, a quorum shall be achieved with one fewer member than one-half of the full membership.

(b) The appointed members shall include representatives of health care payers, providers, suppliers, purchasers, researchers, consumers, and labor. Representatives of program data submitters shall not constitute a majority of members. The members shall have knowledge and experience with health care data, privacy, and security.

(c) Each appointed member shall serve a term of two years, except one-half of the initial appointments shall be for one year. The director may remove a member for cause.

(d) (1) The data release committee shall make recommendations about all applications seeking either program data with direct personal identifiers or the transmission of standardized datasets, except for data requests from other state agencies. Upon request of the director, the data release committee shall also make recommendations about other applications for program data.

(2) In making recommendations about applications seeking program data, except for data requests from other state agencies, the data release committee shall consider whether the use of the data is consistent with the goals of the system, whether it provides greater transparency regarding health care costs, utilization, quality, or equity, or how the information may be used to inform policy decisions regarding the provision of quality health care, improving public health, reducing health disparities, advancing health coverage, or reducing health care costs.

(e) Upon request of the director, the data release committee shall generally advise the director about privacy and security matters related to the program and provide feedback on the program's data application review processes and other matters.

(f) The chairperson of the data release committee shall be appointed from among the members by the director.

(g) A member of the data release committee appointed from outside state government shall serve without compensation, but shall receive a per diem for each day's attendance at a data release committee meeting. All members shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the committee.

SEC. 107. Section 127674 of the Health and Safety Code is amended to read:

127674. (a) The department shall expend the General Fund moneys appropriated in the 2018–19 Budget Act (Chapter 23 of the Statutes of 2019) for the purposes of this chapter and the former Health Care Transparency Database to fund the implementation and operation of the program.

(b) The Health Care Payments Data Program shall not be funded with General Fund moneys beyond moneys appropriated in the 2018–19 Budget Act.

(c) The Health Care Payments Data Fund is hereby established within the department for the purpose of receiving and expending revenues collected pursuant to this chapter.

(d) All revenues collected pursuant to this chapter shall be deposited in the fund. Any amounts raised by the collection of the revenues shall remain in the fund and shall be available in succeeding years upon appropriation by the Legislature.

(e) The department shall seek to maximize federal financial participation from the Medicaid program for the system, working through the sole state agency for Medicaid, the State Department of Health Care Services, and shall do so while relying on moneys appropriated from the General Fund in the 2018–19 Budget Act, and on an ongoing basis using any federally allowed fund source for the state match.

(f) (1) The department may impose a data user fee for an eligible user that is in compliance with this chapter, including, but not limited to, provisions related to consumer privacy and data security.

(2) In establishing the user fee schedule and fee waivers, the department shall work with the advisory committee to make considerations for state agencies, data submitters, and consumer organizations that have been awarded reasonable advocacy and witness fees in a proceeding or proceedings of the Department of Managed Health Care pursuant to Section 1348.9.

(3) The department shall adopt regulations on the fee waiver consistent with subdivisions (e) and (f) of Section 127673.

(g) On or before March 1, 2023, the office shall submit a report to the Legislature on recommendations for funding options for the program pursuant to Section 9795 of the Government Code.

(h) The department may accept foundation funding from foundations not affiliated or controlled by a health care entity.

SEC. 108. Section 127674.1 of the Health and Safety Code is amended to read:

127674.1. The department shall notify the Department of Managed Health Care or the Department of Insurance, as appropriate, if a health care service plan or health insurer fails to comply with this chapter. The Department of Managed Health Care and the Department of Insurance shall take appropriate action necessary to bring the plan or insurer into compliance.

SEC. 109. Section 127675 of the Health and Safety Code is amended to read:

127675. (a) This chapter shall apply to a manufacturer of a prescription drug that is purchased or reimbursed by any of the following:

(1) A state purchaser in California, including, but not limited to, the Public Employees' Retirement System, the State Department of Health Care Services, the Department of General Services, and the Department of Corrections and Rehabilitation, or an entity acting on behalf of a state purchaser.

(2) A licensed health care service plan.

(3) A health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(4) A pharmacy benefit manager as defined in subdivision (j) of Section 4430 of the Business and Professions Code.

(b) For the purposes of this chapter, the term "department" shall mean the Department of Health Care Access and Information.

SEC. 110. Section 127677 of the Health and Safety Code is amended to read:

127677. (a) A manufacturer of a prescription drug with a wholesale acquisition cost of more than forty dollars ($40) for a course of therapy shall notify each purchaser described in Section 127675 if the increase in the wholesale acquisition cost of a prescription drug is more than 16 percent, including the proposed increase and the cumulative increases that occurred within the previous two calendar years prior to the current year. For purposes of this section, a "course of therapy" is defined as either of the following:

(1) The recommended daily dosage units of a prescription drug pursuant to its prescribing label as approved by the federal Food and Drug Administration for 30 days.

(2) The recommended daily dosage units of a prescription drug pursuant to its prescribing label as approved by the federal Food and Drug Administration for a normal course of treatment that is less than 30 days.

(b) The notice required by subdivision (a) shall be provided in writing at least 60 days prior to the planned effective date of the increase.

(c) (1) The notice required by subdivision (a) shall include the date of the increase, the current wholesale acquisition cost of the prescription drug, and the dollar amount of the future increase in the wholesale acquisition cost of the prescription drug.

(2) The notice required by subdivision (a) shall include a statement regarding whether a change or improvement in the drug necessitates the price increase. If so, the manufacturer shall describe the change or improvement.

(d) The notice required by subdivision (a) shall be provided to each state purchaser and other purchasers described in paragraphs (2) to (4), inclusive, of subdivision (a) of Section 127675 if a purchaser registers with the department for the purpose of this notification. The department shall make available to manufacturers a list of registered purchasers for the purpose of this notification.

(e) If a pharmacy benefit manager receives a notice of an increase in wholesale acquisition cost consistent with subdivision (a), it shall notify its large contracting public and private purchasers of the increase. For the purposes of this section, a “large purchaser” means a purchaser that provides coverage to more than 500 covered lives.

SEC. 111. Section 127679 of the Health and Safety Code is amended to read:

127679. (a) On a quarterly basis at a time prescribed by the department and in a format prescribed by the department, commencing no earlier than January 1, 2019, a manufacturer shall report to the department all of the following information for each drug for which an increase in wholesale acquisition cost is described in Section 127677:

(1) A description of the specific financial and nonfinancial factors used to make the decision to increase the wholesale acquisition cost of the drug and the amount of the increase, including, but not limited to, an explanation of how these factors explain the increase in the wholesale acquisition cost of the drug.

(2) A schedule of wholesale acquisition cost increases for the drug for the previous five years if the drug was manufactured by the company.

(3) If the drug was acquired by the manufacturer within the previous five years, all of the following information:

(A) The wholesale acquisition cost of the drug at the time of acquisition and in the calendar year prior to acquisition.

(B) The name of the company from which the drug was acquired, the date acquired, and the purchase price.

(C) The year the drug was introduced to market and the wholesale acquisition cost of the drug at the time of introduction.

(4) The patent expiration date of the drug if it is under patent.

(5) If the drug is a multiple source drug, an innovator multiple source drug, a noninnovator multiple source drug, or a single source drug, as defined in subparagraph (A) of paragraph (7) of subdivision (k) of Section 1396r–8 of Title 42 of the United States Code.

(6) A description of the change or improvement in the drug, if any, that necessitates the price increase.

(7) Volume of sales of the manufacturer’s drug in the United States for the previous year.

(b) The manufacturer may limit the information reported pursuant to subdivision (a) to that which is otherwise in the public domain or publicly available.

(c) The department shall publish the information provided to it pursuant to this section on its internet website on no less than a quarterly basis. The information shall be published within 60 days of receipt from a manufacturer. The information shall be published in a manner that identifies the information that is disclosed on a per-drug basis and shall not be aggregated in a manner that would not allow identification of the drug.

(d) The department shall be responsible for the enforcement of this section.

(e) A manufacturer of a prescription drug subject to this chapter that does not report the information required pursuant to this section is liable for a civil penalty of one thousand dollars ($1,000) per day for every day after the reporting period described in this section that the required information is not reported.

(f) A civil penalty shall be assessed and recovered in a civil action brought by the office in the name of the people of the State of California. Assessment of a civil penalty may, at the request of any manufacturer of a prescription drug subject to this section, be reviewed on appeal, and the penalty may be reduced or waived for good cause.

(g) Any money received by the department pursuant to this section shall be paid into the Managed Care Fund.

SEC. 112. Section 127681 of the Health and Safety Code is amended to read:

127681. (a) A manufacturer of a prescription drug shall notify the department in writing if it is introducing a new prescription drug to market at a wholesale acquisition cost that exceeds the threshold set for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)). The notice shall be provided in writing within three days after the release of the drug in the commercial market. A manufacturer may make this notification pending approval by the federal Food and Drug Administration, if commercial availability is expected within three days of approval.

(b) No later than 30 days after notification pursuant to this section, a manufacturer shall report all of the following information to the department in a format prescribed by the department:

(1) A description of the marketing and pricing plans used in the launch of the new drug in the United States and internationally.

(2) The estimated volume of patients that may be prescribed the drug.

(3) If the drug was granted breakthrough therapy designation or priority review by the federal Food and Drug Administration prior to final approval.

(4) The date and price of acquisition if the drug was not developed by the manufacturer.

(c) The manufacturer may limit the information reported pursuant to subdivision (b) to that which is otherwise in the public domain or publicly available.

(d) The department shall publish the information provided to it pursuant to this section on its internet website on no less than a quarterly basis. The information shall be published in a manner that identifies the information that is disclosed on a per-drug basis and shall not be aggregated in a manner that would not allow identification of the drug.

(e) The department shall be responsible for the enforcement of this section.

(f) A manufacturer of a prescription drug subject to this chapter that does not report the information required pursuant to this section is liable for a civil penalty of one thousand dollars ($1,000) per day for every day after the notification period described in this section that the required information is not reported.

(g) A civil penalty shall be assessed and recovered in a civil action brought by the department in the name of the people of the State of California. Assessment of a civil penalty may, at the request of any manufacturer of a prescription drug subject to this section, be reviewed on appeal, and the penalty may be reduced or waived for good cause.

(h) Any money received by the department pursuant to this section shall be paid into the Managed Care Fund.

SEC. 113. Section 127683 of the Health and Safety Code is amended to read:

127683. (a) Funding for the actual and necessary expenses of the department to conduct the activities described in this section and in Sections 127676, 127679, 127681, and 127685, shall be provided, subject to appropriation by the Legislature, from transfers of moneys from the Managed Care Fund and the Insurance Fund.

(b) The share of funding from the Managed Care Fund shall be based on the number of covered lives in the state that are covered under plans regulated by the Department of Managed Health Care, including covered lives under Medi-Cal managed care, as determined by the Department of Managed Health Care, in proportion to the total number of all covered lives in the state.

(c) The share of funding to be provided from the Insurance Fund shall be based on the number of covered lives in the state that are covered under health insurance policies and benefit plans regulated by the Department of Insurance, including covered lives under Medicare supplement plans, as determined by the Department of Insurance, in proportion to the total number of all covered lives in the state.

SEC. 114. Section 127685 of the Health and Safety Code is amended to read:

127685. (a) The department may adopt regulations or issue guidance for the implementation of this chapter. All information that is required to be reported to the department pursuant to this chapter shall be reported in a form prescribed by the department, commencing in the first calendar quarter of 2019.

(b) The department may consult with the Department of Managed Health Care, the Department of Insurance, the California State Board of Pharmacy, and any state purchaser of prescription drugs, or an entity acting on behalf of a state purchaser, in issuing

guidance or adopting necessary regulations pursuant to subdivision (a), in posting information on its internet website pursuant to this chapter, and in taking any other action for the purpose of implementing this chapter.

SEC. 115. Article 1 (commencing with Section 127750) of Chapter 1 of Part 3 of Division 107 of the Health and Safety Code is repealed.

SEC. 116. Chapter 1.5 (commencing with Section 127825) is added to Part 3 of Division 107 of the Health and Safety Code, to read:

CHAPTER 1.5. Behavioral Health Grants

127825. (a) As a component of the Children and Youth Behavioral Health Initiative established pursuant to Chapter 2 (commencing with Section 5961) of Part 7 of Division 5 of the Welfare and Institutions Code, the office is hereby authorized to award competitive grants to entities and individuals it deems qualified to expand the supply of behavioral health counselors, coaches, peer supports, and other allied health care providers serving children and youth, including those at schoolsites.

(b) For the purposes of this chapter, "behavioral health coach" means a new category of behavioral health provider trained specifically to help address the unmet mental health and substance use needs of children and youth. Recognizing that unmet mental health and substance use needs create learning barriers, behavioral health coaches shall engage and support children and youth in cultural, linguistic, and age-appropriate services, with the ability to refer and link to higher levels of care, as needed. As members of a care team, behavioral health professionals serving as a coach receive appropriate supervision from licensed staff. Training and qualifications include, but are not limited to, psychoeducation, system navigation, crisis deescalation, safety planning, coping skills, and motivational interviewing.

SEC. 117. Section 127885 of the Health and Safety Code is amended to read:

127885. (a) The department shall maintain a Health Professions Career Opportunity Program that shall include, but not be limited to, all of the following:

(1) Implementing programs at colleges and universities selected by the department, which may include public and private institutions.

(A) In selecting campuses for the programs, the department shall give priority to campuses in medically underserved areas or with students from groups underrepresented in medicine, demonstrated commitment to diversity and associated institutional change, a track record of providing tailored student support, and strong health professions school partnerships.

(B) The programs shall include one or both of the following:

(i) Pipeline programs that provide comprehensive academic enrichment, career development, mentorship, and advising in order to support students from underrepresented regions and backgrounds to pursue health careers. This may include internships and fellowships to enable students to compete for admission to graduate health professions schools or employment in the health field, including, but not limited to, both of the following:

(I) Paid summer internships for students interning in community health centers, public health departments, public behavioral health settings, and with geriatric providers, as well as community-based initiatives that promote health equity.

(II) One-year postundergraduate fellowships for in-depth, pregraduate school experience in primary care and prevention, behavioral health, and geriatric health.

(ii) Annual postbaccalaureate reapplicant slots and the provision of student scholarships for reapplicant postbaccalaureate students to cover program tuition.

(2) Producing and disseminating a series of publications aimed at informing and motivating minority and disadvantaged students to pursue health professional careers.

(3) Conducting a conference series aimed at informing students of opportunities in health professional training and mechanisms of successfully preparing to enter the training.

(4) Providing support and technical assistance to health professional schools and colleges as well as to student and community organizations active in health professional development of underrepresented groups in medicine.

(5) Conducting relevant health workforce information and data analysis regarding underrepresented groups in medicine.

(6) Providing necessary consultation, recruitment, and counseling through other means.

(7) Supporting and encouraging health professionals in training who are from underrepresented groups to practice in health professional shortage areas of California.

(b) This section shall be implemented only to the extent that funds are appropriated for its purposes in the annual Budget Act or other statute.

SEC. 118. Section 127900 of the Health and Safety Code is amended to read:

127900. (a) The Legislature finds and declares that evidence exists to support the development of health promotion and health-risk reduction programs as an effective method of constraining the annual inflation rate for expenditures in the health industry. It is, therefore, the intent of the Legislature that a health manpower education program be developed to demonstrate the health promotion and health-risk reduction concept at educational institutions, with special emphasis on health manpower development in urban areas having a disproportionate share of disadvantaged and indigent persons.

(b) The department shall establish a contract program for funding allied health manpower training projects related to health promotion and health-risk reduction. The contract program shall provide funds to eligible institutions, as determined by the department, for all of the following purposes:

(1) Teaching existing and future primary care providers about health-risk reduction through the institutions' basic curricula.

(2) Recruiting, remediating, and retaining minority allied health professionals, including, but not limited to, physician assistants, nurse practitioners, nurse-midwives, public health nurses, health educators, dieticians, and nutritionists, especially those who provide in-home patient care.

(3) Increasing the supply of medical care in underserved urban areas and demonstrating methods which reduce cost through the use of allied health personnel.

(c) (1) These funds shall be available to institutions which currently operate programs for training family physicians, other primary care physicians, and those health professionals identified in paragraph (2) of subdivision (b).

(2) For purposes of this subdivision, "family physician" means a primary care physician and surgeon who renders continued comprehensive and preventative health care services to individuals and families, and who has received specialized training in an approved family medicine residency for three years after graduation from an accredited medical school.

(d) The recipients of the funds shall provide, but shall not be limited to providing, orientation and training of primary care providers in teaching methods related to patient health education and health promotion, such as educating allied health professionals in the principles of self-care management as it relates to specific health problems in medically underserved communities.

(e) The department shall consult with organizations and experts in the field regarding the establishment of this program, and beginning with the 1986–87 fiscal year, this program shall be implemented to the extent funds are provided in the Budget Act. This program shall be designed to accommodate an appropriation request in the range of forty thousand dollars ($40,000) to eighty thousand dollars ($80,000) per year.

(f) The director of the department may waive any of the requirements of subdivisions (b) and (c) if a potential contractor demonstrates an ability to meet the goals and objectives of the program.

SEC. 119. Article 2.5 (commencing with Section 127925) of Chapter 2 of Part 3 of Division 107 of the Health and Safety Code is repealed.

SEC. 120. Section 127940 of the Health and Safety Code is amended to read:

127940. (a) In administering the National Health Service Corps State Loan Repayment Program in accordance with Section 254q-1 of Title 42 of the United States Code and related federal regulations, the Department of Health Care Access and Information shall strive, whenever feasible, to equitably distribute loan repayment awards between eligible urban and rural program sites, after taking into account the availability of health care services in the communities to be served and the number of individuals to be served in each program site.

(b) The department shall set a reasonable deadline for when all applications are required to be received.

(c) All eligible applications shall be given consideration before any award is granted.

(d) The department shall include all federally qualified health centers located in California in the program's certified eligible site list.

(e) As part of a program applicant's initial application, program sites shall agree to provide matching funds.

SEC. 121. Section 127985 of the Health and Safety Code is amended to read:

127985. A person shall not be awarded a scholarship under subdivision (a) or (b) of Section 127980 unless:

(a) They are a resident of California.

(b) They are licensed as a registered nurse by this state.

(c) They have complied with all the regulations adopted pursuant to this article.

(d) They have agreed that they will continue their education to completion of the bachelor's degree or a program supplemental to a bachelor's degree required for admission to master level studies in nursing, and that after completion of the requirements of subdivision (a) or (b) of Section 127980 and within a period of time to be determined by the department, will enroll in an accredited master's degree program in teaching or supervision in a clinical nursing area.

(e) They agree that immediately upon completion of their graduate study, either master's degree or post-master's program, they will assume an employment obligation in California in teaching or supervision in a clinical nursing area, for not less than one year.

SEC. 122. Section 127995 of the Health and Safety Code is amended to read:

127995. The department shall administer the program of nursing education scholarships and shall for this purpose, adopt regulations as it determines are necessary to carry out this article.

SEC. 123. Section 128000 of the Health and Safety Code is amended to read:

128000. Applications for scholarships shall be made to the department, upon forms provided by it, at the times and in the manner prescribed by the regulations adopted by the office.

SEC. 124. Section 128005 of the Health and Safety Code is amended to read:

128005. The department shall award the scholarships to the applicants that it determines are best fitted to undertake the educational program for which the scholarships are awarded and will be the best qualified to teach or supervise. In awarding the scholarships the department may give a preference to applicants who are willing to be available, upon the completion of their educational program, for a position in any part of the state. The department shall not, however, award any scholarship to an applicant if it determines that the applicant has adequate financial resources to pay the cost of the education necessary to qualify them for teaching or supervision in a clinical area.

SEC. 125. Section 128020 of the Health and Safety Code is amended to read:

128020. A scholarship shall remain in effect only during the period, as determined by the department, that the person receiving the award achieves satisfactory progress and is regularly enrolled, within the terms of this article, as a full-time student.

SEC. 126. Section 128030 of the Health and Safety Code is amended to read:

128030. The department, in cooperation with the California Postsecondary Education Commission, shall administer the program established pursuant to this article and shall for this purpose, adopt regulations as it determines are reasonably necessary to carry out this article.

SEC. 127. Section 128035 of the Health and Safety Code is amended to read:

128035. The department is authorized to make grants, from funds appropriated by the Legislature for this purpose, to assist organizations in meeting the cost of special projects to plan, develop, or establish innovative programs of education in the health professions, or for research in the various fields related to education in the health professions, or to develop training for new types of health professions personnel, or to meet the costs of planning experimental teaching facilities.

In determining priority of project applications, the department shall give the highest priority to:

(1) Applicants able to obtain commitments for matching planning funds from other governmental and private sources.

(2) Applicants who develop a preliminary plan that conforms to the criteria stated hereinabove for innovative programs of education in the health sciences.

(3) Applicants that in its judgment are most able to translate a plan into a feasible program.

SEC. 128. Section 128040 of the Health and Safety Code is amended to read:

128040. (a) The Department of Health Care Access and Information shall report to the Legislature on or before June 30, 2002, on the feasibility of establishing a California dental loan forgiveness program utilizing the same general guidelines applicable to the federal National Health Service Corps State Loan Repayment Program (42 U.S.C.A. Sec. 254q-1; 42 C.F.R., Part 62, Subpart C (commencing with Section 62.51)), except as follows:

(1) A dentist shall be eligible to participate in the loan forgiveness program if they provide full-time or half-time dental services in either of the following:

(A) A dental health professional shortage area (DHPSA), established pursuant to Section 254e(a) of Title 42 of the United States Code.

(B) An area of the state where unmet priority needs for dentists exist as determined by the department.

(2) Matching funds to repay a portion of the dentist's outstanding loan amount shall be required from the practice site areas or from other private nonprofit sources.

(3) A qualifying practice site shall include a private dental practice.

(b) (1) The report required under subdivision (a) shall include all of the following:

(A) A projection of the dentist-to-population ratio for California in the next decade.

(B) A determination of the future need for dentists and dental care in underserved communities. The department shall work collaboratively with organizations that represent providers of dental services to underserved communities in making this determination.

(C) A report on the utilization by dentists of tuition loan repayment programs at the federal and state level and identify the barriers to full utilization of these loan repayment programs.

(D) A report on the projected cost increase of dental school education at public and private postsecondary educational institutions.

(E) A report on the implications of administering an additional program, including a cost analysis.

(2) The report also shall include recommendations on whether a program described in subdivision (a) should be established and, if so, suggested funding sources. In making its recommendations, the department shall consider the impact of the program on access to dental services in areas of the state that currently have a shortage of dentists.

SEC. 129. The heading of Article 5 (commencing with Section 128050) of Chapter 2 of Part 3 of Division 107 of the Health and Safety Code is amended to read:

Article 5. Health Care Workforce Research and Data Center

SEC. 130. Section 128050 of the Health and Safety Code is amended to read:

128050. The Department of Health Care Access and Information shall establish a health care workforce research and data center to serve as the central source of health care workforce and educational data in the state. The research and data center will serve as the state's central source of healthcare workforce and education data. The research and data center shall be responsible for the collection, analysis, and distribution of information on the educational and employment trends for health care occupations and distribution in the state. The activities of the research and data center shall be funded by appropriations made from the California Health Data and Planning Fund in accordance with subdivision (h) of Section 127280.

SEC. 131. Section 128051 of the Health and Safety Code is amended to read:

128051. The Department of Health Care Access and Information shall work with the Employment Development Department's Labor Market Information Division, state licensing boards, and state higher education entities to collect, to the extent available, all of the following data:

(a) The current supply of health care workers, by specialty.

(b) The geographical distribution of health care workers, by specialty.

(c) The diversity of the health care workforce, by specialty, including, but not necessarily limited to, data on race, ethnicity, and languages spoken.

(d) The current and forecasted demand for health care workers, by specialty.

(e) The educational capacity to produce trained, certified, and licensed health care workers, by specialty and by geographical distribution, including, but not necessarily limited to, the number of educational slots, the number of enrollments, the attrition rate, and wait time to enter the program of study.

SEC. 132. Section 128052 of the Health and Safety Code is amended to read:

128052. The Department of Health Care Access and Information shall prepare an annual report to the Legislature that does all of the following:

(a) Identifies education and employment trends in the health care profession.

(b) Reports on the current supply and demand for health care workers in California and gaps in the educational pipeline producing workers in specific occupations and geographic areas.

(c) Recommends state policy needed to address issues of workforce shortage and distribution.

(d) Describes the health care workforce program outcomes and effectiveness.

SEC. 133. The heading of Article 1 (commencing with Section 128125) of Chapter 3 of Part 3 of Division 107 of the Health and Safety Code is amended to read:

Article 1. Health Workforce Pilot Projects

SEC. 134. Section 128130 of the Health and Safety Code is amended to read:

128130. For the purposes of this article:

(a) “Department” means the Department of Health Care Access and Information.

(b) “Approved project” means an educational or training program approved by the office that does any of the following on a pilot program basis:

(1) Teaches new skills to existing categories of health care personnel.

(2) Develops new categories of health care personnel.

(3) Accelerates the training of existing categories of health care personnel.

(4) Teaches new health care roles to previously untrained persons, and that has been so designated by the department.

(c) “Trainee” means a person to be taught health care skills.

(d) “Supervisor” means a person designated by the project sponsor who already possesses the skills to be taught the trainees and is certified or licensed in California to perform the health care tasks involving the skills.

(e) “Health care services” means the practice of medicine, dentistry, nursing, including, but not limited to, specialty areas of nursing such as midwifery, pharmacy, optometry, podiatry, and psychology.

SEC. 135. Section 128135 of the Health and Safety Code is amended to read:

128135. The department may designate experimental health workforce projects as approved projects where the projects are sponsored by community hospitals or clinics, nonprofit educational institutions, or government agencies engaged in health or education activities. Nothing in this section shall preclude approved projects from utilizing the offices of physicians, dentists, pharmacists, and other clinical settings as training sites.

SEC. 136. Section 128140 of the Health and Safety Code is amended to read:

128140. Notwithstanding any other provision of law, a trainee in an approved project may perform health care services under the supervision of a supervisor where the general scope of the services has been approved by the department.

SEC. 137. Section 128155 of the Health and Safety Code is amended to read:

128155. The department, after one or more public hearings thereon, shall establish minimum standards, guidelines, and instructions for pilot projects. Advance notice of the hearing shall be sent to all interested parties and shall include a copy of the proposed minimum standards, guidelines, and instructions.

Organizations requesting designation as approved projects shall complete and submit to the department an application, that shall include a description of the project indicating the category of person to be trained, the tasks to be taught, the numbers of trainees and supervisors, a description of the health care agency to be used for training students, and a description of the types of patients likely to be seen or treated. Additionally, the application shall contain a description of all of the following:

(a) The evaluation process to be used.

(b) The baseline data and information to be collected.

(c) The nature of program data that will be collected and the methods for collecting and analyzing the data.

(d) Provision for protecting the safety of patients seen or treated in the project.

(e) A statement of previous experience in providing related health care services.

SEC. 138. Section 128165 of the Health and Safety Code is amended to read:

128165. The department shall carry out periodic onsite visitations of each approved project and shall evaluate each project to determine the following:

(a) The new health skills taught or extent that existing skills have been reallocated.

(b) Implication of the project for existing licensure laws with suggestions for changes in the law where appropriate.

(c) Implications of the project for health services curricula and for the health care delivery systems.

(d) Teaching methods used in the project.

(e) The quality of care and patient acceptance in the project.

(f) The extent that persons with the new skills could find employment in the health care system, assuming laws were changed to incorporate their skill.

(g) The cost of care provided in the project, the likely cost of this care if performed by the trainees subsequent to the project, and the cost for provision of this care by current providers thereof.

All data collected by the department and by projects approved pursuant to this article shall become public information, with due regard for the confidentiality of individual patient information. The raw data on which projects' reports are based and the data on which the department's evaluation is based shall be available on request for review by interested parties. The department shall provide a reasonable opportunity for interested parties to submit dissenting views or challenges to reports to the Legislature and professional licensing boards required by this section. The department shall publish those comments, subject only to nonsubstantive editing, as part of its annual, or any special, reports.

SEC. 139. Section 128170 of the Health and Safety Code is amended to read:

128170. The department shall approve a sufficient number of projects to provide a basis for testing the validity of the experiment.

SEC. 140. Section 128175 of the Health and Safety Code is amended to read:

128175. The department shall seek the advice of appropriate professional societies and appropriate healing arts licensing boards prior to designating approved projects. In the case of projects sponsored by a state agency, the following additional procedures shall apply:

(a) A hearing shall be conducted by a disinterested state government official selected by the director of the department from a state agency other than the department or the proponent of the project. The cost of the services of the disinterested state governmental official shall be paid by the department pursuant to an interagency agreement with the state agency represented by the state governmental official.

(b) A notice of hearing shall be sent by the department to interested parties, as designated by the director of the department, by registered mail no less than 30 days preceding the date of the hearing. The notice shall include, but not be limited to, the date,

time, location, and subject matter of the hearing, and shall include a copy of the application for a pilot project that is the subject of the hearing.

(c) A verbatim transcript of the hearing shall be prepared and distributed to interested parties upon request.

(d) Within 60 days of the release of the transcript, the department shall submit a recommendation on the proposal to the director of the department and shall send copies to the interested parties.

(e) The director of the department shall accept comments on the recommendations, and, on or after 30 days after transmittal of the recommendations, the director of the department shall approve or disapprove the proposed project.

SEC. 141. Section 128180 of the Health and Safety Code is amended to read:

128180. The department shall not approve a project for a period lasting more than two training cycles plus a preceptorship of more than 24 months, unless the department determines that the project is likely to contribute substantially to the availability of high-quality health services in the state or a region thereof.

SEC. 142. Section 128190 of the Health and Safety Code is amended to read:

128190. The department may extend the geriatric technician pilot project, known as the Health Manpower Pilot Project No. 152, for a minimum of four additional years, pursuant to reapplication by the sponsoring agency. The project shall continue to meet the applicable requirements established by the department. The number of sponsors authorized to participate in the pilot project may be expanded to a maximum of five.

SEC. 143. Section 128195 of the Health and Safety Code is amended to read:

128195. (a) The department shall issue followup reports on geriatric technician pilot projects approved by the department following 24 months of implementation of the employment utilization phase of each project. The reports shall contain all of the following information:

(1) A description of the persons trained, including, but not limited to, the following:

(A) The total number of persons who entered training.

(B) The total number of persons who completed training.

(C) The selection method, including descriptions of any nonquantitative criteria used by employers to refer persons to training.

(D) The education and experience of the trainees prior to training.

(E) Demographic characteristics of the trainees, as available.

(2) An analysis of the training completed, including, but not limited to, the following:

(A) Curriculum and core competencies.

(B) Qualifications of the instructor.

(C) Changes in the curriculum during the pilot project or recommended for the future.

(D) The nature of clinical and didactic training, including the ratio of students to instructors.

(3) A summary of the specific services provided by geriatric technicians.

(4) The new health skills taught or the extent to which existing skills have been reallocated.

(5) Implications of the project for existing licensure laws with suggestions for changes in the law where appropriate.

(6) Implications of the project for health services curricula and for health care delivery systems.

(7) Teaching methods used in the project.

(8) The quality of care, including pertinent medication errors, incident reports, and patient acceptance in the project.

(9) The extent to which persons with new skills could find employment in the health care system, assuming laws were changed to incorporate their skills.

(10) The cost of care provided in the project, the likely cost of this care if performed by the trainees subsequent to the project, and the cost for provision of this care by current providers thereof.

(b) Notwithstanding any other provision of law, issuance of the reports described in subdivision (a) shall not require that the department terminate the geriatric technician pilot projects authorized by the department.

SEC. 144. Article 2 (commencing with Section 128198) of Chapter 3 of Part 3 of Division 107 of the Health and Safety Code is repealed.

SEC. 145. Section 128205 of the Health and Safety Code is amended to read:

128205. As used in this article, and Article 2 (commencing with Section 128250), the following terms have the following meanings:

(a) “Family physician” means a primary care physician and surgeon who is prepared to and renders continued comprehensive and preventative health care services to individuals and families and who has received specialized training in an approved family medicine residency for three years after graduation from an accredited medical school.

(b) “Primary care physician” means a physician who is prepared to and renders continued comprehensive and preventative health care services, and has received specialized training in the areas of internal medicine, obstetrics and gynecology, or pediatrics.

(c) “Council” means the California Health Workforce Education and Training Council.

(d) “Graduate medical education” means residency programs for education or training in one or more specialties or subspecialties following graduation from medical school.

(e) “Health professions education and training” means any formal organized education or training undertaken for the purpose of gaining knowledge and skills necessary to practice a specific health profession or to provide a role in a health care setting. Health professions education and training includes any type of health professions training program, including shadowing programs, participating in rotations, affiliation agreements, and accredited or accreditation-eligible programs, at any educational level, including certificate, undergraduate, graduate, professional, or postgraduate, and in any clinical discipline, excluding graduate medical education.

(f) “Programs that train primary care physician’s assistants” means a program that has been approved for the training of primary care physician assistants pursuant to Section 3513 of the Business and Professions Code.

(g) “Programs that train primary care nurse practitioners” means a program that is operated by a California school of medicine or nursing, or that is authorized by the Regents of the University of California or by the Trustees of the California State University, or that is approved by the Board of Registered Nursing.

(h) “Programs that train registered nurses” means a program that is operated by a California school of nursing and approved by the Board of Registered Nursing, or that is authorized by the Regents of the University of California, the Trustees of the California State University, or the Board of Governors of the California Community Colleges, and that is approved by the Board of Registered Nursing.

(i) “Teaching health center” means a community-based ambulatory patient care center that operates a primary care residency program. Community-based ambulatory patient care settings include, but are not limited to, federally qualified health centers, community mental health centers, rural health clinics, health centers operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization, and entities receiving funds under Title X of the federal Public Health Service Act (Public Law 91-572).

SEC. 146. Section 128207 of the Health and Safety Code is repealed.

SEC. 147. Section 128215 of the Health and Safety Code is amended to read:

128215. (a) There is hereby created a California Health Workforce Education and Training Council that shall be responsible for helping coordinate California’s health workforce education and training to develop a health workforce that meets California’s health care needs. The council shall be composed of 17 members who, together, represent various graduate medical education and training programs, health professions, including, but not limited to, specialties for primary care and behavioral health, and consumer representatives who shall serve at the pleasure of their appointing authorities, as follows:

(1) Six members appointed by the Governor.

(2) One member who shall be the Director of the Department of Health Care Services, or the director’s designee.

(3) One member who shall be the Director of the Department of Health Care Access and Information, or the director's designee.

(4) Three members appointed by the Speaker of the Assembly.

(5) Three members appointed by the Chairperson of the Senate Committee on Rules.

(6) One member who shall be the President of the University of California, or the president's designee.

(7) One member who shall be the Chancellor of the California State University, or the chancellor's designee.

(8) One member who shall be the Chancellor of the California Community Colleges, or the chancellor's designee.

(b) Members of the council appointed under paragraphs (1), (4), and (5) of subdivision (a) shall be appointed for a term of four years, except that the term of office of the initial members appointed under paragraph (1) shall expire at the end of two years.

SEC. 148. Section 128220 of the Health and Safety Code is amended to read:

128220. The members of the council, other than state employees, shall receive compensation of twenty-five dollars ($25) for each day's attendance at a council meeting, in addition to actual and necessary travel expenses incurred in the course of attendance at a council meeting.

SEC. 149. Section 128224 of the Health and Safety Code is repealed.

SEC. 150. Section 128225 of the Health and Safety Code is repealed.

SEC. 151. Section 128225 is added to the Health and Safety Code, to read:

128225. (a) The council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:

(1) Develop graduate medical education and workforce training and development priorities for the state.

(2) Discuss and make recommendations to the Department of Health Care Access and Information regarding the use of health care education and training funds appropriated by the Legislature for programs administered by the department under this part.

(3) Develop standards and guidelines for residency and health professions education and training programs funded under this part.

(4) Review outcomes data from funded programs, as provided to the council by the department, to reprioritize and reassess the graduate medical education and health professions education and training needs of California's communities.

(5) Explore options for developing a broad graduate medical education and health professions education and training funding strategy.

(6) Advocate for additional funds and additional sources of funds to stimulate expansion of graduate medical education and health professions education and training in California.

(7) Provide technical assistance and support for establishing new graduate medical education and health professions education and training programs in California.

(8) Review and recommend health professions career pathways or ladders.

(b) The council shall carry out the duties imposed upon it by this chapter with primary consideration given to increasing workforce diversity and furthering improved access, quality, and equity of health care for underserved, underrepresented, and Medi-Cal populations. Further, the council shall carry out the duties imposed upon it by this chapter with a primary focus on primary care, behavioral health, oral health, and allied health.

SEC. 152. Section 128230 of the Health and Safety Code is amended to read:

128230. When funding primary care and family medicine programs or departments, primary care and family medicine residencies, and programs for the training of primary care physician assistants, primary care nurse practitioners, or registered nurses, the department shall give priority to programs that have demonstrated success in the following areas:

(a) Graduating individuals who practice in medically underserved areas.

(b) Enrolling members of underrepresented groups in medicine to the program.

(c) Locating the program's main training site in a medically underserved area.

(d) Operating a main training site at which the majority of the patients are Medi-Cal recipients.

SEC. 153. Section 128235 of the Health and Safety Code is amended to read:

128235. Pursuant to this article and Article 2 (commencing with Section 128250), the Director of the Department of Health Care Access and Information shall do all of the following:

(a) Develop application and contract criteria based on healthcare workforce needs and the priorities of the council.

(b) Determine whether primary care and family medicine, primary care physician's assistant training program proposals, primary care nurse practitioner training program proposals, and registered nurse training program proposals submitted to the department for participation in the state medical contract program established by this article and Article 2 (commencing with Section 128250) meet the standards established by the council.

(c) Select and contract on behalf of the state with accredited medical schools, teaching health centers, programs that train primary care physician's assistants, programs that train primary care nurse practitioners, hospitals, and other health care delivery systems for the purpose of training undergraduate medical students and residents in the specialties of internal medicine, obstetrics and gynecology, pediatrics, and family medicine. Contracts shall be awarded to those institutions that best demonstrate the ability to provide quality education and training and to retain students and residents in specific areas of California where there is a recognized unmet priority need for primary care family physicians. Contracts shall be in conformity with the contract criteria developed by the Department of Health Care Access and Information.

(d) Select and contract on behalf of the state with programs that train registered nurses. Contracts shall be awarded to those institutions that best demonstrate the ability to provide quality education and training and to retain students and residents in specific areas of California where there is a recognized unmet priority need for registered nurses. Contracts shall be in conformity with the contract criteria developed by the Department of Health Care Access and Information.

(e) Terminate, upon 30 days' written notice, the contract of any institution whose program does not meet the standards established by the council or that otherwise does not maintain proper compliance with this part, except as otherwise provided in contracts entered into by the director pursuant to this article and Article 2 (commencing with Section 128250).

(f) Instruct the council to create subcommittees as may be required from time to time in the discretion of the Director of the Department of Health Care Access and Information.

SEC. 154. Section 128240 of the Health and Safety Code is repealed.

SEC. 155. Section 128240.1 of the Health and Safety Code is repealed.

SEC. 156. Section 128241 of the Health and Safety Code is repealed.

SEC. 157. Article 2 (commencing with Section 128250) of Chapter 4 of Part 3 of Division 107 of the Health and Safety Code is repealed.

SEC. 158. The heading of Article 3 of Chapter 4 of Part 3 of Division 107 of the Health and Safety Code is repealed.

SEC. 159. The heading of Chapter 5 (commencing with Section 128330) of Part 3 of Division 107 of the Health and Safety Code is amended to read:

CHAPTER 5. Health Professions Education Programs

SEC. 160. The heading of Article 1 (commencing with Section 128330) of Chapter 5 of Part 3 of Division 107 of the Health and Safety Code is amended to read:

Article 1. Health Professions Education Programs

SEC. 161. Section 128330 of the Health and Safety Code is amended to read:

128330. As used in this article:

(a) "Board" means the Board of Trustees of the Health Professions Education Foundation.

(b) "Council" means the California Health Workforce Education and Training Council.

(c) "Director" means the Director of the Department of Health Care Access and Information.

(d) “Foundation” means the Health Professions Education Foundation.

(e) “Health professions” or “health professionals” means physicians and surgeons licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or pursuant to the Osteopathic Act, dentists, registered nurses, and other health professionals determined by the department to be needed in medically underserved areas.

(f) “Department” means the Department of Health Care Access and Information.

(g) “Underrepresented groups” means populations that are underrepresented in medicine, dentistry, nursing, or other health professions as determined by the department. The department, upon a finding that the action is necessary to meet the health care needs of medically underserved areas, may add a group comprising the economically disadvantaged to those groups authorized to receive assistance under this article. The department shall recognize that it is especially important that medical and dental care be provided in a way that is sensitive to the sociocultural variables that affect a person’s health.

SEC. 162. Section 128335 of the Health and Safety Code is amended to read:

128335. (a) The department shall establish a nonprofit public benefit corporation, to be known as the Health Professions Education Foundation, that shall be governed by a board consisting of nine members appointed by the Governor, one member appointed by the Speaker of the Assembly, one member appointed by the Senate Committee on Rules, and two members appointed by the Medical Board of California. The members of the foundation board appointed by the Governor, Speaker of the Assembly, and Senate Committee on Rules may include representatives of minority groups which are underrepresented in the health professions, persons employed as health professionals, and other appropriate members of health or related professions. All persons considered for appointment shall have an interest in health programs, an interest in health educational opportunities for underrepresented groups, and the ability and desire to solicit funds for the purposes of this article as determined by the appointing power. The chairperson of the council shall also be a nonvoting, ex officio member of the board.

(b) The Governor shall appoint the president of the board of trustees from among those members appointed by the Governor, the Speaker of the Assembly, the Senate Committee on Rules, and the Medical Board of California.

(c) The director, after consultation with the president of the board, may appoint a council of advisers comprised of up to nine members. The council shall advise the director and the board on technical matters and programmatic issues related to the Health Professions Education Foundation Program.

(d) Members of the board and members of the council shall serve without compensation but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the board or the council. The Medical Board of California shall reimburse the members it appointed to the foundation board for any actual and necessary expenses incurred in connection with their duties as members of the foundation board.

(e) The foundation shall be subject to the Nonprofit Public Benefit Corporation Law (Part 2 (commencing with Section 5110) of Division 2 of Title 2 of the Corporations Code), except that if there is a conflict with this article and the Nonprofit Public Benefit Corporation Law (Part 2 (commencing with Section 5110) of Division 2 of Title 2 of the Corporations Code), this article shall prevail.

(f) This section shall remain in effect only until January 1, 2022, and as of that date is repealed.

SEC. 163. Section 128337 is added to the Health and Safety Code, to read:

128337. Notwithstanding any other law, on or before October 1, 2021, the nonprofit public benefit corporation known as the Health Professions Education Foundation shall be dissolved. All assets, including records, and any liabilities shall be transferred to the department.

SEC. 164. Section 128338 is added to the Health and Safety Code, to read:

128338. Effective with the dissolution of the Health Professions Education Foundation, any reference to the Health Professions Education Foundation, or the Foundation, in this chapter shall be deemed a reference to the department.

SEC. 165. Section 128340 of the Health and Safety Code is repealed.

SEC. 166. Section 128345 of the Health and Safety Code is amended to read:

128345. The department may do any of the following:

(a) Solicit and receive funds from business, industry, foundations, and other private or public sources for the purpose of providing financial assistance in the form of scholarships or loans to students from underrepresented groups. These funds shall be expended by the department after transfer to the Health Professions Education Fund, created pursuant to Section 128355.

(b) Disburse private sector moneys deposited in the Health Professions Education Fund to students from underrepresented groups enrolled in or graduated from schools of medicine, dentistry, nursing, or other health professions in the form of loans or scholarships.

(c) Encourage private sector institutions, including hospitals, community clinics, and other health agencies to identify and provide educational experiences to students from underrepresented groups who are potential applicants to schools of medicine, dentistry, nursing, or other health professions.

(d) Implement the Steven M. Thompson Physician Corps Loan Repayment Program and the Volunteer Physician Program, as provided under Article 5 (commencing with Section 128550).

SEC. 167. Section 128350 of the Health and Safety Code is amended to read:

128350. The department shall do all of the following:

(a) Provide technical and staff support to the programs in meeting all of its responsibilities.

(b) Provide financial management for the Health Professions Education Fund.

(c) Enter into contractual agreements with students from underrepresented groups for the disbursement of scholarships or loans in return for the commitment of these students to practice their profession in an area in California designated as deficient in primary care services.

(d) Disseminate information regarding the areas in the state that are deficient in primary care services to potential applicants for the scholarships or loans.

(e) Monitor the practice locations of the recipients of the scholarships or loans.

(f) Recover funds, in accordance with the terms of the contractual agreements, from recipients of scholarships or loans who fail to begin or complete their obligated service. Funds so recovered shall be redeposited in the Health Professions Education Fund.

(g) Contract with the institutions that train family practice residents, in order to increase the participation of students from underrepresented groups in entering the specialty of family practice. The director may seek the recommendations of the council as to what programs best demonstrate the ability to meet this objective.

(h) Contract with training institutions that are involved in osteopathic postgraduate training in general or family practice medicine, in order to increase the participation of students from underrepresented groups participating in the practice of osteopathic medicine. The director may seek the recommendations of the council as to what programs have demonstrated the ability to meet this objective.

(i) Enter into contractual agreements with graduated health professionals to repay some or all of the debts they incurred in health professional schools in return for practicing their professions in an area in California designated as deficient in primary care services.

(j) Contract with institutions that award baccalaureate of science degrees in nursing in order to increase the participation of students from underrepresented groups in the nursing profession. The director may seek the recommendations of the council as to what programs have demonstrated the ability to meet this objective.

SEC. 168. Section 128355 of the Health and Safety Code is amended to read:

128355. There is hereby created within the department a Health Professions Education Fund. The primary purpose of this fund is to provide scholarships and loans to students from underrepresented groups who are accepted to or enrolled in schools of medicine, dentistry, nursing, or other health professions. The fund shall also be used to pay for the cost of administering the program and for any other purpose authorized by this article. The level of expenditure by the department for the administrative support of the program created pursuant to this article shall be subject to review and approval annually through the State Budget process. The department may receive private donations to be deposited into this fund. All money in the fund is continuously appropriated to the department for the purposes of this article. The department shall manage this fund prudently in accordance with other provisions of law.

SEC. 169. Section 128360 of the Health and Safety Code is repealed.

SEC. 170. Section 128360 is added to the Health and Safety Code, to read:

128360. (a) In administering this chapter, the department shall be exempt from 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 opportunities for public participation as it administers the Health Professions Education Programs. Information about each type of scholarship or loan repayment opportunity shall be publicly available at least 60 days prior to any application deadline. This information shall include eligibility criteria and the application process, materials, and deadlines, and shall be posted on the department's internet website and be available directly from the department. All the information shall remain posted and available during the entire application period for a funding cycle.

(b) Regulations that have been adopted to administer this chapter prior to the effective date of this section are repealed as of the effective date of this section.

SEC. 171. Section 128365 of the Health and Safety Code is amended to read:

128365. Notwithstanding any other provision, applications for financial assistance under this article, or other documents that the department reasonably determines should not be discussed in public due to privacy considerations shall be exempt from the disclosure provisions of the Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

SEC. 172. Section 128370 of the Health and Safety Code is amended to read:

128370. Notwithstanding any other law, the department may exempt from public disclosure any document in the possession of the department that pertains to a donation made pursuant to this article if the donor has requested anonymity.

SEC. 173. Section 128371 of the Health and Safety Code is amended to read:

128371. (a) The Legislature finds and declares that it is in the best interest of the State of California to provide persons who are not lawfully present in the United States with the state benefits provided by those programs listed in subdivision (d), and therefore, enacts this section pursuant to Section 1621(d) of Title 8 of the United States Code.

(b) A program listed in subdivision (d) shall not deny an application based on the citizenship status or immigration status of the applicant.

(c) For any program listed in subdivision (d), when mandatory disclosure of a social security number is required, an applicant shall provide their social security number, if one has been issued, or an individual tax identification number that has been or will be submitted.

(d) This section applies to all of the following:

(1) Programs supported through the Health Professions Education Fund pursuant to Section 128355.

(2) The Registered Nurse Education Fund created pursuant to Section 128400.

(3) The Mental Health Practitioner Education Fund created pursuant to Section 128458.

(4) The Vocational Nurse Education Fund created pursuant to Section 128500.

(5) The Medically Underserved Account for Physicians created pursuant to Section 128555.

(6) Loan forgiveness and scholarship programs created pursuant to Part 3.1 (commencing with Section 5820) of Division 5 of the Welfare and Institutions Code.

(7) The Song-Brown Health Care Workforce Training Act created pursuant to Article 1 (commencing with Section 128200) of Chapter 4.

(8) To the extent permitted under federal law, the program administered by the department pursuant to the federal National Health Service Corps State Loan Repayment Program (42 U.S.C. Sec. 254q-1), commonly known as the California State Loan Repayment Program.

(9) The programs administered by the department pursuant to the Health Professions Career Opportunity Program (Section 127885), commonly known as the Mini Grants Program, and California's Student/Resident Experiences and Rotations in Community Health, commonly known as the CalSEARCH program.

SEC. 174. Section 128375 of the Health and Safety Code is amended to read:

128375. (a) The Legislature hereby finds and declares that an adequate supply of professional nurses is critical to assuring the health and well-being of the citizens of California, particularly those who live in medically underserved areas.

(b) The Legislature further finds that changes in the health care system of this state have increased the need for more highly skilled nurses. These changes include advances in medical technology and pharmacology, that necessitate the use of more highly skilled nurses in acute care facilities. Further, the containment of health care costs has led to increased reliance on home health care and outpatient services and to a higher proportion of more acutely ill patients in acute care facilities. Long-term care facilities also need more highly educated nursing personnel. Both shifts require a larger number of skilled nursing personnel.

(c) The Legislature further finds and declares that in nursing, as in other professions, certain populations are underrepresented. The Legislature also finds and declares that it is especially important that nursing care be provided in a way that is sensitive to the sociocultural variables that affect a person's health. The Legislature recognizes that the financial burden of obtaining a baccalaureate degree is considerable and that persons from families lacking adequate financial resources may need financial assistance to complete a baccalaureate degree.

SEC. 175. Section 128385 of the Health and Safety Code is amended to read:

128385. (a) There is hereby created the Registered Nurse Education Program within the department. Persons participating in this program shall be persons who agree in writing prior to graduation to serve in an eligible county health facility, an eligible state-operated health facility, a health workforce shortage area, or a California nursing school, as designated by the director of the department. Persons agreeing to serve in eligible county health facilities, eligible state-operated health facilities, or health workforce shortage areas, and master's or doctoral students agreeing to serve in a California nursing school may apply for scholarship or loan repayment. The Registered Nurse Education Program shall be administered in accordance with Article 1 (commencing with Section 128330), except that all funds in the Registered Nurse Education Fund shall be used only for the purpose of promoting the education of registered nurses and related administrative costs. The department shall adopt both of the following:

(1) A standard contractual agreement to be signed by the director and any student who has received an award to work in an eligible county health facility, an eligible state-operated health facility, or in a health workforce shortage area that would require a period of obligated professional service in the areas of California designated by the department as deficient in primary care services. The obligated professional service shall be in direct patient care. The agreement shall include a clause entitling the state to recover the funds awarded plus the maximum allowable interest for failure to begin or complete the service obligation.

(2) Maximum allowable amounts for scholarships, educational loans, and loan repayment programs in order to assure the most effective use of these funds.

(b) Applicants may be persons licensed as registered nurses, graduates of associate degree nursing programs prior to entering a program granting a baccalaureate of science degree in nursing, or students entering an entry-level master's degree program in registered nursing or other registered nurse master's or doctoral degree program approved by the Board of Registered Nursing. Priority shall be given to applicants who hold associate degrees in nursing.

(c) Registered nurses and students shall commit to teaching nursing in a California nursing school for five years in order to receive a scholarship or loan repayment for a doctoral degree program.

(d) As used in this section, "eligible county health facility" means a county health facility that has been determined by the department to have a nursing vacancy rate greater than noncounty health facilities located in the same health facility planning area.

(e) As used in this section, "eligible state-operated health facility" means a state-operated health facility that has been determined by the department to have a nursing vacancy rate greater than noncounty health facilities located in the same health facility planning area.

SEC. 176. Section 128395 of the Health and Safety Code is repealed.

SEC. 177. Section 128401 of the Health and Safety Code is amended to read:

128401. (a) The Department of Health Care Access and Information shall establish the statewide Associate Degree Nursing (A.D.N.) Scholarship Program.

(b) Scholarships under the program shall be available only to students in counties determined to have the most significant need. Need in a county shall be established based on consideration of all the following factors:

(1) Counties with a registered nurse-to-population ratio equal to or less than 500 registered nurses per 100,000 individuals.

(2) County unemployment rate.

(3) County level of poverty.

(c) A scholarship recipient shall be required to complete, at a minimum, an associate degree in nursing and work in a medically underserved area in California upon obtaining their license from the Board of Registered Nursing.

(d) The department shall consider the following factors when selecting recipients for the A.D.N. Scholarship Program:

(1) An applicant's economic need, as established by the federal poverty index.

(2) Applicants who demonstrate cultural and linguistic skills and abilities.

(e) The program shall be funded from the Registered Nurse Education Fund established pursuant to Section 128400 and administered by the department within the office. The department shall allocate a portion of the moneys in the fund for the program established pursuant to this section, in addition to moneys otherwise allocated pursuant to this article for scholarships and loans for associate degree nursing students.

(f) No additional staff or General Fund operating costs shall be expended for the program.

(g) The department may accept private or federal funds for purposes of the A.D.N. Scholarship Program.

(h) The department shall post A.D.N. Scholarship Program statistics and updates on its internet website.

SEC. 178. Article 3 (commencing with Section 128425) of Chapter 5 of Part 3 of Division 107 of the Health and Safety Code is repealed.

SEC. 179. Section 128454 of the Health and Safety Code is amended to read:

128454. (a) There is hereby created the Licensed Mental Health Service Provider Education Program within the Department of Health Care Access and Information.

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

(1) "Licensed mental health service provider" means a psychologist licensed by the Board of Psychology, registered psychologist, postdoctoral psychological assistant, postdoctoral psychology trainee employed in an exempt setting pursuant to Section 2910 of the Business and Professions Code or employed pursuant to a State Department of Health Care Services waiver pursuant to Section 5751.2 of the Welfare and Institutions Code, marriage and family therapist, associate marriage and family therapist, licensed clinical social worker, associate clinical social worker, licensed professional clinical counselor, and associate professional clinical counselor.

(2) "Mental health professional shortage area" means an area designated as such by the Health Resources and Services Administration (HRSA) of the United States Department of Health and Human Services.

(c) Commencing January 1, 2005, any licensed mental health service provider, including a mental health service provider who is employed at a publicly funded mental health facility or a public or nonprofit private mental health facility that contracts with a county mental health entity or facility to provide mental health services, who provides direct patient care in a publicly funded facility or a mental health professional shortage area may apply for grants under the program to reimburse their educational loans related to a career as a licensed mental health service provider.

(d) The department shall adopt all of the following:

(1) A standard contractual agreement to be signed by the director and any licensed mental health service provider who is serving in a publicly funded facility or a mental health professional shortage area that would require the licensed mental health service provider who receives a grant under the program to work in the publicly funded facility or a mental health professional shortage area for at least one year.

(2) The maximum allowable total grant amount per individual licensed mental health service provider.

(3) The maximum allowable annual grant amount per individual licensed mental health service provider.

(e) The department shall develop the program, which shall comply with all of the following requirements:

(1) The total amount of grants under the program per individual licensed mental health service provider shall not exceed the amount of educational loans related to a career as a licensed mental health service provider incurred by that provider.

(2) The program shall keep the fees from the different licensed providers separate to ensure that all grants are funded by those fees collected from the corresponding licensed provider groups.

(3) A loan forgiveness grant may be provided in installments proportionate to the amount of the service obligation that has been completed.

(4) The number of persons who may be considered for the program shall be limited by the funds made available pursuant to Section 128458.

(f) This section shall become operative on July 1, 2018.

SEC. 180. Section 128456 of the Health and Safety Code is repealed.

SEC. 181. Section 128458 of the Health and Safety Code is amended to read:

128458. There is hereby established in the State Treasury the Mental Health Practitioner Education Fund. The moneys in the fund, upon appropriation by the Legislature, shall be available for expenditure by the Department of Health Care Access and Information for purposes of this article.

SEC. 182. Section 128485 of the Health and Safety Code is amended to read:

128485. There is hereby created the Vocational Nurse Education Program within the Department of Health Care Access and Information. Persons participating in this program shall be persons who agree in writing prior to completion of vocational nursing school to serve in an eligible county health facility, an eligible state-operated health facility, or a health workforce shortage area, as designated by the director of the department. Persons agreeing to serve in eligible county health facilities, eligible state-operated health facilities, or health workforce shortage areas may apply for scholarship or loan repayment. The Vocational Nurse Education Program shall be administered in accordance with Article 1 (commencing with Section 128330), except that all funds in the Vocational Nurse Education Fund shall be used only for the purpose of promoting the education of vocational nurses and related administrative costs. The department shall adopt both of the following:

(a) A standard contractual agreement to be signed by the director and any student who has received an award to work in an eligible county health facility, an eligible state-operated health facility, or in a health workforce shortage area that would require a period of obligated professional service in the areas of California designated by the department as deficient in primary care services. The obligated professional service shall be in direct patient care. The agreement shall include a clause entitling the state to recover the funds awarded plus the maximum allowable interest for failure to begin or complete the service obligation.

(b) Maximum allowable amounts for scholarships, educational loans, and loan repayment programs in order to assure the most effective use of these funds.

(c) A person who qualifies for admission to a vocational nursing program that is accredited by the board of Vocational Nursing and Psychiatric Technicians may apply for funding under the Vocational Nurse Education Program by establishing a contractual agreement in accordance with subdivision (a).

(d) A person who holds a current valid license as a vocational nurse who wishes to seek an associate of science degree in nursing from an accredited college may apply for funding under the Vocational Nurse Education Program by establishing a contractual agreement in accordance with subdivision (a) unless the person is able to qualify under subdivision (a) of Section 128385 under the Registered Nurse Education Program.

SEC. 183. Section 128495 of the Health and Safety Code is repealed.

SEC. 184. Section 128550 of the Health and Safety Code is amended to read:

128550. (a) There is hereby established within the Department of Health Care Access and Information the California Physician Corps Program.

(b) Commencing July 1, 2006, both of the following programs shall be transferred from the Medical Board of California to the California Physician Corps Program within the department and operated pursuant to this article:

(1) The Steven M. Thompson Physician Corps Loan Repayment Program.

(2) The Physician Volunteer Program developed by the Medical Board of California.

(c) The department may enter into an interagency agreement with the Medical Board of California to implement the transfer of programs as provided under subdivision (b).

SEC. 185. Section 128551 of the Health and Safety Code is amended to read:

128551. (a) It is the intent of this article that the department provide the ongoing program management of the two programs identified in subdivision (b) of Section 128550 as a part of the California Physician Corps Program.

(b) For purposes of subdivision (a), the department shall consult with the Medical Board of California and shall establish and consult with an advisory committee of not more than seven members, that shall include two members recommended by the California Medical Association and may include other members of the medical community, including ethnic representatives, medical schools, health advocates representing ethnic communities, primary care clinics, public hospitals, and health systems, statewide agencies administering state and federally funded programs targeting underserved communities, and members of the public with expertise in health care issues.

SEC. 186. Section 128552 of the Health and Safety Code is amended to read:

128552. For purposes of this article, the following definitions shall apply:

(a) “Account” means the Medically Underserved Account for Physicians established within the Health Professions Education Fund pursuant to this article.

(b) “Fund” means the Health Professions Education Fund.

(c) “Medi-Cal threshold languages” means primary languages spoken by limited-English-proficient (LEP) population groups meeting a numeric threshold of 3,000, eligible LEP Medi-Cal beneficiaries residing in a county, 1,000 Medi-Cal eligible LEP beneficiaries residing in a single ZIP Code, or 1,500 LEP Medi-Cal beneficiaries residing in two contiguous ZIP Codes.

(d) “Medically underserved area” means an area defined as a health professional shortage area in Part 5 of Subchapter A of Chapter 1 of Title 42 of the Code of Federal Regulations or an area of the state where unmet priority needs for physicians exist as determined by the department.

(e) “Medically underserved population” means the Medi-Cal program and uninsured populations.

(f) “Department” means the Department of Health Care Access and Information.

(g) “Physician Volunteer Program” means the Physician Volunteer Registry Program established by the Medical Board of California.

(h) “Practice setting,” for the purposes of this article only, means either of the following:

(1) A community clinic as defined in subdivision (a) of Section 1204 and subdivision (c) of Section 1206, a clinic owned or operated by a public hospital and health system, or a clinic owned and operated by a hospital that maintains the primary contract with a county government to fulfill the county’s role pursuant to Section 17000 of the Welfare and Institutions Code, which is located in a medically underserved area and at least 50 percent of whose patients are from a medically underserved population.

(2) A physician owned and operated medical practice setting that provides primary care located in a medically underserved area and has a minimum of 50 percent of patients who are uninsured, Medi-Cal beneficiaries, or beneficiaries of another publicly funded program that serves patients who earn less than 250 percent of the federal poverty level.

(i) “Primary specialty” means family practice, internal medicine, pediatrics, or obstetrics/gynecology.

(j) “Program” means the Steven M. Thompson Physician Corps Loan Repayment Program.

(k) “Selection committee” means a minimum three-member committee of the board, that includes a member that was appointed by the Medical Board of California.

SEC. 187. Section 128553 of the Health and Safety Code is amended to read:

128553. (a) Program applicants shall possess a current valid license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act.

(b) The department shall develop guidelines using the criteria specified in subdivision (c) for selection and placement of applicants. The department shall interpret the guidelines to apply to both osteopathic and allopathic physicians and surgeons.

(c) The guidelines shall meet all of the following criteria:

(1) Provide priority consideration to applicants that are best suited to meet the cultural and linguistic needs and demands of patients from medically underserved populations and who meet one or more of the following criteria:

(A) Speak a Medi-Cal threshold language.

(B) Come from an economically disadvantaged background.

(C) Have received significant training in cultural and linguistically appropriate service delivery.

(D) Have three years of experience providing health care services to medically underserved populations or in a medically underserved area, as defined in subdivision (e) of Section 128552.

(E) Have recently obtained a license to practice medicine.

(2) Include a process for determining the needs for physician services identified by the practice setting and for ensuring that the practice setting meets the definition specified in subdivision (h) of Section 128552.

(3) Give preference to applicants who have completed a three-year residency in a primary specialty.

(4) Give preference to applicants who agree to practice in a medically underserved area, as defined in subdivision (e) of Section 128552, and who agree to serve a medically underserved population.

(5) Give priority consideration to applicants from rural communities who agree to practice in a physician owned and operated medical practice setting as defined in paragraph (2) of subdivision (i) of Section 128552.

(6) Include a factor ensuring geographic distribution of placements.

(7) Provide priority consideration to applicants who agree to practice in a geriatric care setting and are trained in geriatrics, and who can meet the cultural and linguistic needs and demands of a diverse population of older Californians. On and after January 1, 2009, up to 15 percent of the funds collected pursuant to Section 2436.5 of the Business and Professions Code shall be dedicated to loan assistance for physicians and surgeons who agree to practice in geriatric care settings or settings that primarily serve adults over the age of 65 years or adults with disabilities.

(d) (1) The department may appoint a selection committee that provides policy direction and guidance over the program and that complies with the requirements of subdivision (l) of Section 128552.

(2) The department may award up to 20 percent of the available positions to program applicants from specialties outside of the primary care specialties.

(e) Program participants shall meet all of the following requirements:

(1) Shall be working in or have a signed agreement with an eligible practice setting.

(2) Shall have full-time status at the practice setting. Full-time status shall be defined by the department and the department may establish exemptions from this requirement on a case-by-case basis.

(3) Shall commit to a minimum of three years of service in a medically underserved area. Leaves of absence shall be permitted for serious illness, pregnancy, or other natural causes. The department shall develop the process for determining the maximum permissible length of an absence and the process for reinstatement. Loan repayment shall be deferred until the physician is back to full-time status.

(f) The department shall adopt a process that applies if a physician is unable to complete their three-year obligation.

(g) The department, in consultation with those identified in subdivision (b) of Section 128551, shall develop a process for outreach to potentially eligible applicants.

(h) The department may adopt any other standards of eligibility, placement, and termination appropriate to achieve the aim of providing competent health care services in approved practice settings.

SEC. 188. Section 128554 of the Health and Safety Code is repealed.

SEC. 189. Section 128555 of the Health and Safety Code is amended to read:

128555. (a) The Medically Underserved Account for Physicians is hereby established within the Health Professions Education Fund. The primary purpose of this account is to provide funding for the ongoing operations of the Steven M. Thompson Physician

Corps Loan Repayment Program provided for under this article. This account also may be used to provide funding for the Physician Volunteer Program provided for under this article.

(b) All moneys in the Medically Underserved Account contained within the Contingent Fund of the Medical Board of California shall be transferred to the Medically Underserved Account for Physicians on July 1, 2006.

(c) Funds in the account shall be used to repay loans as follows per agreements made with physicians:

(1) Funds paid out for loan repayment may have a funding match from foundations or other private sources.

(2) Loan repayments may not exceed one hundred five thousand dollars ($105,000) per individual licensed physician.

(3) Loan repayments may not exceed the amount of the educational loans incurred by the physician participant.

(d) Notwithstanding Section 11105 of the Government Code, effective January 1, 2006, the department may seek and receive matching funds from foundations and private sources to be placed in the account. “Matching funds” shall not be construed to be limited to a dollar-for-dollar match of funds.

(e) Funds placed in the account for purposes of this article, including funds received pursuant to subdivision (d), are, notwithstanding Section 13340 of the Government Code, continuously appropriated for the repayment of loans. This subdivision shall not apply to funds placed in the account pursuant to Section 1341.45 and Section 14197.2 of the Welfare and Institutions Code.

(f) The account shall also be used to pay for the cost of administering the program and for any other purpose authorized by this article. The costs for administration of the program may be up to 5 percent of the total state appropriation for the program and shall be subject to review and approval annually through the state budget process. This limitation shall only apply to the state appropriation for the program.

(g) The department shall manage the account established by this section prudently in accordance with the other provisions of law.

SEC. 190. Section 128556 of the Health and Safety Code is amended to read:

128556. The terms of loan repayment granted under this article shall be established by the department.

SEC. 191. Section 128557 of the Health and Safety Code is repealed.

SEC. 192. Article 6 (commencing with Section 128560) of Chapter 5 of Part 3 of Division 107 of the Health and Safety Code is repealed.

SEC. 193. Part 4 (commencing with Section 128600) of Division 107 of the Health and Safety Code is repealed.

SEC. 194. Section 128681 of the Health and Safety Code is repealed.

SEC. 195. Section 128690 of the Health and Safety Code is amended to read:

128690. Intermediate care facilities/developmentally disabled—nursing, as defined in subdivision (h) of Section 1250, and intermediate care facilities/developmentally disabled-continuous nursing, as defined in subdivision (m) of Section 1250, are not subject to this chapter.

SEC. 196. Section 128700 of the Health and Safety Code is amended to read:

128700. As used in this chapter, the following terms mean:

(a) “Ambulatory surgery procedures” mean those procedures performed on an outpatient basis in the general operating rooms, ambulatory surgery rooms, endoscopy units, or cardiac catheterization laboratories of a hospital or a freestanding ambulatory surgery clinic.

(b) “Emergency department” means, in a hospital licensed to provide emergency medical services, the location in which those services are provided.

(c) “Encounter” means a face-to-face contact between a patient and the provider who has primary responsibility for assessing and treating the condition of the patient at a given contact and exercises independent judgment in the care of the patient.

(d) “Freestanding ambulatory surgery clinic” means a surgical clinic that is licensed by the state under paragraph (1) of subdivision (b) of Section 1204.

(e) “Health facility” or “health facilities” means all health facilities required to be licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2.

(f) “Hospital” means all health facilities except skilled nursing, intermediate care, congregate living, and hospice health facilities.

(g) “Department” means the Department of Health Care Access and Information.

(h) “Risk-adjusted outcomes” means the clinical outcomes of patients grouped by diagnoses or procedures that have been adjusted for demographic and clinical factors.

SEC. 197. Section 128705 of the Health and Safety Code is amended to read:

128705. On and after January 1, 1986, any reference in this code to the Advisory Health Council or the California Health Policy and Data Advisory Commission shall be deemed a reference to the department.

SEC. 198. Section 128730 of the Health and Safety Code is amended to read:

128730. (a) Effective January 1, 1986, the department shall be the single state agency designated to collect the following health facility or clinic data for use by all state agencies:

(1) Data required by the department pursuant to Section 127285.

(2) Data required in the Medi-Cal cost reports pursuant to Section 14170 of the Welfare and Institutions Code.

(3) Data items formerly required by the California Health Facilities Commission that are listed in Sections 128735 and 128740. Information collected pursuant to subdivision (g) of Section 128735 and Sections 128736 and 128737 shall be made available to the State Department of Health Care Services, the State Department of Public Health, and the California Health Benefit Exchange. The departments and the Exchange shall ensure that the patient’s rights to confidentiality shall not be violated in any manner. The departments and the Exchange shall comply with all applicable policies and requirements involving review and oversight by the State Committee for the Protection of Human Subjects.

(b) The department shall consolidate any and all of the reports listed under this section or Sections 128735 and 128740, to the extent feasible, to minimize the reporting burdens on hospitals, provided, however, that the department shall neither add nor delete data items from the Hospital Discharge Abstract Data Record or the quarterly reports without prior authorizing legislation, unless specifically required by federal law or regulation or judicial decision.

(c) The Exchange shall report to the Governor and the Legislature on or before August 1, 2023, on the impacts to the Exchange associated with paragraph (3) of subdivision (a), including the impacts on premium rates for health plans offered through the Exchange. The report shall be submitted in compliance with Section 9795 of the Government Code.

SEC. 199. Section 128734 of the Health and Safety Code is amended to read:

128734. (a) Each organization that operates, conducts, owns, or maintains a skilled nursing facility licensed pursuant to subdivision (c) of Section 1250 shall file with the department as part of the information required in subdivisions (a) to (e), inclusive, of Section 128735, whether the licensee, or a general partner, director, or officer of the licensee, has an ownership or control interest of 5 percent or more in a related party that provides any service to the skilled nursing facility. If the licensee, or the general partner, director, or officer of the licensee has such an interest, the licensee shall disclose all services provided to the skilled nursing facility, the number of individuals who provide that service at the skilled nursing facility, and any other information requested by the department. If goods, fees, and services collectively worth ten thousand dollars ($10,000) or more per year are delivered to the skilled nursing facility, the disclosure required pursuant to this subdivision shall include the related party’s profit and loss statement, and the Payroll-Based Journal public use data of the previous quarter for the skilled nursing facility’s direct caregivers.

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

(1) “Direct caregiver” shall have the same meaning as that term is defined in Section 1276.65.

(2) “Profit and loss statement” means the most recent annual statement on profits and losses finalized by a related party for the most recent year available.

(3) “Related party” means an organization related to the licensee provider or that is under common ownership or control, as defined in Section 413.17(b) of Title 42 of the Code of Federal Regulations.

(c) Current licensees shall provide the information required by this section to the department in a manner prescribed by the department.

(d) The provisions of this section shall become effective on January 1, 2020.

SEC. 200. Section 128735 of the Health and Safety Code is amended to read:

128735. An organization that operates, conducts, owns, or maintains a health facility, and the officers thereof, shall make and file with the department, at the times as the department shall require, all of the following reports on forms specified by the department that are in accord, if applicable, with the systems of accounting and uniform reporting required by this part, except that the reports required pursuant to subdivision (g) shall be limited to hospitals:

(a) A balance sheet detailing the assets, liabilities, and net worth of the health facility at the end of its fiscal year.

(b) A statement of income, expenses, and operating surplus or deficit for the annual fiscal period, and a statement of ancillary utilization and patient census.

(c) A statement detailing patient revenue by payer, including, but not limited to, Medicare, Medi-Cal, and other payers, and revenue center.

(d) A statement of cashflows, including, but not limited to, ongoing and new capital expenditures and depreciation.

(e) (1) A statement reporting the information required in subdivisions (a), (b), (c), and (d) for each separately licensed health facility operated, conducted, or maintained by the reporting organization.

(2) Notwithstanding paragraph (1), a health facility that receives a preponderance of its revenue from associated comprehensive group practice prepayment health care service plans and that is operated as a unit of a coordinated group of health facilities under common management may report the information required pursuant to subdivisions (a) and (d) for the group and not for each separately licensed health facility.

(f) Data reporting requirements established by the department shall be consistent with national standards, as applicable.

(g) A Hospital Discharge Abstract Data Record that includes all of the following:

(1) Date of birth.

(2) Sex.

(3) Race.

(4) ZIP Code.

(5) Preferred language spoken.

(6) Patient social security number, if it is contained in the patient’s medical record.

(7) Prehospital care and resuscitation, if any, including all of the following:

(A) “Do not resuscitate” (DNR) order on admission.

(B) “Do not resuscitate” (DNR) order after admission.

(8) Admission date.

(9) Source of admission.

(10) Type of admission.

(11) Discharge date.

(12) Principal diagnosis and whether the condition was present on admission.

(13) Other diagnoses and whether the conditions were present on admission.

(14) External causes of morbidity and whether present on admission.

(15) Principal procedure and date.

(16) Other procedures and dates.

(17) Total charges.

(18) Disposition of patient.

(19) Expected source of payment.

(20) Elements added pursuant to Section 128738.

(h) It is the intent of the Legislature that the patient's rights of confidentiality shall not be violated in any manner. Patient social security numbers and other data elements that the department believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(i) A person reporting data pursuant to this section shall not be liable for damages in an action based on the use or misuse of patient-identifiable data that has been mailed or otherwise transmitted to the department pursuant to the requirements of subdivision (g).

(j) A hospital shall use coding from the International Classification of Diseases in reporting diagnoses and procedures.

(k) On or before July 1, 2021, the department shall promulgate regulations as necessary to implement subdivision (e). A health facility that receives a preponderance of its revenue from associated comprehensive group practice prepayment health care service plans and that is operated as a unit of a coordinated group of health facilities under common management shall comply with the reporting requirements of subdivisions (b), (c), and (e) once the department finalizes related regulations.

SEC. 201. Section 128736 of the Health and Safety Code is amended to read:

128736. (a) Each hospital shall file an Emergency Care Data Record for each patient encounter in a hospital emergency department. The Emergency Care Data Record shall include all of the following:

(1) Date of birth.

(2) Sex.

(3) Race.

(4) Ethnicity.

(5) Preferred language spoken.

(6) ZIP Code.

(7) Patient social security number, if it is contained in the patient's medical record.

(8) Service date.

(9) Principal diagnosis.

(10) Other diagnoses.

(11) External causes of morbidity.

(12) Principal procedure.

(13) Other procedures.

(14) Disposition of patient.

(15) Expected source of payment.

(16) Elements added pursuant to Section 128738.

(b) It is the expressed intent of the Legislature that the patient's rights of confidentiality shall not be violated in any manner. Patient social security numbers and any other data elements that the department believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(c) No person reporting data pursuant to this section shall be liable for damages in any action based on the use or misuse of patient-identifiable data that has been mailed or otherwise transmitted to the department pursuant to the requirements of

subdivision (a).

(d) Data reporting requirements established by the department shall be consistent with national standards as applicable.

(e) This section shall become operative on January 1, 2004.

SEC. 202. Section 128737 of the Health and Safety Code is amended to read:

128737. (a) Each general acute care hospital and freestanding ambulatory surgery clinic shall file an Ambulatory Surgery Data Record for each patient encounter during which at least one ambulatory surgery procedure is performed. The Ambulatory Surgery Data Record shall include all of the following:

(1) Date of birth.

(2) Sex.

(3) Race.

(4) Ethnicity.

(5) Preferred language spoken.

(6) ZIP Code.

(7) Patient social security number, if it is contained in the patient's medical record.

(8) Service date.

(9) Principal diagnosis.

(10) Other diagnoses.

(11) Principal procedure.

(12) Other procedures.

(13) External causes of morbidity.

(14) Disposition of patient.

(15) Expected source of payment.

(16) Elements added pursuant to Section 128738.

(b) It is the expressed intent of the Legislature that the patient's rights of confidentiality shall not be violated in any manner. Patient social security numbers and any other data elements that the department believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(c) No person reporting data pursuant to this section shall be liable for damages in any action based on the use or misuse of patient-identifiable data that has been mailed or otherwise transmitted to the office pursuant to the requirements of subdivision (a).

(d) Data reporting requirements established by the department shall be consistent with national standards as applicable.

(e) This section shall become operative on January 1, 2004.

SEC. 203. Section 128738 of the Health and Safety Code is amended to read:

128738. (a) The department shall allow and provide for, in accordance with appropriate regulations, additions or deletions to the patient level data elements listed in subdivision (g) of Section 128735, Section 128736, and Section 128737, to meet the purposes of this chapter.

(b) Prior to any additions or deletions, all of the following shall be considered:

(1) Utilization of sampling to the maximum extent possible.

(2) Feasibility of collecting data elements.

(3) Costs and benefits of collection and submission of data.

(4) Exchange of data elements as opposed to addition of data elements.

(c) The department shall add no more than a net of 15 elements to each data set over any five-year period. Elements contained in the uniform claims transaction set or uniform billing form required by the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg) shall be exempt from the 15-element limit.

(d) The department, in order to minimize costs and administrative burdens, shall consider the total number of data elements required from hospitals and freestanding ambulatory surgery clinics, and optimize the use of common data elements.

SEC. 204. Section 128740 of the Health and Safety Code is amended to read:

128740. (a) The following summary financial and utilization data shall be reported to the department by a hospital within 45 days of the end of a calendar quarter. Adjusted reports reflecting changes as a result of audited financial statements may be filed within four months of the close of the hospital's fiscal or calendar year. The quarterly summary financial and utilization data shall conform to the uniform description of accounts as contained in the Accounting and Reporting Manual for California Hospitals and shall include all of the following:

(1) Number of licensed beds.

(2) Average number of available beds.

(3) Average number of staffed beds.

(4) Number of discharges.

(5) Number of inpatient days.

(6) Number of outpatient visits.

(7) Total operating expenses.

(8) Total inpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(9) Total outpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(10) Deductions from revenue in total and by component, including the following: Medicare contractual adjustments, Medi-Cal contractual adjustments, and county indigent program contractual adjustments, other contractual adjustments, bad debts, charity care, restricted donations and subsidies for indigents, support for clinical teaching, teaching allowances, and other deductions.

(11) Total capital expenditures.

(12) Total net fixed assets.

(13) Total number of inpatient days, outpatient visits, and discharges by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, self-pay, charity, and other payers.

(14) Total net patient revenues by payer including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(15) Other operating revenue.

(16) Nonoperating revenue net of nonoperating expenses.

(b) The department shall make available at cost, to any person, a hard copy of any hospital report made pursuant to this section and in addition to hard copies, shall make available at cost, a computer tape of all reports made pursuant to this section within 105 days of the end of every calendar quarter.

(c) The department shall adopt by regulation guidelines for the identification, assessment, and reporting of charity care services. In establishing the guidelines, the department shall consider the principles and practices recommended by professional health care industry accounting associations for differentiating between charity services and bad debts. The department shall further conduct the onsite validations of health facility accounting and reporting procedures and records as are necessary to assure that reported data are consistent with regulatory guidelines.

SEC. 205. Section 128745 of the Health and Safety Code is amended to read:

128745. (a) Commencing July 1993, and annually thereafter, the department shall publish risk-adjusted outcome reports in accordance with the following schedule:

Publication Date	Period Covered	Procedures and Conditions Covered
July 1993	1988–90	3
July 1994	1989–91	6
July 1995	1990–92	9

Reports for subsequent years shall include conditions and procedures and cover periods as appropriate.

(b) The procedures and conditions for risk-adjusted outcome reports pursuant to subdivision (a) shall be divided among medical, surgical, and obstetric conditions or procedures and shall be selected by the department. The department shall publish the risk-adjusted outcome reports for selected conditions and procedures by individual hospital, individual medical group, or individual physician as selected by the department in consultation with medical specialists in the relevant area of practice. The selections, under this subdivision, shall be in accordance with all of the following criteria:

(1) The patient discharge abstract contains sufficient data to undertake a valid risk adjustment. The risk adjustment report shall ensure that public hospitals and other hospitals serving primarily low-income patients are not unfairly discriminated against.

(2) The relative importance of the procedure and condition in terms of the cost of cases and the number of cases and the seriousness of the health consequences of the procedure or condition.

(3) Ability to measure outcome and the likelihood that care influences outcome.

(4) Reliability of the diagnostic and procedure data.

(c) (1) In addition to any other established and pending reports, on or before July 1, 2002, the department shall publish a risk-adjusted outcome report for coronary artery bypass graft surgery by hospital for all hospitals opting to participate in the report. This report shall be updated on or before July 1, 2003.

(2) The department shall publish at least one risk-adjusted outcome report for coronary artery bypass graft surgery, transcatheter aortic valve replacement, or any type of interventional cardiovascular procedure for procedures performed in the state. For any type of interventional cardiovascular procedure other than coronary artery bypass graft surgery or transcatheter aortic valve replacement, the department shall only select from interventional cardiovascular procedures recommended by the clinical panel established by Section 128748, not to exceed one additional interventional cardiovascular procedure every three years. In each year, the reports shall compare risk-adjusted outcomes by hospital, medical group, or physician as selected by the department after consultation with the clinical panel. Upon the recommendation of the clinical panel based on statistical and technical considerations, information on individual hospitals, individual medical groups, or individual physicians may be excluded from the reports.

(3) Each hospital shall produce and file with the department, at the times as the department shall require, reports of data the department needs to prepare risk-adjusted outcome reports under this subdivision. Unless otherwise recommended by the clinical panel established by Section 128748, the department shall continue to collect the same data used for the most recent risk-adjusted model developed for the California Coronary Artery Bypass Graft Outcomes Reporting Program. Upon recommendation of the clinical panel, the department may add any clinical data elements included in the Society of Thoracic Surgeons' database or other relevant databases to be collected from hospitals. Prior to any additions from the Society of Thoracic Surgeons' database, or other relevant databases, the following factors shall be considered:

(A) Utilization of sampling to the maximum extent possible.

(B) Exchange of data elements as opposed to addition of data elements.

(4) Upon recommendation of the clinical panel, the department may add, delete, or revise clinical data elements to be collected from hospitals for outcome reports under this subdivision. Prior to any additions or deletions, all of the following factors shall be considered:

(A) Utilization of sampling to the maximum extent possible.

(B) Feasibility of collecting data elements.

(C) Costs and benefits of collection and submission of data.

(D) Exchange of data elements as opposed to addition of data elements.

(5) The department shall collect the minimum data necessary for purposes of testing or validating a risk-adjusted model for the outcome reports under this subdivision.

(6) Patient medical record numbers and any other data elements that the department believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(d) The annual reports shall compare the risk-adjusted outcomes experienced by all patients treated for the selected conditions and procedures in each California hospital during the period covered by each report, to the outcomes expected. Outcomes shall be reported in at least the following groupings for each hospital, medical group, or physician:

(1) “Higher than average outcomes,” for hospitals with risk-adjusted outcomes higher than the norm.

(2) “Average outcomes,” for hospitals with average risk-adjusted outcomes.

(3) “Lower than average outcomes,” for hospitals with risk-adjusted outcomes lower than the norm.

(e) For outcome reports under this subdivision for which auditing is appropriate, the department shall conduct periodic auditing of data at hospitals.

(f) The department shall either include in the annual reports required under this section, or make separately available at cost to any person requesting it, risk-adjusted outcomes data assessing the statistical significance of hospital, medical group, or physician data at each of the following three levels: 99-percent confidence level (0.01 p-value), 95-percent confidence level (0.05 p-value), and 90-percent confidence level (0.10 p-value). The department shall include any other analysis or comparisons of the data in the annual reports required under this section that the department deems appropriate to further the purposes of this chapter.

SEC. 206. Section 128747 of the Health and Safety Code is amended to read:

128747. Commencing July 1, 2002, and biennially thereafter, the department shall evaluate the impact of the department’s published risk-adjusted outcome reports required by Section 128745 on mortality rates in California and on any other measure of quality the department deems appropriate. The department shall also coordinate with other state agencies in promoting prevention and educational initiatives on those reported procedures and conditions.

SEC. 207. Section 128748 of the Health and Safety Code is amended to read:

128748. (a) This section shall apply to any risk-adjusted outcome report under Section 128745.

(b) This subdivision applies to risk-adjusted outcome reports under subdivision (c) of Section 128745.

(1) The department shall obtain data necessary to complete a risk-adjusted outcome report from hospitals. If necessary data for an outcome report is available only from the department of a physician and not the hospital where the patient received treatment, then the hospital shall make a reasonable effort to obtain the data from the physician’s office and provide the data to the department. In the event that the department finds any errors, omissions, discrepancies, or other problems with submitted data, the department shall contact either the hospital or physician’s office that maintains the data to resolve the problems.

(2) The department shall collect the minimum data necessary for purposes of testing or validating a risk-adjusted model. Except for data collected for purposes of testing or validating a risk-adjusted model, the department shall not collect data for an outcome report nor issue an outcome report until the clinical panel established pursuant to this section has approved the risk-adjusted model.

(c) For each risk-adjusted outcome report on a medical, surgical, or obstetric condition or procedure that includes reporting of data by an individual physician or an individual medical group authorized by subdivision (b) of Section 128745, the department director shall appoint a clinical panel, which shall have nine members. Three members shall be appointed from a list of three or more names submitted by the physician specialty society that most represents physicians performing the medical, surgical, and obstetric procedure for which data is collected. Three members shall be appointed from a list of three or more names submitted by the California Medical Association. Three members shall be appointed from lists of names submitted by consumer organizations. At least one-half of the appointees from the lists submitted by the physician specialty society and the California Medical Association, and at least one appointee from the lists submitted by consumer organizations, shall be experts in collecting

and reporting outcome measurements for physicians, medical groups, or hospitals. The panel may include physicians from another state. The panel shall review and approve the development of the risk-adjustment model to be used in preparation of the outcome report.

(d) For risk-adjusted outcome reports authorized by subdivision (c) of Section 128745 the following shall apply:

(1) The California Coronary Artery Bypass Graft Outcomes Reporting Program Clinical Advisory Panel shall become the clinical panel for those outcome reports and this panel shall be renamed by the department.

(2) This clinical panel shall be comprised of at least 9 and no more than 13 members. The department director shall have the authority to appoint the members of the clinical panel. Three members shall be appointed from a list of three or more names submitted by the California Chapter of the American College of Cardiology. Three members shall be appointed from a list of three or more names submitted by the California Medical Association. Three members shall be appointed from lists of names submitted by consumer organizations. Any additional members shall be appointed at the discretion of the department director. If, at the time the department decides to report on a procedure, the panel does not have members with expertise in that procedure, the department shall seek to appoint two new members with expertise in that procedure from a list submitted by the California Chapter of the American College of Cardiology. At least one-half of the appointees from the lists submitted by the California Chapter of the American College of Cardiology, and the California Medical Association, and at least one appointee from the lists submitted by consumer organizations, shall be experts in collecting and reporting outcome measurements. The panel may include physicians from another state.

(3) The panel shall review and approve the development of the risk-adjustment model to be used in preparation of the outcome report.

(e) Any report that includes reporting by an individual physician shall include, at a minimum, the risk-adjusted outcome data for each physician. The department may also include in the report, after consultation with the clinical panel, any explanatory material, comparisons, groupings, and other information to facilitate consumer comprehension of the data.

(f) Members of a clinical panel shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the clinical panel.

SEC. 208. Section 128750 of the Health and Safety Code is amended to read:

128750. (a) Prior to the public release of the annual outcome reports, the department shall furnish a preliminary report to each hospital that is included in the report. The department shall allow the hospital and chief of staff 60 days to review the outcome scores and compare the scores to other California hospitals. A hospital or its chief of staff that believes that the risk-adjusted outcomes do not accurately reflect the quality of care provided by the hospital may submit a statement to the department, within the 60 days, explaining why the outcomes do not accurately reflect the quality of care provided by the hospital. The statement shall be included in an appendix to the public report, and a notation that the hospital or its chief of staff has submitted a statement shall be displayed wherever the report presents outcome scores for the hospital.

(b) (1) Prior to the public release of any outcome report that includes data by a physician or medical group, the department shall furnish a preliminary report to each physician or medical group that is included in the report. The department shall allow the physician or medical group 30 days from the date the department sends the report to the physician or medical group to review the outcome scores and compare the scores to other California physicians or medical groups, respectively. A physician or medical group that believes that the risk-adjusted outcome does not accurately reflect the quality of care provided by the physician or medical group may submit a statement to the department within the 30 days, explaining why the outcomes do not accurately reflect the quality of care provided by the physician or medical group.

(2) The department shall promptly review the statement and shall respond to the physician or medical group with one of the following conclusions:

(A) The statement reveals a flaw in the accuracy of the reported data relating to the physician or medical group that materially diminishes the validity of the report. If this finding is made, the data for that physician or medical group shall not be included in the report until the flaw in the data is corrected.

(B) The statement reveals a flaw in the risk-adjustment model that materially diminishes the value of the report for all physicians or medical groups. If this finding is made, the report using that risk-adjustment model shall not be issued until the flaw is corrected.

(C) The statement does not reveal a flaw in either the accuracy of the reported data relating to the physician or medical group, or the risk-adjustment model in which case the report shall be used, unless the physician or medical group chooses to use the procedure set forth in paragraph (3).

(3) If a physician or medical group is not satisfied with the conclusion reached by the department, the physician or medical group shall notify the department of that fact. Upon receipt of the notice, the department shall forward the statement to the appropriate clinical panel appointed pursuant to Section 128748. The department shall forward the statement with any information identifying the physician or medical group or the hospital of the physician or medical group redacted, or shall adopt other means to ensure the physician or medical group's identity is not revealed to the panel. The clinical panel shall promptly review the statement and the conclusion of the office and shall respond by either upholding the conclusion or reaching one of the other conclusions set forth in this subdivision. The panel decision shall be the final determination regarding the statement. The process set forth in this subdivision shall be completed within 60 days from the date the department sends the report to each physician or medical group included in the report. If a decision by either the department or the clinical panel cannot be reached within the 60-day period, then the outcome report may be issued but shall not include data for the physician or medical group submitting the statement.

(c) The department shall, in addition to public reports, provide hospitals and the chiefs of staff of the medical staffs with a report containing additional detailed information derived from data summarized in the public outcome reports as an aid to internal quality assurance.

(d) If, pursuant to the recommendations of the department, the Legislature subsequently amends Section 128735 to authorize the collection of additional discharge data elements, then the outcome reports for conditions and procedures for which sufficient data is not available from the current abstract record will be produced following the collection and analysis of the additional data elements.

(e) The recommendations of the department for the addition of data elements to the discharge abstract should take into consideration the technical feasibility of developing reliable risk-adjustment factors for additional procedures and conditions as determined by the department with the advice of the research community, physicians and surgeons, hospitals, consumer or patient advocacy groups, and medical records personnel.

(f) The department at a minimum shall identify a limited set of core clinical data elements to be collected for all of the selected procedures and conditions and unique clinical variables necessary for risk adjustment of specific conditions and procedures selected for the outcomes report program. In addition, the department should give careful consideration to the costs associated with the additional data collection and the value of the specific information to be collected.

(g) The department shall also engage in a continuing process of data development and refinement applicable to both current and prospective outcome studies.

SEC. 209. Section 128755 of the Health and Safety Code is amended to read:

128755. (a) (1) Hospitals shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 with the department within four months after the close of the hospital's fiscal year except as provided in paragraph (2).

(2) If a licensee relinquishes the facility license or puts the facility license in suspense, the last day of active licensure shall be deemed a fiscal year end.

(3) The department shall make the reports filed pursuant to this subdivision available no later than three months after they were filed.

(b) (1) Skilled nursing facilities, intermediate care facilities, intermediate care facilities/developmentally disabled, hospice facilities, and congregate living facilities, including nursing facilities certified by the State Department of Health Care Services to participate in the Medi-Cal program, shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 with the department within four months after the close of the facility's fiscal year, except as provided in paragraph (2).

(2) (A) If a licensee relinquishes the facility license or puts the facility licensure in suspense, the last day of active licensure shall be deemed a fiscal year end.

(B) If a fiscal year end is created because the facility license is relinquished or put in suspense, the facility shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 within two months after the last day of active licensure.

(3) The department shall make the reports filed pursuant to paragraph (1) available not later than three months after they are filed.

(4) (A) Effective for fiscal years ending on or after December 31, 1991, the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 shall be filed with the department by electronic media, as determined by the department.

(B) Congregate living health facilities are exempt from the electronic media reporting requirements of subparagraph (A).

(c) A hospital shall file the reports required by subdivision (g) of Section 128735 as follows:

(1) For patient discharges on or after January 1, 1999, through December 31, 1999, the reports shall be filed semiannually by each hospital or its designee not later than six months after the end of each semiannual period, and shall be available from the department no later than six months after the date that the report was filed.

(2) For patient discharges on or after January 1, 2000, through December 31, 2000, the reports shall be filed semiannually by each hospital or its designee not later than three months after the end of each semiannual period. The reports shall be filed by electronic tape, diskette, or similar medium as approved by the department. The department shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the department, it shall not be approved as filed and shall be rejected. The report shall be considered not filed as of the date the facility is notified that the report is rejected. A report shall be available from the department no later than 15 days after the date that the report is approved.

(3) For patient discharges on or after January 1, 2001, the reports shall be filed by each hospital or its designee for report periods and at times determined by the department. The reports shall be filed by online transmission in formats consistent with national standards for the exchange of electronic information. The department shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the department, it shall not be approved as filed and shall be rejected. The report shall be considered not filed as of the date the facility is notified that the report is rejected. A report shall be available from the department no later than 15 days after the date that the report is approved.

(d) The reports required by subdivision (a) of Section 128736 shall be filed by each hospital for report periods and at times determined by the department. The reports shall be filed by online transmission in formats consistent with national standards for the exchange of electronic information. The department shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the department, it shall not be approved as filed and shall be rejected. The report shall be considered not filed as of the date the facility is notified that the report is rejected. A report shall be available from the department no later than 15 days after the report is approved.

(e) The reports required by subdivision (a) of Section 128737 shall be filed by each hospital or freestanding ambulatory surgery clinic for report periods and at times determined by the department. The reports shall be filed by online transmission in formats consistent with national standards for the exchange of electronic information. The department shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the department, it shall not be approved as filed and shall be rejected. The report shall be considered not filed as of the date the facility is notified that the report is rejected. A report shall be available from the department no later than 15 days after the report is approved.

(f) Facilities shall not be required to maintain a full-time electronic connection to the office for the purposes of online transmission of reports as specified in subdivisions (c), (d), and (e). The department may grant exemptions to the online transmission of data requirements for limited periods to facilities. An exemption may be granted only to a facility that submits a written request and documents or demonstrates a specific need for an exemption. Exemptions shall be granted for no more than one year at a time, and for no more than a total of five consecutive years.

(g) The reports referred to in paragraph (2) of subdivision (a) of Section 128730 shall be filed with the department on the dates required by applicable law and shall be available from the department no later than six months after the date that the report was filed.

(h) The department shall post on its internet website and make available to any person a copy of any report referred to in subdivision (a), (b), (c), (d), or (g) of Section 128735, subdivision (a) of Section 128736, subdivision (a) of Section 128737, Section 128740, and, in addition, shall make available in electronic formats reports referred to in subdivision (a), (b), (c), (d), or (g) of Section 128735, subdivision (a) of Section 128736, subdivision (a) of Section 128737, Section 128740, and subdivisions (a) and (c) of Section 128745, unless the department determines that an individual patient’s rights of confidentiality would be violated. The department shall make the reports available at cost.

SEC. 210. Section 128760 of the Health and Safety Code is amended to read:

128760. (a) On and after January 1, 1986, the systems of health facility accounting and auditing formerly approved by the California Health Facilities Commission shall remain in full force and effect for use by health facilities, but shall be maintained by the department.

(b) The department shall allow and provide, in accordance with appropriate regulations, for modifications in the accounting and reporting systems for use by health facilities in meeting the requirements of this chapter if the modifications are necessary to do any of the following:

(1) To correctly reflect differences in size of, provision of, or payment for, services rendered by health facilities.

(2) To correctly reflect differences in scope, type, or method of provision of, or payment for, services rendered by health facilities.

(3) To avoid unduly burdensome costs for those health facilities in meeting the requirements of differences pursuant to paragraphs (1) and (2).

(c) The department shall allow and provide, in accordance with appropriate regulations, for modifications to discharge data reporting format and frequency requirements if these modifications will not impair the department's ability to process the data or interfere with the purposes of this chapter. This modification authority shall not permit the department to administratively require the reporting of discharge data items not specified pursuant to Section 128735.

(d) The department shall allow and provide, in accordance with appropriate regulations, for modifications to emergency care data reporting format and frequency requirements if these modifications will not impair the department's ability to process the data or interfere with the purposes of this chapter. This modification authority shall not permit the department to require administratively the reporting of emergency care data items not specified in subdivision (a) of Section 128736.

(e) The department shall allow and provide, in accordance with appropriate regulations, for modifications to ambulatory surgery data reporting format and frequency requirements if these modifications will not impair the department's ability to process the data or interfere with the purposes of this chapter. The modification authority shall not permit the department to require administratively the reporting of ambulatory surgery data items not specified in subdivision (a) of Section 128737.

(f) The department shall adopt comparable modifications to the financial reporting requirements of this chapter for county hospital systems consistent with the purposes of this chapter.

SEC. 211. Section 128765 of the Health and Safety Code is amended to read:

128765. (a) The department shall maintain a file of all the reports filed under this chapter at its Sacramento office. Subject to any rules the department may prescribe, these reports shall be produced and made available for inspection upon the demand of any person, and shall also be posted on its internet website with the exception of discharge and encounter data that shall be available for public inspection unless the department determines, pursuant to applicable law, that an individual patient's rights of confidentiality would be violated.

(b) The reports published pursuant to Section 128745 shall include an executive summary, written in plain English to the maximum extent practicable, that shall include, but not be limited to, a discussion of findings, conclusions, and trends concerning the overall quality of medical outcomes, including a comparison to reports from prior years, for the procedure or condition studied by the report. The department shall disseminate the reports as widely as practical to interested parties, including, but not limited to, hospitals, providers, the media, purchasers of health care, consumer or patient advocacy groups, and individual consumers. The reports shall be posted on the department's internet website.

(c) Copies certified by the department as being true and correct copies of reports properly filed with the department pursuant to this chapter, together with summaries, compilations, or supplementary reports prepared by the department, shall be introduced as evidence, where relevant, at any hearing, investigation, or other proceeding held, made, or taken by any state, county, or local governmental agency, board, or commission that participates as a purchaser of health facility services pursuant to the provisions of a publicly financed state or federal health care program. Each of these state, county, or local governmental agencies, boards, and commissions shall weigh and consider the reports made available to it pursuant to this subdivision in its formulation and implementation of policies, regulations, or procedures regarding reimbursement methods and rates in the administration of these publicly financed programs.

(d) The department shall compile and publish summaries of individual facility and aggregate data that do not contain patient-specific information for the purpose of public disclosure. Upon request, these shall include summaries of observation services data, in a format prescribed by the department. The summaries shall be posted on the department's internet website. The department may initiate and conduct studies as it determines will advance the purposes of this chapter.

(e) In order to ensure that accurate and timely data are available to the public in useful formats, the department shall establish a public liaison function. The public liaison shall provide technical assistance to the general public on the uses and applications of individual and aggregate health facility data and shall provide the director with an annual report on changes that can be made to improve the public's access to data.

SEC. 212. Section 128766 of the Health and Safety Code is amended to read:

128766. (a) Notwithstanding Section 128765 or any other provision of law, the department, upon request, shall disclose information collected pursuant to subdivision (g) of Section 128735 and Sections 128736 and 128737, to any California hospital and any local health department or local health officer in California as set forth in Part 3 (commencing with Section 101000) of

Division 101. The department shall disclose this same information to the United States Department of Health and Human Services or any of its subsidiary agencies, including the National Center for Health Statistics or any other unit of the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the Health Resources and Services Administration, the Indian Health Service, Tribal Epidemiology Centers, which are defined as public health authorities pursuant to the federal Indian Health Care Improvement Act (25 U.S.C. Sec. 1601 et seq.), the National Institutes of Health, or the National Cancer Institute, or the Veterans Health Care Administration within the United States Department of Veterans Affairs, for the purposes of conducting a statutorily authorized activity. All disclosures made pursuant to this section shall be consistent with the standards and limitations applicable to the disclosure of limited data sets as provided in Section 164.514 of Part 164 of Title 45 of the Code of Federal Regulations, relating to the privacy of health information.

(b) Any hospital that receives information pursuant to this section shall not disclose that information to any person or entity, except in response to a court order, search warrant, or subpoena, or as otherwise required or permitted by the federal medical privacy regulations contained in Parts 160 and 164 of Title 45 of the Code of Federal Regulations. In no case shall a hospital, contractor, or subcontractor reidentify or attempt to reidentify any information received pursuant to this section.

(c) No disclosure shall be made pursuant to this section if the director of the department has determined that the disclosure would create an unreasonable risk to patient privacy. The director shall provide a written explanation of the determination to the requester within 60 days.

SEC. 213. Section 128770 of the Health and Safety Code is amended to read:

128770. (a) Any health facility or freestanding ambulatory surgery clinic that does not file any report as required by this chapter with the department is liable for a civil penalty of one hundred dollars ($100) a day for each day the filing of any report is delayed. No penalty shall be imposed if an extension is granted in accordance with the guidelines and procedures established by the department.

(b) Any health facility that does not use an approved system of accounting pursuant to the provisions of this chapter for purposes of submitting financial and statistical reports as required by this chapter shall be liable for a civil penalty of not more than five thousand dollars ($5,000).

(c) Civil penalties are to be assessed and recovered in a civil action brought in the name of the people of the State of California by the department. Assessment of a civil penalty may, at the request of any health facility or freestanding ambulatory surgery clinic, be reviewed on appeal, and the penalty may be reduced or waived for good cause.

(d) Any money that is received by the department pursuant to this section shall be paid into the General Fund.

SEC. 214. Section 128775 of the Health and Safety Code is amended to read:

128775. (a) Any health facility or freestanding ambulatory surgery clinic affected by any determination made under this part by the department may petition the department for review of the decision. This petition shall be filed with the department within 15 business days, or within a greater time as the department may allow, and shall specifically describe the matters which are disputed by the petitioner.

(b) A hearing shall be commenced within 60 calendar days of the date on which the petition was filed. The hearing shall be held before an employee of the department, or an administrative law judge employed by the Office of Administrative Hearings. If held before an employee of the department, the hearing shall be held in accordance with any procedures as the office shall prescribe. If held before an administrative law judge employed by the Office of Administrative Hearings, the hearing shall be held in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. The employee or administrative law judge shall prepare a recommended decision including findings of fact and conclusions of law and present it to the department for its adoption. The decision of the department shall be in writing and shall be final. The decision of the department shall be made within 60 calendar days after the conclusion of the hearing and shall be effective upon filing and service upon the petitioner.

(c) Judicial review of any final action, determination, or decision may be had by any party to the proceedings as provided in Section 1094.5 of the Code of Civil Procedure. The decision of the department shall be upheld against a claim that its findings are not supported by the evidence unless the court determines that the findings are not supported by substantial evidence.

(d) The employee of the office, or the administrative law judge employed by the Office of Administrative Hearings or the Office of Administrative Hearings, may issue subpoenas and subpoenas duces tecum in a manner and subject to the conditions established by Article 11 (commencing with Section 11450.10) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of the Government Code.

(e) This section shall become operative on July 1, 1997.

SEC. 215. Section 128782 of the Health and Safety Code is amended to read:

128782. Notwithstanding any other provision of law, upon the request of a small and rural hospital, as defined in Section 124840, the department shall do all of the following:

(a) If the hospital did not file financial reports with the department by electronic media as of January 1, 1993, the department shall, on a case-by-case basis, do one of the following:

(1) Exempt the small and rural hospital from any electronic filing requirements of the department regarding annual or quarterly financial disclosure reports specified in Sections 128735 and 128740.

(2) Provide a one-time reduction in the fee charged to the small and rural hospital not to exceed the maximum amount assessed pursuant to Section 127280 by an amount equal to the costs incurred by the small and rural hospital to purchase the computer hardware and software necessary to comply with any electronic filing requirements of the department regarding annual or quarterly financial disclosure reports specified in Sections 128735 and 128740.

(b) The department shall provide a one-time reduction in the fee charged to the small and rural hospital not to exceed the maximum amount assessed pursuant to Section 127280 by an amount equal to the costs incurred by the small and rural hospital to purchase the computer software and hardware necessary to comply with any electronic filing requirements of the department regarding reports specified in Sections 128735, 128736, and 128737.

(c) The department shall provide the hospital with assistance in meeting the requirements specified in paragraphs (1) and (2) of subdivision (c) of Section 128755 that the reports required by subdivision (g) of Section 128735 be filed by electronic media or by online transmission. The assistance shall include the provision to the hospital by the department of a computer program or computer software to create an electronic file of patient discharge abstract data records. The program or software shall incorporate validity checks and edit standards.

(d) The department shall provide the hospital with assistance in meeting the requirements specified in subdivision (d) of Section 128755 that the reports required by subdivision (a) of Section 128736 be filed by online transmission. The assistance shall include the provision to the hospital by the department of a computer program or computer software to create an electronic file of emergency care data records. The program or software shall incorporate validity checks and edit standards.

(e) The department shall provide the hospital with assistance in meeting the requirements specified in subdivision (e) of Section 128755 that the reports required by subdivision (a) of Section 128737 be filed by online transmission. The assistance shall include the provision to the hospital by the department of a computer program or computer software to create an electronic file of ambulatory surgery data records. The program or software shall incorporate validity checks and edit standards.

SEC. 216. Section 128785 of the Health and Safety Code is amended to read:

128785. On January 1, 1986, all regulations previously adopted by the California Health Facilities Commission that relate to functions vested in the department and that are in effect on that date, shall remain in effect and shall be fully enforceable to the extent that they are consistent with this chapter, as determined by the department, unless and until readopted, amended, or repealed by the department.

SEC. 217. Section 128790 of the Health and Safety Code is amended to read:

128790. Pursuant to Section 16304.9 of the Government Code, the Controller shall transfer to the department the unexpended balance of funds as of January 1, 1986, in the California Health Facilities Commission Fund, available for use in connection with the performance of the functions of the California Health Facilities Commission to which it has succeeded pursuant to this chapter.

SEC. 218. Section 128795 of the Health and Safety Code is amended to read:

128795. All officers and employees of the California Health Facilities Commission who, on December 31, 1985, are serving the state civil service, other than as temporary employees, and engaged in the performance of a function vested in the department by this chapter shall be transferred to the department. The status, positions, and rights of persons shall not be affected by the transfer and shall be retained by them as officers and employees of the department, pursuant to the State Civil Service Act except as to positions exempted from civil service.

SEC. 219. Section 128800 of the Health and Safety Code is amended to read:

128800. The department shall have possession and control of all records, papers, offices, equipment, supplies, moneys, funds, appropriations, land, or other property, real or personal, held for the benefit or use of the California Health Facilities Commission for the performance of functions transferred to the department by this chapter.

SEC. 220. Section 128805 of the Health and Safety Code is amended to read:

128805. The department may enter into agreements and contracts with any person, department, agency, corporation, or legal entity as are necessary to carry out the functions vested in the department by this chapter or any other law.

SEC. 221. Section 128810 of the Health and Safety Code is amended to read:

128810. The department shall administer this chapter and shall make all regulations necessary to implement the provisions and achieve the purposes stated herein.

SEC. 222. The heading of Chapter 2 of Part 5 of Division 107 of the Health and Safety Code is repealed.

SEC. 223. The heading of Chapter 3 of Part 5 of Division 107 of the Health and Safety Code is repealed.

SEC. 224. Section 129010 of the Health and Safety Code is amended to read:

129010. Unless the context otherwise requires, the definitions in this section govern the construction of this chapter and of Section 32127.2.

(a) “Bondholder” means the legal owner of a bond or other evidence of indebtedness issued by a political subdivision or a nonprofit corporation.

(b) “Borrower” means a political subdivision or nonprofit corporation that has secured or intends to secure a loan for the construction of a health facility.

(c) “Construction, improvement, or expansion” or “construction, improvement, and expansion” includes construction of new buildings, expansion, modernization, renovation, remodeling and alteration of existing buildings, acquisition of existing buildings or health facilities, and initial or additional equipping of any of these buildings.

In connection therewith, “construction, improvement, or expansion” or “construction, improvement, and expansion” includes the cost of construction or acquisition of all structures, including parking facilities, real or personal property, rights, rights-of-way, the cost of demolishing or removing any buildings or structures on land so acquired, including the cost of acquiring any land where the buildings or structures may be moved, the cost of all machinery and equipment, financing charges, interest (prior to, during and for a period after completion of the construction), provisions for working capital, reserves for principal and interest and for extensions, enlargements, additions, replacements, renovations and improvements, cost of engineering, financial and legal services, plans, specifications, studies, surveys, estimates of cost and of revenues, administrative expenses, expenses necessary or incident to determining the feasibility or practicability of constructing or incident to the construction; or the financing of the construction or acquisition.

(d) “Committee” means the Advisory Loan Insurance Committee.

(e) “Debenture” means any form of written evidence of indebtedness issued by the State Treasurer pursuant to this chapter, as authorized by Section 4 of Article XVI of the California Constitution.

(f) “Fund” means the Health Facility Construction Loan Insurance Fund.

(g) “Health facility” means any facility providing or designed to provide services for the acute, convalescent, and chronically ill and impaired, including, but not limited to, public health centers, community mental health centers, facilities for the developmentally disabled, nonprofit community care facilities that provide care, habilitation, rehabilitation or treatment to developmentally disabled persons, facilities for the treatment of chemical dependency, including a community care facility, licensed pursuant to Chapter 3 (commencing with Section 1500) of Division 2, a clinic, as defined pursuant to Chapter 1 (commencing with Section 1200) of Division 2, an alcoholism recovery facility, defined pursuant to former Section 11834.11, and a structure located adjacent or attached to another type of health facility and that is used for storage of materials used in the treatment of chemical dependency, and general tuberculosis, mental, and other types of hospitals and related facilities, such as laboratories, outpatient departments, extended care, nurses’ home and training facilities, offices and central service facilities operated in connection with hospitals, diagnostic or treatment centers, extended care facilities, nursing homes, and rehabilitation facilities. “Health facility” also means an adult day health center and a multilevel facility. Except for facilities for the developmentally disabled, facilities for the treatment of chemical dependency, or a multilevel facility, or as otherwise provided in this subdivision, “health facility” does not include any institution furnishing primarily domiciliary care.

“Health facility” also means accredited nonprofit work activity programs as defined in subdivision (e) of Section 19352 and Section 19355 of the Welfare and Institutions Code, and nonprofit community care facilities as defined in Section 1502, excluding foster family homes, foster family agencies, adoption agencies, and residential care facilities for the elderly.

Unless the context dictates otherwise, “health facility” includes a political subdivision of the state or nonprofit corporation that operates a facility included within the definition set forth in this subdivision.

(h) “Department” means the Department of Health Care Access and Information.

(i) “Lender” means the provider of a loan and its successors and assigns.

(j) “Loan” means money or credit advanced for the costs of construction or expansion of the health facility, and includes both initial loans and loans secured upon refinancing and may include both interim, or short-term loans, and long-term loans. A duly authorized bond or bond issue, or an installment sale agreement, may constitute a “loan.”

(k) “Maturity date” means the date that the loan indebtedness would be extinguished if paid in accordance with periodic payments provided for by the terms of the loan.

(l) “Mortgage” means a first mortgage on real estate. “Mortgage” includes a first deed of trust.

(m) “Mortgagee” includes a lender whose loan is secured by a mortgage. “Mortgagee” includes a beneficiary of a deed of trust.

(n) “Mortgagor” includes a borrower, a loan to whom is secured by a mortgage, and the trustor of a deed of trust.

(o) “Nonprofit corporation” means any corporation formed under or subject to the Nonprofit Public Benefit Corporation Law (Part 2 (commencing with Section 5110) of Division 2 of Title 1 of the Corporations Code) that is organized for the purpose of owning and operating a health facility and that also meets the requirements of Section 501(c)(3) of the Internal Revenue Code.

(p) “Political subdivision” means any city, county, joint powers entity, local hospital district, or the California Health Facilities Authority.

(q) “Project property” means the real property where the health facility is, or is to be, constructed, improved, or expanded, and also means the health facility and the initial equipment in that health facility.

(r) “Public health facility” means any health facility that is or will be constructed for and operated and maintained by any city, county, or local hospital district.

(s) “Adult day health center” means a facility defined under subdivision (b) of Section 1570.7, that provides adult day health care, as defined under subdivision (a) of Section 1570.7.

(t) “Multilevel facility” means an institutional arrangement where a residential facility for the elderly is operated as a part of, or in conjunction with, an intermediate care facility, a skilled nursing facility, or a general acute care hospital. “Elderly,” for the purposes of this subdivision, means a person 60 years of age or older.

(u) “State plan” means the plan described in Section 129020.

SEC. 225. Section 129015 of the Health and Safety Code is amended to read:

129015. The department shall administer this chapter and shall make all regulations necessary to implement the provisions and achieve the purposes stated herein.

SEC. 226. Section 129020 of the Health and Safety Code is amended to read:

129020. The department shall implement the loan insurance program for the construction, improvement, and expansion of public and nonprofit corporation health facilities so that, in conjunction with all other existing facilities, the necessary physical facilities for furnishing adequate health facility services will be available to all the people of the state.

Every odd-numbered year the department shall develop a state plan for use under this chapter. The plan shall include an overview of the changes in the health care industry, an overview of the financial status of the fund and the loan insurance program implemented by the department, a statement of the guiding principles of the loan insurance program, an evaluation of the program’s success in meeting its mission as outlined in Section 129005, a discussion of administrative, procedural, or statutory changes that may be needed to improve management of program risks or to ensure the program effectively addresses the health needs of Californians, and the priority needs to be addressed by the loan insurance program.

The health facility construction loan insurance program shall provide for health facility distribution throughout the state in a manner that will make all types of health facility services reasonably accessible to all persons in the state according to the state

plan.

SEC. 227. Section 129022 of the Health and Safety Code is amended to read:

129022. Applications submitted to the department shall be signed under penalty of perjury by the applicant.

SEC. 228. Section 129030 of the Health and Safety Code is amended to read:

129030. The proceeds of all loans insured pursuant to this chapter shall be disbursed only upon order of the department or its designated agent. The department shall make regulations to insure the security of these proceeds.

SEC. 229. Section 129035 of the Health and Safety Code is amended to read:

129035. From time to time the department or its designated agent shall inspect each project for which loan insurance was approved, as needed, and if the inspection so warrants, the department or agent shall certify that the work has been performed upon the project, or purchases have been made, in accordance with the approved plans and specifications, and that payment of an installment of the loan proceeds is due to the borrower. The department shall charge the borrower a fee for these inspections and certifications, that in no instance shall exceed four dollars ($4) for each one thousand dollars ($1,000) of the borrower's loan that is insured. These fees shall be deposited in the fund.

SEC. 230. Section 129040 of the Health and Safety Code is amended to read:

129040. (a) The department shall establish a premium charge for the insurance of loans under this chapter, and this charge shall be deposited in the fund. A one-time nonrefundable premium charge shall be paid at the time the loan is insured. The premium rate may vary based upon the assessed level of relative financial risk determined pursuant to Section 129051, but shall in no event be greater than 3 percent. The amount of premium shall be computed on the basis of the application of the rate to the total amount of principal and interest payable over the term of the loan.

(b) The department may annually charge a portion of the premium in advance commencing at the time of issuing or extending the commitment until the date the loan is insured or the commitment expires. The amount of the advance premium shall not exceed six dollars ($6) per year for each one thousand dollars ($1,000) of principal of the proposed loan. The total dollar amount of the premium advanced shall be nonrefundable and shall be credited against the amount of the premium charged pursuant to this section, or if the commitment expires and the loan is not insured, the advance shall be retained by the department to offset costs and expenses of the department related to preliminary work, underwriting the loan commitment, and monitoring construction.

SEC. 231. Section 129045 of the Health and Safety Code is amended to read:

129045. The department shall annually report to the Legislature the financial status of the program and its insured portfolio, including the status of all borrowers in each stage of default and the department's efforts to collect from borrowers that have defaulted on their debt service payments.

SEC. 232. Section 129049 of the Health and Safety Code is amended to read:

129049. (a) The department may, at the request of a hospital, commission an independent study of market need and feasibility, as required by the United States Department of Housing and Urban Development, as part of an application for mortgage insurance for hospitals pursuant to Section 1715z-7 of Title 12 of the United States Code, or any other federal mortgage insurance program for health-related facilities.

(b) The cost of the feasibility study permitted pursuant to subdivision (a) shall be paid for by the department from reimbursements received from the applicant.

(c) Notwithstanding any other provision of law, the department may directly retain independent feasibility consultants and require a deposit from the applicant for the entire cost of the services at the time they are requested.

(d) The department shall charge applicants a fee for the reasonable costs of administering this article.

(e) The program provided for in this article shall be administered in conformance with the requirements of the United States Department of Housing and Urban Development for feasibility studies authorized by this section and the applicable requirements of state law pertaining to contracts.

SEC. 233. Section 129050 of the Health and Safety Code is amended to read:

129050. A loan shall be eligible for insurance under this chapter if all of the following conditions are met:

(a) The loan shall be secured by a first mortgage, first deed of trust, or other first priority lien on a fee interest of the borrower or by a leasehold interest of the borrower having a term of at least 20 years, including options to renew for that duration, longer than the term of the insured loan. The security for the loan shall be subject only to those conditions, covenants and restrictions, easements, taxes, and assessments of record approved by the office, and other liens securing debt insured under this chapter. The department may require additional agreements in security of the loan.

(b) The borrower obtains an American Land Title Association title insurance policy with the department designated as beneficiary, with liability equal to the amount of the loan insured under this chapter, and with additional endorsements that the department may reasonably require.

(c) The proceeds of the loan shall be used exclusively for the construction, improvement, or expansion of the health facility, as approved by the department under Section 129020. However, loans insured pursuant to this chapter may include loans to refinance another prior loan, whether or not state insured and without regard to the date of the prior loan, if the department determines that the amount refinanced does not exceed 90 percent of the original total construction costs and is otherwise eligible for insurance under this chapter. The department may not insure a loan for a health facility that the office determines is not needed pursuant to subdivision (k).

(d) The loan shall have a maturity date not exceeding 30 years from the date of the beginning of amortization of the loan, except as authorized by subdivision (e), or 75 percent of the department's estimate of the economic life of the health facility, whichever is the lesser.

(e) The loan shall contain complete amortization provisions requiring periodic payments by the borrower not in excess of its reasonable ability to pay as determined by the department. The department shall permit a reasonable period of time during which the first payment to amortization may be waived on agreement by the lender and borrower. The department may, however, waive the amortization requirements of this subdivision and of subdivision (g) of this section when a term loan would be in the borrower's best interest.

(f) The loan shall bear interest on the amount of the principal obligation outstanding at any time at a rate, as negotiated by the borrower and lender, as the department finds necessary to meet the loan money market. As used in this chapter, "interest" does not include premium charges for insurance and service charges if any. Where a loan is evidenced by a bond issue of a political subdivision, the interest thereon may be at any rate the bonds may legally bear.

(g) The loan shall provide for the application of the borrower's periodic payments to amortization of the principal of the loan.

(h) The loan shall contain those terms and provisions with respect to insurance, repairs, alterations, payment of taxes and assessments, foreclosure proceedings, anticipation of maturity, additional and secondary liens, and other matters the department may in its discretion prescribe.

(i) The loan shall have a principal obligation not in excess of an amount equal to 90 percent of the total construction cost.

(j) The borrower shall offer reasonable assurance that the services of the health facility will be made available to all persons residing or employed in the area served by the facility.

(k) The department has determined that the facility is needed by the community to provide the specified services. In making this determination, the department shall do all of the following:

(1) Require the applicant to describe the community needs the facility will meet and provide data and information to substantiate the stated needs.

(2) Require the applicant, if appropriate, to demonstrate participation in the community needs assessment required by Section 127350.

(3) Survey appropriate local officials and organizations to measure perceived needs and verify the applicant's needs assessment.

(4) Use any additional available data relating to existing facilities in the community and their capacity.

(5) Contact other state and federal departments that provide funding for the programs proposed by the applicant to obtain those departments' perspectives regarding the need for the facility. Additionally, the department shall evaluate the potential effect of proposed health care reimbursement changes on the facility's financial feasibility.

(6) Consider the facility's consistency with the Cal-Mortgage state plan.

(l) In the case of acquisitions, a project loan shall be guaranteed only for transactions not in excess of the fair market value of the acquisition.

Fair market value shall be determined, for purposes of this subdivision, pursuant to the following procedure, that shall be utilized during the department's review of a loan guarantee application:

(1) Completion of a property appraisal by an appraisal firm qualified to make appraisals, as determined by the department, before closing a loan on the project.

(2) Evaluation of the appraisal in conjunction with the book value of the acquisition by the department. When acquisitions involve additional construction, the department shall evaluate the proposed construction to determine that the costs are reasonable for the type of construction proposed. In those cases where this procedure reveals that the cost of acquisition exceeds the current value of a facility, including improvements, then the acquisition cost shall be deemed in excess of fair market value.

(m) Notwithstanding subdivision (i), any loan in the amount of ten million dollars ($10,000,000) or less may be insured up to 95 percent of the total construction cost.

In determining financial feasibility of projects of counties pursuant to this section, the department shall take into consideration any assistance for the project to be provided under Section 14085.5 of the Welfare and Institutions Code or from other sources. It is the intent of the Legislature that the department endeavor to assist counties in whatever ways are possible to arrange loans that will meet the requirements for insurance prescribed by this section.

(n) The project's level of financial risk meets the criteria in Section 129051.

SEC. 234. Section 129051 of the Health and Safety Code is amended to read:

129051. (a) The department shall develop and implement a system for assessing the relative financial risk of the applicant. The system shall include, but is not limited to, an assessment of the applicant's financial strength, credit history, security for the loan, cash-flow, and ability to repay the debt.

(b) The department shall establish a maximum acceptable level of financial risk for the projects it insures. The department may only approve a project if its risk level is below the established maximum, except as provided in subdivision (c).

(c) The department may approve a project with a level of insurance risk that exceeds the established maximum if the department determines that the project meets a significant community need or will be a sole community provider.

SEC. 235. Section 129052 of the Health and Safety Code is amended to read:

129052. A pledge by or to the department of, or the grant to the department of a security interest in, revenues, moneys, accounts, accounts receivable, contract rights, general intangibles, documents, instruments, chattel paper, and other rights to payment of whatever kind made by or to the department pursuant to the authority granted in this chapter shall be valid and binding from the time the pledge is made for the benefit of pledgees and successors thereto. The revenues, moneys, accounts, accounts receivable, contract rights, general intangibles, documents, instruments, chattel paper, and other rights to payment of whatever kind pledged by or to the department or its assignees shall immediately be subject to the lien of the pledge without physical delivery or further act. The lien of such pledge shall be valid and binding against all parties, irrespective of whether the parties have notice of the lien. The indenture, trust agreement, resolution, or another instrument by which such pledge is created need not be recorded or the security interest otherwise perfected.

SEC. 236. Section 129055 of the Health and Safety Code is amended to read:

129055. In order to comply with subdivision (j) of Section 129050, any borrower that is certified for reimbursement for cost of care under Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code shall demonstrate that its facility is used by persons for whom the cost of care is reimbursed under that chapter, in a proportion that is reasonable based upon the proportion of Medi-Cal patients in the community served by the borrower and by persons for whom the costs of care is reimbursed under Title XVIII of the federal Social Security Act in a proportion that is reasonable based upon the proportion of Medicare patients in the community served by the borrower.

For the purposes of this chapter, the community means the service areas or patient populations for which the health facility provides health care services, unless the department determines that, or the borrower demonstrates to the satisfaction of the office that, a different definition is more appropriate for the borrower's facility.

SEC. 237. Section 129065 of the Health and Safety Code is amended to read:

129065. As part of its assurance under subdivision (j) of Section 129050, any borrower that is a general acute care hospital or acute psychiatric hospital shall agree to the following actions:

(a) To advise each person seeking services at the borrower's facility as to the person's potential eligibility for Medi-Cal and Medicare benefits or benefits from other governmental third party payers.

(b) To make available to the department and to any interested person a list of physicians with staff privileges at the borrower's facility, that includes:

(1) Name.

(2) Speciality.

(3) Language spoken.

(4) Whether takes Medi-Cal and Medicare patients.

(5) Business address and phone number.

(c) To inform in writing on a periodic basis all practitioners of the healing arts having staff privileges in the borrower's facility as to the existence of the facility's community service obligation. The required notice to practitioners shall contain a statement, as follows:

"This hospital has agreed to provide a community service and to accept Medi-Cal and Medicare patients. The administration and enforcement of this agreement is the responsibility of the Department of Health Care Access and Information and this facility."

(d) To post notices in the following form, that shall be multilingual where the borrower serves a multilingual community, in appropriate areas within the facility, including but not limited to, admissions offices, emergency rooms, and business offices:

NOTICE OF COMMUNITY SERVICE OBLIGATION

"This facility has agreed to make its services available to all persons residing or employed in this area. This facility is prohibited by law from discriminating against Medi-Cal and Medicare patients. Should you believe you may be eligible for Medi-Cal or Medicare, you should contact our business office (or designated person or office) for assistance in applying. You should also contact our business office (or designated person or office) if you are in need of a physician to provide you with services at this facility. If you believe that you have been refused services at this facility in violation of the community service obligation you should inform (designated person or office) and the Department of Health Care Access and Information."

The borrower shall provide copies of this notice for posting to all welfare offices in the county where the borrower's facility is located.

SEC. 238. Section 129070 of the Health and Safety Code is amended to read:

129070. In the event the borrower cannot demonstrate that it meets the requirement of Section 129055, it may nonetheless be eligible for a loan under this chapter if it presents a plan that is satisfactory to the department that details the reasonable steps and timetables that the borrower agrees to take to bring the facility into compliance with Section 129055.

SEC. 239. Section 129075 of the Health and Safety Code is amended to read:

129075. (a) Each borrower shall provide any reports as may be required of it by Part 5 (commencing with Section 128675), from which the department shall determine the borrower's compliance with subdivision (j) of Section 129050.

(b) If a report indicates noncompliance with subdivision (j) of Section 129050, Section 129055, or Section 129065, the department shall require the borrower to submit a plan detailing the steps and timetables the borrower will take to bring the facility into compliance.

(c) The department shall annually report to the Legislature the extent of the borrowers' compliance with their community service obligations pursuant to subdivision (j) of Section 129050, Section 129055, and Section 129065.

SEC. 240. Section 129080 of the Health and Safety Code is amended to read:

129080. The department may impose additional appropriate remedies and sanctions against a borrower when any of the following occurs:

(a) The department determines that the annual compliance report required in Section 129075 indicates that the borrower is out of compliance with subdivision (j) of Section 129050.

(b) A facility fails to carry out the actions agreed to in a plan approved by the department pursuant to Section 129070.

(c) The facility fails to submit compliance reports as required by Section 129075. The additional remedies include referring the violation to the office of Attorney General of California for legal action authorized under existing law or other remedy at law or equity.

However, the remedies obtainable by legal action shall not include withdrawal or cancellation of the loan insurance provided under this chapter.

SEC. 241. Section 129085 of the Health and Safety Code is amended to read:

129085. (a) If a borrower is unable to comply with subdivision (j) of Section 129050 due to selective provider contracting under the Medi-Cal program, and the department has determined the borrower has negotiated in good faith but was not awarded a contract, the borrower may be eligible for insurance under this chapter as provided in subdivision (b).

(b) The department may determine that a noncontracting borrower shall be considered as meeting the requirements of subdivision (j) of Section 129050 if the borrower otherwise provides a community service in accordance with regulations adopted by the department. The regulations shall describe alternative methods of meeting the obligation, that may include, but not be limited to, providing free care, charity care, trauma care, community education, or primary care outreach and care to the elderly, in amounts greater than the community average. The regulations shall include a requirement that a general acute care hospital, that is not a small and rural hospital as defined in Section 124840, shall have, and continue to maintain, a 24-hour basic emergency medical service with a physician on duty, if it provided this service on January 1, 1990. The department shall have the authority to waive this requirement upon a determination by the director that this requirement would create a hardship for the hospital, be inconsistent with regionalization of emergency medical services, or not be in the best interest of the population served by the hospital.

SEC. 242. Section 129087 of the Health and Safety Code is amended to read:

129087. The department shall develop and maintain a formal system of monitoring borrowers, in order to assist the department in detecting at the earliest possible date those borrowers who are experiencing financial difficulties. This system shall include, but shall not be limited to, all of the following:

(a) A method of tracking the receipt of information that borrowers are required by law and regulatory agreement to submit to the department.

(b) A process for thoroughly reviewing borrowers' financial statements, budgets, auditor's management letters, and health facility utilization trends.

(c) Timely and structured site visits to insured facilities.

SEC. 243. Section 129090 of the Health and Safety Code is amended to read:

129090. Pursuant to this chapter, political subdivisions and nonprofit corporations may apply for state insurance of needed construction, improvement, or expansion loans for construction, remodeling, or acquisition of health facilities to be or already owned, established, and operated by them as provided in this chapter. Applications shall be submitted to the department by the nonprofit corporation or political subdivision authorized to construct and operate a health facility. Each application shall conform to the requirements of the department, shall be submitted in the manner and form prescribed by the department, and shall be accompanied by an application fee of one-half of 1 percent of the amount of the loan applied for, but in no case shall the application fee exceed five hundred dollars ($500). The fees shall be deposited by the department in the fund and used to defray the office's expenditures in the administration of this chapter.

SEC. 244. Section 129092 of the Health and Safety Code is amended to read:

129092. Notwithstanding any other provision of law, upon the application of a borrower for insurance, the department shall perform a feasibility study relating to the proposed project, the cost of which shall be paid by the applicant. The department may retain independent consultants and require a deposit from the applicant for such services, upon submission of the application. This section shall take effect on January 1, 2001.

SEC. 245. Section 129095 of the Health and Safety Code is amended to read:

129095. (a) The department shall not regulate, impose requirements on, or require approval by the department of a professional, or a fee charged by a professional, used by applicants for the initial application for loan insurance. The choice of any professional and the funding source used shall be left entirely to the participants.

(b) For purposes of this section, "professional" includes, but is not limited to, an underwriter, bond counsel, or consultant.

(c) Nothing in this section shall prohibit the department, in the event of defaults, from taking any action authorized under this chapter to protect the financial interest of the state.

SEC. 246. Section 129100 of the Health and Safety Code is amended to read:

129100. Every applicant for insurance shall be afforded an opportunity for a fair hearing before the committee upon 10 days' written notice to the applicant. If the department, after affording reasonable opportunity for development and presentation of the application and after receiving the advice of the committee, finds that an application complies with the requirements of this article and of Section 129020 and is otherwise in conformity with the state plan, it may approve the application for insurance. The department shall consider and approve applications in the order of relative need set forth in the state plan in accordance with Section 129020. Judicial review of a final decision made under this section may be had by filing a petition for writ of mandate. Any petition shall be filed within 30 days after the date of the final decision of the department.

SEC. 247. Section 129105 of the Health and Safety Code is amended to read:

129105. The department may upon application of the borrower insure any loan that is eligible for insurance under this chapter, and upon the terms prescribed by the department, may make commitments for the insuring of the loans prior to their date of execution or disbursement thereon. The decision to grant loan insurance upon an application of the borrower is within the discretion of the director of the department. Showing need for the project or meeting the eligibility requirements for loan insurance and establishing financial feasibility of the project or recommendation for approval from the committee does not create any entitlement to loan insurance.

SEC. 248. Section 129110 of the Health and Safety Code is amended to read:

129110. Any contract of insurance executed by the department under this chapter shall be conclusive evidence of the eligibility of the loan for insurance and the validity of any contract of insurance so executed shall be incontestable from the date of the execution of the contract, except in case of fraud or misrepresentation on the part of the lender.

SEC. 249. Section 129125 of the Health and Safety Code is amended to read:

129125. In any case when the lender under a loan to a nonprofit corporation insured under this chapter shall have foreclosed and taken possession of the property under a mortgage in accordance with regulations of, and within a period to be determined by the department, or shall, with the consent of the department, have otherwise acquired the property from the borrower after default, the lender shall be entitled to receive the benefit of the insurance as provided in this section, upon (a) the prompt conveyance to the office of title to the property that meets the requirements of the regulations of the department in force at the time the loan was insured, and that is evidenced in the manner prescribed by the regulations, and (b) the assignment to the department of all claims of the lender against the borrower or others arising out of the loan transaction or foreclosure proceedings except claims that may have been released with the consent of the department. Upon the conveyance and assignment, the department shall notify the Treasurer, who shall issue to the lender debentures having a total face value equal to the outstanding value of the loan.

For the purposes of this section, the outstanding value of the loan shall be determined, in accordance with the regulations prescribed by the department, by (a) adding to the amounts of the original principal obligation of the loan and interest that are accrued and unpaid the amount of all payments that have been made by the lender for the following: taxes and assessments, ground rents, water rates, and other liens that are prior to the mortgage; charges for the administration, operation, maintenance and repair of the health facility property; insurance on the project property, loan insurance premiums, and any tax imposed by a city or county upon any deed or other instrument by which the property was acquired by the lender and transferred or conveyed to the office; and the costs of foreclosure or of acquiring the property by other means actually paid by the lender and approved by the department; and by (b) deducting from the total amount any amounts received by the lender after the borrower's default on account of the loans or as rent or other income from the property.

SEC. 250. Section 129130 of the Health and Safety Code is amended to read:

129130. In any case when a political subdivision defaults on the payment of interest or principal accrued and due on bonds or other evidences of indebtedness insured under this chapter, debentures in an amount equal to the outstanding original principal obligation and interest on the bonds that were accrued and unpaid on the date of default and bearing interest at a rate equal to and payment schedule identical with those of the bonds shall be issued by the Treasurer upon notification thereof by the department to the bondholders upon the surrender of the bonds to the department.

In any case in which a hospital district defaults on the payment of interest or principal accrued and due on an insured loan secured by a first mortgage, first deed of trust, or other security agreement as authorized by Section 32127.2, debentures in an amount equal to the outstanding original principal obligation and interest on the bonds that were accrued and unpaid on the date of default and bearing interest at a rate equal to and payment schedule identical with those of the bonds shall be issued by the Treasurer upon notification thereof by the department to the bondholders upon surrender of the bonds to the department after the state has enforced its rights under the first mortgage, first deed of trust, or other security agreement.

SEC. 251. Section 129135 of the Health and Safety Code is amended to read:

129135. Notwithstanding any requirement contained in this chapter relating to acquisition of title and possession of the project property by the lender and its subsequent conveyance and transfer to the department, and for the purpose of avoiding unnecessary conveyance expense in connection with payment of insurance benefits under the provisions of this chapter, the department may, subject to regulations that it may prescribe, permit the lender to tender to the department a satisfactory conveyance of title and transfer of possession direct from the borrower or other appropriate grantor and to pay to the lender the insurance benefits to which it would otherwise be entitled if the conveyance had been made to the lender and from the lender to the department.

SEC. 252. Section 129140 of the Health and Safety Code is amended to read:

129140. Upon receiving notice of the default of any loan insured under this chapter, the department, in its discretion and for the purpose of avoiding foreclosure under Section 129125 and notwithstanding the fact that it has previously approved a request of the lender for extensions of the time for curing the default and of the time for commencing foreclosure proceedings or for otherwise acquiring title to the project property, or has approved a modification of the loan for the purpose of changing the amortization provisions by recasting the unpaid balance, may acquire the loan and security agreements securing the loans upon the issuance to the lender of debentures in an amount equal to the unpaid principal balance of the loan plus any accrued unpaid loan interest plus reimbursement for the costs and attorney's fees of the lender enumerated in Section 129125.

After the acquisition of the loan and security interests therefor by the department, the lender shall have no further rights, liabilities, or obligations with respect thereto. The provisions of Section 129125 relating to the issuance of debentures incident to the acquisition of foreclosed properties shall apply with respect to debentures issued under this section, and the provisions of this chapter relating to the rights, liabilities, and obligations of a lender shall apply with respect to the department when it has acquired an insured loan under this section, in accordance with and subject to any regulations prescribed by the department modifying the provisions to the extent necessary to render their application for these purposes appropriate and effective.

SEC. 253. Section 129145 of the Health and Safety Code is amended to read:

129145. Notwithstanding any other provision of this chapter, after the department determines that the lender and borrower have exhausted all reasonable means of curing any default, the department within its discretion may, when it is in the best interests of the state, the borrower, and the lender, cure the default of the borrower by making payment from the fund directly to the lender of any amounts of the original principal obligation and interest of the loan that are accrued and unpaid. The payment shall be secured by an assignment to the department of a pro rata share of the security agreements made to the lender and, upon the payment, the borrower shall become liable for repayment of the amount thereof to the office over a period and at a rate of interest as shall be determined by the department.

SEC. 254. Section 129150 of the Health and Safety Code is amended to read:

129150. The department may at any time, under the terms and conditions that it may prescribe, consent to the lender's release of the borrower from its liability under the loan or the security agreement securing the loan, or consent to the release of parts of the project property from the lien of any security agreement.

SEC. 255. Section 129152 of the Health and Safety Code is amended to read:

129152. If a borrower fails to submit a required report, or upon any other default of any regulatory or contractual term or covenant, whether or not a default has been declared, the department first shall informally communicate with the borrower. If the borrower fails to submit the required report or otherwise cure the default, the department shall issue a formal demand in writing

stating the nature of the default and requiring the borrower to submit a detailed plan of correction that is acceptable to the office. If the borrower fails to either submit a plan, or timely cure the default, the department shall perform an onsite visit. If the department determines the borrower is not making sufficient progress in submitting any required reports or otherwise curing any default, the department may require the borrower, at the borrower's expense, to employ an independent consultant or professional, acceptable to the department, to conduct a program audit. If the borrower fails to adopt the recommendations of the independent consultant or professional made in the program audit, or if the borrower fails to otherwise timely cure the default, the department shall have all the remedies set forth in the Section 129173.

SEC. 256. Section 129155 of the Health and Safety Code is amended to read:

129155. Debentures issued under this chapter shall be in the form and denomination, subject to the terms and conditions, and include provisions for redemption, if any, as may be prescribed by the department with the approval of the Treasurer, and may be in coupon or registered form.

SEC. 257. Section 129160 of the Health and Safety Code is amended to read:

129160. (a) (1) All debentures issued under this chapter to any lender or bondholder shall be executed in the name of the fund as obligor, shall be signed by the Treasurer, and shall be negotiable. Pursuant to Sections 129125 and 129130, all debentures shall be dated as of the date of the institution of foreclosure proceedings or as of the date of the acquisition of the property after default by other than foreclosure, or as of another date as the department, in its discretion, may establish.

(2) The debentures shall bear interest from that date at a rate equal to the insured loan or bonds, and shall be payable on a payment schedule identical with payments on the insured loan or bonds. The Treasurer shall take appropriate steps to the extent feasible to provide that interest on the debentures is exempt from federal income taxation under Section 103 of the Internal Revenue Code to the extent interest on the insured loan or bonds is exempt from federal income taxation under Section 103 of the Internal Revenue Code on the date the insured loan or bonds is exchanged for debentures. All debentures shall be exempt, both as to principal and interest, from all taxation now or hereafter imposed by the state or local taxing agencies, shall be paid out of the fund, which shall be primarily liable therefor, and shall be, pursuant to Section 4 of Article XVI of the California Constitution, fully and unconditionally guaranteed as to principal and interest by the State of California, which guaranty shall be expressed on the face of the debentures.

(3) If the fund fails to pay upon demand, when due, the principal of, or interest on, any debentures issued under this chapter, the Treasurer shall pay to the holders the amount thereof, which amount, notwithstanding Section 13340 of the Government Code, is hereby continuously appropriated from the General Fund, without regard to fiscal years, and thereupon to the extent of the amount so paid the Treasurer shall succeed to all the rights of the holders of the debentures. The fund shall be liable for repayment to the General Fund of any money paid from the General Fund pursuant to this section in accordance with procedures jointly established by the Treasurer and the department.

(b) Any debenture issued under this article shall be paid on a par with general obligation bonds issued by the state.

SEC. 258. Section 129165 of the Health and Safety Code is amended to read:

129165. Notwithstanding any other provision of law relating to the acquisition, management or disposal of real property by the state, the department shall have power to deal with, operate, complete, lease, rent, renovate, modernize, insure, or sell for cash or credit, in its discretion, any properties conveyed to it in exchange for debentures as provided in this chapter; and notwithstanding any other provision of law, the department shall also have power to pursue to final collection by way of compromise or otherwise all claims against borrowers assigned by lenders to the department as provided in this chapter. All income from the operation, rental, or lease of the property and all proceeds from the sale thereof shall be deposited in the fund and all costs incurred by the office in its exercise of powers granted in this section shall be met by the fund.

The power to convey and to execute in the name of the department deeds of conveyance, deeds of release, assignments and satisfactions of loans and mortgages, and any other written instrument relating to real or personal property or any interest therein acquired by the department pursuant to the provisions of this chapter may be exercised by the department or by any officer of the department appointed by it.

SEC. 259. Section 129170 of the Health and Safety Code is amended to read:

129170. No lender or borrower shall have any right or interest in any property conveyed to the department or in any claim assigned to it, nor shall the department owe any duty to any lender or borrower with respect to the management or disposal of this property.

SEC. 260. Section 129172 of the Health and Safety Code is amended to read:

129172. Notwithstanding any other provision of law, if, prior to foreclosing on any collateral provided by a borrower, the department institutes a judicial proceeding or takes any action against a borrower to enforce compliance with the obligations set out in the regulatory agreement, the contract of insurance, or any other contractual loan closing document or law, including, but not limited to, Section 129173, that remedy or action shall not constitute an action within the meaning of subdivision (a) of Section 726 of the Code of Civil Procedure, or in any way constitute a violation of the intent or purposes of Section 726 of the Code of Civil Procedure, or constitute a money judgment or a deficiency judgment within the meaning of Sections 580a, 580b, 580d, or subdivision (b) of Section 726 of the Code of Civil Procedure. However, these provisions of the Code of Civil Procedure shall apply to any judicial proceeding instituted, or nonjudicial foreclosure action taken by the department to collect the principal and interest due on the loan with the borrower.

SEC. 261. Section 129173 of the Health and Safety Code is amended to read:

129173. (a) In fulfilling the purposes of this article, as set forth in Section 129005, and upon making a determination that the financial status of a borrower may jeopardize a borrower's ability to fulfill its obligations under any insured loan transaction so as to threaten the economic interest of the department in the borrower or to jeopardize the borrower's ability to continue to provide needed health care services in its community, including, but not limited to, a declaration of default under any contract related to the transaction, the borrower missing any payment to its lender, or the borrower's accounts payable exceeding three months, the department may assume or direct managerial or financial control of the borrower in any or all of the following ways:

(1) The department may supervise and prescribe the activities of the borrower in the manner and under the terms and conditions as the office may stipulate in any contract with the borrower.

(2) Notwithstanding the provisions of the articles of incorporation or other documents of organization of a nonprofit corporation borrower, this control may be exercised through the removal and appointment by the department of members of the governing body of the borrower sufficient so that the new members constitute a voting majority of the governing body.

(3) In the event the borrower is a nonprofit corporation or a political subdivision, the department may request the Secretary of the California Health and Human Services Agency to appoint a trustee. The trustee shall have full and complete authority of the borrower over the insured project, including all property on which the department holds a security interest. No trustee shall be appointed unless approved by the department. A trustee appointed by the secretary pursuant to this subdivision may exercise all the powers of the officers and directors of the borrower, including the filing of a petition for bankruptcy. No action at law or in equity may be maintained by any party against the office or a trustee by reason of their exercising the powers of the officers and directors of a borrower pursuant to the direction of, or with the approval of, the secretary.

(4) The department may institute any action or proceeding, or the department may request the Attorney General to institute any action or proceeding against any borrower, to obtain injunctive or other equitable relief, including the appointment of a receiver for the borrower or the borrower's assets, in the superior court in and for the county in which the assets or a substantial portion of the assets are located. The proceeding under this section for injunctive relief shall conform with the requirements of Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure, except that the department shall not be required to allege facts necessary to show lack of adequate remedy at law, or to show irreparable loss or damage. Injunctive relief may compel the borrower, its officers, agents, or employees to perform each and every provision contained in any regulatory agreement, contract of insurance, or any other loan closing document to which the borrower is a party, or any obligation imposed on the borrower by law, and require the carrying out of any and all covenants and agreements and the fulfillment of all duties imposed on the borrower by law or those documents.

A receiver may be appointed pursuant to Chapter 5 (commencing with Section 564) of Title 7 of Part 2 of the Code of Civil Procedure. In cooperation with the Attorney General, the department shall develop and maintain a list of receivers who have demonstrated experience both in the health care field and as a receiver. Upon a proper showing, the court shall grant the relief provided by law and requested by the department or the Attorney General. No receiver shall be appointed unless approved by the department. The department shall establish reporting requirements for receivers to ensure that the department is fully apprised of all costs incurred and progress made by the receiver. A receiver appointed by the superior court pursuant to this subdivision and Section 564 of the Code of Civil Procedure may, with the approval of the court, exercise all of the powers of the officers and directors of the borrower, including the filing of a petition for bankruptcy. No action at law or in equity may be maintained by any party against the department, the Attorney General, or a receiver by reason of their exercising the powers of the officers and directors of a borrower pursuant to the order of, or with the approval of, the superior court.

(5) The borrower shall inform the department in advance of all meetings of its governing body. The borrower shall not exclude the department from attending any meeting of the borrower's governing body.

(b) Other than the loan insured under this chapter, the department shall not be liable for any debt of a borrower, or to a borrower, as a result of the department asserting its legal remedies against a borrower insured under this chapter.

(c) It is the intent of the Legislature that this section is remedial in nature, and is applicable retroactively to any health facility construction loans in existence at the time of its enactment, to the extent that the application of this section does not unlawfully impair existing contract rights.

SEC. 262. Section 129174 of the Health and Safety Code is amended to read:

129174. (a) In the event a borrower has defaulted in making its payments on the loan insured by the department to the lender or the borrower's bond trustee, at any time thereafter, the office may do any of the following:

(1) Decease a portion or all of the bonds or may purchase a portion or all of the bonds at a private or public sale or on the open market. For this purpose, the department may use any funds available, including, but not limited to, funds in the Health Facility Construction Loan Insurance Fund, funds that the department may receive either from settlement or recoveries from lawsuits, funds from the sale of assets of the borrower, or funds held by the borrower's bond trustee. If requested by the department, the Treasurer shall purchase the bonds on behalf of the office. Upon the purchase of any bonds under this section, the department shall direct the borrower's bond trustee to cancel the bonds purchased.

(2) Issue bonds used for the sole purpose of refunding any part or all of the defaulted bonds, provided that, in the opinion of the department, there are adequate present value savings to refund all or part of the defaulted bonds. If requested by the department, the Treasurer shall act as the issuer for this purpose.

(3) Require the lender or borrower's bond trustee to accelerate the borrower's debt and the maturity dates of the bonds, if any. If the bond trustee accelerates the bond debt and maturity dates, the department shall pay from the fund to the lender or borrower's bond trustee the full amount of the remaining principal of the loan, any interest accrued and unpaid on this amount, and any costs enumerated in Section 129125.

(b) For the purposes of this section, "bonds" mean bonds, certificate of participation, notes, or other evidence of indebtedness of a loan insured by the department.

SEC. 263. Section 129174.1 of the Health and Safety Code is amended to read:

129174.1. In the event an obligor on a loan insured by the department is the subject of an order for relief in bankruptcy and that a plan has been proposed for confirmation, upon a certification by the department that the insurance is in place and would be in place if the plan were confirmed, then the department shall have the right to vote whether to accept or reject the plan on behalf of the holders of the loan insured by the department.

SEC. 264. Section 129175 of the Health and Safety Code is amended to read:

129175. Should a borrower be more than 10 days delinquent in paying the premium charges or inspection fees for insurance under this chapter, the department shall notify the borrower in writing. If that payment remains delinquent more than 30 days after the sending of the department's notice to the borrower, the department shall make every reasonable effort to notify the lender in writing. If that delinquency continues, on the 31st day after sending of the department's notice to the lender, the insurance shall be terminated and become null and void.

SEC. 265. Section 129180 of the Health and Safety Code is amended to read:

129180. The obligation to pay any subsequent premium charge for insurance shall cease, and all rights of the lender and the borrower under this chapter shall terminate as of the date of the notice, as herein provided, in the event that (a) any lender under a loan forecloses on the mortgaged property, or has otherwise acquired the project property from the borrower after default, but does not convey the property to the department in accordance with this chapter, and the department is given written notice thereof, or (b) the borrower pays the obligation under the loan in full prior to the maturity thereof, and the department is given written notice thereof.

SEC. 266. Section 129185 of the Health and Safety Code is amended to read:

129185. The department is authorized to terminate any insurance contract upon joint request by the borrower and the lender and upon payment of a termination charge that the department determines to be equitable, taking into consideration the necessity of protecting the fund. Upon the termination, borrowers and lenders shall be entitled to the rights, if any, that they would be entitled to under this chapter if the insurance contract were terminated by payment in full of the insured loan.

SEC. 267. Section 129200 of the Health and Safety Code is amended to read:

129200. There is hereby established a Health Facility Construction Loan Insurance Fund, that shall be used by the department as a revolving fund for carrying out the provisions and administrative costs of this chapter. Notwithstanding Section 13340 of the Government Code, the money in the fund is hereby continuously appropriated to the department without regard to fiscal years for the purposes of this chapter.

SEC. 268. Section 129205 of the Health and Safety Code is amended to read:

129205. Moneys in the fund not needed for the current operations of the department under this chapter shall be invested pursuant to law. The department may, with the approval of the State Treasurer, purchase the debentures issued under this chapter. Debentures so purchased shall be canceled and not reissued.

SEC. 269. Section 129210 of the Health and Safety Code is amended to read:

129210. (a) The department's authorization to insure health facility construction, improvement, and expansion loans under this chapter shall be limited to a total of not more than three billion dollars ($3,000,000,000).

(b) Notwithstanding the limitation in subdivision (a), the department may exceed the specific dollar limitation in either of the following instances:

(1) Refinancing a preexisting loan, if the refinancing results in savings to the health facility and increases the probability that a loan can be repaid.

(2) The need for financing results from earthquakes or other natural disasters.

SEC. 270. Section 129220 of the Health and Safety Code is amended to read:

129220. The department shall establish an Advisory Loan Insurance Committee which shall be comprised of nine members, eight of whom shall be appointed by the director of the department. Of the nine members, seven shall be appointed from outside state government and two shall be appointed from inside state government. The Director of Finance shall appoint one of the members chosen from inside state government. The members of the committee shall be qualified in the field of financial analysis, management, operations, or construction, improvement, or expansion of health facilities. Those members appointed from outside state government shall be reimbursed one hundred dollars ($100) for each day spent in the performance of official duties. All members shall be reimbursed for reasonable and necessary expenses.

SEC. 271. Section 129221 of the Health and Safety Code is amended to read:

129221. The duties of the committee shall include, but not be limited to, the following:

(a) The committee shall assist the director of the department in formulating policy concerning financial analysis, management, operation, or construction, improvement, or expansion of health facilities, and shall, at the request of the director of the department, provide overall policy advice, guidance, and recommendations. The committee shall also provide the department with advice and comment on the state plan prepared pursuant to Section 129020.

(b) The committee shall also review and analyze the feasibility, level of financial risk, and community benefit assessments made by the department on applications submitted for approval. The committee shall recommend to the director whether an application should be approved and whether any conditions should be attached to that approval. Loans that are currently insured by the department and subsequently are refinanced to obtain a lower interest rate or emergency working capital loans insured pursuant to Section 129091 shall not require the review of the committee.

SEC. 272. Section 129230 of the Health and Safety Code is amended to read:

129230. It is the intent of the Legislature in enacting this article to encourage the development of facilities for community-based programs that assist mental health clients living in any institutional setting, including state and local inpatient hospitals, skilled nursing homes, intermediate care facilities, and community care facilities to move to more independent living arrangements. It is further the intent of the Legislature to encourage local programs to seek funding for facility development from private sources and with the assistance provided pursuant to this chapter.

To achieve this purpose in determining eligibility for loan insurance pursuant to this chapter, the following special provisions apply to facilities approved in the local mental health program and meeting the intentions of this article:

(a) Facilities shall not require approval pursuant to Section 129295 by the statewide system of health facility planning, the area health planning agency, or the Health Advisory Council, for the issuance of loan insurance, unless specifically required for the facilities by the facility category of licensure.

(b) Notwithstanding subdivision (i) of Section 129050, any loan of under three hundred thousand dollars ($300,000) for a nonprofit corporation as well as a political subdivision may be fully insured equal to the total construction cost, except a loan to any proprietary corporation that is insured pursuant to subdivision (d) of this section.

(c) The local mental health program may provide all application fees, inspection fees, premiums and other administrative payments required by this chapter, except with respect to any loan to a proprietary corporation that is insured pursuant to subdivision (d) of this section.

(d) The borrower may be a proprietary corporation, provided that the facility is leased to the local mental health program for the duration of the insurance agreement. In these instances, all provisions in this chapter and this article that apply to a nonprofit corporation shall apply to the proprietary corporation, except as provided in subdivisions (b) and (c) of this section.

(e) For the purposes of this article, subdivision (c) of Section 129010 shall include the purchase of existing buildings.

(f) Facilities shall not require approval pursuant to Section 129020 by the statewide system of health facility planning, the area health planning agency, or the Health Advisory Council, for the issuance of loan insurance, until the director of the department determines that the state plan developed pursuant to Section 129020 adequately and comprehensively addresses the need for community mental health facilities and that finding is reported to the appropriate policy committees of the Legislature.

SEC. 273. Section 129295 of the Health and Safety Code is amended to read:

129295. The department may insure, pursuant to this article, loans to nonprofit borrowers that are not licensed to operate the facilities for which the loans are insured, provided that the borrower has entered into a long-term residency lease agreement with a service provider selected by the applicable regional center to operate that facility. The number of facilities for which loans are insured under this section shall not exceed 100 and the aggregate amount of loans insured under this section shall not exceed one hundred million dollars ($100,000,000).

SEC. 274. Section 129330 of the Health and Safety Code is amended to read:

129330. In each even-numbered year, the department shall contract for an actuarial study to determine the reserve sufficiency of funds in the Health Facility Construction Loan Insurance Fund. The study shall examine the portfolio of existing insured loans and shall estimate the amount of reserve funds that the department should reasonably have available to be able to respond adequately to potential foreseeable risks, including extraordinary administrative expenses and actual defaults. Actuarial study contracts shall be exempt from Section 10373 of the Public Contract Code and shall be considered sole-source contracts.

SEC. 275. Section 129335 of the Health and Safety Code is amended to read:

129335. (a) In each odd-numbered year when the reserve balance in the fund is projected to be in excess of that actuarially needed, the department may, subject to authority in the Budget Act, grant excess reserve funds to rural hospitals.

(b) Whenever the department administers the grant program, it shall do so by a competitive process where potential grantees have sufficient time to apply. Priority for funds shall be given to alternative rural hospitals and rural hospitals that are sole community providers. Priority shall also be given to applicants that are otherwise financially viable, but request one-time financial assistance for equipment expenditures or other capital outlays. The maximum amount of any grant for a single project in any one grant year shall be two hundred fifty thousand dollars ($250,000).

(c) For the purposes of this article, “rural hospital” shall have the same meaning as contained in subdivision (a) of Section 124840.

SEC. 276. Section 129355 of the Health and Safety Code is amended to read:

129355. (a) “Community health center facilities,” as used in this article, means those licensed, nonprofit primary care clinics as defined in paragraph (1) of subdivision (a) of Section 1204.

(b) Notwithstanding subdivision (i) of Section 129050, any loan in the amount of five million dollars ($5,000,000) or less for a community health center facility pursuant to this chapter may be insured up to 95 percent of the total construction cost.

(c) Community health center facilities applying for any loan insurance pursuant to this chapter, may use existing equity in buildings, equipment, and donated assets, including, but not limited to, land and receipts from expenses related to the capital

outlay for the project, notwithstanding the date of occurrence to meet the equity requirements of this chapter. In determining the value of the equity in any donated property, the department may use the original purchase price or the current appraised value.

(d) Any state plan referred to in Section 129020 developed by the department shall include a chapter identifying any impediments that preclude small facilities from utilizing the California Health Facility Construction Loan Insurance Program. The state plan shall also include specific programmatic remedies to enable small projects to utilize the program if impediments are found.

SEC. 277. Chapter 2 (commencing with Section 129375) of Part 6 of Division 107 of the Health and Safety Code is repealed.

SEC. 278. Section 129680 of the Health and Safety Code is amended to read:

129680. (a) It is the intent of the Legislature that hospital buildings that house patients who have less than the capacity of normally healthy persons to protect themselves, and that must be reasonably capable of providing services to the public after a disaster, shall be designed and constructed to resist, insofar as practical, the forces generated by earthquakes, gravity, and winds. In order to accomplish this purpose, the department shall propose proper building standards for earthquake resistance based upon current knowledge, and provide an independent review of the design and construction of hospital buildings.

(b) Local jurisdictions are preempted from the enforcement of all building standards published in the California Building Standards Code relating to the regulation of hospital buildings and the enforcement of other regulations adopted pursuant to this chapter, and all other applicable state laws, including plan checking and inspection of the design and details of the architectural, structural, mechanical, plumbing, electrical, and fire and panic safety systems, and the observation of construction. The department shall assume these responsibilities.

(c) Where local jurisdictions have more restrictive requirements for the enforcement of building standards, other building regulations, and construction supervision, these requirements shall be enforced by the department.

(d) Each local jurisdiction shall keep the department advised as to the existence of any more restrictive local requirements. Where a reasonable doubt exists as to whether the requirements of the local jurisdiction are more restrictive, the effect of these requirements shall be determined by the Hospital Building Safety Board.

It is further the intent of the Legislature that the department, with the advice of the Hospital Building Safety Board, may conduct or enter into contracts for research regarding the reduction or elimination of seismic or other safety hazards in hospital buildings or research regarding hospital building standards.

SEC. 279. Section 129715 of the Health and Safety Code is amended to read:

129715. “Director” means the Director of the Department of Health Care Access and Development.

SEC. 280. Section 129730 of the Health and Safety Code is amended to read:

129730. (a) Space for the following functions shall be considered “outpatient clinical services,” when provided in a freestanding building that is separated from a hospital building where inpatient hospital services are provided: administrative space; central sterile supply; storage; morgue and autopsy facilities; employee dressing rooms and lockers; janitorial and housekeeping facilities; and laundry.

(b) The outpatient portions of the following services may also be delivered in a freestanding building and shall be considered “outpatient clinical services:” surgical; chronic dialysis; psychiatry; rehabilitation; occupational therapy; physical therapy; maternity; dentistry; and chemical dependency.

(c) Services that duplicate basic services, as defined in subdivision (a) of Section 1250, or services that are provided as part of a basic service, but are not required for facility licensure may also be provided in a freestanding building.

(d) The department shall not approve any plans that propose to locate any function listed in subdivision (a) in a freestanding building until the State Department of Health Services certifies to the department that it has received and approved a plan acceptable to the State Department of Health Services that demonstrates how the health facility will continue to provide all basic services in the event of any emergency when the freestanding building may no longer remain functional.

(e) Services listed in subdivisions (b) and (c) are subject to the same 25-percent inpatient limitation described in Section 129725.

SEC. 281. Section 129740 of the Health and Safety Code is amended to read:

129740. “Department” means the Department of Health Care Access and Information.

SEC. 282. Section 129750 of the Health and Safety Code is amended to read:

129750. The department shall observe the construction of, or addition to, any hospital building or the reconstruction or alteration of any hospital building, as it deems necessary to comply with this chapter for the protection of life and property.

SEC. 283. Section 129760 of the Health and Safety Code is amended to read:

129760. The governing board of each hospital or other hospital governing authority, before adopting any plans for the hospital building, shall submit the plans to the department for approval and shall pay the fees prescribed in this chapter.

SEC. 284. Section 129761 of the Health and Safety Code is amended to read:

129761. The department shall use, to the extent possible, information technology to facilitate the timely performance of its duties and responsibilities under this chapter.

SEC. 285. Section 129765 of the Health and Safety Code is amended to read:

129765. (a) Except as set forth in subdivision (b), the application for approval of the plans shall be accompanied by the plans, including full, complete, and accurate specifications, and structural design computations, which shall comply with the requirements prescribed by the department. The department may permit electronic submission, review, and approval of plans.

(b) Notwithstanding subdivision (a), the department, in its sole discretion, may enter into a written agreement with the hospital governing authority for the phased submittal and approval of plans. The department shall charge a fee for the review and approval of plans submitted pursuant to this subdivision. This fee shall be based on the estimated cost, but shall not exceed the actual cost, of the entire phased review and approval process for those plans. This fee shall be deducted from the application fee pursuant to Section 129785.

SEC. 286. Section 129770 of the Health and Safety Code is amended to read:

129770. (a) The department shall pass upon and approve or reject all plans for the construction or the alteration of any hospital building, independently reviewing the design to assure compliance with the requirements of this chapter. The department shall review the structural systems and related details, including the independent review of the geological data. Geological data shall be reviewed by an engineering geologist, and structural design data shall be reviewed by a structural engineer.

(b) Whenever the department finds a violation of this chapter that requires correction, a citation of the violation shall be issued to the hospital governing board or authority in writing and shall include a proper reference to the regulation or statute being violated.

SEC. 287. Section 129775 of the Health and Safety Code is amended to read:

129775. (a) Except as otherwise provided in subdivision (b), plans submitted pursuant to this chapter for work that affects structural elements shall contain an assessment of the nature of the site and potential for earthquake damage, based upon geologic and engineering investigations and reports by competent personnel of the causes of earthquake damage. One-story Type V wood frame or light steel frame, or light steel and wood frame construction of 4,000 square feet or less, shall be exempt from the provisions of this section, unless the project is within a special study zone established pursuant to Section 2622 of the Public Resources Code.

(b) The requirements of subdivision (a) may be waived by the department when the department determines that these requirements for the proposed hospital project are unnecessary and would not be beneficial to the safety of the public. The department, after consultation with the Building Safety Board, shall adopt regulations defining the criteria upon which the determination of a waiver shall be made.

SEC. 288. Section 129785 of the Health and Safety Code is amended to read:

129785. (a) (1) The department shall determine an application filing fee that will cover the costs of administering this chapter. For a hospital facility, as defined in subdivision (a), (b), or (f) of Section 1250, the fee shall not exceed 2 percent of a project's estimated construction cost. For a skilled nursing or intermediate care facility, as defined in subdivision (c), (d), (e), or (g) of Section 1250, the fee shall not exceed 1.5 percent of a project's estimated construction cost. Application filing fees shall be established in accordance with applicable procedures established in Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of Title 2 of the Government Code.

(2) Notwithstanding paragraph (1), the minimum application filing fee in any case shall be two hundred fifty dollars ($250).

(b) The department shall issue an annual permit upon submission of an application, pursuant to Section 129765, for one or more projects of a hospital facility, as defined in subdivision (a), (b), or (f) of Section 1250, if the total estimated construction cost is fifty thousand dollars ($50,000) or less per fiscal year. The fee for the annual permit shall be five hundred dollars ($500) and shall be in lieu of an application filing fee. The annual permit shall cover all projects undertaken for a particular hospital facility up to a total estimated construction cost of fifty thousand dollars ($50,000) during the state fiscal year in which the annual permit is issued. If a hospital facility chooses not to apply for an annual permit to cover a project or projects costing fifty thousand dollars ($50,000) or less in total, the hospital facility may instead submit the project or projects for review and approval as otherwise specified in this chapter, including paying the application filing fee determined under subdivision (a).

(c) The department shall issue an annual permit upon submission of an application, pursuant to Section 129765, for one or more projects of a skilled nursing or intermediate care facility, as defined in subdivision (c), (d), (e), or (g) of Section 1250, if the total estimated construction cost is twenty-five thousand dollars ($25,000) or less per fiscal year. The fee for the annual permit shall be two hundred fifty dollars ($250) and shall be in lieu of an application filing fee. The annual permit shall cover all projects undertaken for a particular skilled nursing or intermediate care facility up to a total estimated construction cost of twenty-five thousand dollars ($25,000) during the state fiscal year in which the annual permit is issued. If a skilled nursing or intermediate care facility chooses not to apply for an annual permit to cover a project or projects costing twenty-five thousand dollars ($25,000) or less in total, the skilled nursing or intermediate care facility may instead submit the project or projects for review and approval as otherwise specified in this chapter, including paying the application filing fee determined under subdivision (a).

(d) If the actual construction cost exceeds the estimated construction cost by more than 5 percent, a further fee shall be paid to the department, based on the above schedule and computed on the amount that the actual cost exceeds the amount of the estimated cost. If the estimated construction cost exceeds the actual construction cost by more than 5 percent, the department shall refund the excess portion of any paid fees, based on the above schedule and computed on the amount that the estimated cost exceeds the amount of the actual cost. A refund is not required if the applicant did not complete construction or alteration of 75 percent of the square footage included in the project, as contained in the approved drawings and specifications for the project. In addition, the department shall adopt regulations specifying other circumstances when the department shall refund to an applicant all or part of any paid fees for projects submitted under this chapter. The regulations shall include, but not be limited to, refunds of paid fees for a project that is determined by the department to be exempt or otherwise not reviewable under this chapter, and for a project that is withdrawn by the applicant prior to the commencement of review by the department of the drawing and specifications submitted for the project. All refunds pursuant to this section shall be paid from the Hospital Building Account in the Architecture Public Building Fund, as established pursuant to Section 129795.

SEC. 289. Section 129787 of the Health and Safety Code is amended to read:

129787. (a) The payment of the filing fee described in Section 129785 may be postponed by the department if all of the following conditions are met:

(1) The proposed construction or alteration has been proposed as a result of any event that has been declared to be a disaster by the Governor.

(2) The department determines that the applicant cannot presently afford to pay the filing fee.

(3) The applicant has applied for federal disaster relief from the Federal Emergency Management Agency (FEMA) with respect to the disaster described in paragraph (1).

(4) The applicant is expected to receive disaster assistance within one year from the date of the application.

(b) If the department does not receive full payment of any fee for which payment has been postponed pursuant to subdivision (a) within one year from the date of plan approval, the statewide department may request an offset from the Controller for the unpaid amount against any amount owed by the state to the applicant, and may request additional offsets against amounts owed by the state to the applicant until the fee is paid in full. This subdivision shall not be construed to establish an offset as described in the preceding sentence as the exclusive remedy for the collection of any unpaid fee amount as described in that same sentence.

SEC. 290. Section 129790 of the Health and Safety Code is amended to read:

129790. The department shall propose specific space, architectural, structural, mechanical, plumbing, and electrical standards for correctional treatment centers in cooperation with the Board of Corrections, the Department of Corrections, and the Department of the Youth Authority.

SEC. 291. Section 129795 of the Health and Safety Code is amended to read:

129795. All fees shall be paid into the State Treasury and credited to the Hospital Building Fund, that is hereby created and continuously appropriated without regard to fiscal years for the use of the department, subject to approval of the Department of Finance, in carrying out this chapter. Adjustments in the amounts of the fees, as determined by the department and approved by the Department of Finance, shall be made within the limits set in Section 129785 in order to maintain a reasonable working balance in the account. Notwithstanding any other provision of law, any moneys collected pursuant to this chapter contained in the hospital building fund established by the Department of Finance, that are in the fund on January 1, 1994, shall be available for expenditure in accordance with this section.

SEC. 292. Section 129800 of the Health and Safety Code is amended to read:

129800. The director shall request the Department of Finance or the Auditor General to perform an audit of the uses of fees collected pursuant to Section 129785. This audit shall include, but not be limited to, an accounting of staff resources allocated to hospital plan reviews by the department and by the Office of the State Architect in the Department of General Services since these reviews are funded by fees collected pursuant to Section 129785. If the Department of Finance and the Auditor General indicate that other audit responsibilities will prohibit them from performing and completing the audit within six months of being initially requested to do so, then the department may contract with an independent organization to perform the audit.

SEC. 293. Section 129805 of the Health and Safety Code is amended to read:

129805. (a) All plans and specifications shall be prepared under the responsible charge of an architect or a structural engineer, or both. A structural engineer shall prepare the structural design and shall sign plans and specifications related thereto. Administration of the work of construction shall be under the responsible charge of the architect and structural engineer, except that where plans and specifications for alterations or repairs do not affect architectural or structural conditions, the plans and specifications may be prepared under the responsible charge of, and work of construction may be administered by, a professional engineer duly qualified to perform the services and holding a valid certificate under Chapter 7 (commencing with Section 6700) of Division 3 of the Business and Professions Code for performance of services in that branch of engineering in which the plans, specifications, and estimates and work of construction are applicable.

(b) The department may exempt projects from the requirements of subdivision (a) where the plans and specifications are not ordinarily, in the standard practice of architecture and engineering, prepared by licensed architects or registered engineers, or both, and are not a component of a project prepared under the responsible charge of a licensed architect or registered engineer, or both. To implement this authority, the department shall adopt regulations, consistent with this section, that specify which projects may be exempted from the requirements of subdivision (a).

SEC. 294. Section 129810 of the Health and Safety Code is amended to read:

129810. Before commencing any construction or alteration of any hospital building, the written approval of the necessary plans as to safety of design and construction, by the department, shall be obtained.

SEC. 295. Section 129812 of the Health and Safety Code is amended to read:

129812. Notwithstanding any other provision of law, the department may utilize an over-the-counter plan review process.

SEC. 296. Section 129820 of the Health and Safety Code is amended to read:

129820. No contract for the construction or alteration of any hospital building, made or executed on or after January 1, 1983, by the governing board or authority of any hospital or other similar public board, body, or officer otherwise vested with authority to make or execute the contract, is valid, and no money shall be paid for any work done under the contract or for any labor or materials furnished in constructing or altering the hospital building, unless all of the following requirements are satisfied:

(a) The plans and specifications comply with this chapter and the requirements contained in the California Building Standards Code.

(b) The written approval thereof has first been obtained from the department.

(c) The hospital building is to be accessible to, and usable by, persons with disabilities.

(d) The plans and specifications comply with the fire and panic safety requirements of the California Building Standards Code.

SEC. 297. Section 129825 of the Health and Safety Code is amended to read:

129825. (a) The hospital governing board or authority shall provide for and require competent and adequate inspection during construction or alteration by an inspector satisfactory to the architect or structural engineer, or both, and the department. Except as otherwise provided in subdivision (b), the inspector shall act under the direction of the architect or structural engineer, or both, and be responsible to the board or authority. Nothing in this section shall be construed to prohibit any licensed architect, structural engineer, mechanical engineer, electrical engineer, or any facility maintenance personnel, if approved by the department, from performing the duties of an inspector.

(b) If alterations or repairs are to be conducted under the supervision of a professional engineer pursuant to Section 129805, the inspector need only be satisfactory to the department and to the professional engineer, and the inspector shall act under the direction of the professional engineer.

(c) The department shall make an inspection of the hospital buildings and of the work of construction or alteration as in its judgment is necessary or proper for the enforcement of this chapter and the protection of the safety of the public.

Whenever the department finds a violation of this chapter that requires correction, the citation of the violation shall be issued to the hospital governing board or authority in writing and shall include a proper reference to the regulation or statute being violated.

(d) The department shall approve inspectors that shall be limited to the following:

(1) “A” inspectors, who may inspect all areas of construction specialty, including, but not limited to, structural.

(2) “B” inspectors, who may inspect all areas of construction specialty, except structural.

(3) “C” inspectors, who may inspect one or more areas of construction specialty, including structural, but may not inspect the scope of construction specialties authorized for “A” or “B” inspectors.

(e) (1) As part of its approval process, the department shall initially and periodically examine inspectors by giving either a written examination or a written and oral examination. The department may charge a fee for the examination process calculated to cover its costs. Inspectors who have not passed a written examination shall not be approved by the department until they have successfully passed the written examination. No employee of the department performing field inspections or supervising the field inspections shall be approved as an inspector on any construction project pursuant to this chapter for a period of one year after leaving employment of the department.

(2) The department shall develop regulations for the testing and approval of inspectors.

SEC. 298. Section 129830 of the Health and Safety Code is amended to read:

129830. From time to time, as the work of construction or alteration progresses and whenever the department requires, the architect or structural engineer, or both, in charge of construction or registered engineer in charge of other work, the inspector on the work, and the contractor shall each make a report, duly verified by them, upon a form prescribed by the department showing, of their personal knowledge, that the work during the period covered by the report has been performed and materials used and installed are in accordance with the approved plans and specifications, setting forth detailed statements of fact as required by the department.

The term “personal knowledge,” as used in this section and as applied to the architect or registered engineer, or both, means the personal knowledge that is obtained by periodic visits to the project site of reasonable frequency, for the purpose of general observation of the work, and that is also obtained from the reporting of others as to the progress of the work, testing of materials, and inspection and superintendence of the work that is performed between the periodic visits of the architect or the registered engineer. Reasonable diligence shall be exercised in obtaining the facts.

The term “personal knowledge,” as applied to the inspector, means the actual personal knowledge that is obtained from the inspector’s personal continuous inspection of the work of construction in all stages of its progress at the site where the inspector is responsible for inspection, and when work is carried out away from the site, that personal knowledge that is obtained from the reporting of others on the testing or inspection of materials and workmanship, for compliance with plans, specifications, or applicable standards. Reasonable diligence shall be exercised in obtaining the facts.

The term “personal knowledge,” as applied to the contractor, means the personal knowledge that is obtained from the construction of the building. The exercise of reasonable diligence to obtain the facts is required.

SEC. 299. Section 129835 of the Health and Safety Code is amended to read:

129835. Upon written request to the department by the governing board or authority of any hospital, the department shall make, or cause to be made, an examination and report on the condition of any hospital building subject to the payment by the governing board or authority of the actual expenses incurred by the department.

SEC. 300. Section 129840 of the Health and Safety Code is amended to read:

129840. Subsequent to the occurrence of any earthquake, the department may make, or cause to be made, studies of health facilities within the area involved.

SEC. 301. Section 129850 of the Health and Safety Code is amended to read:

129850. Except as provided in Sections 18929 and 18930, the department shall from time to time make any regulations that it deems necessary, proper, or suitable to effectually carry out this chapter. The department shall also propose and submit building standards to the California Building Standards Commission for adoption and approval pursuant to Chapter 4 (commencing with Section 18935) of Part 2.5 of Division 13 relating to seismic safety for hospital buildings.

SEC. 302. Section 129851 of the Health and Safety Code is amended to read:

129851. Written rules and regulations by the department to clarify the application of the California Building Standards Code pursuant to this chapter shall be made available to the public upon request.

SEC. 303. Section 129853 of the Health and Safety Code is amended to read:

129853. (a) The person or entity requesting a copy of construction documents maintained by the department shall bear the actual cost of producing the copy of those documents, including staff time spent retrieving, inspecting, and handling the documents, copying costs, and shipping costs.

(b) The department shall provide an estimate of the costs described in subdivision (a) to the requester before the department begins to make those copies.

SEC. 304. Section 129855 of the Health and Safety Code is amended to read:

129855. The department may enter into any agreements and contracts with any qualified person, department, agency, corporation, or legal entity, as determined by the department, when necessary in order to facilitate the timely performance of the duties and responsibilities relating to the review and inspection of architectural, mechanical, electrical, and plumbing systems of hospital buildings to be constructed or altered or buildings under construction or alteration.

If the department determines that the structural review of plans for a hospital building cannot be completed without undue delay, the department may enter into contractual agreements with private structural engineers or local governments for the purpose of facilitating the timely performance of the duties and responsibilities relating to the review and inspection of plans and specifications of the structural systems of hospital construction projects.

The department, with the advice of the Building Safety Board, shall prepare regulations, containing qualification criteria, for implementing the contractual agreement provisions of this section.

SEC. 305. Section 129856 of the Health and Safety Code is amended to read:

129856. (a) Contingent on an appropriation in the annual Budget Act, the department shall establish a program for training fire and life safety officers. The goal of this program shall be to provide a sufficient number of qualified persons to facilitate the timely performance of the department's duties and responsibilities relating to the review of plans and specifications pertaining to the design and observation of construction of hospital buildings and buildings described in paragraphs (2) and (3) of subdivision (b) of Section 129725, in order to ensure compliance with applicable facility design and construction codes and standards.

(b) The department shall prepare a comprehensive report on the training program setting forth its goals, objectives, and structure. The report shall include the number of fire and life safety officers to be trained annually, a timeline for training completion, a process for gathering information to evaluate the training programs efficiency that includes dropout and retention rates, and a mechanism to annually assess the need for the training program to continue. The report shall be submitted to the Joint Legislative Budget Committee by April 1, 2007.

(c) The department may establish other training programs as necessary to ensure that a sufficient number of qualified persons are available to facilitate the timely performance of the department's duties and responsibilities relating to the review of plans and specifications pertaining to the design and construction of hospital buildings and buildings described in paragraphs (2) and (3) of subdivision (b) of Section 129725, to ensure compliance with applicable safety codes and standards.

(d) If additional training programs are established pursuant to subdivision (c), the department shall prepare a comprehensive report on the training program setting forth its goals, objectives, and structure. The report shall include the number of individuals trained pursuant to subdivision (c) annually, a timeline for training completion, a process for gathering information to evaluate the training programs efficiency that includes dropout and retention rates, and a mechanism to annually assess the need for the training program to continue. The report shall be submitted to the Joint Legislative Budget Committee three years after the training program has been implemented.

SEC. 306. Section 129875 of the Health and Safety Code is amended to read:

129875. Construction or alterations of buildings specified in paragraphs (2) and (3) of subdivision (b) of Section 129725 shall conform to the latest edition of the California Building Standards Code. The department shall independently review and inspect these buildings. For purposes of this section, “construction or alteration” includes the conversion of a building to a purpose specified in paragraphs (2) and (3) of subdivision (b) of Section 129725. Any construction or alteration of any building subject to this section shall be exempt from any plan review and approval or construction inspection requirement of any city or county.

The department may also exempt from the plan review process or expedite those projects undertaken by an applicant for a hospital building that the department determines do not materially alter the mechanical, electrical, architectural, or structural integrity of the facility. The department shall set forth criteria to expedite projects or to implement any exemptions made pursuant to this paragraph.

The Legislature recognizes the relative safety of single-story, wood-frame, and light steel frame construction for use in housing patients requiring skilled nursing and intermediate care services and it is, therefore, the intent of the Legislature to provide for reasonable flexibility in seismic safety standards for these structures. The department shall be reasonably flexible in the application of seismic standards for other buildings by allowing incidental and minor nonstructural additions or nonstructural alterations to be accomplished with simplified written approval procedures as established by the department, with the advice of the Division of the State Architect and the Office of the State Fire Marshal.

The department shall implement, and modify, as necessary, criteria to exempt from the plan review process or expedite those projects for alterations of hospital buildings, and for those specified in paragraphs (2) and (3) of subdivision (b) of Section 129725 that may include, but are not limited to, renovations, remodeling, or installations of necessary equipment such as hot water heaters, air-conditioning units, dishwashers, laundry equipment, handrails, lights, television brackets, small emergency generators (up to 25 kilowatts), storage shelves, and similar plant operations equipment; and decorative materials such as wall coverings, floor coverings, and paint.

The department shall include provisions for onsite field approvals by available department construction advisers and the preapproval of projects that comply with the requirements for which the department has developed standard architectural or engineering detail, or both standard architectural and engineering detail.

SEC. 307. Section 129875.1 of the Health and Safety Code is amended to read:

129875.1. (a) Notwithstanding Section 129875, projects for the construction or alterations of buildings specified in paragraph (1) of subdivision (a) of Section 129725 that are single-story, wood-frame or light steel frame construction and buildings specified in paragraphs (2) and (3) of subdivision (b) of Section 129725 shall be exempt from plan review and inspection by the department prior to construction if the facility demonstrates to the department, by written description of the project, that all of the following conditions are met:

(1) The construction or alteration is undertaken to repair existing systems or to keep up the course of normal or routine maintenance.

(2) The construction or alteration either restores the facility to the same operational status, or improves operational status from its operating condition immediately prior to the event, occurrence, or condition that necessitated the alteration.

(3) The scope of the construction or alteration is not ordinarily within the standard of practice of a licensed architect or registered engineer.

(4) The construction or alteration does not degrade the status or condition of the fire and life safety system from the status of the system immediately prior to the event, occurrence, or condition that necessitated the alteration.

(b) Upon completion of construction or alteration of any building subject to this section, and prior to use of the repaired system or other subject of the construction or alteration, the department shall inspect and approve the work. The department may require an interim inspection for code compliance when walls, ceilings, or other materials or finishes will cover the final work.

(c) Upon compliance with subdivision (a), the department shall issue a building permit.

SEC. 308. Section 129880 of the Health and Safety Code is amended to read:

129880. (a) The department may exempt from its plan review process construction or alteration projects for hospital buildings and buildings described in paragraphs (2) and (3) of subdivision (b) of Section 129725 with estimated construction costs of fifty thousand dollars ($50,000) or less. The criteria for exemption shall include, but not be limited to, plans that have been stamped and signed by the design professionals of record.

(b) Projects that have been split into a series of smaller projects in order to avoid the qualifying dollar limits shall not be approved. The department shall maintain its construction observation mandate to ensure public safety and California Building Standards Code compliance for approved projects.

(c) A presubmittal meeting between the department and the design professionals shall be required for construction or alteration projects for hospital buildings and buildings described in paragraphs (2) and (3) of subdivision (b) of Section 129725 with estimated construction costs of twenty million dollars ($20,000,000) or more.

(d) The department may adopt regulations for this section to make specific the exemption criteria and processes authorized pursuant to subdivision (a), and the complete plan review process required pursuant to subdivision (c).

SEC. 309. Section 129885 of the Health and Safety Code is amended to read:

129885. (a) A city or county, as applicable, shall have plan review and building inspection responsibilities for the construction or alteration of buildings described in paragraph (1) of subdivision (b) of Section 129725. The building standards for the construction or alteration of buildings specified in paragraph (1) of subdivision (b) of Section 129725 established or applied by a city or county, shall not be more restrictive or comprehensive than comparable building standards established, or otherwise applied, to clinics licensed pursuant to Chapter 1 (commencing with Section 1200) of Division 2. For chronic dialysis and surgical services buildings, construction or alteration shall include conversion of a building to a purpose specified in paragraph (1) of subdivision (b) of Section 129725.

(b) Upon the initial submittal to a city or county by the governing authority or owner of a hospital for plan review and building inspection services for buildings described in paragraph (1) of subdivision (b) of Section 129725 for chronic dialysis and surgical services, the city or county shall reply in writing to the hospital as to whether or not the plan review by the city or county will include a certification as to whether or not the clinic project submitted for plan review meets the clinic standards propounded by the department in the California Building Standards Code.

If the city or county indicates that its review will include this certification, it shall do all of the following:

(1) Apply the applicable clinic provisions of the latest edition of the California Building Standards Code.

(2) Certify in writing to the applicant within 30 days of completion of construction whether or not the standards have been met.

(c) If, upon initial submittal, the city or county indicates that its plan review will not include this certification, the governing authority or owner shall submit the plans to the Department of Health Care Access and Information and the department shall review the plans for certification to determine whether or not the clinic project meets the standards propounded by the department in the California Building Standards Code.

(d) When the department performs the certification review, the department shall charge a fee in an amount not to exceed its actual cost.

(e) Notwithstanding subdivision (a), the governing authority of a hospital may request the Department of Health Care Access and Information to perform plan review and building inspection services for buildings described in paragraph (1) of subdivision (b) of Section 129725 and Section 129730. The department shall perform these services upon request and shall charge an amount equal to its standard fee for the construction and alteration of hospital buildings. The construction or alteration of these buildings shall conform to the applicable provisions of the latest edition of the California Building Standards Code for purposes of the plan review and building inspection of the department pursuant to this subdivision. The department shall issue the building permit and certificate of occupancy for these facilities.

(f) A building described in paragraph (1) of subdivision (b) of Section 129725 that is subject to the plan review and building inspection of the department pursuant to subdivision (e), may be designated by the governing authority or owner of the hospital as a “hospital building” as long as the building remains under the jurisdiction of the department. This hospital building shall be reviewed and inspected according to the standards and requirements of the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983 (Chapter 1 (commencing with Section 129675)).

(g) When a building is accepted for review by the department pursuant to subdivision (e), the governing authority of the hospital shall not request the city or county, as applicable, to conduct plan review and building inspection for any subsequent alteration of the same building, unless written notification is submitted to the department by the governing authority or owner of the hospital.

SEC. 310. Section 129890 of the Health and Safety Code is amended to read:

129890. (a) Notwithstanding any other provision of law, the department shall, on or before January 1, 1991, set forth and implement criteria for the alteration or construction of buildings specified in subdivision (a) of Section 129725 that provide for onsite field review and approval by construction advisers of the department and provide for preapproval of project plans that comply with the requirements for which the department has developed standard architectural or engineering detail, or both standard architectural and engineering detail.

(b) Onsite field reviews shall be performed by available area construction advisers of the department. The area construction advisers shall have the responsibility to coordinate any approvals required by the State Fire Marshal. The approvals may be obtained prior to the start of construction or on a deferred basis, at the discretion of the area construction adviser.

(c) An annual building permit project classified as a “field review” shall be reviewed and approved by the area construction adviser.

(d) Effective January 1, 1991, all plans submitted for the alteration or construction of buildings specified in subdivision (a) of Section 129725 to the department for plan review shall be evaluated to determine if it is exempt from the plan review process or if it qualifies for an expedited plan review. The evaluation shall give priority to plans that are for minor renovation, remodeling, or installation of equipment.

SEC. 311. Section 129895 of the Health and Safety Code is amended to read:

129895. (a) The department shall adopt by regulations seismic safety standards for hospital equipment anchorages, as defined by the department, to include, but not be limited to, architectural, mechanical, and electrical components, supports, and attachments. Those regulations shall include criteria for the testing of equipment anchorages.

(b) Any fixed hospital equipment anchorages purchased or acquired on or after either the effective date of the regulations adopted pursuant to subdivision (a) shall not be used or installed in any hospital building unless the equipment anchorages are approved by the department.

(c) Manufacturers, designers, or suppliers of equipment anchorages may submit data sufficient for the office to evaluate equipment anchorages’ seismic safety prior to the selection of equipment anchorages for any specific hospital building.

(d) The department may charge a fee based on the actual costs incurred by it for data review, approvals, and field inspections pursuant to this section.

SEC. 312. Section 129900 of the Health and Safety Code is amended to read:

129900. Notwithstanding any other provision of law, plans for the construction or alteration of any hospital building, or any building specified in Section 129875, that are prepared by or under the supervision of the Department of General Services shall not require the review and approval of the department. In lieu of review and approval by the department, the Department of General Services shall certify to the department that the plans are in full conformance with all applicable building standards and the requirements of this chapter. The Department of General Services shall also observe all aspects of construction and alteration, including the architectural, structural, mechanical, plumbing and electrical systems.

It is the intent of the Legislature that projects developed by, or under the supervision of, the Department of General Services shall still meet all applicable building standards published in the State Building Standards Code relating to the regulation of hospital projects where applicable, and all regulations adopted pursuant to this chapter and all other applicable state laws.

SEC. 313. Section 129905 of the Health and Safety Code is amended to read:

129905. Subject to the complete exemption contained in paragraphs (6) and (7) of subdivision (b) of Section 129725, and notwithstanding any other provision of law, plans for the construction or alteration of any hospital building, as defined in Section 1250, or any building specified in Section 129875, that are prepared by or under the supervision of the Department of Corrections or on behalf of the Department of the Youth Authority, shall not require the review and approval of the statewide department. In lieu of review and approval by the statewide department, the Department of Corrections and the Department of the Youth Authority shall certify to the statewide department that their plans and construction are in full conformance with all applicable building standards, including, but not limited to, fire and life and safety standards, and the requirements of this chapter for the

architectural, structural, mechanical, plumbing, and electrical systems. The Department of Corrections and the Department of the Youth Authority shall use a secondary peer review procedure to review designs to ensure the adherence to all design standards for all new construction projects, and shall ensure that the construction is inspected by a competent, onsite inspector to ensure the construction is in compliance with the design and plan specifications.

Subject to the complete exemption contained in paragraphs (6) and (7) of subdivision (b) of Section 129725, and notwithstanding any other provision of law, plans for the construction or alteration of any correctional treatment center that are prepared by or under the supervision of a law enforcement agency of a city, county, or city and county shall not require the review and approval of the statewide department. In lieu of review and approval by the statewide department, the law enforcement agency of a city, county, or city and county shall certify to the statewide department that the plans and construction are in full conformance with all applicable building standards, including, but not limited to, fire and life and safety standards, and the requirements of this chapter for the architectural, structural, mechanical, plumbing, and electrical systems.

It is the intent of the Legislature that, except as specified in this section, all hospital buildings as defined by this chapter constructed by or under the supervision of the Department of Corrections or local law enforcement agencies, or constructed on behalf of the Department of the Youth Authority shall at a minimum meet all applicable regulations adopted pursuant to this chapter and all other applicable state laws.

SEC. 314. Section 129925 of the Health and Safety Code is amended to read:

129925. There is in the department a Hospital Building Safety Board that shall be appointed by the director. The board shall advise the director and, notwithstanding Section 13142.6 and except as provided in Section 18945, shall act as a board of appeals in all matters relating to the administration and enforcement of building standards relating to the design, construction, alteration, and seismic safety of hospital building projects submitted to the department pursuant to this chapter.

Further, notwithstanding Section 13142.6, the board shall act as the board of appeals in matters relating to all fire and panic safety regulations and alternate means of protection determinations for hospital building projects submitted to the department pursuant to this chapter.

SEC. 315. Section 129930 of the Health and Safety Code is amended to read:

129930. The board shall consist of 16 members appointed by the director of the department. Of the appointive members, two shall be structural engineers, two shall be architects, one shall be an engineering geologist, one shall be a geotechnical engineer, one shall be a mechanical engineer, one shall be an electrical engineer, one shall be a hospital facilities manager, one shall be a local building official, one shall be a general contractor, one shall be a fire and panic safety representative, one shall be a hospital inspector of record, and three shall be members of the general public.

SEC. 316. Section 129940 of the Health and Safety Code is amended to read:

129940. (a) There shall be six ex officio members of the board, who shall be the director of the department, the State Fire Marshal, the State Geologist, the Executive Director of the California Building Standards Commission, the State Director of Health Services, and the Deputy Director of the Division of Facilities Development in the department, or their officially designated representatives.

(b) The director may also appoint up to three additional ex officio members, with the advice of the chair. On January 1, 1994, director-appointed ex officio members may continue to serve until appointment of their successors by the director.

SEC. 317. Section 129950 of the Health and Safety Code is amended to read:

129950. The board shall be served by an executive director who shall be a member of the department staff.

SEC. 318. Section 129975 of the Health and Safety Code is amended to read:

129975. The director of the department may conduct studies relating to the implementation of this chapter to ensure that the implementation of its provisions results in the least amount of increases in costs, staffing, and regulation.

SEC. 319. Section 129980 of the Health and Safety Code is amended to read:

129980. Whenever any construction or alteration of any hospital building is being performed contrary to the provisions of this chapter, the department may order the construction or alteration stopped by written notice served upon any persons engaged in or causing the work to be done. Upon service of the written notice, all construction or alteration shall cease until an authorization

to remove the notice is issued by the department. Any person so served shall, upon request made within 15 days of the written notice, be entitled to a hearing pursuant to Section 11506 of the Government Code.

SEC. 320. Section 129985 of the Health and Safety Code is amended to read:

129985. (a) Whenever it is necessary to make an inspection to enforce any of the provisions of this chapter or whenever the department or its authorized representatives has reasonable cause to believe that there exists in any building or upon any premises any condition or a violation of any applicable building standards that makes the building or premises unsafe, dangerous, or hazardous, the department or its authorized representatives may enter the building or premises at any reasonable time to make an inspection or to perform any authorized duty. Prior to an entry authorized by this section, the authorized representatives of the department shall first present proper identification and credentials and request entry. In the event that the building or premises are unoccupied, there shall be a reasonable effort made to locate the owner or other person or persons having control or charge of the building or premises in order to request an entry. If a request for entry is refused, the department or its authorized representatives shall have recourse to any remedy prescribed by law to secure entry.

(b) Whenever the owner, occupant, or other person having control or charge of the building or premises is presented with a proper inspection warrant or other authorization prescribed by law to secure entry and a request for entry is made, the owner, occupant, or other person having control or charge of the building or premises shall promptly permit the entry of the authorized representatives of the department for the purpose of inspection and examination authorized by this chapter.

SEC. 321. Section 129990 of the Health and Safety Code is amended to read:

129990. The department may order the vacating of any building or structure found to have been in violation of the adopted regulations of the department and may order the use of the building or structure discontinued within the time prescribed by the department upon the service of notice to the owner or other person having control or charge of the building or structure. Any owner or person having control so served shall, upon request made within 15 days of the written notice, be entitled to a hearing pursuant to Section 11506 of the Government Code.

SEC. 322. Section 130000 of the Health and Safety Code is amended to read:

130000. (a) The Legislature hereby finds and declares the following:

(1) The Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983 was created because of the loss of life in the collapse of hospitals during the Sylmar earthquake of 1971.

(2) We were reminded of the vulnerability of hospitals in the Northridge earthquake of January 17, 1994.

(3) Several hospitals built prior to the act suffered major damage and had to be evacuated.

(4) Hospitals built to the Alfred E. Alquist Hospital Facilities Seismic Safety Act standards resisted the Northridge earthquakes with very little structural damage demonstrating the value and necessity of this act.

(5) Both pre- and post-act hospitals suffered damage to architecture and to power and water systems that prevented hospitals from being operational, caused the loss of one life, triggered evacuations, unacceptable property losses, and added additional concerns on emergency medical response.

(6) An earthquake survivability inventory of California's hospitals completed by the Department of Health Care Access and Information in December 1989 indicated that over 83 percent of the state's hospital beds were in buildings that did not comply with the Alfred E. Alquist Hospital Facilities Seismic Safety Act because they were issued permits prior to the effective date of the act. Furthermore, 26 percent of the beds are in buildings posing significant risks of collapse since they were built before modern earthquake codes. The older hospitals pose significant threats of collapse in major earthquakes and loss of functions in smaller or more distant earthquakes.

(7) The 1989 survey also states: "Of the 490 hospitals surveyed, nine hospitals are in Alquist–Priolo Earthquake Fault Rupture Zones, 31 are in areas subject to soil liquefaction, 14 in areas with landslide potential, 33 in flood zones, and 29 have a possible loss or disruption of access. Two hundred five hospitals had no emergency fuel for their main boilers on hand, 19 had no emergency fuel for their emergency generators. Onsite emergency potable water was available at 273 hospitals and nonpotable water was available at 102 hospitals. Four hundred eighteen hospitals had emergency radios onsite, and 419 hospitals had inadequate or partially adequate equipment anchorage. In terms of available emergency preparedness, inadequate or partially inadequate equipment anchorage is still the most widespread shortcoming."

(8) This survey identifies many of the shortcomings that caused 23 hospitals to suspend some or all operations after the Northridge earthquake. However, one hospital was rebuilt to comply with the Alfred E. Alquist Hospital Facilities Seismic Safety

Act after an older hospital building had partially collapsed in the 1971 Sylmar earthquake. The rebuilt hospital suffered failures in water distribution systems and had to be evacuated.

(9) The state must rely on hospitals to support patients and offer medical aid to earthquake victims.

(b) Therefore, it is the intent of the Legislature, that:

(1) By enacting this article, the state shall take steps to ensure that the expected earthquake performance of hospital buildings housing inpatients and providing primary basic services is disclosed to public agencies that have a need and a right to know, because the medical industry cannot immediately bring all hospital buildings into compliance with the Alfred E. Alquist Hospital Facilities Seismic Safety Act.

(2) The state shall encourage structural retrofits or replacements of hospital buildings housing inpatients and providing primary basic services that place lives at risk because of their potential for collapse during an earthquake.

(3) The state shall also encourage retrofits and enhancements to critical hospital architecture, equipment, and utility and communications systems to improve the ability of hospitals to remain operational for those hospitals that do not pose risk to life.

SEC. 323. Section 130005 of the Health and Safety Code is amended to read:

130005. By June 30, 1996:

(a) The Department of Health Care Access and Information, hereinafter called the department, shall develop definitions of earthquake performance categories for earthquake ground motions for both new and existing hospitals that are:

(1) Reasonably capable of providing services to the public after a disaster, designed and constructed to resist, insofar as practical, the forces generated by earthquakes, gravity, and winds, and in full compliance with the regulations and standards developed by the department pursuant to the Alfred E. Alquist Hospital Facilities Seismic Safety Act.

(2) In substantial compliance with the pre-1973 California Building Standards Codes, but not in substantial compliance with the regulations and standards developed by the department pursuant to the Alfred E. Alquist Hospital Facilities Seismic Safety Act. These buildings may not be repairable or functional but will not significantly jeopardize life.

(3) Potentially at significant risk of collapse and that represent a danger to the public.

(b) The department may define other earthquake performance categories as it deems necessary to meet the intent of this article and the Alfred E. Alquist Hospital Facilities Seismic Safety Act.

(c) Earthquake performance categories shall also include subgradations for risk to life, structural soundness, building contents, and nonstructural systems that are critical to providing basic services to hospital inpatients and the public after a disaster.

(d) Earthquake performance categories shall, as far as practicable, use language consistent with definitions and concepts as developed in the model codes and other state and federal agencies. Where the department finds that deviations from other's definitions and concepts are necessary and warranted to comply with the intent of the Alfred E. Alquist Hospital Facilities Seismic Safety Act, the act that added this article, or the specific nature or functions of hospitals, the department shall provide supporting documentation that justifies these differences.

(e) Insofar as practicable, the department shall define rapid seismic evaluation procedures that will allow owners to determine with reasonable certainty the existing applicable earthquake performance categories and the minimum acceptable earthquake performance categories for hospital buildings. These procedures shall allow for abbreviated analysis when known vulnerability is clear and when construction in accordance with post-1973 codes allows for an evaluation focusing on limited structural and nonstructural elements.

(f) The department, in consultation with the Hospital Building Safety Board, shall develop regulations to identify the most critical nonstructural systems and to prioritize the timeframes for upgrading those systems that represent the greatest risk of failure during an earthquake.

(g) The department shall develop regulations as they apply to the administration of seismic standards for retrofit designs, construction, and field reviews for the purposes of this article.

(h) The department shall develop regulations for the purpose of reviewing requests and granting delays to hospitals demonstrating a need for more time to comply with Section 130060.

(i) The department shall submit all information developed pursuant to subdivisions (a) to (f), inclusive, to the California Building Standards Commission by June 30, 1996.

(j) The department shall submit all information developed pursuant to subdivisions (g) and (h) to the California Building Standards Commission by December 31, 1996.

(k) “Hospital building,” as used in Article 8 and Article 9 of this chapter means a hospital building as defined in Section 129725 and that is also licensed pursuant to subdivision (a) of Section 1250, but does not include these buildings if the beds licensed pursuant to subdivision (a) of Section 1250, as of January 1, 1995, comprise 10 percent or less of the total licensed beds of the total physical plant, and does not include facilities owned or operated, or both, by the Department of Corrections.

SEC. 324. Section 130010 of the Health and Safety Code is amended to read:

130010. The department is responsible for reviewing and approving seismic evaluation reports, compliance schedules and construction documents that are developed by hospital owners, and field review of construction for work done pursuant to this article.

SEC. 325. Section 130020 of the Health and Safety Code is amended to read:

130020. (a) By December 31, 1996, the California Building Standards Commission shall review, revise as necessary and adopt earthquake performance categories, seismic evaluation procedures, and standards and timeframes for upgrading the most critical nonstructural systems as developed by the department. By June 30, 1997, the California Building Standards Commission shall review, revise as necessary, and adopt seismic retrofit building standards and procedures for reviewing requests and granting delays to hospitals that demonstrate a need for more time to comply with Section 130060.

(b) For purposes of this section all submittals made by the department pursuant to subdivisions (i) and (j) of Section 130005 shall be deemed as emergency regulations and adopted as such.

SEC. 326. Section 130025 of the Health and Safety Code is amended to read:

130025. (a) In the event of a seismic event, or other natural or manmade calamity that the department believes is of a magnitude so that it may have compromised the structural integrity of a hospital building, or any major system of a hospital building, the department shall send one or more authorized representatives to examine the structure or system. “System” for these purposes shall include, but not be limited to, the electrical, mechanical, plumbing, and fire and life safety system of the hospital building. If, in the opinion of the department, the structural integrity of the hospital building or any system has been compromised and damaged to a degree that the hospital building has been made unsafe to occupy, the department may cause to be placed on the hospital building either a red tag, a yellow tag, or a green tag.

(b) A “red” tag shall mean the hospital building is unsafe and shall be evacuated immediately. Access to red-tagged buildings shall be restricted to persons authorized by the department to enter.

(c) A “yellow” tag shall mean that the hospital building has been authorized for limited occupancy, and the authorized representative of the department shall write directly on the yellow tag that portion of the hospital building that may be entered with or without restriction and those portions that may not.

(d) A “green” tag shall mean the hospital building and all of its systems have been inspected by an authorized agent of the department, and have been found to be safe for use and occupancy.

(e) Any law enforcement or other public safety agency of this state shall grant access to hospital buildings by authorized representatives of the department upon the showing of appropriate credentials.

(f) For purposes of this section, “hospital building” includes the buildings referred to in paragraphs (2) and (3) of subdivision (b) of Section 129725.

SEC. 327. Section 130050 of the Health and Safety Code is amended to read:

130050. (a) Within three years after the adoption of the standards described in Section 130020, owners of all general acute care hospitals shall:

(1) Conduct seismic evaluations in accordance with procedures developed by the department pursuant to subdivision (e) of Section 130005 and submit evaluations to the department for its review and approval.

(2) Identify the most critical nonstructural systems that represent the greatest risk of failure during an earthquake and submit the timetables for upgrading those systems pursuant to subdivision (f) of Section 130005 to the department for its review and approval.

(3) With respect to the nonstructural performance evaluation required by this subdivision, the evaluation need not exceed those required by the nonstructural performance category the hospital owner has elected. Additional evaluations shall be obtained if the hospital owner elects to obtain a higher nonstructural performance category at a future date. A hospital owner shall report to the department all deficiencies that are pertinent to the nonstructural performance category the hospital owner has elected to attain. A complete nonstructural evaluation and list of nonstructural deficiencies shall be submitted to the department prior to the hospital owner selling or leasing the hospital to another party.

(b) Within three years after the adoption of standards described in Section 130020, owners of all general acute care hospitals shall prepare a plan and compliance schedule for each building under the department's jurisdiction that indicates the steps by which the hospital intends to bring their hospital buildings into substantial compliance with the regulations and standards developed by the department pursuant to the Alfred E. Alquist Hospital Facilities Seismic Safety Act and this act, identifies the phasing out of or retrofit of noncomplying structures and systems, or outlines steps for relocation of acute care services to facilities that comply with the regulations and standards developed by the department pursuant to the Alfred E. Alquist Hospital Facilities Seismic Safety Act and this act, and presents comprehensive plans and compliance schedules to the department for its review and approval, and integrates this schedule into the facility's master plan.

(c) Owners of all general acute care hospitals may be granted a one year allowance from the requirements of subdivision (b) by the department if they demonstrate a need for more time to prepare plans and compliance schedules for their buildings.

SEC. 328. Section 130055 of the Health and Safety Code is amended to read:

130055. Within 60 days following the department's approval of the report submitted pursuant to subdivision (b) of Section 130050, general acute hospital building owners shall do all of the following:

(a) Inform the local office of emergency services or the equivalent agency, the Office of Emergency Services, and the department, of each building's expected earthquake performance.

(b) Include all pertinent information regarding the building's expected earthquake performance in emergency training, response, and recovery plans.

(c) Include all pertinent information regarding the building's expected earthquake performance in capital outlay plans.

SEC. 329. Section 130060 of the Health and Safety Code is amended to read:

130060. (a) (1) After January 1, 2008, a general acute care hospital building that is determined to be a potential risk of collapse or pose significant loss of life shall only be used for nonacute care hospital purposes, unless an extension of this deadline has been granted and either of the following occurs before the end of the extension:

(A) A replacement building has been constructed and a certificate of occupancy has been granted by the department for the replacement building.

(B) A retrofit has been performed on the building and a construction final has been obtained by the department.

(2) An extension of the deadline may be granted by the department upon a demonstration by the owner that compliance will result in a loss of health care capacity that may not be provided by other general acute care hospitals within a reasonable proximity. In its request for an extension of the deadline, a hospital shall state why the hospital is unable to comply with the January 1, 2008, deadline requirement.

(3) Prior to granting an extension of the January 1, 2008, deadline pursuant to this section, the department shall do all of the following:

(A) Provide public notice of a hospital's request for an extension of the deadline. The notice, at a minimum, shall be posted on the department's internet website, and shall include the facility's name and identification number, the status of the request, and the beginning and ending dates of the comment period, and shall advise the public of the opportunity to submit public comments pursuant to subparagraph (C). The department shall also provide notice of all requests for the deadline extension directly to interested parties upon request of the interested parties.

(B) Provide copies of extension requests to interested parties within 10 working days to allow interested parties to review and provide comment within the 45-day comment period. The copies shall include those records that are available to the public pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(C) Allow the public to submit written comments on the extension proposal for a period of not less than 45 days from the date of the public notice.

(b) (1) It is the intent of the Legislature, in enacting this subdivision, to facilitate the process of having more hospital buildings in substantial compliance with this chapter and to take nonconforming general acute care hospital inpatient buildings out of service more quickly.

(2) The functional contiguous grouping of hospital buildings of a general acute care hospital, each of which provides, as the primary source, one or more of the hospital's eight basic services as specified in subdivision (a) of Section 1250, may receive a five-year extension of the January 1, 2008, deadline specified in subdivision (a) of this section pursuant to this subdivision for both structural and nonstructural requirements. A functional contiguous grouping refers to buildings containing one or more basic hospital services that are either attached or connected in a way that is acceptable to the State Department of Health Care Services. These buildings may be either on the existing site or a new site.

(3) To receive the five-year extension, a single building containing all of the basic services or at least one building within the contiguous grouping of hospital buildings shall have obtained a building permit prior to 1973 and this building shall be evaluated and classified as a nonconforming, Structural Performance Category-1 (SPC-1) building. The classification shall be submitted to and accepted by the Department of Health Care Access and Information. The identified hospital building shall be exempt from the requirement in subdivision (a) until January 1, 2013, if the hospital agrees that the basic service or services that were provided in that building shall be provided, on or before January 1, 2013, as follows:

(A) Moved into an existing conforming Structural Performance Category-3 (SPC-3), Structural Performance Category-4 (SPC-4), or Structural Performance Category-5 (SPC-5) and Non-Structural Performance Category-4 (NPC-4) or Non-Structural Performance Category-5 (NPC-5) building.

(B) Relocated to a newly built compliant SPC-5 and NPC-4 or NPC-5 building.

(C) Continued in the building if the building is retrofitted to an SPC-5 and NPC-4 or NPC-5 building.

(4) A five-year extension is also provided to a post-1973 building if the hospital owner informs the Department of Health Care Access and Information that the building is classified as SPC-1, SPC-3, or SPC-4 and will be closed to general acute care inpatient service use by January 1, 2013. The basic services in the building shall be relocated into an SPC-5 and NPC-4 or NPC-5 building by January 1, 2013.

(5) SPC-1 buildings, other than the building identified in paragraph (3) or (4), in the contiguous grouping of hospital buildings shall also be exempt from the requirement in subdivision (a) until January 1, 2013. However, on or before January 1, 2013, at a minimum, each of these buildings shall be retrofitted to an SPC-2 and NPC-3 building, or no longer be used for general acute care hospital inpatient services.

(c) On or before March 1, 2001, the department shall establish a schedule of interim work progress deadlines that hospitals shall be required to meet to be eligible for the extension specified in subdivision (b). To receive this extension, the hospital building or buildings shall meet the year 2002 nonstructural requirements.

(d) A hospital building that is eligible for an extension pursuant to this section shall meet the January 1, 2030, nonstructural and structural deadline requirements if the building is to be used for general acute care inpatient services after January 1, 2030.

(e) Upon compliance with subdivision (b), the hospital shall be issued a written notice of compliance by the department. The department shall send a written notice of violation to hospital owners that fail to comply with this section. The department shall make copies of these notices available on its internet website.

(f) (1) A hospital that has received an extension of the January 1, 2008, deadline pursuant to subdivision (a) or (b) may request an additional extension of up to two years for a hospital building that it owns or operates and that meets the criteria specified in paragraph (2), (3), or (5).

(2) The department may grant the additional extension if the hospital building subject to the extension meets all of the following criteria:

(A) The hospital building is under construction at the time of the request for extension under this subdivision and the purpose of the construction is to meet the requirements of subdivision (a) to allow the use of the building as a general acute care hospital building after the extension deadline granted by the department pursuant to subdivision (a) or (b).

(B) The hospital building plans were submitted to the department and were deemed ready for review by the department at least four years prior to the applicable deadline for the building. The hospital shall indicate, upon submission of its plans, the SPC-1 building or buildings that will be retrofitted or replaced to meet the requirements of this section as a result of the project.

(C) The hospital received a building permit for the construction described in subparagraph (A) at least two years prior to the applicable deadline for the building.

(D) The hospital submitted a construction timeline at least two years prior to the applicable deadline for the building demonstrating the hospital's intent to meet the applicable deadline. The timeline shall include all of the following:

(i) The projected construction start date.

(ii) The projected construction completion date.

(iii) Identification of the contractor.

(E) The hospital is making reasonable progress toward meeting the timeline set forth in subparagraph (D), but factors beyond the hospital's control make it impossible for the hospital to meet the deadline.

(3) The department may grant the additional extension if the hospital building subject to the extension meets all of the following criteria:

(A) The hospital building is owned by a health care district that has, as owner, received the extension of the January 1, 2008, deadline, but where the hospital is operated by an unaffiliated third-party lessee pursuant to a facility lease that extends at least through December 31, 2009. The district shall file a declaration with the department with a request for an extension stating that, as of the date of the filing, the district has lacked, and continues to lack, unrestricted access to the subject hospital building for seismic planning purposes during the term of the lease, and that the district is under contract with the county to maintain hospital services when the hospital comes under district control. The department shall not grant the extension if an unaffiliated third-party lessee will operate the hospital beyond December 31, 2010.

(B) The hospital building plans were submitted to the department and were deemed ready for review by the department at least four years prior to the applicable deadline for the building. The hospital shall indicate, upon submission of its plans, the SPC-1 building or buildings that will be retrofitted or replaced to meet the requirements of this section as a result of the project.

(C) The hospital received a building permit for the construction described in subparagraph (B) by December 31, 2011.

(D) The hospital submitted, by December 31, 2011, a construction timeline for the building demonstrating the hospital's intent and ability to meet the deadline of December 31, 2014. The timeline shall include all of the following:

(i) The projected construction start date.

(ii) The projected construction completion date.

(iii) Identification of the contractor.

(E) The hospital building is under construction at the time of the request for the extension, the purpose of the construction is to meet the requirements of subdivision (a) to allow the use of the building as a general acute care hospital building after the extension deadline granted by the office pursuant to subdivision (a) or (b), and the hospital is making reasonable progress toward meeting the timeline set forth in subparagraph (D).

(F) The hospital granted an extension pursuant to this paragraph shall submit an additional status report to the department, equivalent to that required by subdivision (c) of Section 130061, no later than June 30, 2013.

(4) An extension granted pursuant to paragraph (3) shall be applicable only to the health care district applicant and its affiliated hospital while the hospital is operated by the district or an entity under the control of the district.

(5) The department may grant the additional extension if the hospital building subject to the extension meets all of the following criteria:

(A) The hospital owner submitted to the department, prior to June 30, 2009, a request for review using current computer modeling utilized by the department and based upon software developed by the Federal Emergency Management Agency (FEMA), referred to as Hazards US, and the building was deemed SPC-1 after that review.

(B) The hospital building plans for the building are submitted to the department and deemed ready for review by the department prior to July 1, 2010. The hospital shall indicate, upon submission of its plans, the SPC-1 building or buildings that shall be retrofitted or replaced to meet the requirements of this section as a result of the project.

(C) The hospital receives a building permit from the department for the construction described in subparagraph (B) prior to January 1, 2012.

(D) The hospital submits, prior to January 1, 2012, a construction timeline for the building demonstrating the hospital's intent and ability to meet the applicable deadline. The timeline shall include all of the following:

(i) The projected construction start date.

(ii) The projected construction completion date.

(iii) Identification of the contractor.

(E) The hospital building is under construction at the time of the request for the extension, the purpose of the construction is to meet the requirements of subdivision (a) to allow the use of the building as a general acute care hospital building after the extension deadline granted by the department pursuant to subdivision (a) or (b), and the hospital is making reasonable progress toward meeting the timeline set forth in subparagraph (D).

(F) The hospital owner completes construction such that the hospital meets all criteria to enable the department to issue a certificate of occupancy by the applicable deadline for the building.

(6) A hospital located in the County of Sacramento, San Mateo, or Santa Barbara or the City of San Jose or the City of Willits that has received an additional extension pursuant to paragraph (2) or (5) may request an additional extension until September 1, 2015, to obtain either a certificate of occupancy from the department for a replacement building, or a construction final from the department for a building on which a retrofit has been performed.

(7) A hospital denied an extension pursuant to this subdivision may appeal the denial to the Hospital Building Safety Board.

(8) The department may revoke an extension granted pursuant to this subdivision for any hospital building where the work of construction is abandoned or suspended for a period of at least one year, unless the hospital demonstrates in a public document that the abandonment or suspension was caused by factors beyond its control.

(g) (1) Notwithstanding subdivisions (a), (b), (c), and (f), and Sections 130061.5 and 130064, a hospital that has received an extension of the January 1, 2008, deadline pursuant to subdivision (a) or (b) also may request an additional extension of up to seven years for a hospital building that it owns or operates. The department may grant the extension subject to the hospital meeting the milestones set forth in paragraph (2).

(2) The hospital building subject to the extension shall meet all of the following milestones, unless the hospital building is reclassified as SPC-2 or higher as a result of its Hazards US score:

(A) The hospital owner submits to the department, no later than September 30, 2012, a letter of intent stating whether it intends to rebuild, replace, or retrofit the building, or remove all general acute care beds and services from the building, and the amount of time necessary to complete the construction.

(B) The hospital owner submits to the department, no later than September 30, 2012, a schedule detailing why the requested extension is necessary, and specifically how the hospital intends to meet the requested deadline.

(C) The hospital owner submits to the department, no later than September 30, 2012, an application ready for review seeking structural reassessment of each of its SPC-1 buildings using current computer modeling based upon software developed by FEMA, referred to as Hazards US.

(D) The hospital owner submits to the department, no later than January 1, 2015, plans ready for review consistent with the letter of intent submitted pursuant to subparagraph (A) and the schedule submitted pursuant to subparagraph (B).

(E) The hospital owner submits a financial report to the department at the time the plans are submitted pursuant to subparagraph (D). The report shall demonstrate the hospital owner's financial capacity to implement the construction plans submitted pursuant to subparagraph (D).

(F) The hospital owner receives a building permit consistent with the letter of intent submitted pursuant to subparagraph (A) and the schedule submitted pursuant to subparagraph (B), no later than July 1, 2018.

(3) To evaluate public safety and determine whether to grant an extension of the deadline, the department shall consider the structural integrity of the hospital's SPC-1 buildings based on its Hazards US scores, community access to essential hospital services, and the hospital owner's financial capacity to meet the deadline as determined by either a bond rating of BBB or below or the financial report on the hospital owner's financial capacity submitted pursuant to subparagraph (E) of paragraph (2). The criteria contained in this paragraph shall be considered by the department in its determination of the length of an extension or whether an extension should be granted.

(4) The extension or subsequent adjustments granted pursuant to this subdivision may not exceed the amount of time that is reasonably necessary to complete the construction specified in paragraph (2).

(5) If the circumstances underlying the request for extension submitted to the department pursuant to paragraph (2) change, the hospital owner shall notify the department as soon as practicable, but in no event later than six months after the hospital owner discovered the change of circumstances. The department may adjust the length of the extension granted pursuant to paragraphs (2) and (3) as necessary, but in no event longer than the period specified in paragraph (1).

(6) A hospital denied an extension pursuant to this subdivision may appeal the denial to the Hospital Building Safety Board.

(7) The department may revoke an extension granted pursuant to this subdivision for any hospital building when it is determined that any information submitted pursuant to this section was falsified, or if the hospital failed to meet a milestone set forth in paragraph (2), or where the work of construction is abandoned or suspended for a period of at least six months, unless the hospital demonstrates in a publicly available document that the abandonment or suspension was caused by factors beyond its control.

(8) Regulatory submissions made by the department to the California Building Standards Commission to implement this section shall be deemed to be emergency regulations and shall be adopted as emergency regulations.

(9) The hospital owner that applies for an extension pursuant to this subdivision shall pay the office an additional fee, to be determined by the department, sufficient to cover the additional reasonable costs incurred by the department for maintaining the additional reporting requirements established under this section, including, but not limited to, the costs of reviewing and verifying the extension documentation submitted pursuant to this subdivision. This additional fee shall not include any cost for review of the plans or other duties related to receiving a building or occupancy permit.

(10) This subdivision shall become operative on the date that the State Department of Health Care Services receives all necessary federal approvals for a 2011–12 fiscal year hospital quality assurance fee program that includes three hundred twenty million dollars ($320,000,000) in fee revenue to pay for health care coverage for children, which is made available as a result of the legislative enactment of a 2011–12 fiscal year hospital quality assurance fee program.

(h) A critical access hospital located in the City of Tehachapi may submit a seismic safety extension application pursuant to subdivision (g), notwithstanding deadlines in that subdivision that are earlier than the effective date of the act that added this subdivision. The submitted application shall include a timetable as required pursuant to subdivision (g).

(i) (1) A hospital located in the Tarzana neighborhood of the City of Los Angeles that has received extensions pursuant to subdivisions (b) and (g) may request an additional extension for a single building until October 1, 2022, in order to obtain a certificate of occupancy from the department for a replacement building.

(2) The hospital owner seeking the extension shall submit a written request that includes a timeline specifying how the hospital intends to meet the new deadline, including the construction document submission dates. The following timeline shall be met for construction document submissions:

(A) No later than January 1, 2018, the hospital owner shall submit construction documents, deemed ready for review, related to the first final review of the second increment with information including the building core and shell of the hospital. Failure to submit the construction documents by January 1, 2018, shall result in the assessment of a fine of five thousand dollars ($5,000) per calendar day until the documents are submitted.

(B) No later than March 1, 2018, the hospital owner shall submit construction documents, deemed ready for review, related to the first final review of the first increment with information including the structural foundation, frame, and underslab utilities of the hospital. Failure to submit the construction documents by March 1, 2018, shall result in the assessment of a fine of five thousand dollars ($5,000) per calendar day until the documents are submitted.

(C) No later than September 1, 2018, the hospital owner shall submit construction documents, deemed ready for review, related to the first final review of the third increment with information on the build-out of the hospital. Failure to submit the construction documents by September 1, 2018, shall result in the assessment of a fine of five thousand dollars ($5,000) per calendar day until the documents are submitted.

(D) No later than November 1, 2018, the hospital owner shall submit construction documents, deemed ready for review, related to the first final review of the fourth increment with information on the seismic support and anchorage of the hospital. Failure to submit the construction documents by November 1, 2018, shall result in the assessment of a fine of five thousand dollars ($5,000) per calendar day until the documents are submitted.

(E) The hospital owner may submit a written request to the department seeking an extension of the deadlines set forth in subparagraphs (A), (B), (C), and (D). The written request shall state with specificity the reason for the request and how the

reason preventing compliance with the deadlines was outside of the control of the hospital owner. After review of the request for extension, the department may grant the request for a period of time not to exceed 30 calendar days. If the department grants the request for an extension, no fine shall accrue or be imposed during the extension period.

(3) Notwithstanding any other law, any fines assessed pursuant to paragraph (2) shall be deposited into the General Fund following a determination on appeal, if any. A hospital assessed a fine pursuant to this subdivision may appeal the assessment to the Hospital Building Safety Board, provided the hospital posts the funds for any fines to be held by the department pending the resolution of the appeal.

(4) The department shall not issue a certificate of occupancy for the single replacement building until such time as all assessed fines accrued pursuant to paragraph (2) have been paid in full, or, if an appeal is pending, have been posted subject to resolution of an appeal. Fines deposited by the hospital pursuant to paragraph (3) shall be considered paid in full for purposes of issuing a certificate of occupancy pursuant to this paragraph. This paragraph is in addition to, and is not intended to supersede, any other requirements that must be met by the hospital for issuance by the department of a certificate of occupancy.

SEC. 330. Section 130061 of the Health and Safety Code is amended to read:

130061. (a) An owner of a general acute care hospital building that is classified as a nonconforming Structural Performance Category-1 (SPC-1) building, who has not requested an extension of the deadline described in subdivision (a) or (b) of Section 130060, shall submit a report to the department no later than April 15, 2007, describing the status of each building in complying with the requirements of Section 130060. The report shall identify at least all of the following:

(1) Each building that is subject to subdivision (a) of Section 130060.

(2) The project number or numbers for retrofit or replacement of each building.

(3) The projected construction start date or dates and projected construction completion date or dates.

(4) The building or buildings to be removed from acute care service and the projected date or dates of this action.

(b) An owner of a general acute care hospital building that is classified as a nonconforming, Structural Performance Category-1 (SPC-1) building, who has requested an extension of the deadline described in subdivision (a) or (b) of Section 130060, shall submit a report to the department no later than June 30, 2009, describing the status of each building in complying with the requirements of Section 130060. The report shall identify, at a minimum, all of the following:

(1) Each building that is subject to subdivision (a) of Section 130060.

(2) The project number or numbers for retrofit or replacement of each building.

(3) The projected construction start date or dates and projected construction completion date or dates.

(4) The building or buildings to be removed from acute care service and the projected date or dates of that action.

(c) An owner of a general acute care hospital building that is classified as a nonconforming, Structural Performance Category-1 (SPC-1) building, shall submit a report to the department no later than November 1, 2010, describing the status of each building in complying with the requirements of Section 130060, and annually thereafter shall update the department with any changes or adjustments. The report shall identify at least all of the following:

(1) For each building that is subject to subdivision (a) of Section 130060 that is planned for retrofit or replacement, the report shall identify:

(A) Whether the hospital owner intends to retrofit or replace the building to SPC-2, SPC-3, SPC-4, or SPC-5.

(B) The deadline, as described in Section 130060 or 130061.5, for retrofit or replacement of the building that the hospital owner intends to meet, and the applicable extension for which the hospital owner has been approved.

(C) The project number or numbers for retrofit or replacement of each building.

(D) The projected construction start date or dates and projected construction completion date or dates.

(E) The most recent project status and approvals.

(F) The number of inpatient beds and patient days, by type of unit and type of service to be provided.

(2) For the building or buildings to be removed from acute care service, the following information shall be included:

(A) The projected date or dates the building will be removed from service.

(B) The planned uses of the building or buildings to be removed from acute care service.

(C) The inpatient services currently delivered in the building or buildings.

(D) The number of inpatient beds and patient days, by type of unit and type of service, for the years 2008, 2009, and 2010.

(E) Whether the general acute care services and beds will be relocated to a new or retrofitted building and any corresponding building sites or project numbers.

(3) Each hospital owner shall also report, for each facility for which any buildings will be removed from acute care service, any net change in the number of inpatient beds, by type of unit and type of service, taking into account beds provided in buildings to be taken out of service, beds provided in buildings to be retrofitted or replaced, and beds provided in any other buildings used for general acute care inpatient services by the facility.

(4) Each hospital owner shall report any general acute care hospital inpatient service that is provided in any general acute care hospital building that is rated SPC-1.

(5) Each hospital owner shall report the final configuration of all buildings on its campus showing how each building will comply with the SPC-5/NPC-4 or 5 requirements, whether by retrofit or by replacement, and the type of services that will be provided in each general acute care hospital building.

(d) The department shall make the information required by subdivisions (a) and (b), available on its internet website within 90 days of receipt of this information.

(e) The department shall make the information required by subdivision (c) available on its internet website within 90 days of receipt of this information. The department shall include the hospital name, hospital owners, and location of the buildings included in the report, and, to the extent possible, for service areas containing buildings for which hospital owners report information pursuant to subdivision (c), include information on the number of inpatient beds, by type of unit and type of service, provided by facilities operating buildings that are classified as SPC-2, SPC-3, SPC-4, and SPC-5.

(f) Hospitals that have not reported pursuant to this section are not eligible for the extension provided in subdivision (f) of Section 130060.

(g) A hospital that has not submitted a report pursuant to this section shall be assessed a fine of ten dollars ($10) per licensed acute care bed per day, but in no case to exceed one thousand dollars ($1,000) per day for each SPC-1 building not in compliance with this section until it has complied with the provisions of this section. These fines shall be deposited into the Hospital Building Fund as specified pursuant to Section 129795. A hospital assessed a fine pursuant to this section may appeal the assessment to the Hospital Building Safety Board.

SEC. 331. Section 130061.5 of the Health and Safety Code is amended to read:

130061.5. (a) The Legislature finds and declares the following:

(1) By enacting this section, the Legislature reinforces its commitment to ensuring the seismic safety of hospitals in California. In order to meet that commitment, this section provides a mechanism for hospitals that lack the financial capacity to retrofit Structural Performance Category-1 (SPC-1) buildings by 2013 to, instead, redirect available capital and borrowing capacity to replace those building by 2020. The mechanism is intended to allow these hospitals to meet the seismic requirements, and provide state agencies and the public with more timely and detailed information about the progress these hospitals are making toward seismic safety compliance.

(2) This section requires hospitals seeking this assistance to demonstrate that their financial condition does not allow them to retrofit these buildings by 2013, and requires them to meet specified benchmarks in order to be eligible for the extended timelines set forth in this section. Failure to meet any of these benchmarks shall result in the hospital being noncompliant and subject the hospital to loss of licensure.

(3) It is the intent of the Legislature to ensure the continuation of services in medically underserved communities in which the closure of the hospital would have significant negative impacts on access to health care services in the community.

(4) It is also the intent of the Legislature that this section be implemented very narrowly to target only facilities that are essential providers in underserved communities and that lack the financial capacity to retrofit SPC-1 buildings by 2013.

(b) A hospital owner may meet the requirements of subdivision (a) of Section 130060 by replacing all of its buildings subject to that subdivision by January 1, 2020, if it meets all of the following conditions:

(1) The hospital owner has requested an extension of the deadline described in subdivision (a) or (b) of Section 130060.

(2) (A) The department certifies that the hospital owner lacks the financial capacity to meet the requirements of subdivision (a) of Section 130060 for that building. In order to receive the certification, the hospital owner shall file with the department by January 1, 2009, financial information as required by the department. This information shall include a schedule demonstrating that, as of the end of the hospital owner's most recent fiscal year for which the hospital owner has filed its annual financial data with the department by July 1, 2007, the hospital owner's annual financial data for that fiscal year show that the hospital owner meets all of the following financial conditions:

(i) The owner's net long-term debt to capitalization ratio, as measured by the ratio of net long-term debt to net long-term debt plus equity, was above 60 percent.

(ii) The owner's debt service coverage, as measured by the ratio of net income plus depreciation expense plus interest expense to current maturities on long-term debt plus interest expense, was below 4.5.

(iii) The owner's cash-to-debt ratio, as measured by the ratio of cash plus marketable securities plus limited use cash plus limited use investments to current maturities on long-term debt plus net long-term debt, was below 90 percent.

(B) The department shall certify that a hospital owner applying for relief under this subdivision meets each of these financial conditions. For the purposes of this subdivision, a hospital owner shall be eligible for certification only if the annual financial data required by this paragraph for the hospital owners and all of its hospital affiliates, considered in total, meets all of these financial conditions. For purposes of this section, "hospital affiliate" means any hospital owned by an entity that controls, is controlled by, or is under the common control of, directly or through intermediate entity, the entity that owns the specified hospital. The applicant hospital owner shall bear all costs for review, but not to exceed the costs of review, of its financial information.

(3) The hospital owner files with the department, by January 1, 2009, a declaration that the hospital for which the hospital owner is seeking relief under this subdivision shall satisfy all of the following conditions:

(A) The hospital shall maintain a contract with the California Medical Assistance Commission (CMAC) under the selective provider contracting program, unless in an open area as established by CMAC.

(B) The hospital shall maintain at least basic emergency medical services if the hospital provided emergency medical services at the basic or higher level as of July 1, 2007.

(C) The hospital meets any of the following criteria:

(i) The hospital is located within a Medically Underserved Area or a Health Professions Shortage Area designated by the federal government pursuant to Sections 330 and 332 of the federal Public Health Service Act (42 U.S.C. Secs. 254b and 254e).

(ii) The department determines, by means of a health impact assessment, that removal of the building or buildings from service may diminish significantly the availability or accessibility of health care services to an underserved community.

(iii) The CMAC determines that the hospital is essential to providing and maintaining Medi-Cal services in the hospital's service area.

(iv) The hospital demonstrates that, based on annual utilization data submitted to the office for 2006 or later, the hospital had in one year over 30 percent of all discharges for either Medi-Cal or indigent patients in the county in which the hospital is located.

(4) The hospital owner submits, by January 1, 2010, a facility master plan for all the buildings that are subject to subdivision (a) of Section 130060 that the hospital intends to replace by January 1, 2020. The facility master plan shall identify at least all of the following:

(A) Each building that is subject to subdivision (a) of Section 130060.

(B) The plan to replace each building with buildings that would be in compliance with subdivision (a) of Section 130065.

(C) The building or buildings to be removed from acute care service and the projected date or dates of that action.

(D) The location for any new building or buildings, including, but not limited to, whether the owner has received a permit for that location. The replacement buildings shall be planned within the same service area as the buildings to be removed from service.

(E) A copy of the preliminary design for the new building or buildings.

(F) The number of beds available for acute care use in each new building.

(G) The timeline for completed plan submission.

(H) The proposed construction timeline.

(I) The proposed cost at the time of submission.

(J) A copy of any records indicating the hospital governing board's approval of the facility plan.

(5) By January 1, 2013, the hospital owner submits to the department a building plan that is deemed ready for review by the department, for each building.

(6) By January 1, 2015, the hospital owner receives a building permit to begin construction, for each building that the owner intends to replace pursuant to the master plan.

(7) Within six months of receipt of the building permit, the hospital owner submits a construction timeline that identifies at least all of the following:

(A) Each building that is subject to subdivision (a) of Section 130060.

(B) The project number or numbers for replacement of each building.

(C) The projected construction start date or dates and projected construction completion date or dates.

(D) The building or buildings to be removed from acute care.

(E) The estimated cost of construction.

(F) The name of the contractor.

(8) Every six months thereafter, the hospital owner reports to the department on the status of the project, including any delays or circumstances that could materially affect the estimated completion date.

(9) The hospital owner pays to the department an additional fee, to be determined by the department, sufficient to cover the additional cost incurred by the department for maintaining all reporting requirements established under this section, including, but not limited to, the costs of reviewing and verifying the financial information submitted pursuant to paragraph (2). This additional fee shall not include any cost for review of the plans or other duties related to receiving a building or occupancy permit.

(c) The department may also approve an extension of the deadline described in subdivision (a) or (b) of Section 130060 for a general acute care hospital building that is classified as a nonconforming SPC-1 building and is owned or operated by a county, city, or county and city that has requested an extension of this deadline by June 30, 2009, if the owner files a declaration with the department stating that as of the date of that filing the owner lacks the ability to meet the requirements of subdivision (a) of Section 130060 for that building pursuant to subdivision (b) of that section. The declaration shall state the commitment of the hospital to replace those buildings by January 1, 2020, with other buildings that meet the requirements of Section 130065 and shall meet the requirements of paragraphs (4) to (9), inclusive, of subdivision (b).

(d) A hospital filing a declaration pursuant to this section but failing to meet any of the deadlines set forth in this section shall be deemed in violation of this section and Section 130060, and shall be subject to loss of licensure.

SEC. 332. Section 130062 of the Health and Safety Code is amended to read:

130062. (a) For the purposes of this section, the following terms have the following meanings:

(1) "Rebuild plan" means a plan to meet seismic standards primarily by constructing a new conforming SPC-5 building for use in lieu of an SPC-1 building.

(2) "Removal plan" means a plan to meet seismic standards primarily by removing acute care services or beds from the hospital's license.

(3) "Replacement plan" means a plan to meet seismic standards primarily by relocating acute care services or beds from nonconforming buildings into a conforming building.

(4) “Retrofit plan” means a plan to meet seismic standards primarily by modifying the building in a manner that brings the building up to SPC-2, SPC-4D, or SPC-5 standards.

(b) (1) Except as specified in paragraph (2), all hospitals seeking an extension for their SPC-1 buildings shall submit to the department an application, in a manner acceptable to the department, by April 1, 2019.

(2) If Providence Tarzana Medical Center in the City of Los Angeles or UCSF Benioff Children’s Hospital in the City of Oakland seeks an extension for its SPC-1 buildings, it shall submit to the department an application, in a manner acceptable to the department, by September 1, 2019.

(3) At a minimum, an application described in paragraph (1) or (2) shall state which of the seismic compliance methods described in subdivision (a) will be used for each SPC-1 building.

(c) A hospital owner that has been granted an extension pursuant to subdivision (g) of Section 130060 or subdivision (b) of Section 130061.5 may request, and the department shall grant, an additional extension of time as set forth in this section.

(d) (1) For a hospital that seeks an extension for compliance based on a replacement plan or retrofit plan, the owner shall submit a construction schedule, obtain a building permit, and begin construction by April 1, 2020.

(2) Using the construction schedule submitted pursuant to paragraph (1), the hospital and the department shall identify at least two major milestones relating to the compliance plan that will be used as the basis for determining whether the hospital is making adequate progress toward meeting the seismic compliance deadline.

(3) Failure to comply with the requirements described in paragraph (1) or (2), or to meet any milestone agreed to pursuant to paragraph (2), shall result in the assessment of a fine of five thousand dollars ($5,000) per calendar day until the requirements or milestones, respectively, are met.

(4) Final seismic compliance shall be achieved by July 1, 2022.

(e) (1) For a hospital that seeks an extension for compliance based on a rebuild plan, the department shall grant an extension of up to five years. The owner shall submit, in a manner acceptable to the department, no later than July 1, 2020, the rebuild plan, deemed ready for review, and shall submit a construction schedule, obtain a building permit, and begin construction no later than January 1, 2022.

(2) The hospital and the department shall identify at least two major milestones, agreed upon by the hospital and the department, that will be used as the basis for determining whether the hospital is making adequate progress toward meeting the seismic compliance deadline.

(3) Failure to comply with the requirements described in paragraph (1) or (4), or to meet any milestone agreed to pursuant to paragraph (2) or (4), shall result in the assessment of a fine of five thousand dollars ($5,000) per calendar day until the requirements or milestones, respectively, are met.

(4) For a hospital that has previously submitted to the department a rebuild project under construction, the department may accept certification from the hospital that it has obtained appropriate building permits consistent with an approved incremental plan review and that construction thereunder has commenced and is continuing. The previously approved construction schedule shall be amended to reflect the extension being requested, and at least two new major milestones shall be identified. The owner shall not be required to resubmit construction plans previously submitted to the department, and the department may not impose new or different requirements for any increment already approved or building permit already issued by the department as a condition for granting an extension.

(5) Final seismic compliance shall be achieved, and a certificate of occupancy shall be obtained, by January 1, 2025.

(f) The department may grant an adjustment to the requirements described in paragraph (1) or (2) of subdivision (d) or paragraph (1) or (4) of subdivision (e), or the milestones agreed to pursuant to paragraph (2) of subdivision (d) or paragraph (2) or (4) of subdivision (e), as necessary to deal with contractor, labor, or material delays, or with acts of God, or with governmental entitlements, experienced by the hospital. If that adjustment is granted, the hospital shall submit a revised construction schedule, and the hospital and the department shall identify at least two new major milestones consistent with the adjustment. Failure to comply with the revised construction schedule or meet any of the major milestones shall result in penalties as specified in paragraph (3) of subdivision (d) and paragraph (3) of subdivision (e). The adjustment shall not exceed the corresponding final seismic compliance date specified in paragraph (4) of subdivision (d) or paragraph (5) of subdivision (e).

(g) The duration of an extension granted by the department pursuant to this section shall not exceed the maximums permitted by this section. Moreover, within that limit, the department shall not grant an extension that exceeds the amount of time needed by the owner to come into compliance. The determination by the department regarding the length of the extension to be granted

shall be based upon a showing by the owner of the facts necessitating the additional time. It shall include a review of the plan and all the documentation submitted in the application for the extension, and shall permit only that additional time necessary to allow the owner to deal with compliance plan issues that cannot be fully met without the extension.

(h) No extension shall be granted pursuant to this section for SPC-1 buildings unless the owner has submitted to the department, by January 1, 2018, a seismic compliance plan.

(i) An extension shall not be granted pursuant to this section for seismic compliance based upon a removal plan.

(j) (1) Except as specified in paragraph (2), in lieu of the reporting requirements described in Section 130061, a hospital granted an extension pursuant to this section shall provide a quarterly status report to the department, with the first report due on July 1, 2019, and every October 1, January 1, April 1, and July 1 thereafter, until seismic compliance is achieved.

(2) In lieu of the reporting requirements described in Section 130061, if Providence Tarzana Medical Center in the City of Los Angeles or UCSF Benioff Children's Hospital in the City of Oakland is granted an extension pursuant to this section based on an application submitted on or after April 1, 2019, the first quarterly status report shall be due on October 1, 2019, and every January 1, April 1, July 1, and October 1 thereafter, until seismic compliance is achieved.

(3) The office shall post the status reports described in paragraphs (1) and (2) on its internet website.

(k) Before June 1, 2019, the office shall provide the Legislature with an inventory of the SPC category of each hospital building. A report submitted to the Legislature pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code.

(l) (1) The office may revoke an extension granted pursuant to this section for a hospital building where the assessment for a penalty exceeds 60 days.

(2) Notwithstanding any other law, any penalties assessed pursuant to this section shall be deposited into the General Fund within 45 days of assessment or within 45 days following a determination on appeal, if any. A hospital assessed a penalty pursuant to this section may appeal the assessment to the Hospital Building Safety Board, provided the hospital posts the funds for any penalties with the department, to be held pending the resolution of the appeal.

(3) The department shall not issue a construction final or certificate of occupancy for the building until all assessed penalties accrued pursuant to this section have been paid in full or, if an appeal is pending, have been posted subject to resolution of the appeal. Penalties deposited by the hospital pursuant to paragraph (2) shall be considered paid in full for purposes of issuing a construction final or certificate of occupancy. This paragraph is in addition to, and is not intended to supersede, any other requirements that must be met by the hospital for issuance of a construction final or certificate of occupancy.

(m) The department may promulgate emergency regulations as necessary to implement this section.

SEC. 333. Section 130063 of the Health and Safety Code is amended to read:

130063. (a) With regard to a general acute care hospital building located in Seismic Zone 3 as indicated in the 1995 edition of the California Building Standards Code, any hospital may request an exemption from Non-Structural Performance Category-3 requirements in Title 24 of the California Code of Regulations if the hospital building complies with the year 2002 nonstructural requirements.

(b) The department shall determine the maximum allowable level of earthquake ground shaking potential for purposes of this section.

(c) To qualify for an exemption under this section, a hospital shall provide a site-specific engineering geologic report that demonstrates an earthquake ground shaking potential below the maximum allowable level of earthquake ground shaking potential determined by the department pursuant to subdivision (b).

(d) (1) To demonstrate an earthquake ground shaking potential as provided in subdivision (c), a hospital shall submit a site-specific engineering geologic report to the department.

(2) The department shall forward the report received from a hospital to the Division of Mines and Geology in the Department of Conservation for purposes of a review.

(3) If, after review of the analysis, the Division of Mines and Geology concurs with the findings of the report, it shall return the report with a statement of concurrence to the office. Upon the receipt of the statement, if the ground shaking potential is below that established pursuant to subdivision (b), the department shall grant the exemption requested.

(e) A hospital building that is eligible for an exemption under this section shall meet the January 1, 2030, nonstructural requirement deadline if the building is to be used for general acute care inpatient services after January 1, 2030.

(f) A hospital requesting an exemption pursuant to this section shall pay the actual expenses incurred by the department and the Division of Mines and Geology.

(g) All regulatory submissions to the California Building Standards Commission made by the department for purposes of this section shall be deemed to be emergency regulations and shall be adopted as emergency regulations. This emergency regulation authority shall remain in effect until January 1, 2004.

SEC. 334. Section 130063.1 of the Health and Safety Code is amended to read:

130063.1. Notwithstanding Section 130063, a county-owned general acute care hospital building is allowed an extension of the Non-structural Performance Category-2 requirements of Title 24 of the California Code of Regulations if all of the following conditions are met:

(a) The county submitted the compliance plan on or before January 1, 2001.

(b) The county submitted the Non-structural Performance Category-2 building plans to the Department of Health Care Access and Information on or before September 1, 2001.

(c) The county complies with the year 2002 nonstructural requirements established by regulation 12 months after receipt of the building permit approval letter from the Department of Health Care Access and Information.

SEC. 335. Section 130064 of the Health and Safety Code is amended to read:

130064. (a) In lieu of the extension described in subdivision (f) of Section 130060, the department may grant an extension to a general acute care hospital pursuant to either subdivision (c) or (f) if the hospital building will not meet the seismic safety standards of that section by January 1, 2013, due to a local planning delay.

(b) When applying for an extension under this section, the owner of the general acute care hospital shall submit to the department documentation that includes at least all of the following:

(1) The original schedule of the project or projects as had been originally anticipated.

(2) The schedule of the project or projects as currently projected.

(3) A timeline for the submission of documents to the local planning authority or jurisdiction.

(4) Documentation that the local planning authority for the project and for the enabling phases of the project does not grant approvals prior to November 1, 2010, where the hospital had originally filed the local application prior to January 1, 2008.

(5) A proposed construction timeframe demonstrating the completion of the project once the permit is issued. The construction timeframe shall be approved by the department and shall only include the amount of time that is reasonably necessary to complete the construction required to meet the seismic safety requirements.

(c) The department may grant an extension, in full one-year increments, but no longer than three consecutive years, that compensates for delays determined pursuant to subdivision (d).

(d) The department shall conduct a comprehensive review of the schedule for the project or projects according to criteria specified in this section. This review shall encompass the project or projects under the jurisdiction of the department, as well as other project phases not under the jurisdiction of the department. The department shall consider the cumulative effect of local approval timelines for all elements of the project or projects, inclusive of changes in scope or sequence of the project or projects required by the local planning process. The department may grant extensions based on an evaluation of each of the following circumstances:

(1) Where the local planning authority approvals have delayed or will delay the construction start date of the project or projects.

(2) Where the local conditions of approval on a project or projects extend the duration beyond the originally anticipated construction completion date.

(3) Where the cumulative effect of delays on the project or projects creates additional construction delays due to local seasonal weather impact requirements of the local planning authority.

(4) Construction related to the seismic retrofit or replacement project has begun by January 1, 2013.

(5) The project or projects were submitted for review by the department no later than January 1, 2009.

(6) The project or projects have received a building permit from the department no later than January 1, 2012.

(e) Every six months after the approval of the extension, the hospital owner shall report to the department on the status of the project or projects, demonstrating that it is making reasonable progress toward meeting the construction timeline.

(f) The department may grant an additional extension of up to two years in addition to the extension granted pursuant to subdivisions (c) and (d) only if the project or projects meet all of the following criteria:

(1) A matrix of buildings at the hospital that identifies compliance of each building to the standards required by Section 130065 at the completion of the project or projects.

(2) The construction timelines submitted pursuant to subdivision (a) were determined to go beyond three years from the date the building permit was issued.

(3) Acute care services will not be provided in any SPC-1 building at any time during the extension.

(4) The hospital demonstrates that it has, and maintains throughout the extension, life safety systems in all acute care patient care areas that do not depend on, and are not routed through, an SPC-1 building.

(5) The hospital either demonstrates that the SPC-1 building does not pose a structural risk to an adjoining hospital building that is used for acute care services or mitigates the risk in accordance with a deadline described in subdivision (f) of Section 130060 that the department determines will best protect patient safety.

(g) The department may revoke an extension granted pursuant to this section for any hospital building where the work of construction is abandoned or suspended for a period of at least six months, unless the hospital demonstrates that the abandonment or suspension was caused by factors beyond its control.

(h) The department may revoke an extension granted pursuant to this section if it is determined that any information submitted pursuant to this section was falsified in any manner by the hospital or if the hospital fails to meet any of the criteria or conditions specified in this section.

(i) Regulatory submissions made by the department to the California Building Standards Commission pursuant to this section shall be deemed, and shall be adopted as, emergency regulations.

(j) The hospital owner that applies for an extension pursuant to this section shall pay to the department an additional fee, to be determined by the department, sufficient to cover the additional cost incurred by the office for maintaining all reporting requirements established under this section, including, but not limited to, the costs of reviewing and verifying the extension documentation submitted pursuant to this section. This additional fee shall not include any cost for review of the plans or other duties related to receiving a building or occupancy permit.

(k) A hospital denied an extension pursuant to this section may appeal the denial to the Hospital Building Safety Board.

SEC. 336. Section 130065 of the Health and Safety Code is amended to read:

130065. In accordance with the compliance schedule approved by the department, but in any case no later than January 1, 2030, owners of all acute care inpatient hospitals shall either:

(a) Demolish, replace, or change to nonacute care use all hospital buildings not in substantial compliance with the regulations and standards developed by the department pursuant to the Alfred E. Alquist Hospital Facilities Seismic Safety Act and this act.

(b) Seismically retrofit all acute care inpatient hospital buildings so that they are in substantial compliance with the regulations and standards developed by the department pursuant to the Alfred E. Alquist Hospital Facilities Seismic Safety Act and this act.

Upon compliance with this section, the hospital shall be issued a written notice of compliance by the department. The department shall send a written notice of violation to hospital owners that fail to comply with this section.

SEC. 337. Section 130066 of the Health and Safety Code is amended to read:

130066. Before January 1, 2020, the owner of an acute care inpatient hospital whose building does not substantially comply with the seismic safety regulations or standards described in Section 130065 shall submit to the department an attestation that the board of directors of that hospital is aware that the hospital building is required to meet the January 1, 2030, deadline for substantial compliance with those regulations and standards.

SEC. 338. Section 130070 of the Health and Safety Code is amended to read:

130070. The department shall notify the State Department of Public Health of the hospital owners that have received a written notice of violation for failure to comply with either Section 130060 or 130065. Unless the hospital places its license in voluntary suspense, the State Department of Public Health shall suspend or refuse to renew the license of a hospital that has received a notice of violation from the department because of its failure to comply with either Section 130060 or 130065. The license shall be reinstated or renewed upon presentation to the State Department of Public Health of a written notice of compliance issued by the department.

SEC. 339. The heading of Chapter 2 of Part 7 of Division 107 of the Health and Safety Code is repealed.

SEC. 340. Division 109.7 (commencing with Section 130290) is added to the Health and Safety Code, to read:

DIVISION 109.7. California Health and Human Services Data Exchange Framework

130290. (a) On or before July 1, 2022, and subject to an appropriation in the annual Budget Act, the California Health and Human Services Agency, along with its departments and offices and in consultation with stakeholders and local partners, shall establish the California Health and Human Services Data Exchange Framework that shall include a single data sharing agreement and common set of policies and procedures that will leverage and advance national standards for information exchange and data content, and that will govern and require the exchange of health information among health care entities and government agencies in California.

(1) The California Health and Human Services Data Exchange Framework is not intended to be an information technology system or single repository of data, rather it is technology agnostic and is a collection of organizations that are required to share health information using national standards and a common set of policies in order to improve the health outcomes of the individuals they serve.

(2) The California Health and Human Services Data Exchange Framework will be designed to enable and require real-time access to, or exchange of, health information among health care providers and payers through any health information exchange network, health information organization, or technology that adheres to specified standards and policies.

(3) The California Health and Human Services Data Exchange Framework shall align with state and federal data requirements, including the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), the Confidentiality of Medical Information Act of 1996 (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code), and other applicable state and federal privacy laws related to the sharing of data among and between providers, payers, and the government, while also streamlining and reducing reporting burden.

(4) For the purposes of this section, “health information” means:

(A) For hospitals, clinics, and physician practices, at a minimum, the United States Core Data for Interoperability Version 1, until October 6, 2022. After that date, it shall include all electronic health information as defined under federal regulation in Section 171.102 of Title 45 of the Code of Federal Regulations and held by the entity.

(B) For health insurers and health care service plans, at a minimum, the data required to be shared under the Centers for Medicare and Medicaid Services Interoperability and Patient Access regulations for public programs as contained in United States Department of Health and Human Services final rule CMS-9115-F, 85 FR 25510.

(b) (1) On or before January 31, 2024, the entities listed in subdivision (f), except those identified in paragraph (2), shall exchange health information or provide access to health information to and from every other entity in subdivision (f) in real time as specified by the California Health and Human Services Agency pursuant to the California Health and Human Services Data Exchange Framework data sharing agreement for treatment, payment, or health care operations.

(2) The requirement in paragraph (1) shall not apply to physician practices of fewer than 25 physicians, rehabilitation hospitals, long-term acute care hospitals, acute psychiatric hospitals, critical access hospitals, and rural general acute care hospitals with fewer than 100 acute care beds, state-run acute psychiatric hospitals, and any nonprofit clinic with fewer than 10 health care providers until January 31, 2026.

(c) The California Health and Human Services Agency shall convene a stakeholder advisory group no later than September 1, 2021, to advise on the development and implementation of the California Health and Human Services Data Exchange Framework.

(1) The members of the stakeholder advisory group shall be appointed by the Secretary of California Health and Human Services and shall not have a financial interest, individually or through a family member, related to issues the stakeholder

advisory group will advise on.

(2) The stakeholder advisory group shall be composed of health care stakeholders and experts, including representatives of all the following:

(A) The State Department of Health Care Services.

(B) The State Department of Social Services.

(C) The Department of Managed Health Care.

(D) The Department of Health Care Access and Information.

(E) The State Department of Public Health.

(F) The Department of Insurance.

(G) The Public Employees' Retirement System.

(H) The California Health Benefit Exchange.

(I) Health care service plans and health insurers.

(J) Physicians, including those with small practices.

(K) Hospitals, including public, private, rural, and critical access hospitals.

(L) Clinics, long-term care facilities, behavioral health facilities, or substance use disorder facilities.

(M) Consumers.

(N) Organized labor.

(O) Privacy and security professionals.

(P) Health information technology professionals.

(Q) Community health information organizations.

(R) County health, social services, and public health.

(S) Community-based organizations providing social services.

(3) The stakeholder advisory group shall provide information and advice to the California Health and Human Services Agency on health information technology issues, including all of the following:

(A) Identify which data beyond health information as defined in paragraph (4) of subdivision (a), at minimum, should be shared for specified purposes between the entities outlined in this subdivision and subdivision (f).

(B) Identify gaps, and propose solutions to gaps, in the life cycle of health information, including gaps in any of the following:

(i) Health information creation, including the use of national standards in clinical documentation, health plan records, and social services data.

(ii) Translation, mapping, controlled vocabularies, coding, and data classification.

(iii) Storage, maintenance, and management of health information.

(iv) Linking, sharing, exchanging, and providing access to health information.

(C) Identify ways to incorporate data related to social determinants of health, such as housing and food insecurity, into shared health information.

(D) Identify ways to incorporate data related to underserved or underrepresented populations, including, but not limited to, data regarding sexual orientation and gender identity and racial and ethnic minorities.

(E) Identify ways to incorporate relevant data on behavioral health and substance use disorder conditions.

(F) Address the privacy, security, and equity risks of expanding care coordination, health information exchange, access, and telehealth in a dynamic technological, and entrepreneurial environment, where data and network security are under constant threat of attack.

(G) Develop policies and procedures consistent with national standards and federally adopted standards in the exchange of health information and ensure that health information sharing broadly implements national frameworks and agreements consistent with federal rules and programs.

(H) Develop definitions of complete clinical, administrative, and claims data consistent with federal policies and national standards.

(I) Identify how all payers will be required to provide enrollees with electronic access to their health information, consistent with rules applicable to federal payer programs.

(J) Assess governance structures to help guide policy decisions and general oversight.

(K) Identify federal, state, private, or philanthropic sources of funding that could support data access and exchange.

(4) The stakeholder advisory group shall hold public meetings with stakeholders, solicit input, and set its own meeting agendas. Meetings of the stakeholder advisory group are subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

(5) The members of the stakeholder advisory group shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the group.

(d) No later than April 1, 2022, the California Health and Human Services Agency shall submit an update, including written recommendations, to the Legislature based on input from the stakeholder advisory group on the issues identified in paragraph (3) of subdivision (c).

(e) On or before January 31, 2023, the California Health and Human Services Agency shall work with the California State Association of Counties to encourage the inclusion of county health, public health, and social services, to the extent possible, as part of the California Health and Human Services Data Exchange Framework in order to assist both public and private entities to connect through uniform standards and policies. It is the intent of the Legislature that all state and local public health agencies will exchange electronic health information in real time with participating health care entities to protect and improve the health and well-being of Californians.

(f) On or before January 31, 2023, and in alignment with existing federal standards and policies, the following health care organizations shall execute the California Health and Human Services Data Exchange Framework data sharing agreement pursuant to subdivision (a):

(1) General acute care hospitals, as defined by Section 1250.

(2) Physician organizations and medical groups.

(3) Skilled nursing facilities, as defined by Section 1250, that currently maintain electronic records.

(4) Health care service plans and disability insurers that provide hospital, medical, or surgical coverage that are regulated by the Department of Managed Health Care or the Department of Insurance. This section shall also apply to a Medi-Cal managed care plan under a comprehensive risk contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code that is not regulated by the Department of Managed Health Care or the Department of Insurance.

(5) Clinical laboratories, as that term is used in Section 1265 of the Business and Professions Code, and that are regulated by the State Department of Public Health.

(6) Acute psychiatric hospitals, as defined by Section 1250.

(g) The California Health and Human Services Agency shall work with experienced nonprofit organizations and entities represented in the stakeholder advisory group in subdivision (c) to provide technical assistance to the entities outlined in subdivisions (e) and (f).

(h) On or before July 31, 2022, the California Health and Human Services Agency shall develop in consultation with the stakeholder advisory group in subdivision (c) a strategy for unique, secure digital identities capable of supporting master patient indices to be implemented by both private and public organizations in California.

(i) For purposes of implementing this section, including, but not limited to, hiring staff and consultants, facilitating and conducting meetings, conducting research and analysis, and developing the required reports, the California Health and Human Services Agency may enter into exclusive or nonexclusive contracts on a bid or negotiated basis. Contracts entered into or amended pursuant to this section shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services. No person hired or otherwise retained pursuant to this subdivision shall be permitted to have any financial interest in the California Health and Human Services Data Exchange Framework or shall be, or be affiliated with, any health care organization required to participate in the California Health and Human Services Data Exchange Framework pursuant to subdivisions (b) and (f). The term "person," as used in this subdivision, means any individual, partnership, joint venture, association, corporation, or any other organization or any combination thereof.

(j) All actions to implement the California Health and Human Services Data Exchange Framework, including the adoption or development of any data sharing agreement, requirements, policies and procedures, guidelines, subgrantee contract provisions, or reporting requirements, shall be exempt from the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The California Health and Human Services Agency, or a designee department or office under its jurisdiction, shall release program notices that detail the requirements of the California Health and Human Services Data Exchange Framework.

SEC. 341. Section 131300 of the Health and Safety Code is amended to read:

131300. (a) The State Department of Public Health is hereby authorized to establish the Office of Suicide Prevention in the department pursuant to this chapter. The responsibilities of the office, if established, may include all of the following:

(1) Providing information and technical assistance to statewide and regional partners regarding best practices on suicide prevention policies and programs.

(2) Conducting state level assessment of regional and statewide suicide prevention policies and practices, including other states' suicide prevention policies, and including specific metrics and domains as appropriate.

(3) Monitoring and disseminating data to inform prevention efforts at the state and local levels.

(4) Convening experts and stakeholders, including, but not limited to, stakeholders representing populations with high rates of suicide, to encourage collaboration and coordination of resources for suicide prevention.

(5) Reporting on progress to reduce rates of suicide.

(b) If established, the office may focus activities on groups with the highest risk, including youth, Native American youth, older adults, veterans, and LGBTQ people.

SEC. 342. Section 10144.53 is added to the Insurance Code, to read:

10144.53. (a) (1) A disability insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, that is required to provide coverage for medically necessary treatment of mental health and substance use disorders pursuant to Sections 10144.5, 10144.51, and 10144.52 shall cover the provision of the services identified in the fee-for-service reimbursement schedule published by the State Department of Health Care Services, as described in subparagraph (B) of paragraph (5) of subdivision (c), when those services are delivered at schoolsites pursuant to this section, regardless of the network status of the local educational agency, institution of higher education, or health care provider.

(2) This section does not relieve a local educational agency or institution of higher education from requirements to accommodate or provide services to students with disabilities pursuant to any applicable state and federal law, including, but not limited to, the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.), Part 30 (commencing with Section 56000) of Division 4 of Title 2 of the Education Code, Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code, and Chapter 3 (commencing with Section 3000) of Division 1 of Title 5 of the California Code of Regulations.

(b) The following definitions apply for purposes of this section:

(1) "Health care provider" has the same meaning as defined in paragraph (4) of subdivision (a) of Section 10144.5 and paragraph (5) of subdivision (c) of Section 10144.51.

(2) "Institution of higher education" means the California Community Colleges, the California State University, or the University of California.

(3) “Local educational agency” means a school district, county office of education, charter school, the California Schools for the Deaf, and the California School for the Blind.

(4) “Medically necessary treatment of a mental health or substance use disorder” has the same meaning as defined in paragraph (3) of subdivision (a) of Section 10144.5.

(5) “Mental health and substance use disorders” has the same meaning as defined in paragraph (2) of subdivision (a) of Section 10144.5.

(6) “Schoolsite” means a facility or location used for public kindergarten, elementary, secondary, or postsecondary purposes. “Schoolsite” also includes a location not owned or operated by a public school, or public school district if the school or school district provides or arranges for the provision of medically necessary treatment of a mental health or substance use disorder to its students at that location, including off-campus clinics, mobile counseling services, and similar locations.

(7) “Utilization review” has the same meaning as defined in paragraph (3) of subdivision (f) of Section 10144.52.

(c) If a local educational agency or institution of higher education provides or arranges for the provision of treatment of a mental health or substance use disorder services subject to this section by a health care provider at a schoolsite for an individual 25 years of age or younger, the student’s disability insurer shall reimburse the local educational agency or institution of higher education for those services.

(1) A disability insurer shall not require prior authorization for services provided pursuant to this section.

(2) A disability insurer may conduct a postclaim review to determine appropriate payment of the claim. Payment for services subject to this section may be denied only if the disability insurer reasonably determines that the services were provided to a student not covered by the insurer, were never performed, or were not provided by a health care provider appropriately licensed or authorized to provide the services.

(3) Notwithstanding paragraph (1), a disability insurer may require prior authorization for services as authorized by the commissioner, pursuant to subdivision (d).

(4) A local educational agency, community college district, the California State University system, or the Regents of the University of California may consolidate claims for purposes of submission to a disability insurer.

(5) A disability insurer shall provide reimbursement for services provided to students pursuant to this section at the greater of either of the following amounts:

(A) The disability insurer’s contracted rate with the local educational agency, institution of higher education, or health care provider, if any.

(B) The fee-for-service reimbursement rate published by the State Department of Health Care Services for the same or similar services provided in an outpatient setting, pursuant to Section 5961.4 of the Welfare and Institutions Code.

(6) A disability insurer shall provide reimbursement for services provided pursuant to this section in compliance with the requirements for timely payment of claims as required by this chapter.

(7) Services provided pursuant to this section shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing.

(8) An individual or entity shall not bill the policyholder or insured, nor seek reimbursement from the policyholder or insured, for services provided pursuant to this section.

(d) No later than December 31, 2023, the commissioner shall issue guidance to disability insurers regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Guidance issued pursuant to this subdivision shall be effective only until the commissioner adopts regulations pursuant to the Administrative Procedure Act.

SEC. 343. Section 1370 of the Penal Code is amended to read:

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

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

(i) The court shall order that the mentally incompetent defendant be delivered by the sheriff to a State Department of State Hospitals facility, as defined in Section 4100 of the Welfare and Institutions Code, as directed by the State Department of State Hospitals, or to any other available public or private treatment facility, including a community-based residential treatment system established pursuant to Article 1 (commencing with Section 5670) of Chapter 2.5 of Part 2 of Division 5 of the Welfare and Institutions Code if the facility has a secured perimeter or a locked and controlled treatment facility, approved by the community program director that will promote the defendant's speedy restoration to mental competence, or placed on outpatient status as specified in Section 1600.

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

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

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

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

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

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

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

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

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

(F) A defendant charged with a violent felony may be placed on outpatient status, as specified in Section 1600, only if the court finds that the placement will not pose a danger to the health or safety of others. If the court places a defendant charged with a violent felony on outpatient status, as specified in Section 1600, the court shall serve copies of the

placement order on defense counsel, the sheriff in the county where the defendant will be placed, and the district attorney for the county in which the violent felony charges are pending against the defendant.

(G) If, at any time after the court has declared a defendant incompetent to stand trial pursuant to this section, counsel for the defendant or a jail medical or mental health staff provider provides the court with substantial evidence that the defendant's psychiatric symptoms have changed to such a degree as to create a doubt in the mind of the judge as to the defendant's current mental incompetence, the court may appoint a psychiatrist or a licensed psychologist to opine as to whether the defendant has regained competence. If, in the opinion of that expert, the defendant has regained competence, the court shall proceed as if a certificate of restoration of competence has been returned pursuant to paragraph (1) of subdivision (a) of Section 1372, except that a presumption of competency shall not apply and a hearing shall be held to determine whether competency has been restored.

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

(I) The defendant has regained competence.

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

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

(ii) If, in the opinion of the department's expert, the defendant has regained competence, the court shall proceed as if a certificate of restoration of competence has been returned pursuant to paragraph (1) of subdivision (a) of Section 1372, except that a presumption of competency shall not apply and a hearing shall be held to determine whether competency has been restored.

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

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

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

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

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

(I) The defendant lacks capacity to make decisions regarding antipsychotic medication, the defendant's mental disorder requires medical treatment with antipsychotic medication, and, if the defendant's mental disorder is not treated with antipsychotic medication, it is probable that serious harm to the physical or mental health of the defendant will result. Probability of serious harm to the physical or mental health of the defendant requires evidence that the defendant is presently suffering adverse effects to their physical or mental health, or the defendant has previously suffered these effects as a result of a mental disorder and their condition is substantially deteriorating. The fact that a defendant has a diagnosis of a mental disorder does not alone establish probability of serious harm to the physical or mental health of the defendant.

(II) The defendant is a danger to others, in that the defendant has inflicted, attempted to inflict, or made a serious threat of inflicting substantial physical harm on another while in custody, or the defendant had inflicted, attempted to inflict, or made a serious threat of inflicting substantial physical harm on another that resulted in the defendant being taken into custody, and the defendant presents, as a result of mental disorder or mental defect, a demonstrated

danger of inflicting substantial physical harm on others. Demonstrated danger may be based on an assessment of the defendant's present mental condition, including a consideration of past behavior of the defendant within six years prior to the time the defendant last attempted to inflict, inflicted, or threatened to inflict substantial physical harm on another, and other relevant evidence.

(III) The people have charged the defendant with a serious crime against the person or property, involuntary administration of antipsychotic medication is substantially likely to render the defendant competent to stand trial, the medication is unlikely to have side effects that interfere with the defendant's ability to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a reasonable manner, less intrusive treatments are unlikely to have substantially the same results, and antipsychotic medication is in the defendant's best medical interest in light of their medical condition.

(ii) If the court finds any of the conditions described in clause (i) to be true, the court shall issue an order authorizing involuntary administration of antipsychotic medication to the defendant when and as prescribed by the defendant's treating psychiatrist at any facility housing the defendant for purposes of this chapter. The order shall be valid for no more than one year, pursuant to subparagraph (A) of paragraph (7). The court shall not order involuntary administration of psychotropic medication under subclause (III) of clause (i) unless the court has first found that the defendant does not meet the criteria for involuntary administration of psychotropic medication under subclause (I) of clause (i) and does not meet the criteria under subclause (II) of clause (i).

(iii) In all cases, the treating hospital, facility, or program may administer medically appropriate antipsychotic medication prescribed by a psychiatrist in an emergency as described in subdivision (m) of Section 5008 of the Welfare and Institutions Code.

(iv) If the court has determined that the defendant has the capacity to make decisions regarding antipsychotic medication, and if the defendant, with advice of their counsel, consents, the court order of commitment shall include confirmation that antipsychotic medication may be given to the defendant as prescribed by a treating psychiatrist pursuant to the defendant's consent. The commitment order shall also indicate that, if the defendant withdraws consent for antipsychotic medication, after the treating psychiatrist complies with the provisions of subparagraph (C), the defendant shall be returned to court for a hearing in accordance with subparagraphs (C) and (D) regarding whether antipsychotic medication shall be administered involuntarily.

(v) If the court has determined that the defendant has the capacity to make decisions regarding antipsychotic medication and if the defendant, with advice from their counsel, does not consent, the court order for commitment shall indicate that, after the treating psychiatrist complies with the provisions of subparagraph (C), the defendant shall be returned to court for a hearing in accordance with subparagraphs (C) and (D) regarding whether antipsychotic medication shall be administered involuntarily.

(vi) A report made pursuant to paragraph (1) of subdivision (b) shall include a description of antipsychotic medication administered to the defendant and its effects and side effects, including effects on the defendant's appearance or behavior that would affect the defendant's ability to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a reasonable manner. During the time the defendant is confined in a State Department of State Hospitals facility or other treatment facility or placed on outpatient status, either the defendant or the people may request that the court review any order made pursuant to this subdivision. The defendant, to the same extent enjoyed by other patients in the State Department of State Hospitals facility or other treatment facility, shall have the right to contact the patients' rights advocate regarding the defendant's rights under this section.

(C) If the defendant consented to antipsychotic medication as described in clause (iv) of subparagraph (B), but subsequently withdraws their consent, or, if involuntary antipsychotic medication was not ordered pursuant to clause (v) of subparagraph (B), and the treating psychiatrist determines that antipsychotic medication has become medically necessary and appropriate, the treating psychiatrist shall make efforts to obtain informed consent from the defendant for antipsychotic medication. If informed consent is not obtained from the defendant, and the treating psychiatrist is of the opinion that the defendant lacks capacity to make decisions regarding antipsychotic medication based on the conditions described in subclause (I) or (II) of clause (i) of subparagraph (B), the treating psychiatrist shall certify whether the lack of capacity and any applicable conditions described above exist. That certification shall contain an assessment of the current mental status of the defendant and the opinion of the treating psychiatrist that involuntary antipsychotic medication has become medically necessary and appropriate.

(D) (i) If the treating psychiatrist certifies that antipsychotic medication has become medically necessary and appropriate pursuant to subparagraph (C), antipsychotic medication may be administered to the defendant for not more than 21 days, provided, however, that, within 72 hours of the certification, the defendant is provided a medication review hearing before an administrative law judge to be conducted at the facility where the defendant is receiving treatment. The treating psychiatrist

shall present the case for the certification for involuntary treatment and the defendant shall be represented by an attorney or a patients' rights advocate. The attorney or patients' rights advocate shall be appointed to meet with the defendant no later than one day prior to the medication review hearing to review the defendant's rights at the medication review hearing, discuss the process, answer questions or concerns regarding involuntary medication or the hearing, assist the defendant in preparing for the hearing and advocating for the defendant's interests at the hearing, review the panel's final determination following the hearing, advise the defendant of their right to judicial review of the panel's decision, and provide the defendant with referral information for legal advice on the subject. The defendant shall also have the following rights with respect to the medication review hearing:

(I) To be given timely access to the defendant's records.

(II) To be present at the hearing, unless the defendant waives that right.

(III) To present evidence at the hearing.

(IV) To question persons presenting evidence supporting involuntary medication.

(V) To make reasonable requests for attendance of witnesses on the defendant's behalf.

(VI) To a hearing conducted in an impartial and informal manner.

(ii) If the administrative law judge determines that the defendant either meets the criteria specified in subclause (I) of clause (i) of subparagraph (B), or meets the criteria specified in subclause (II) of clause (i) of subparagraph (B), antipsychotic medication may continue to be administered to the defendant for the 21-day certification period. Concurrently with the treating psychiatrist's certification, the treating psychiatrist shall file a copy of the certification and a petition with the court for issuance of an order to administer antipsychotic medication beyond the 21-day certification period. For purposes of this subparagraph, the treating psychiatrist shall not be required to pay or deposit any fee for the filing of the petition or other document or paper related to the petition.

(iii) If the administrative law judge disagrees with the certification, medication may not be administered involuntarily until the court determines that antipsychotic medication should be administered pursuant to this section.

(iv) The court shall provide notice to the prosecuting attorney and to the attorney representing the defendant, and shall hold a hearing, no later than 18 days from the date of the certification, to determine whether antipsychotic medication should be ordered beyond the certification period.

(v) If, as a result of the hearing, the court determines that antipsychotic medication should be administered beyond the certification period, the court shall issue an order authorizing the administration of that medication.

(vi) The court shall render its decision on the petition and issue its order no later than three calendar days after the hearing and, in any event, no later than the expiration of the 21-day certification period.

(vii) If the administrative law judge upholds the certification pursuant to clause (ii), the court may, for a period not to exceed 14 days, extend the certification and continue the hearing pursuant to stipulation between the parties or upon a finding of good cause. In determining good cause, the court may review the petition filed with the court, the administrative law judge's order, and any additional testimony needed by the court to determine if it is appropriate to continue medication beyond the 21-day certification and for a period of up to 14 days.

(viii) The district attorney, county counsel, or representative of a facility where a defendant found incompetent to stand trial is committed may petition the court for an order to administer involuntary medication pursuant to the criteria set forth in subclauses (II) and (III) of clause (i) of subparagraph (B). The order is reviewable as provided in paragraph (7).

(3) When the court orders that the defendant be committed to a State Department of State Hospitals facility or other public or private treatment facility, the court shall provide copies of the following documents prior to the admission of the defendant to the State Department of State Hospitals or other treatment facility where the defendant is to be committed:

(A) The commitment order, including a specification of the charges.

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

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

(D) State summary criminal history information.

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

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

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

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

(I) Medical records.

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

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

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

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

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

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

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

(8) For purposes of subparagraph (D) of paragraph (2) and paragraph (7), if the treating psychiatrist determines that there is a need, based on preserving their rapport with the defendant or preventing harm, the treating psychiatrist may request that the facility medical director designate another psychiatrist to act in the place of the treating psychiatrist. If the medical director of

the facility designates another psychiatrist to act pursuant to this paragraph, the treating psychiatrist shall brief the acting psychiatrist of the relevant facts of the case and the acting psychiatrist shall examine the defendant prior to the hearing.

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

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

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

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

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

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

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

(C) If a county does not take custody of a defendant committed to the State Department of State Hospitals within 10 calendar days following notification made pursuant to clause (ii) of subparagraph (B), the county shall be charged the daily rate for a state hospital bed, as established by the State Department of State Hospitals.

(2) If the court has issued an order authorizing the treating facility to involuntarily administer antipsychotic medication to the defendant, the reports made pursuant to paragraph (1) concerning the defendant's progress toward regaining competency shall also consider the issue of involuntary medication. Each report shall include, but not be limited to, all of the following:

(A) Whether or not the defendant has the capacity to make decisions concerning antipsychotic medication.

(B) If the defendant lacks capacity to make decisions concerning antipsychotic medication, whether the defendant risks serious harm to their physical or mental health if not treated with antipsychotic medication.

(C) Whether or not the defendant presents a danger to others if the defendant is not treated with antipsychotic medication.

(D) Whether the defendant has a mental disorder for which medications are the only effective treatment.

(E) Whether there are any side effects from the medication currently being experienced by the defendant that would interfere with the defendant's ability to collaborate with counsel.

(F) Whether there are any effective alternatives to medication.

(G) How quickly the medication is likely to bring the defendant to competency.

(H) Whether the treatment plan includes methods other than medication to restore the defendant to competency.

(I) A statement, if applicable, that no medication is likely to restore the defendant to competency.

(3) After reviewing the reports, the court shall determine whether or not grounds for the order authorizing involuntary administration of antipsychotic medication still exist and shall do one of the following:

(A) If the original grounds for involuntary medication still exist, the order authorizing the treating facility to involuntarily administer antipsychotic medication to the defendant shall remain in effect.

(B) If the original grounds for involuntary medication no longer exist, and there is no other basis for involuntary administration of antipsychotic medication, the order for the involuntary administration of antipsychotic medication shall be vacated.

(C) If the original grounds for involuntary medication no longer exist, and the report states that there is another basis for involuntary administration of antipsychotic medication, the court shall set a hearing within 21 days to determine whether the order for the involuntary administration of antipsychotic medication shall be vacated or whether a new order for the involuntary administration of antipsychotic medication shall be issued. The hearing shall proceed as set forth in subparagraph (B) of paragraph (2) of subdivision (a).

(4) If it is determined by the court that treatment for the defendant's mental impairment is not being conducted, the defendant shall be returned to the committing court, and, if the defendant is not in county custody, returned to the custody of the county. The court shall transmit a copy of its order to the community program director or a designee.

(5) At each review by the court specified in this subdivision, the court shall determine if the security level of housing and treatment is appropriate and may make an order in accordance with its determination. If the court determines that the defendant shall continue to be treated in the State Department of State Hospitals facility or on an outpatient basis, the court shall determine issues concerning administration of antipsychotic medication, as set forth in subparagraph (B) of paragraph (2) of subdivision (a).

(c) (1) At the end of two years from the date of commitment or a period of commitment equal to the maximum term of imprisonment provided by law for the most serious offense charged in the information, indictment, or misdemeanor complaint, or the maximum term of imprisonment provided by law for a violation of probation or mandatory supervision, whichever is shorter, but no later than 90 days prior to the expiration of the defendant's term of commitment, a defendant who has not recovered mental competence shall be returned to the committing court, and custody of the defendant shall be transferred without delay to the committing county and shall remain with the county until further order of the court. The court shall not order the defendant returned to the custody of the State Department of State Hospitals under the same commitment. The court shall notify the community program director or a designee of the return and of any resulting court orders.

(2) (A) The medical director of the State Department of State Hospitals facility or other treatment facility to which the defendant is confined shall provide notification, in compliance with applicable privacy laws, to the committing county's sheriff that immediate transportation will be needed for the defendant pursuant to paragraph (1).

(B) If a county does not take custody of a defendant committed to the State Department of State Hospitals within 10 calendar days following notification pursuant to subparagraph (A), the county shall be charged the daily rate for a state hospital bed, as established by the State Department of State Hospitals.

(3) Whenever a defendant is returned to the court pursuant to paragraph (1) or (4) of subdivision (b) or paragraph (1) of this subdivision and it appears to the court that the defendant is gravely disabled, as defined in subparagraph (A) or (B) of paragraph (1) of subdivision (h) of Section 5008 of the Welfare and Institutions Code, the court shall order the conservatorship investigator of the county of commitment of the defendant to initiate conservatorship proceedings for the defendant pursuant to Chapter 3 (commencing with Section 5350) of Part 1 of Division 5 of the Welfare and Institutions Code. Hearings required in the conservatorship proceedings shall be held in the superior court in the county that ordered the commitment. The court shall transmit a copy of the order directing initiation of conservatorship proceedings to the community program director or a designee, the sheriff and the district attorney of the county in which criminal charges are pending, and the defendant's counsel of record. The court shall notify the community program director or a designee, the sheriff and district attorney of the county in which criminal charges are pending, and the defendant's counsel of record of the outcome of the conservatorship proceedings.

(4) If a change in placement is proposed for a defendant who is committed pursuant to subparagraph (A) or (B) of paragraph (1) of subdivision (h) of Section 5008 of the Welfare and Institutions Code, the court shall provide notice and an opportunity to be heard with respect to the proposed placement of the defendant to the sheriff and the district attorney of the county in which the criminal charges or revocation proceedings are pending.

(5) If the defendant is confined in a treatment facility, a copy of any report to the committing court regarding the defendant's progress toward recovery of mental competence shall be provided by the committing court to the prosecutor and to the defense counsel.

(d) With the exception of proceedings alleging a violation of mandatory supervision, the criminal action remains subject to dismissal pursuant to Section 1385. If the criminal action is dismissed, the court shall transmit a copy of the order of dismissal to the community program director or a designee. In a proceeding alleging a violation of mandatory supervision, if the person is not placed under a conservatorship as described in paragraph (3) of subdivision (c), or if a conservatorship is terminated, the court shall reinstate mandatory supervision and may modify the terms and conditions of supervision to include appropriate mental health treatment or refer the matter to a local mental health court, reentry court, or other collaborative justice court available for improving the mental health of the defendant.

(e) If the criminal action against the defendant is dismissed, the defendant shall be released from commitment ordered under this section, but without prejudice to the initiation of proceedings that may be appropriate under the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code).

(f) As used in this chapter, "community program director" means the person, agency, or entity designated by the State Department of State Hospitals pursuant to Section 1605 of this code and Section 4360 of the Welfare and Institutions Code.

(g) For the purpose of this section, "secure treatment facility" does not include, except for State Department of State Hospitals facilities, state developmental centers, and correctional treatment facilities, any facility licensed pursuant to Chapter 2 (commencing with Section 1250) of, Chapter 3 (commencing with Section 1500) of, or Chapter 3.2 (commencing with Section 1569) of, Division 2 of the Health and Safety Code, or any community board and care facility.

(h) This section does not preclude a defendant from filing a petition for habeas corpus to challenge the continuing validity of an order authorizing a treatment facility or outpatient program to involuntarily administer antipsychotic medication to a person being treated as incompetent to stand trial.

SEC. 344. Section 1370.01 of the Penal Code is amended to read:

1370.01. (a) (1) If the defendant is found mentally competent, the criminal process shall resume, the trial on the offense charged shall proceed, and judgment may be pronounced. If the defendant is found mentally incompetent, the trial, judgment, or hearing on the alleged violation shall be suspended until the person becomes mentally competent, and the court shall order that (A) in the meantime, the defendant be delivered by the sheriff to an available public or private treatment facility approved by the county mental health director that will promote the defendant's speedy restoration to mental competence, or placed on outpatient status as specified in this section, and (B) upon the filing of a certificate of restoration to competence, the defendant be returned to court in accordance with Section 1372. The court shall transmit a copy of its order to the county mental health director or the director's designee.

(2) If the defendant is found mentally incompetent, the court may make a finding that the defendant is an appropriate candidate for diversion pursuant to Chapter 2.8A (commencing with Section 1001.35) of Title 6, and may, if the defendant is eligible pursuant to Section 1001.36, grant diversion for a period not to exceed that set forth in paragraph (1) of subdivision (c). Upon the dismissal of charges at the conclusion of the period of diversion, pursuant to subdivision (e) of Section 1001.36, a defendant shall no longer be deemed incompetent to stand trial pursuant to this section.

(3) Prior to making the order directing that the defendant be confined in a treatment facility or placed on outpatient status, the court shall proceed as follows:

(A) The court shall order the county mental health director or the director's designee to evaluate the defendant and to submit to the court within 15 judicial days of the order a written recommendation as to whether the defendant should be required to undergo outpatient treatment, or committed to a treatment facility. No person shall be admitted to a treatment facility or placed on outpatient status under this section without having been evaluated by the county mental health director or the director's designee. No person shall be admitted to a state hospital under this section.

(B) The court shall hear and determine whether the defendant, with advice of their counsel, consents to the administration of antipsychotic medication, and shall proceed as follows:

(i) If the defendant, with advice of their counsel, consents, the court order of commitment shall include confirmation that antipsychotic medication may be given to the defendant as prescribed by a treating psychiatrist pursuant to the

defendant's consent. The commitment order shall also indicate that, if the defendant withdraws consent for antipsychotic medication, after the treating psychiatrist complies with the provisions of subparagraph (C), the defendant shall be returned to court for a hearing in accordance with this subdivision regarding whether antipsychotic medication shall be administered involuntarily.

(ii) If the defendant does not consent to the administration of medication, the court shall hear and determine whether any of the following is true:

(I) The defendant lacks capacity to make decisions regarding antipsychotic medication, the defendant's mental disorder requires medical treatment with antipsychotic medication, and, if the defendant's mental disorder is not treated with antipsychotic medication, it is probable that serious harm to the physical or mental health of the patient will result. Probability of serious harm to the physical or mental health of the defendant requires evidence that the defendant is presently suffering adverse effects to their physical or mental health, or the defendant has previously suffered these effects as a result of a mental disorder and their condition is substantially deteriorating. The fact that a defendant has a diagnosis of a mental disorder does not alone establish probability of serious harm to the physical or mental health of the defendant.

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

(III) The people have charged the defendant with a serious crime against the person or property; involuntary administration of antipsychotic medication is substantially likely to render the defendant competent to stand trial; the medication is unlikely to have side effects that interfere with the defendant's ability to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a reasonable manner; less intrusive treatments are unlikely to have substantially the same results; and antipsychotic medication is in the patient's best medical interest in light of their medical condition.

(iii) If the court finds any of the conditions described in clause (ii) to be true, the court shall issue an order authorizing the treatment facility to involuntarily administer antipsychotic medication to the defendant when and as prescribed by the defendant's treating psychiatrist. The court shall not order involuntary administration of psychotropic medication under subclause (III) of clause (ii) unless the court has first found that the defendant does not meet the criteria for involuntary administration of psychotropic medication under subclause (I) of clause (ii) and does not meet the criteria under subclause (II) of clause (ii).

(iv) In all cases, the treating hospital, facility, or program may administer medically appropriate antipsychotic medication prescribed by a psychiatrist in an emergency as described in subdivision (m) of Section 5008 of the Welfare and Institutions Code.

(v) Any report made pursuant to subdivision (b) shall include a description of any antipsychotic medication administered to the defendant and its effects and side effects, including effects on the defendant's appearance or behavior that would affect the defendant's ability to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a reasonable manner. During the time the defendant is confined in a treatment facility or placed on outpatient status, either the defendant or the people may request that the court review any order made pursuant to this subdivision. The defendant, to the same extent enjoyed by other patients in the treatment facility, shall have the right to contact the patients' rights advocate regarding the defendant's rights under this section.

(C) If the defendant consented to antipsychotic medication as described in clause (i) of subparagraph (B), but subsequently withdraws their consent, or, if involuntary antipsychotic medication was not ordered pursuant to clause (ii) of subparagraph (B), and the treating psychiatrist determines that antipsychotic medication has become medically necessary and appropriate, the treating psychiatrist shall make efforts to obtain informed consent from the defendant for antipsychotic medication. If informed consent is not obtained from the defendant, and the treating psychiatrist is of the opinion that the defendant lacks capacity to make decisions regarding antipsychotic medication as specified in subclause (I) of clause (ii) of subparagraph (B), or that the defendant is a danger to others as specified in subclause (II) of clause (ii) of subparagraph (B), the committing court shall be notified of this, including an assessment of the current mental status of the defendant and the opinion of the treating psychiatrist that involuntary antipsychotic medication has become medically necessary and appropriate. The court shall provide copies of the report to the prosecuting attorney and to the attorney representing the

defendant and shall set a hearing to determine whether involuntary antipsychotic medication should be ordered in the manner described in subparagraph (B).

(4) When the court, after considering the placement recommendation of the county mental health director required in paragraph (3), orders that the defendant be confined in a public or private treatment facility, the court shall provide copies of the following documents which shall be taken with the defendant to the treatment facility where the defendant is to be confined:

(A) The commitment order, including a specification of the charges.

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

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

(D) State summary criminal history information.

(E) Any arrest reports prepared by the police department or other law enforcement agency.

(F) Any court-ordered psychiatric examination or evaluation reports.

(G) The county mental health director's placement recommendation report.

(5) A person subject to commitment under this section may be placed on outpatient status under the supervision of the county mental health director or the director's designee by order of the court in accordance with the procedures contained in Title 15 (commencing with Section 1600) except that where the term "community program director" appears the term "county mental health director" shall be substituted.

(6) (A) If the defendant is committed or transferred to a public or private treatment facility approved by the county mental health director, the court may, upon receiving the written recommendation of the county mental health director, transfer the defendant to another public or private treatment facility approved by the county mental health director. In the event of dismissal of the criminal charges before the defendant recovers competence, the person shall be subject to the applicable provisions of Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code. Where either the defendant or the prosecutor chooses to contest the order of transfer, a petition may be filed in the court for a hearing, which shall be held if the court determines that sufficient grounds exist. At the hearing, the prosecuting attorney or the defendant may present evidence bearing on the order of transfer. The court shall use the same standards as are used in conducting probation revocation hearings pursuant to Section 1203.2.

(B) Prior to making an order for transfer under this section, the court shall notify the defendant, the attorney of record for the defendant, the prosecuting attorney, and the county mental health director or the director's designee.

(7) If, at any time after the court has declared a defendant incompetent to stand trial pursuant to this section, counsel for the defendant or a jail medical or mental health staff provider provides the court with substantial evidence that the defendant's psychiatric symptoms have changed to such a degree as to create a doubt in the mind of the judge as to the defendant's current mental incompetence, the court may appoint a psychiatrist or a licensed psychologist to opine as to whether the defendant has regained competence. The State Department of State Hospitals may conduct an evaluation of the defendant in county custody pursuant to Section 4335.2 of the Welfare and Institutions Code. If, in the opinion of an expert, the defendant has regained competence, the court shall proceed as if a certificate of restoration of competence has been returned pursuant to paragraph (1) of subdivision (a) of Section 1372, except that a presumption of competency shall not apply and a hearing shall be held to determine whether competency has been restored.

(b) Within 90 days of a commitment made pursuant to subdivision (a), the medical director of the treatment facility to which the defendant is confined shall make a written report to the court and the county mental health director or the director's designee, concerning the defendant's progress toward recovery of mental competence and whether the administration of antipsychotic medication remains necessary. If the defendant is in county custody, the State Department of State Hospitals may conduct a remote telehealth evaluation of the defendant pursuant to Section 4335.2 of the Welfare and Institutions Code and make a written report to the court concerning the defendant's progress toward recovery of mental competence and whether the administration of antipsychotic medication is necessary. Where the defendant is on outpatient status, the outpatient treatment staff shall make a written report to the county mental health director concerning the defendant's progress toward recovery of mental competence. Within 90 days of placement on outpatient status, the county mental health director shall report to the court on this matter. If the defendant has not recovered mental competence, but the report discloses a substantial likelihood that the defendant will regain mental competence in the foreseeable future, the defendant shall remain in the treatment facility or on outpatient status. Thereafter, at six-month intervals or until the defendant becomes mentally competent, where the defendant is confined in a treatment facility, the medical director of the hospital or person in charge of the facility shall report in writing to the court and the

county mental health director or a designee regarding the defendant's progress toward recovery of mental competence and whether the administration of antipsychotic medication remains necessary. If the defendant remains in county custody after the initial 90-day report, the State Department of State Hospitals may conduct a remote telehealth evaluation of the defendant pursuant to Section 4335.2 of the Welfare and Institutions Code and make a written report to the court concerning the defendant's progress toward recovery of mental competence and whether the administration of antipsychotic medication is necessary. Where the defendant is on outpatient status, after the initial 90-day report, the outpatient treatment staff shall report to the county mental health director on the defendant's progress toward recovery, and the county mental health director shall report to the court on this matter at six-month intervals. A copy of these reports shall be provided to the prosecutor and defense counsel by the court. If the report indicates that there is no substantial likelihood that the defendant will regain mental competence in the foreseeable future, the committing court shall order the defendant to be returned to the court for proceedings pursuant to paragraph (2) of subdivision (c). The court shall transmit a copy of its order to the county mental health director or the director's designee.

(c) (1) If, at the end of one year from the date of commitment or a period of commitment equal to the maximum term of imprisonment provided by law for the most serious offense charged in the misdemeanor complaint, whichever is shorter, the defendant has not recovered mental competence, the defendant shall be returned to the committing court. The court shall notify the county mental health director or the director's designee of the return and of any resulting court orders.

(2) Whenever any defendant is returned to the court pursuant to subdivision (b) or paragraph (1) of this subdivision and it appears to the court that the defendant is gravely disabled, as defined in subparagraph (A) of paragraph (1) of subdivision (h) of Section 5008 of the Welfare and Institutions Code, the court shall order the conservatorship investigator of the county of commitment of the defendant to initiate conservatorship proceedings for the defendant pursuant to Chapter 3 (commencing with Section 5350) of Part 1 of Division 5 of the Welfare and Institutions Code. Any hearings required in the conservatorship proceedings shall be held in the superior court in the county that ordered the commitment. The court shall transmit a copy of the order directing initiation of conservatorship proceedings to the county mental health director or the director's designee and shall notify the county mental health director or the director's designee of the outcome of the proceedings.

(d) The criminal action remains subject to dismissal pursuant to Section 1385. If the criminal action is dismissed, the court shall transmit a copy of the order of dismissal to the county mental health director or the director's designee.

(e) If the criminal charge against the defendant is dismissed, the defendant shall be released from any commitment ordered under this section, but without prejudice to the initiation of any proceedings which may be appropriate under Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code.

SEC. 345. Section 1372 of the Penal Code is amended to read:

1372. (a) (1) If the medical director of a state hospital, a person designated by the State Department of State Hospitals at an entity contracted by the department to provide services to a defendant prior to placement in a treatment program or other facility to which the defendant is committed, or the community program director, county mental health director, or regional center director providing outpatient services, determines that the defendant has regained mental competence, the director or designee shall immediately certify that fact to the court by filing a certificate of restoration with the court by certified mail, return receipt requested, or by confidential electronic transmission. This shall include any certificate of restoration filed by the State Department of State Hospitals based on an evaluation conducted pursuant to Section 4335.2 of the Welfare and Institutions Code. For purposes of this section, the date of filing shall be the date on the return receipt.

(2) The court's order committing an individual to a State Department of State Hospitals facility or other treatment facility pursuant to Section 1370 shall include direction that the sheriff shall redeliver the patient to the court without any further order from the court upon receiving from the state hospital or treatment facility a copy of the certificate of restoration.

(3) The defendant shall be returned to the committing court in the following manner, except that a defendant in county custody that the State Department of State Hospitals has evaluated pursuant to Section 4335.2 of the Welfare and Institutions Code and filed a certificate of restoration with the court shall remain in county custody:

(A) A patient who remains confined in a state hospital or other treatment facility shall be redelivered to the sheriff of the county from which the patient was committed. The sheriff shall immediately return the person from the state hospital or other treatment facility to the court for further proceedings.

(B) The patient who is on outpatient status shall be returned by the sheriff to court through arrangements made by the outpatient treatment supervisor.

(C) In all cases, the patient shall be returned to the committing court no later than 10 days following the filing of a certificate of restoration. The state shall only pay for 10 hospital days for patients following the filing of a certificate of restoration of competency. The State Department of State Hospitals shall report to the fiscal and appropriate policy committees of the Legislature on an annual basis in February, on the number of days that exceed the 10-day limit prescribed in this

subparagraph. This report shall include, but not be limited to, a data sheet that itemizes by county the number of days that exceed this 10-day limit during the preceding year.

(b) If the defendant becomes mentally competent after a conservatorship has been established pursuant to the applicable provisions of the Lanterman-Petris-Short Act, Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code, and Section 1370, the conservator shall certify that fact to the sheriff and district attorney of the county in which the defendant's case is pending, defendant's attorney of record, and the committing court.

(c) When a defendant is returned to court with a certification that competence has been regained, the court shall notify either the community program director, the county mental health director, or the regional center director and the Director of Developmental Services, as appropriate, of the date of any hearing on the defendant's competence and whether or not the defendant was found by the court to have recovered competence.

(d) If the committing court approves the certificate of restoration to competence as to a person in custody, the court shall hold a hearing to determine whether the person is entitled to be admitted to bail or released on own recognizance status pending conclusion of the proceedings. If the superior court approves the certificate of restoration to competence regarding a person on outpatient status, unless it appears that the person has refused to come to court, that person shall remain released either on own recognizance status, or, in the case of a developmentally disabled person, either on the defendant's promise or on the promise of a responsible adult to secure the person's appearance in court for further proceedings. If the person has refused to come to court, the court shall set bail and may place the person in custody until bail is posted.

(e) A defendant subject to either subdivision (a) or (b) who is not admitted to bail or released under subdivision (d) may, at the discretion of the court, upon recommendation of the director of the facility where the defendant is receiving treatment, be returned to the hospital or facility of their original commitment or other appropriate secure facility approved by the community program director, the county mental health director, or the regional center director. The recommendation submitted to the court shall be based on the opinion that the person will need continued treatment in a hospital or treatment facility in order to maintain competence to stand trial or that placing the person in a jail environment would create a substantial risk that the person would again become incompetent to stand trial before criminal proceedings could be resumed.

(f) Notwithstanding subdivision (e), if a defendant is returned by the court to a hospital or other facility for the purpose of maintaining competency to stand trial and that defendant is already under civil commitment to that hospital or facility from another county pursuant to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code) or as a developmentally disabled person committed pursuant to Article 2 (commencing with Section 6500) of Chapter 2 of Part 2 of Division 6 of the Welfare and Institutions Code, the costs of housing and treating the defendant in that facility following return pursuant to subdivision (e) shall be the responsibility of the original county of civil commitment.

SEC. 346. Section 4011.11 of the Penal Code is amended to read:

4011.11. (a) (1) Through December 31, 2022, the board of supervisors in each county, in consultation with the county sheriff, may designate an entity or entities to assist county jail inmates with submitting an application for a health insurance affordability program consistent with federal requirements.

(2) The board of supervisors shall not designate the county sheriff as an entity to assist with submitting an application for a health insurance affordability program for county jail inmates unless the county sheriff agrees to perform this function.

(3) If the board of supervisors designates a community-based organization as an entity to assist with submitting an application for a health insurance affordability program for county jail inmates, the designation shall be subject to approval by the jail administrator or their designee.

(b) (1) The jail administrator, or their designee, may coordinate with an entity designated pursuant to subdivision (a), through December 31, 2022.

(2) Commencing January 1, 2023, the jail administrator, or their designee, shall coordinate with an entity designated pursuant to subdivision (h), as applicable.

(c) Consistent with federal law, a county jail inmate who is currently enrolled in the Medi-Cal program shall remain eligible for, and shall not be terminated from, the program due to their incarceration unless required by federal law, they become otherwise ineligible, or the inmate's suspension of benefits has ended pursuant to Section 14011.10 of the Welfare and Institutions Code.

(d) Notwithstanding any other state law, and only to the extent federal law allows and federal financial participation is available, an entity designated pursuant to subdivision (a) or (h) is authorized to act on behalf of a county jail inmate for the purpose of applying for, or determinations of, Medi-Cal eligibility for acute inpatient hospital services authorized by Section 14053.7 of the Welfare and Institutions Code. An entity designated pursuant to subdivision (a) or (h) shall not determine Medi-Cal eligibility or redetermine Medi-Cal eligibility, unless the entity is the county human services agency.

(e) The fact that an applicant is an inmate shall not, in and of itself, preclude a county human services agency from processing an application for the Medi-Cal program submitted to it by, or on behalf of, that inmate.

(f) For purposes of this section, “health insurance affordability program” means a program that is one of the following:

(1) The state’s Medi-Cal program under Title XIX of the federal Social Security Act.

(2) The state’s children’s health insurance program (CHIP) under Title XXI of the federal Social Security Act.

(3) A program that makes coverage in a qualified health plan through the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code with advance payment of the premium tax credit established under Section 36B of the Internal Revenue Code available to qualified individuals.

(4) A program that makes available coverage in a qualified health plan through the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code with cost-sharing reductions established under Section 1402 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any subsequent amendments to that act.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement this section, in whole or in part, by means of all-county letters or similar instructions, without taking any further regulatory action.

(h) (1) Notwithstanding any other law, commencing January 1, 2023, the board of supervisors in each county, in consultation with the county sheriff, shall designate an entity or entities to assist county jail inmates with submitting an application for, or otherwise assisting their enrollment in, a health insurance affordability program consistent with federal requirements. The board of supervisors in each county, in consultation with the chief probation officer, shall designate an entity or entities to assist juvenile inmates in county juvenile facilities with submitting an application for, or otherwise assisting with an application for enrollment in, a health insurance affordability program consistent with federal requirements.

(2) The board of supervisors shall not designate the county sheriff as an entity to assist with submitting an application for a health insurance affordability program for county jail inmates unless the county sheriff agrees to perform this function, and shall not designate the chief probation officer as an entity to assist with submitting an application for a health insurance affordability program for juvenile inmates unless the chief probation officer agrees to perform this function.

(3) If the board of supervisors designates a community-based organization as an entity to assist with submitting an application for a health insurance affordability program for county jail inmates, the designation for county jail inmates shall be subject to approval by the jail administrator or their designee, and the designation for juvenile inmates shall be subject to approval by the chief probation officer or their designee.

(4) (A) The department shall develop the data elements required to implement this section, in consultation with interested stakeholders that include representatives of counties, county sheriffs, county probation agencies, and whole person care pilot lead entities with experience working with incarcerated individuals.

(B) Notwithstanding any other law, the department, counties, county sheriffs, and county probation agencies shall share the information and data necessary to facilitate the enrollment of inmates in health insurance affordability programs on or before their date of release and to appropriately suspend and unsuspend Medi-Cal coverage for beneficiaries.

(5) (A) No sooner than January 1, 2023, the State Department of Health Care Services, in consultation with counties, county sheriffs, probation departments, Medi-Cal managed care plans, and Medi-Cal behavioral health delivery systems, shall develop and implement a mandatory process by which county jails and county juvenile facilities coordinate with Medi-Cal managed care plans and Medi-Cal behavioral health delivery systems to facilitate continued behavioral health treatment in the community for county jail inmates and juvenile inmates that were receiving behavioral health services before their release.

(B) Notwithstanding any other law, including, but not limited to, Sections 11812 and 11845.5 of the Health and Safety Code and Section 5328 of the Welfare and Institutions Code, the sharing of health information, records, and other data with and among counties, Medi-Cal managed care plans, Medi-Cal behavioral health delivery systems, and other authorized providers or plan entities shall be permitted to the extent necessary to implement this paragraph. The department shall issue guidance identifying permissible data-sharing arrangements.

(C) For purposes of this paragraph, the following definitions shall apply:

(i) “Medi-Cal behavioral health delivery system” has the same meaning as set forth in subdivision (i) of Section 14184.101 of the Welfare and Institutions Code.

(ii) “Medi-Cal managed care plan” has the same meaning as set forth in subdivision (j) of Section 14184.101 of the Welfare and Institutions Code.

SEC. 347. Section 30130.59 is added to the Revenue and Taxation Code, to read:

30130.59. Notwithstanding Section 13340 of the Government Code, if the board, pursuant to subdivision (h) of Section 30130.57, reduces the allocation to the State Department of Public Health state dental program due to a reduction in revenues, there is hereby continuously appropriated from the state General Fund an amount equivalent to the required reduction so that the total funding for the state dental program is maintained at thirty million dollars ($30,000,000) annually.

SEC. 348. Section 4100 of the Welfare and Institutions Code is amended to read:

4100. The department has jurisdiction over the following facilities:

(a) Atascadero State Hospital.

(b) Coalinga State Hospital.

(c) Metropolitan State Hospital.

(d) Napa State Hospital.

(e) Patton State Hospital.

(f) (1) The Admission, Evaluation, and Stabilization (AES) Center in the County of Kern, and other AES Centers as defined by regulation.

(2) The Director of State Hospitals may adopt emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division of 3 of Title 2 of the Government Code) to implement this subdivision. The adoption of emergency regulations under this paragraph is deemed to address an emergency, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the Director of State Hospitals is hereby exempted for this purpose from the requirements of subdivision (b) of Section 11346.1 of the Government Code.

(g) A county jail treatment facility under contract with the State Department of State Hospitals to provide competency restoration services.

(h) A facility under contract with the State Department of State Hospitals pursuant to Section 4361.6, excluding community-based restoration of competency services that are operated by the county.

(i) Any other State Department of State Hospitals facility subject to available funding by the Legislature.

SEC. 349. Section 4122 of the Welfare and Institutions Code is amended to read:

4122. The State Department of State Hospitals, when it deems it necessary, may, under conditions prescribed by the director, transfer any patients of a state institution under its jurisdiction to another institution. Transfers of patients of state hospitals shall be made in accordance with Section 7300.

The expense of any transfer shall be paid from the moneys available by law for the support of the department or for the support of the institution from which the patient is transferred. Liability for the care, support, and maintenance of the transferred patient in the institution to which they have been transferred shall be the same as if they had originally been committed to the institution. The State Department of State Hospitals shall present to the county, not more frequently than monthly, a claim for the amount due the state for care, support, and maintenance of those patients and which the county shall process and pay pursuant to Chapter 4 (commencing with Section 29700) of Division 3 of Title 3 of the Government Code.

SEC. 350. Section 4147 is added to the Welfare and Institutions Code, to read:

4147. (a) To confront the crisis of individuals found incompetent to stand trial (IST) and in recognition of the importance of these defendants who are committed to the State Department of State Hospitals to begin receiving competency treatment as soon as practicable, the California Health and Human Services Agency along with the State Department of State Hospitals shall convene an Incompetent to Stand Trial Solutions Workgroup to identify short, medium, and long-term solutions to advance alternatives to placement at the State Department of State Hospitals.

(b) Workgroup members shall be appointed by the Secretary of California Health and Human Services and the workgroup shall be chaired by the Director of the State Department of State Hospitals. Members of the workgroup shall serve without

compensation. Members may include, but are not limited to, representatives from the following entities and interested parties:

(1) California Health and Human Services Agency.

(2) State Department of Health Care Services.

(3) State Department of Developmental Services.

(4) Department of Corrections and Rehabilitation.

(5) Department of Finance.

(6) Other state agencies, as needed.

(7) Judicial Council.

(8) Other partners, including local government and justice system representatives of entities involved in the commitment of IST defendants to the State Department of State Hospitals and representatives of patients and their family members, as needed.

(c) The workgroup shall submit recommendations to the California Health and Human Services Agency and the Department of Finance no later than November 30, 2021, outlining short-term solutions that can be accomplished by April 1, 2022, medium-term solutions that can be accomplished by January 10, 2023, and long-term solutions that can be accomplished by January 10, 2024, and January 10, 2025, to support the State Department of State Hospitals in serving individuals with the most intensive behavioral health treatment needs and providing timely access to treatment for individuals found IST on felony charges.

(d) The workgroup may meet as often as bi-weekly until the workgroup is disbanded by the Secretary of California Health and Human Services.

(e) The workgroup may consider, but is not limited to, recommendations that accomplish any of the following:

(1) Reduce the total number of felony defendants determined to be IST.

(2) Reduce the lengths of stay for felony IST patients.

(3) Support felony IST defendants to receive early access to treatment before transfer to a restoration of competency treatment program to achieve stabilization and restoration of competency sooner.

(4) Support increased access to felony IST diversion options.

(5) Expand treatment options for felony IST individuals, such as community-based restoration programs, jail-based competency treatment programs, and state hospital beds.

(6) Create new options for treatment of felony IST defendants including community based, locked and unlocked facilities.

(7) Establish partnerships to facilitate admissions and discharges to reduce recidivism and ensure that the most acute, high-risk, and at need patients receive access to State Department of State Hospitals beds, while patients with lower risk or acuity are treated in appropriate community settings.

(f) (1) Until December 31, 2024, if the Secretary of California Health and Human Services determines that either of the conditions stated in subparagraphs (A) or all of the conditions stated in subparagraph (B) have occurred, the State Department of State Hospitals may take the actions described in paragraph (2), if authorized by the Secretary of California Health and Human Services and the Department of Finance, and after Department of Finance has provided no less than a 30-day notification to the Joint Legislative Budget Committee and the State Department of State Hospitals has provided notification to the county public guardian and county behavioral agencies.

(A) The recommendations required to be completed by subdivision (c) cannot be completed due to reasons outside of the control of the California Health and Human Services Agency or the State Department of State Hospitals.

(B)(i) Insufficient progress has been made in implementing the recommendations in a timely manner to provide timely access to competency treatment for IST defendants committed to the State Department of State Hospitals.

(ii) IST commitments to the State Department of State Hospitals continues to exceed the capacity available, in facilities the department has jurisdiction over pursuant to Section 4100, to provide restoration of competency treatment.

(iii) The State Department of State Hospitals continues to maintain an IST admission waitlist that exceeds the capacity of the facilities within its jurisdiction pursuant to Section 4100 to admit IST commitments.

(iv) As a result of the conditions described in clauses (i) through (iii), inclusive, IST defendants committed to the State Department of State Hospitals are not able to receive timely access to restoration of competency treatment and no reasonable state solutions are available, including timely solutions to increase capacity within the facilities within its jurisdiction pursuant to Section 4100 that may admit IST commitments.

(2) If the requirements of paragraph (1) are met, the State Department of State Hospitals may take the following actions:

(A) The State Department of State Hospitals may discontinue admissions for new patients committed to a state hospital pursuant to Section 5358.

(B) The State Department of State Hospitals may, following the determination by the Secretary of California Health and Human Services pursuant to paragraph (1), impose patient reduction targets over the next three fiscal years for patients committed to a state hospital pursuant to Section 5358. Reduction targets shall only be to the minimum level necessary to achieve timely access to treatment for IST commitments, as determined by the State Department of State Hospitals and the Secretary of California Health and Human Services and will allow no less than a minimum of six months for the first reduction target to be achieved.

(C) The State Department of State Hospitals may charge 150 percent of the daily bed rate for counties, pursuant to Section 4330, that exceed the bed usage for patients admitted pursuant to Section 5358 and that are above the specified patient reduction targets made pursuant to subparagraph (B).

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of State Hospitals may implement, interpret, or make specific this section by means of a departmental letter or other similar instruction, as necessary.

(h) Contracts awarded pursuant to this section, including contracts to implement solutions developed by the Incompetent to Stand Trial Solutions Workgroup, shall be exempt from the requirements contained in the Public Contract Code, Section 19130 of the Government Code, Section 4101.5, and the State Administrative Manual and shall not be subject to approval by the Department of General Services.

SEC. 351. Section 4335.2 is added to the Welfare and Institutions Code, to read:

4335.2. (a) As used in this section, “department” means the State Department of State Hospitals.

(b) The Legislature finds and declares that the purpose of this section is to establish a program for the department to perform reevaluations primarily through telehealth evaluations for felony incompetent to stand trial (IST) individuals in jail who have been waiting for admission to the department 60 days or more from the date of commitment. The goals of this program are:

(1) To permit the department to conduct reevaluations of IST defendants committed to the department and awaiting admission to department facilities.

(2) To reduce the growing list of IST defendants awaiting placement to a department facility for competency restoration treatment.

(3) To help address the significant impacts of the COVID-19 pandemic on the IST waitlist through identification of individuals on the waitlist who have restored to competency in jail, are nonrestorable, are malingering, may be divertible, or have stabilized and are appropriate for outpatient treatment.

(4) To reduce the timeframe for a competency evaluation for IST defendants in jail and reduce unnecessary costly hospitalizations.

(5) To offer expert forensic mental health consultation to assist in identifying ISTs who may be appropriate for community placement. This supports the principles of deinstitutionalization for individuals who can best be supported in the least restrictive setting in the community.

(6) To offer expert medication consultation and technical assistance to local sheriffs to support effective use of psychotropic medications and stabilization of IST defendants awaiting placement to a department facility.

(7) To require courts and local county jails to provide to the department all relevant medical, behavioral, and court records of IST defendants committed to the department for evaluation purposes.

(8) To require local county jails to provide the department access to IST defendants in county jails and for local county jails to ensure the department the ability to provide reevaluations for IST defendants remotely.

(c) Beginning July 1, 2021, the department, or its designee, shall have the authority and sole discretion to consider and conduct reevaluations for IST defendants committed to and awaiting admission to the department for 60 days or more. A reevaluation shall involve a review by a department clinician or contracted clinician of an IST defendant's relevant medical and mental health records, including prior mental health evaluations and an evaluation of the IST defendant by that department clinician or contracted clinician. If not already provided, the court shall provide the department with all IST defendant records pursuant to paragraph (3) of subdivision (a) of Section 1370 of the Penal Code and paragraph (4) of subdivision (a) of Section 1370.01 of the Penal Code, including any updated medical and behavioral health records requested by the department. At the sole discretion of the department, the department clinician or contracted clinician may conduct in person, or video telehealth, evaluations of IST defendants at the local jail for those IST patients awaiting admission more than 60 days since their commitment to the department. The local jail shall provide the department confidential access to the IST defendant for reevaluation, including establishing and maintaining remote access capabilities at the jail for the department to remotely access the IST defendant. Reevaluations provided by the department clinician or contracted clinician shall include, but are not limited to, the following:

(1) Evaluations, including assessment of malingering, pursuant to paragraph (1) of subdivision (b) of Section 1370 of the Penal Code, subdivision (b) of Section 1370.01 of the Penal Code, or paragraph (1) of subdivision (a) of Section 1372 of the Penal Code.

(2) Assessments to determine whether the IST defendant should be referred to the county for further evaluation for potential participation in the county diversion program, if one exists, pursuant to clause (v) of subparagraph (B) of paragraph (1) of subdivision (a) of Section 1370 of the Penal Code or paragraph (2) of subdivision (a) of Section 1370.01 of the Penal Code, or other outpatient treatment program.

(3) Evaluations on whether the IST defendant is substantially unlikely to be restored to competence in the foreseeable future pursuant to paragraph (1) of subdivision (b) of Section 1370 of the Penal Code or subdivision (b) of Section 1370.01 of the Penal Code.

(4) Psychopharmacology evaluations in which a department clinician will identify IST defendants who may need psychotropic medications, a psychopharmacology consultation, or an involuntary medication order.

(5) A written report from the department clinician or contracted clinician of their evaluations of the IST defendant, as well as any conclusions of mental health status and recommendations the clinician may have of placement of the IST defendant.

(d) Written reports shall be filed with the court in the committing county. That report shall be accepted by courts, either pursuant to paragraph (1) of subdivision (b) of Section 1370 of the Penal Code, subdivision (b) of Section 1370.01 of the Penal Code, or paragraph (1) of subdivision (a) of Section 1372 of the Penal Code.

(e) The department shall provide funding based on a flat rate set by the department to local county jails for reimbursement of information technology support and a portion of staff time utilized to facilitate telehealth interviews and evaluations of felony IST defendants in the jail. One-time funding based on a flat rate set by the department will be made available for reimbursement to the county sheriff upon agreement to facilitate telehealth evaluations in the jail. In addition, a flat rate, set by the department, for reimbursement of each telehealth evaluation conducted by the department for an IST defendant and facilitated by the jail will be paid on a quarterly basis in arrears following conclusion of the telehealth evaluation.

(f) Any contracts awarded to implement this chapter shall be exempt from the requirements contained in the Public Contract Code and the State Administrative Manual and shall not be subject to approval by the Department of General Services.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the state hospitals and the department may implement, interpret, or make specific this section by means of a departmental letter or other similar instruction, as necessary.

(h) The department and any of the designated evaluators shall be provided access to the defendant's medical records, including mental health records for purposes of conducting a reevaluation of the competency status of the defendant.

SEC. 352. Section 4361 of the Welfare and Institutions Code is amended to read:

4361. (a) As used in this section, "department" means the State Department of State Hospitals.

(b) The purpose of this chapter is to, subject to appropriation by the Legislature, promote the diversion of individuals with serious mental disorders as prescribed in Chapter 2.8A (commencing with Section 1001.35) of Title 6 of Part 2 of the Penal Code, and to assist counties in providing diversion for individuals with serious mental illnesses who may otherwise be found incompetent to stand trial and committed to the State Department of State Hospitals for restoration of competency. In implementing this chapter, the department shall consider local discretion and flexibility in diversion activities that meet the community's needs and provide for the safe and effective treatment of individuals with serious mental disorders across a continuum of care.

(c) (1) Subject to appropriation by the Legislature, the department may solicit proposals from, and may contract with, a county to help fund the development or expansion of pretrial diversion described in Chapter 2.8A (commencing with Section 1001.35) of Title 6 of Part 2 of the Penal Code, for the population described in subdivision (b) and that meets all of the following criteria:

(A) Participants are individuals diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder, who have the potential to be found incompetent to stand trial for felony charges, pursuant to Section 1368 of the Penal Code, or who have been found incompetent to stand trial pursuant to clause (iv) of subparagraph (B) of paragraph (1) of subdivision (a) of Section 1370 of the Penal Code.

(B) There is a significant relationship between the individual's serious mental disorder and the charged offense, or between the individual's conditions of homelessness and the charged offense.

(C) The individual does not pose an unreasonable risk of danger to public safety, as defined in Section 1170.18 of the Penal Code, if treated in the community.

(2) A county submitting a proposal for funding under this chapter shall designate a lead entity to apply for the funds. This lead entity shall show in its proposal that it has support from other county entities or other relevant entities, including courts, that are necessary to provide successful diversion of individuals under the contract.

(d) When evaluating proposals from the county, the department, in consultation with the Council on Criminal Justice and Behavioral Health within the Department of Corrections and Rehabilitation, shall prioritize proposals that demonstrate the potential to reduce referrals to the department of felony defendants who are likely to be found incompetent to stand trial, and that demonstrate all of the following:

(1) Provision of clinically appropriate or evidence-based mental health treatment and wraparound services across a continuum of care, as appropriate, to meet the individual needs of the diversion participant. For purposes of this section, "wraparound services" means services provided in addition to the mental health treatment necessary to meet the individual's needs for successfully managing the individual's mental health symptoms and to successfully live in the community. Wraparound services provided by the diversion program may include, but are not limited to, forensic assertive community treatment teams, crisis residential services, intensive case management, criminal justice coordination, peer support, supportive housing, substance use disorder treatment, and vocational support.

(2) Collaboration between community stakeholders and other partner government agencies in the diversion of individuals with serious mental disorders.

(3) Connection of individuals to services in the community after they have completed diversion as provided in this chapter.

(e) The department may also provide funding in the contract with the county, subject to appropriation by the Legislature, to cover the cost of providing postbooking assessment of defendants who are likely to be found incompetent to stand trial on felony charges to determine whether the defendant would benefit from diversion as included in the contract.

(f) The department may also provide funding in the contract with the county, subject to appropriation by the Legislature, to cover the cost of in-jail treatment prior to the placement in the community for up to an average of 15 days for defendants who have been approved by the court for diversion as included in the contract.

(g) A county contracted pursuant to this chapter shall report data and outcomes to the department, within 90 days of the end of each quarter, regarding those individuals targeted by the contract and in the program. This subdivision does not preclude the department from specifying reporting formats or from modifying, reducing, or adding data elements or outcome measures from a contracting county, as needed to provide for reporting of effective data and outcome measures. Notwithstanding any other law, but only to the extent not prohibited by federal law, the county shall provide specific patient information to the department for reporting purposes. The patient information is confidential and is not open to public inspection. A contracting county shall, at a minimum, report all of the following:

(1) The number of individuals that the court ordered to postbooking diversion and the length of time for which the defendant has been ordered to diversion.

(2) The number of individuals originally declared incompetent to stand trial on felony charges that the court ultimately ordered to diversion.

(3) The number of individuals participating in diversion.

(4) The name, social security number, date of birth, and demographics of each individual participating in the program. This information is confidential and is not open to public inspection.

(5) The length of time in diversion for each participating individual. This information is confidential and is not open to public inspection.

(6) The types of services and supports provided to each individual participating in diversion. This information is confidential and is not open to public inspection.

(7) The number of days each individual was in jail prior to placement in diversion. This information is confidential and is not open to public inspection.

(8) The number of days that each individual spent in each level of care facility. This information is confidential and is not open to public inspection.

(9) The diagnoses of each individual participating in diversion. This information is confidential and is not open to public inspection.

(10) The nature of the charges for each individual participating in diversion. This information is confidential and is not open to public inspection.

(11) The number of individuals who completed diversion.

(12) The name, social security number, and birth date of each individual who did not complete diversion and the reasons for not completing. This information is confidential and is not open to public inspection.

(h) Contracts awarded pursuant to this chapter are exempt from the requirements contained in the Public Contract Code and the State Administrative Manual and are not subject to approval by the Department of General Services.

(i) (1) In order to receive funds pursuant to this chapter, a county's proposal shall demonstrate a 20-percent match of county funds toward the total cost of diversion to be funded through the contract.

(2) Notwithstanding paragraph (1), a proposal from a small county shall demonstrate a 10-percent match of county funds toward the total cost of diversion to be funded through the contract. For purposes of this paragraph, "small county" means a county with a population of 200,000 or less based on the most recent available estimates of population data determined by the Demographic Research Unit of the Department of Finance.

(3) The funds shall not be used to supplant existing services or services reimbursable from an available source but rather to expand upon them or support new services for which existing reimbursement may be limited. Up to 5 percent of the required county match may be met through county administrative costs associated with development and evaluation activities for diversion.

(j) (1) Beginning July 1, 2021, subject to appropriation by the Legislature, the department may amend contracts with a county to fund the expansion of an existing department-funded pretrial diversion as described in Chapter 2.8A (commencing with Section 1001.35) of Title 6 of Part 2 of the Penal Code, for the population described in subdivision (b) and that meets both of the following criteria:

(A) All participants identified for potential diversion are found incompetent to stand trial on a felony charge.

(B) Participants diverted through a program expansion suffer from a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, excluding antisocial personality disorder, borderline personality disorder, and pedophilia.

(2) Counties expanding their programs under this section will not be required to meet any additional match funding requirements.

(k) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the state hospitals and the department may implement, interpret, or make specific this section by means of a departmental letter or other similar instruction, as necessary.

(l) The department shall have access to the arrest records and state summary of criminal history of defendants who are participating or have participated in the diversion program. The information may be used solely for the purpose of looking at the recidivism rate for those patients.

SEC. 353. Chapter 6.7 (commencing with Section 4361.5) is added to Part 3 of Division 4 of the Welfare and Institutions Code, to read:

CHAPTER 6.7. State Department of State Hospitals: Contracting Facilities

4361.5. For purposes of this chapter, “department” means the State Department of State Hospitals.

4361.6. (a) Subject to an appropriation by the Legislature for this express purpose, the department may contract as follows:

(1) For subacute bed capacity, including, but not limited to, institutions for mental disease, mental health rehabilitation centers, skilled nursing facilities, or any other treatment options, such as community-based restoration of competency services, to address the increasing number of patient referrals to the department.

(2) With private or public entities to house and treat individuals committed to the department pursuant to Sections 1026, 1370, and 2972 of the Penal Code or Section 5358 of this code. Contracted funds may include any of the following:

(A) Program implementation costs, including funds for projects to modify, expand, or retrofit a space.

(B) One-time purchases of patient and staff furnishings and minor equipment.

(C) Activities related to recruitment and training of staff before program activation.

(D) Operating expenses.

(b) Contracts awarded pursuant to this chapter shall be exempt from the requirements contained in Section 19130 of the Government Code, the Public Contract Code, Section 4101.5 of this code, and the State Administrative Manual. These contracts shall not be subject to approval by the Department of General Services.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of a departmental letter or other similar instruction, as necessary.

SEC. 354. Section 5886 of the Welfare and Institutions Code is amended to read:

5886. (a) The Mental Health Student Services Act is hereby established as a mental health partnership grant program for the purpose of establishing mental health partnerships between a county’s mental health or behavioral health departments and school districts, charter schools, and the county office of education within the county.

(b) The Mental Health Services Oversight and Accountability Commission shall award grants to county mental health or behavioral health departments to fund partnerships between educational and county mental health entities. Subject to an appropriation for this purpose, commencing with the 2021–22 fiscal year, the commission shall award a grant under this section to a county mental health or behavioral health department or another lead agency, as identified by the partnership within each county that meets the requirements of this section.

(1) County, city, or multicounty mental health or behavioral health departments, or a consortium of those entities, including multicounty partnerships, may, in partnership with one or more school districts and at least one of the following educational entities located within the county, apply for a grant to fund activities of the partnership:

(A) The county office of education.

(B) A charter school.

(2) An educational entity may be designated as the lead agency at the request of the county, city, or multicounty department, or consortium, and authorized to submit the application. The county, city, or multicounty department, or consortium, shall be the grantee and receive any grant funds awarded pursuant to this section even if an educational entity is designated as the lead agency and submits the application pursuant to this paragraph.

(c) The commission shall establish criteria for awarding funds under the grant program, including the allocation of grant funds pursuant to this section, and shall require that applicants comply with, at a minimum, all of the following requirements:

(1) That all school districts, charter schools, and the county office of education have been invited to participate in the partnership, to the extent possible.

(2) That applicants include with their application a plan developed and approved in collaboration with participating educational entity partners and that include a letter of intent, a memorandum of understanding, or other evidence of support or approval by the governing boards of all partners.

(3) That plans address all of the following goals:

(A) Preventing mental illnesses from becoming severe and disabling.

(B) Improving timely access to services for underserved populations.

(C) Providing outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.

(D) Reducing the stigma associated with the diagnosis of a mental illness or seeking mental health services.

(E) Reducing discrimination against people with mental illness.

(F) Preventing negative outcomes in the targeted population, including, but not limited to:

(i) Suicide and attempted suicide.

(ii) Incarceration.

(iii) School failure or dropout.

(iv) Unemployment.

(v) Prolonged suffering.

(vi) Homelessness.

(vii) Removal of children from their homes.

(viii) Involuntary mental health detentions.

(4) That the plan includes a description of the following:

(A) The need for mental health services for children and youth, including campus-based mental health services, as well as potential gaps in local service connections.

(B) The proposed use of funds, which shall include, at a minimum, that funds will be used to provide personnel or peer support.

(C) How the funds will be used to facilitate linkage and access to ongoing and sustained services, including, but not limited to, objectives and anticipated outcomes.

(D) How the partnership will collaborate with preschool and childcare providers, or other early childhood service organizations, to ensure the mental health needs of children are met before and after they transition to a school setting.

(E) The partnership's ability to do all of the following:

(i) Obtain federal Medicaid or other reimbursement, including Early and Periodic Screening, Diagnostic, and Treatment funds, when applicable, or to leverage other funds, when feasible.

(ii) Collect information on the health insurance carrier for each child or youth, with the permission of the child or youth's parent, to allow the partnership to seek reimbursement for mental health services provided to children and youth, where applicable.

(iii) Engage a health care service plan or a health insurer in the mental health partnership, when applicable, and to the extent mutually agreed to by the partnership and the plan or insurer.

(iv) Administer an effective service program and the degree to which mental health providers and educational entities will support and collaborate to accomplish the goals of the effort.

(v) Connect children and youth to a source of ongoing mental health services, including, but not limited to, through Medi-Cal, specialty mental health plans, county mental health programs, or private health coverage.

(vi) Continue to provide services and activities under this program after grant funding has been expended.

(d) Grants awarded pursuant to this section shall be used to provide support services that include, at a minimum, all of the following:

(1) Services provided on school campuses, to the extent practicable.

(2) Suicide prevention services.

(3) Drop-out prevention services.

(4) Outreach to high-risk youth and young adults, including, but not limited to, foster youth, youth who identify as lesbian, gay, bisexual, transgender, or queer, and youth who have been expelled or suspended from school.

(5) Placement assistance and development of a service plan that can be sustained over time for students in need of ongoing services.

(e) Funding may also be used to provide other prevention, early intervention, and direct services, including, but not limited to, hiring qualified mental health personnel, professional development for school staff on trauma-informed and evidence-based mental health practices, and other strategies that respond to the mental health needs of children and youth, as determined by the commission.

(f) The commission shall determine the amount of grants and shall take into consideration the level of need and the number of schoolage youth in participating educational entities when determining grant amounts. In determining the distribution of funds appropriated in the 2021–22 fiscal year, the commission shall take into consideration any previous funding the grantee received under this section.

(g) The commission may establish incentives to provide matching funds by awarding additional grant funds to partnerships that do so.

(h) If the commission is unable to provide a grant to a partnership in a county because of a lack of applicants or because no applicants met the minimum requirements within the timeframes established by the commission, the commission may redistribute those funds to other eligible grantees.

(i) Partnerships currently receiving grants from the Investment in Mental Health Wellness Act of 2013 (Part 3.8 (commencing with Section 5848.5)) are eligible to receive a grant under this section for the expansion of services funded by that grant or for the inclusion of additional educational entity partners within the mental health partnership.

(j) Grants awarded pursuant to this section may be used to supplement, but not supplant, existing financial and resource commitments of the county, city, or multi-county mental health or behavioral health departments, or a consortium of those entities, or educational entities that receive a grant.

(k) (1) The commission shall develop metrics and a system to measure and publicly report on the performance outcomes of services provided using the grants.

(2) (A) The commission shall provide a status report to the fiscal and policy committees of the Legislature on the progress of implementation of this section no later than March 1, 2022, and provide an updated report no later than March 1, 2024. The reports shall address, at a minimum, all of the following:

(i) Successful strategies.

(ii) Identified needs for additional services.

(iii) Lessons learned.

(iv) Numbers of, and demographic information for, the schoolage children and youth served.

(v) Available data on outcomes, including, but not limited to, linkages to ongoing services and success in meeting the goals identified in paragraph (3) of subdivision (c).

(B) The reports to be submitted pursuant to this paragraph shall be submitted in compliance with Section 9795 of the Government Code.

(l) This section does not require the use of funds allocated for the purpose of satisfying the minimum funding obligation under Section 8 of Article XVI of the California Constitution for the partnerships established by this section.

(m) The commission may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis in order to implement this section. Contracts entered into or amended pursuant to this subdivision are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(n) This section shall be implemented only to the extent moneys are appropriated in the annual Budget Act or another statute for purposes of this section.

SEC. 355. Part 7 (commencing with Section 5960) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 7. Behavioral Health Services and Supports

CHAPTER 1. Behavioral health continuum infrastructure program

5960. The department may establish the Behavioral Health Continuum Infrastructure Program pursuant to this chapter if the Legislature appropriates funds for this purpose.

5960.05. If the department establishes the program pursuant to this chapter, the department may award competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets or to invest in needed mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources to build new capacity or expand existing capacity for short-term crisis stabilization, acute and subacute care, crisis residential, community-based mental health residential, substance use disorder residential, peer respite, mobile crisis, community and outpatient behavioral health services, and other clinically enriched longer term treatment and rehabilitation options for persons with behavioral health disorders in the least restrictive and least costly setting.

5960.1. Except as provided in Section 5960.15, the department shall determine the methodology and distribution of the grant funds appropriated for the program pursuant to Section 5960.05 to those entities it deems qualified.

5960.15. An entity shall meet all of the following conditions in order to receive grant funds pursuant to Section 5960.05, to the extent applicable and as required by the department:

(a) Provide matching funds or real property.

(b) Expend funds to supplement and not supplant existing funds to construct, acquire, and rehabilitate real estate assets.

(c) Report data to the department within 90 days of the end of each quarter for the first five years.

(d) Operate services in the financed facility for the intended purpose for a minimum of 30 years.

5960.2. (a) This chapter shall be implemented only if, and to the extent that, the department determines that federal financial participation under the Medi-Cal program, including but not limited to the increased federal funding available pursuant to Section 9813 of the federal American Rescue Plan Act of 2021 (Pub. Law 117-2), is not jeopardized.

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

5960.25. For purposes of implementing this chapter, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this 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.

5960.3. (a) Notwithstanding any other law, a facility project funded by a grant pursuant to this chapter shall be deemed consistent and in conformity with any applicable local plan, standard, or requirement, and allowed as a permitted use, within the zone in which the structure is located, and shall not be subject to a conditional use permit, discretionary permit, or to any other discretionary reviews or approvals.

(b) Notwithstanding any other law, the California Environmental Quality Act (Division 13 (commencing with Section 21000) of the Public Resources Code) shall not apply to a project, including a phased project, funded by a grant pursuant to this chapter if, where applicable, all of the following applicable requirements are satisfied:

(1) The project is not acquired by eminent domain.

(2) The project applicant demonstrates that the project is, and will continue to be, licensed by and in good standing with the department or other state licensing entity at the time of, and for the duration of, occupancy. The project shall be in decent, safe, and sanitary condition at the time of occupancy.

(3) The project applicant requires all contractors and subcontractors performing work on the facility project to pay prevailing wages for any proposed rehabilitation, construction, or major alterations in accordance with Chapter 1 (commencing with Section 1720) of Part 7 of Division 2 of the Labor Code.

(4) The project applicant obtains an enforceable commitment that all contractors and subcontractors performing work on the project will use a skilled and trained workforce for any proposed rehabilitation, construction, or major alterations in accordance with Chapter 2.9 (commencing with Section 2600) of Part 1 of Division 2 of the Public Contract Code.

(5) The project applicant submits to the lead agency a letter of support, or other durable documentary proof for the project, from a county, city, or other local public entity for any new proposed construction, major alteration work, or rehabilitation.

(6) The project applicant demonstrates that not less than ninety-five percent of the total cost of any new construction, facility acquisition, or rehabilitation project is paid for with public funds, private non-profit funds, or philanthropic funds.

(7) The project applicant demonstrates that the project expands the availability of behavioral health treatment services in the subject jurisdiction.

(8) The project applicant demonstrates that there are long-term covenants and restrictions that require the project to be used to provide behavioral health treatment for no less than 30 years, and those covenants and restrictions may not be amended or extinguished by a subsequent title holder, owner, or operator.

(9) The project does not result in any increase in the existing onsite development footprint of structures or improvements.

(c) If a project applicant determines that a project is not subject to the California Environmental Quality Act pursuant to this section, and the lead agency for the project publicly concurs in that determination, the project applicant shall file a notice of exemption with the Office of Planning and Research and the county clerk of the county in which the project is located in the manner specified in subdivisions (b) and (c) of Section 21152 of the Public Resources Code.

5960.35. (a) The following definitions shall apply to this chapter:

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

(2) “Program” means the Behavioral Health Continuum Infrastructure Program authorized by this chapter.

(b) The following provisions shall apply to the implementation of this chapter:

(1) “Low-rent housing project,” as defined in Section 1 of Article XXXIV of the California Constitution, does not apply to any facility project pursuant to this section that meets any one of the following criteria:

(A) The development is privately owned housing, receiving no ad valorem property tax exemption, other than exemptions granted pursuant to subdivision (f) or (g) of Section 214 of the Revenue and Taxation Code, not fully reimbursed to all taxing entities, and not more than 49 percent of the dwellings, apartments, or other living accommodations of the development may be occupied by persons of low income.

(B) The development is privately owned housing, is not exempt from ad valorem taxation by reason of any public ownership, and is not financed with direct long-term financing from a public body.

(C) The development is intended for owner-occupancy, which may include a limited-equity housing cooperative as defined in Section 50076.5 of the Health and Safety Code, or cooperative or condominium ownership, rather than for rental-occupancy.

(D) The development consists of newly constructed, privately owned, one-to-four family dwellings not located on adjoining sites.

(E) The development consists of existing dwelling units leased by the state public body from the private owner of these dwelling units.

(F) The development consists of the rehabilitation, reconstruction, improvement or addition to, or replacement of, dwelling units of a previously existing low-rent housing project, or a project previously or currently occupied by lower income households, as defined in Section 50079.5 of the Health and Safety Code.

(G) The development consists of the acquisition, rehabilitation, reconstruction, improvement, or any combination thereof, of a development which, prior to the date of the transaction to acquire, rehabilitate, reconstruct, improve, or any combination thereof, was subject to a contract for federal or state public body assistance for the purpose of providing affordable housing for low-income households and maintains, or enters into, a contract for federal or state public body assistance for the purpose of providing affordable housing for low-income households.

(2) “Tribal entity” shall mean a federally recognized Indian tribe, tribal organization, or urban Indian organization, as defined in Section 1603 of Title 25 of the United States Code.

5960.4. The provisions of this chapter are severable. If any provision of this chapter or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

5960.45. This chapter shall remain in effect only until January, 1, 2027, and as of that date is repealed.

CHAPTER 2. Children and youth behavioral health initiative act

CHAPTER 2.

5961. (a) This chapter shall be known, and may be cited, as the Children and Youth Behavioral Health Initiative Act.

(b) The Children and Youth Behavioral Health Initiative shall be administered by the California Health and Human Services Agency and its departments, as applicable.

(c) The initiative is intended to transform California's behavioral health system into an innovative ecosystem in which all children and youth 25 years of age and younger, regardless of payer, are screened, supported, and served for emerging and existing behavioral health needs.

(d) Subject to an appropriation by the Legislature for this purpose, the initiative shall include, but need not be limited to, all of the following components:

(1) A behavioral health services and supports virtual platform, as described in Section 5961.1.

(2) School-linked partnership, capacity, and infrastructure grants to qualified entities to support implementation of the initiative for behavioral health services in schools and school-linked settings, as described in Section 5961.2.

(3) Incentive payments to qualifying Medi-Cal managed care plans to implement interventions that increase access to preventive, early intervention, and behavioral health services by school-affiliated behavioral health providers for children in publicly funded childcare and preschool and TK-12 children in public schools, as described in Section 5961.3.

(4) Development and maintenance of a statewide fee schedule for school-linked outpatient mental health and substance use disorder treatment, as described in Section 5961.4.

(5) Development and expansion of evidence-based behavioral health programs, as described in Section 5961.5.

(6) Funding targeted to qualified entities serving individuals 25 years of age and younger through the Behavioral Health Continuum Infrastructure Program, as described in Chapter 1 (commencing with Section 5960).

(7) A comprehensive, and culturally and linguistically proficient, public education and social change campaign in support of the initiative.

(8) Investments for behavioral health workforce, education, and training to foster broad behavioral health capacity in support of the initiative, including a multiyear plan to launch and implement a statewide school behavioral health counselor system pursuant to Chapter 1.5 (commencing with Section 127825) of Part 3 of Division 107 of the Health and Safety Code.

(9) Funding targeted to qualified entities serving individuals 25 years of age and younger through the Mental Health Student Services Act, as described in Chapter 3 (commencing with Section 5886) of Part 4.

(e) Each component of the initiative shall be implemented only if, and to the extent that, the State Department of Health Care Services determines that federal financial participation under the Medi-Cal program is not jeopardized.

(f) For purposes of implementing this chapter, the California Health and Human Services Agency, the State Department of Health Care Services, and the Office of Statewide Health Planning and Development may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this chapter 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.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services and the Office of Statewide Health Planning and Development may implement, interpret, or make specific this chapter, in whole or in part, by means of plan letters, information notices, provider bulletins, or other similar instructions, without taking any further regulatory action.

(h) The Legislature finds and declares that this chapter is a state law within the meaning of Section 1621(d) of Title 8 of the United States Code.

5961.1. (a) As a component of the initiative, the State Department of Health Care Services shall procure and oversee a vendor to establish and maintain a behavioral health services and supports virtual platform that integrates behavioral health screenings, application-based supports, and direct behavioral health services to children and youth 25 years of age and younger, regardless of payer.

(b) Any virtual platform established or procured shall include access in all Medi-Cal threshold languages and shall be culturally appropriate to accommodate the diversity of the population and shall be accessible by telephone.

(c) The virtual platform may provide behavioral health services and supports, including, but not limited to, the following:

(1) Regular, automated behavioral health screenings.

(2) Short-term individual counseling, group counseling, and behavioral health peer and coaching supports.

(3) Interactive education, self-monitoring tools, application-based games, video and book suggestions, automated cognitive behavioral therapy, and mindful exercises designed to build skills and enhance wellbeing.

(4) Access to behavioral health peers, coaches, and licensed clinicians.

(5) Referrals to an individual's commercial health insurance, Medi-Cal managed care plan, county behavioral health, school-linked counselor, or community-based organizations, or other resources for higher-level behavioral health services.

(6) Statewide e-consult service to allow primary care pediatric and family practice providers to receive asynchronous support and consultation to manage behavioral health conditions for their patients.

5961.2. (a) As a component of the initiative, the State Department of Health Care Services, or its contracted vendor, may award competitive grants to entities it deems qualified for the following purposes:

(1) To build partnerships, capacity, and infrastructure supporting ongoing school-linked behavioral health services for children and youth 25 years of age and younger.

(2) To expand access to licensed medical and behavioral health professionals, counselors, peer support specialists, community health workers, and behavioral health coaches serving children and youth.

(3) To build a statewide, community-based organization provider network for behavioral health prevention and treatment services for children and youth, including those attending institutions of higher education.

(4) To enhance coordination and partnerships with respect to behavioral health prevention and treatment services for children and youth via appropriate data sharing systems.

(b) Subject to subdivision (c), entities eligible to receive grants pursuant to this section may include counties, city mental health authorities, tribal entities, local educational agencies, institutions of higher education, publicly funded childcare and preschools, health care service plans, community-based organizations, and behavioral health providers.

(c) The department shall determine the eligibility criteria, grant application process, and methodology for the distribution of funds appropriated for the purposes described in this section to those entities it deems qualified.

(d) The department shall ensure that grant distribution includes, but is not limited to, rural, urban, and suburban regions and geographic distribution among different age cohorts. Allowable activities shall include, but not be limited to, the following:

(1) Addressing behavioral health disparities while providing linguistically and culturally competent services for children and youth who lack access to adequate behavioral health services or otherwise are difficult to reach.

(2) Supporting administrative costs, including planning, project management, training, and technical assistance.

(3) Linking plans, counties, and school districts with local social services and community-based organizations.

(4) Implementing telehealth equipment and virtual systems in schools or near schools.

(5) Implementing data-sharing tools, information technology interfaces, or other technology investments designed to connect to behavioral health services.

(e) Of the funds appropriated for purposes of this section to institutions of higher education, at least two-thirds shall be reserved for California Community Colleges.

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

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

(2) “Health care service plan” has the same meaning as described in subdivision (f) of Section 1345 of the Health and Safety Code.

(3) “Institution of higher education” means the California Community Colleges, the California State University, or the University of California.

(4) “Local educational agency” means a school district, county office of education, charter school, the California Schools for the Deaf, and the California School for the Blind.

(5) “Tribal entity” means a federally recognized Indian tribe, tribal organization, or urban Indian organization.

5961.3. (a) As a component of the initiative, the State Department of Health Care Services shall make incentive payments to qualifying Medi-Cal managed care plans that meet predefined goals and metrics developed pursuant to subdivision (b) associated with targeted interventions that increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for K-12 children in schools.

(b) The department, in consultation with the State Department of Education, Medi-Cal managed care plans, county behavioral health departments, local educational agencies, and other affected stakeholders, shall develop the interventions, goals, and metrics used to determine a Medi-Cal managed care plan’s eligibility to receive the incentive payments described in this section. Higher incentive payments may be made for activities that increase Medi-Cal reimbursable services provided to children and youth, to reduce health equity gaps, and for services provided to children and youth living in transition, are homeless, or are involved in the child welfare system. Interventions, goals, and metrics include, but are not limited to, the following:

(1) Local planning efforts to review existing plans and documents that articulate children and youth needs in the area; compile data; map existing behavioral health providers and resources; identify gaps, disparities, and inequities; and convene stakeholders and develop a framework for a robust and coordinated system of social, emotional, and behavioral health supports for children and youth.

(2) Providing technical assistance to increase coordination and partnerships between schools and health care plans to build an integrated continuum of behavioral health services using contracts, a memorandum of understanding, or other agreements.

(3) Developing or piloting behavioral health wellness programs to expand greater prevention and early intervention practices in school settings, such as Mental Health First Aid and Social and Emotional Learning.

(4) Expanding the workforce by using community health workers or peers to expand the surveillance and early intervention of behavioral health issues in school-age children 0 to 25 years of age, inclusive.

(5) Increasing telehealth in schools and ensure students have access to technological equipment.

(6) Implementing school-based suicide prevention strategies.

(7) Improving performance and outcomes-based accountability for behavioral health access and quality measures through local student behavioral health dashboards or public reporting.

(8) Increasing access to substance use disorder prevention, early intervention, and treatment.

(c) (1) For each Medi-Cal managed care rating period, as defined in paragraph (3) of subdivision (a) of Section 14105.945, that the department implements this section, the department shall determine the amount of incentive payment earned by each qualifying Medi-Cal managed care plan.

(2) Any incentive payments that are eligible for federal financial participation pursuant to subdivision (e) shall be made in accordance with the requirements for incentive arrangements in Section 438.6(b)(2) of Title 42 of the Code of Federal Regulations and any associated federal guidance.

(d) Incentive payments made pursuant to this section shall be used to supplement and not supplant existing payments to Medi-Cal managed care plans. In addition to developing new collaborative initiatives, incentive payments shall be used to build on existing school-based partnerships between schools and applicable Medi-Cal plans, including Medi-Cal behavioral health delivery systems.

(e) The department shall seek any necessary federal approvals to claim federal financial participation for the incentive payments to qualifying Medi-Cal managed care plans described in this section. If federal approval is obtained for one or more Medi-Cal managed care rating periods, the department shall implement this section only to the extent that federal financial participation is

available in that applicable rating period. If federal approval is not obtained for one or more Medi-Cal managed care rating periods, the department may make incentive payments to qualifying Medi-Cal managed care plans as described in this section on a state-only funding basis during the applicable rating period, but only to the extent sufficient funds are appropriated to the department for this purpose and the department determines that federal financial participation for the Medi-Cal program is not otherwise jeopardized as a result.

(f) (1) The department may modify any requirement specified in this section to the extent that it deems the modification necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure that federal financial participation is available or not otherwise jeopardized. The department shall not propose any modification pursuant to this subdivision until the Department of Finance has reviewed and approved a fiscal impact statement.

(2) If the department, after consulting with the State Department of Education, Medi-Cal managed care plans, county behavioral health departments, local educational agencies, and other affected stakeholder entities, determines that the potential modification would be consistent with the goals of this section, the modification may be made in consultation with the Department of Finance and the department shall execute a declaration stating that this determination has been made. The department shall post the declaration on its internet website.

(3) The department shall notify entities consulted in paragraph (2), the Joint Legislative Budget Committee, the Senate Committees on Appropriations, Budget and Fiscal Review, and Health, and the Assembly Committees on Appropriations, Budget, and Health, within 10 business days of that modification or adjustment.

(4) The department shall work with the affected entities and the Legislature to make the necessary statutory changes.

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

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

(2) “Local educational agency” means a school district, county office of education, charter school, the California Schools for the Deaf, and the California School for the Blind.

(3) “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 any provision of Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9.

(4) “Medi-Cal behavioral health delivery system” has the meaning described in subdivision (i) of Section 14184.101.

5961.4. (a) As a component of the initiative, the State Department of Health Care Services shall develop and maintain a school-linked statewide fee schedule for outpatient mental health or substance use disorder treatment provided to a student 25 years of age or younger at a schoolsite.

(b) The department shall develop and maintain a school-linked statewide provider network of schoolsite behavioral health counselors.

(c) (1) Commencing January 1, 2024, and subject to subdivision (d), each Medi-Cal managed care plan and Medi-Cal behavioral health delivery system, as applicable, shall reimburse providers of medically necessary outpatient mental health or substance use disorder treatment provided at a schoolsite to a student 25 years of age or younger who is an enrollee of the plan or delivery system, in accordance with paragraph (2), but only to the extent the Medi-Cal managed care plan or Medi-Cal behavioral delivery system is financially responsible for those schoolsite services under its approved managed care contract with the department.

(2) Providers of medically necessary schoolsite services described in this section shall be reimbursed, at a minimum, at the fee schedule rate or rates developed pursuant to subdivision (a), regardless of network provider status.

(d) This section shall be implemented only to the extent that the department obtains any necessary federal approvals, and federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.

(e) This section does not relieve a local educational agency or institution of higher education from requirements to accommodate or provide services to students with disabilities pursuant to any applicable state and federal law, including, but not limited to, the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.), Part 30 (commencing with Section 56000) of Division 4 of Title 2 of the Education Code, Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code, and Chapter 3 (commencing with Section 3000) of Division 1 of Title 5 of the California Code of Regulations.

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

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

(2) “Institution of higher education” means the California Community Colleges, the California State University, or the University of California.

(3) Local educational agency” means a school district, county office of education, charter school, the California Schools for the Deaf, and the California School for the Blind.

(4) “Medi-Cal behavioral health delivery system” has the meaning described in subdivision (i) of Section 14184.101.

(5) “Medi-Cal managed care plan” means any individual, organization, or entity that enters into a comprehensive risk contract with the department to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries pursuant to any provision of Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9.

(6) “Schoolsite” has the meaning described in paragraph (6) of subdivision (b) of Section 1374.722 of the Health and Safety Code.

5961.5. (a) As a component of the initiative, the State Department of Health Care Services shall develop and select evidence-based interventions and community-defined promising practices to improve outcomes for children and youth with or at high risk for behavioral health conditions.

(b) Prior to selecting the evidence-based interventions, as described in subdivision (a), the department shall establish a workgroup comprised of subject matter experts and affected stakeholders to consider evidence-based interventions based on robust evidence for effectiveness, impact on racial equity, and sustainability.

(c) The department, or its contracted vendor, shall provide competitive grants to entities it deems qualified to support the implementation of the evidence-based interventions and community-defined promising practices developed pursuant to subdivision (a).

(d) Subject to subdivision (e), entities eligible to receive grants pursuant to this section may include Medi-Cal behavioral health delivery systems, city mental health authorities, tribal entities, health care service plans, Medi-Cal managed care plans, community-based organizations, and behavioral health providers. Grants for Medi-Cal behavioral health delivery systems for the purposes described in this section shall be administered through the Behavioral Health Quality Improvement Program pursuant to Section 14184.405.

(e) The department shall determine the eligibility criteria, grant application process, and methodology for the distribution of funds appropriated for the purposes described in this section and in Section 14184.405 to those entities it deems qualified.

(f) As a condition of funding, grant recipients shall share standardized data, in a manner and form determined by the department.

(g) For purposes of this section, “Medi-Cal behavioral health delivery system” shall have the same meaning as specified in subdivision (i) of Section 14184.101.

SEC. 356. Section 7275 of the Welfare and Institutions Code is amended to read:

7275. (a) A patient in a state hospital, their estate, and the guardian or conservator and administrator of the estate of the patient shall cause the patient to be properly and suitably cared for and maintained, and shall pay the costs and charges for transportation to a state institution. The patient in a state hospital and the administrators of their estate, and the estate of the person shall be liable for their care, support, and maintenance in a state institution of which they are a patient. The liability shall exist whether the person has become a patient of a state institution pursuant to the provisions of this code or pursuant to the provisions of Sections 1026, 1368, 1369, 1370, and 1372 of the Penal Code.

(b) This section does not impose liability for the care of persons with intellectual disabilities in state hospitals.

SEC. 357. Section 7276 of the Welfare and Institutions Code is amended to read:

7276. (a) The charge for the care and treatment of all persons who have mental health disorders at state hospitals for whom there is liability to pay therefor shall be determined pursuant to Section 4025. The Director of State Hospitals may reduce, cancel, or remit the amount to be paid by the estate liable for the care and treatment of a person who is an alcoholic or who has a mental health disorder and who is a patient at a state hospital, on satisfactory proof that the estate is unable to pay the cost of that care and treatment or that the amount is uncollectible. If there has been a payment under this section, and the payment or any part thereof is refunded because of the death, leave of absence, or discharge of a patient of the hospital, that amount shall be paid by

the hospital or the State Department of State Hospitals to the person who made the payment upon demand, and in the statement to the Controller the amounts refunded shall be itemized and the aggregate deducted from the amount to be paid into the State Treasury, as provided by law. If a person dies at any time while their estate is liable for their care and treatment at a state hospital, the claim for the amount due may be presented to the executor or administrator of their estate, and paid as a preferred claim, with the same rank in order of preference, as claims for expenses of last illness.

(b) If the Director of State Hospitals delegates to the county the responsibility for determining the ability of a minor child and their parents to pay for state hospital services, the requirements of Sections 5710 and 7275.1 and the policies and procedures established and maintained by the director, including those relating to the collection and accounting of revenue, shall be followed by each county to which that responsibility is delegated.

SEC. 358. Section 7277.1 of the Welfare and Institutions Code is amended to read:

7277.1. In the case of liability for care arising under Section 7275 during the lifetime of a decedent, in which the decedent has been a patient in a state hospital preceding the date of decedent's death, a claim for costs and charges shall be mailed within four months after written request therefor, in the form required by the department, by the fiduciary of the estate or trust or by any other person liable for the claim or any portion thereof.

SEC. 359. Section 7278 of the Welfare and Institutions Code is amended to read:

7278. The State Department of State Hospitals shall, following the admission of a patient into a state hospital, cause an investigation to be made to determine the moneys, property, or interest in property, if any, the patient has, and whether the patient has a duly appointed and acting guardian to protect their property and their property interests.

SEC. 360. Section 7282 of the Welfare and Institutions Code is amended to read:

7282. The State Department of State Hospitals with respect to a state hospital under its jurisdiction, or the State Department of Developmental Services with respect to a state hospital under its jurisdiction, may, in its own name, bring an action to enforce payment for the cost and charges of transportation of a person to a state hospital against any person, guardian, or conservator liable for transportation. The department also may, in its own name, bring an action to recover for the use and benefit of any state hospital or for the state the amount due for the care, support, maintenance, and expenses of any patient therein, against any county, or officer thereof, or against any person, guardian, or conservator liable for the care, support, maintenance, or expenses.

SEC. 361. Section 14000.6 is added to the Welfare and Institutions Code, to read:

14000.6. (a) The Office of Medicare Innovation and Integration is hereby established within the department.

(b) The office shall do all of the following:

(1) Provide focused leadership and expertise on innovative models for Medicare beneficiaries in California, including Medicare-only beneficiaries, and individuals dually eligible for the Medicare and Medi-Cal programs.

(2) Support new and existing models and strategies to benefit Medicare-only beneficiaries in California, in collaboration with local, state, and federal partners and other stakeholders.

(3) Consider and develop strategies for Medicare and Medi-Cal enrollment, benefits, health care delivery systems, and data sharing and reporting, to improve health outcomes, quality, equity, and cost effectiveness.

(4) Develop innovative approaches to integrated models of care and coordinated access to long-term services and supports for Medicare-only beneficiaries and dually eligible beneficiaries.

SEC. 362. Section 14005.18 of the Welfare and Institutions Code is amended to read:

14005.18. (a) (1) An individual is eligible, to the extent required by federal law, as though the individual was pregnant, for all pregnancy-related and postpartum services for a 60-day period beginning on the last day of pregnancy.

(2) For purposes of paragraph (1), "postpartum services" means those services provided after childbirth, child delivery, or miscarriage.

(b) (1) Notwithstanding subdivision (a), Section 15840, the income eligibility requirements specified in Section 15832, and the annual redetermination requirements described in Section 14005.37, a pregnant individual who is receiving health care coverage under a program identified in subdivision (d) and who is diagnosed with a maternal mental health condition shall remain eligible for the Medi-Cal program under their current eligibility category for a period of one year following the last day of the individual's

pregnancy if the individual complies with the requirements specified in subdivision (c) and is otherwise eligible for the Medi-Cal program.

(2) For purposes of this section, “maternal mental health condition” means a mental health condition that occurs during pregnancy or during the postpartum period and, includes, but is not limited to, postpartum depression.

(c) (1) An individual, or a designee of the individual, who seeks to extend Medi-Cal program coverage pursuant to this section shall submit to a county eligibility worker a note from that individual’s treating health care provider stating that the health care provider has diagnosed the individual with a maternal mental health condition within 60 days following the last day of the individual’s pregnancy.

(2) Notwithstanding paragraph (1), an individual who has had Medi-Cal coverage discontinued within the 60-day period beginning on the last day of pregnancy, but who is diagnosed with a maternal mental health condition more than 60 days following the last day of pregnancy and within the time limit described in subdivision (i) of Section 14005.37, may be reinstated to their previous Medi-Cal eligibility pursuant to subdivision (i) of Section 14005.37 by submitting a note, as described in paragraph (1), from the individual’s treating health care provider within the timeframe described in that subdivision.

(d) For purposes of this section, “Medi-Cal program” refers to any of the following programs:

(1) The Medi-Cal Access Program, as described in Chapter 2 (commencing with Section 15810) of Part 3.3.

(2) The Medi-Cal program, as described in this article.

(3) The Perinatal Services Program, as described in Article 4.7 (commencing with Section 14148).

(e) This section does not limit the ability of a qualified individual to apply for and purchase a qualified health plan in Covered California pursuant to Title 22 (commencing with Section 100500) of the Government Code if the qualified individual is otherwise eligible for coverage pursuant to that title.

(f) 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, provider bulletins, or similar instructions, without taking regulatory action.

(g) Implementation of this section is subject to an appropriation in the annual Budget Act for these purposes.

(h) This section shall become inoperative commencing on the date that Section 14005.185 is implemented. If made inoperative, this section shall become operative again if, and upon the date that, Section 14005.185 is no longer implemented. The department shall determine the implementation status of Section 14005.185 and shall post, on the department’s internet website, notice of its determination.

SEC. 363. Section 14005.185 is added to the Welfare and Institutions Code, to read:

14005.185. (a) Notwithstanding Section 15840, the income eligibility requirements specified in Section 15832, and the annual redetermination requirements described in Section 14005.37, a pregnant individual or targeted low-income child who is eligible for and is receiving health care coverage under a Medi-Cal program identified in subdivision (b) shall be eligible for full-scope Medi-Cal benefits for the duration of the pregnancy and for a period of one year following the last day of the individual’s pregnancy.

(b) For purposes of this section, “Medi-Cal program” refers to any of the following programs:

(1) The Medi-Cal Access Program, as described in Chapter 2 (commencing with Section 15810) of Part 3.3.

(2) The Medi-Cal program, as described in this article.

(3) The Perinatal Services Program, as described in Article 4.7 (commencing with Section 14148).

(c) The department shall seek any federal approvals, including under Titles XIX and XXI of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), that it determines are necessary to extend coverage for eligible pregnant and postpartum individuals or targeted low-income children as described in this section.

(d) (1) Except as provided in paragraph (2), coverage described in this section shall commence on April 1, 2022, or the effective date or dates reflected in any necessary federal approvals obtained by the department pursuant to subdivision (c), whichever is later.

(2) Notwithstanding paragraph (1), coverage described in this section for populations authorized under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa) shall be effective on the date reflected in any necessary federal approvals obtained by the department pursuant to subdivision (c).

(e) 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, provider bulletins, or similar instructions, without taking any further regulatory action.

(f) Implementation of this section is subject to an appropriation in the annual Budget Act, or any other act approved by the Legislature, for the purposes described in this section.

(g) (1) Except as provided in paragraph (2), this section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and not otherwise jeopardized.

(2) With respect to coverage described in the section for populations authorized under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa), the department may implement this section prior to receipt of all necessary federal approvals, so long as the department determines that federal financial participation under the Medi-Cal program is not otherwise jeopardized.

SEC. 364. Section 14005.62 is added to the Welfare and Institutions Code, to read:

14005.62. (a) (1) Notwithstanding any other law, for an applicant or beneficiary whose eligibility is not determined using the modified adjusted gross income (MAGI)-based financial methods, as specified in Section 1396a(e)(14) of Title 42 of the United States Code, the department shall seek federal approval to implement a disregard of one hundred thirty thousand dollars ($130,000) in nonexempt property for a case with one member and sixty five thousand dollars ($65,000) for each additional household member, up to a maximum of ten members.

(2) This subdivision shall be implemented only after the director determines that systems have been programmed for the disregards specified in paragraph (1) and they communicate that determination in writing to the Department of Finance, and no sooner than July 1, 2022.

(b) (1) Notwithstanding any other law, for an applicant or beneficiary described in subdivision (a), resources, including property or other assets, shall not be used to determine eligibility under the Medi-Cal program to the extent permitted by federal law. The department shall seek federal authority to disregard all resources as authorized by the flexibilities provided under Section 1396a(r)(2) of Title 42 of the United States Code or other available authorities.

(2) This subdivision shall be implemented only after the director determines that systems have been programmed for these disregards and they communicate that determination in writing to the Department of Finance, and no sooner than January 1, 2024.

(c) (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 this section by means of county letters, provider bulletins or notices, policy letters, or other similar instructions, without taking regulatory action.

(2) Within two years of implementing the requirements set forth in subdivision (b), the department shall do both of the following:

(A) Adopt, amend, or repeal regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code and this section.

(B) Update its notices and forms to delete any reference to limitations on resources or assets.

(d) This section shall only be implemented to the extent consistent with federal law, upon the department obtaining any necessary federal approvals, and to the extent federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.

SEC. 365. Section 14007.8 of the Welfare and Institutions Code is amended to read:

14007.8. (a) (1) An individual who is 25 years of age or younger, and who does not have satisfactory immigration status or is unable to establish satisfactory immigration status as required by Section 14011.2, shall be eligible for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(2) (A) After the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of this paragraph, but no sooner than May 1, 2022, an individual who is 50 years of age or older, and who does not have satisfactory immigrant status or is unable to establish satisfactory immigration status as required by Section 14011.2, shall be eligible for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(B) The effective date of enrollment into the Medi-Cal program for an individual described in this paragraph, and enrolled in the Medi-Cal program pursuant to subdivision (d) of Section 14007.5, shall be on the same day on which the systems are

operational to begin processing new applications pursuant to the director's determination described in subparagraph (A).

(3) (A) An individual enrolled in the Medi-Cal program pursuant to this section and subdivision (d) of Section 14007.5 shall not be required to file a new application for the Medi-Cal program.

(B) The enrollment specified in subparagraph (A) shall be conducted pursuant to an eligibility and enrollment plan, and shall include outreach strategies developed by the department in consultation with interested stakeholders, including, but not limited to, counties, health care service plans, health care providers, consumer advocates, and the Legislature.

(C) The department shall provide monthly updates to the appropriate policy and fiscal committees of the Legislature on the status of the implementation of this section.

(b) To the extent permitted by state and federal law, an individual eligible under this section shall be required to enroll in a Medi-Cal managed care health plan. Enrollment in a Medi-Cal managed care health plan shall not preclude a beneficiary from being enrolled in any other children's Medi-Cal specialty program that they would otherwise be eligible for.

(c) (1) The department shall maximize federal financial participation in implementing this section to the extent allowable. For purposes of implementing this section, the department shall claim federal financial participation to the extent that the department determines it is available.

(2) To the extent that federal financial participation is unavailable, the department shall implement this section using state funds appropriated for this purpose.

(d) This section shall be implemented only to the extent it is in compliance with Section 1621(d) of Title 8 of the United States Code.

(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 the time any necessary regulations are adopted. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(2) Notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(f) In implementing this section, the department may contract, as necessary, on a bid or nonbid basis. This subdivision establishes an accelerated process for issuing contracts pursuant to this section. Those contracts, and any other contracts entered into pursuant to this subdivision, may be on a noncompetitive bid basis and shall be exempt from both of the following:

(1) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part.

(2) Review or approval of contracts by the Department of General Services.

SEC. 366. Section 14011.10 of the Welfare and Institutions Code is amended to read:

14011.10. (a) Except as provided in Sections 14053.7, 14053.8, and 14184.800, benefits provided under this chapter to an individual who is an inmate of a public institution shall be suspended in accordance with Section 1396d(a)(29)(A) of Title 42 of the United States Code as provided in subdivisions (c) and (d).

(b) A county welfare department shall notify the department within 10 days of receiving information that an individual on Medi-Cal in the county is or will be an inmate of a public institution.

(c) Until October 1, 2020, if an individual is a Medi-Cal beneficiary on the date they become an inmate of a public institution, their benefits under this chapter and under Chapter 8 (commencing with Section 14200) shall be suspended effective the date they become an inmate of a public institution. The suspension shall end on the date they are no longer an inmate of a public institution or one year from the date they become an inmate of a public institution, whichever is sooner.

(d) Commencing October 1, 2020, if an individual is a Medi-Cal beneficiary on the date they become an inmate of a public institution, their benefits under this chapter and under Chapter 8 (commencing with Section 14200) shall be suspended effective the date they become an inmate of a public institution. The suspension shall end according to the following:

(1) For an individual who is not defined as a juvenile under Section 1396a(nn)(1)(A) or 1396a(nn)(1)(B) of Title 42 of the United States Code, the suspension shall end on the date the individual is no longer an inmate of a public institution or one year from the date the individual becomes an inmate of a public institution, whichever is sooner.

(2) For an individual who is defined as a juvenile under Section 1396a(nn)(1)(A) or 1396a(nn)(1)(B) of Title 42 of the United States Code, the suspension shall end in accordance with Section 1396a(a)(84) of Title 42 of the United States Code, or one year from the date the individual becomes an inmate of a public institution, whichever is later.

(e) The department, in consultation with stakeholders, including the County Welfare Directors Association of California and advocates, shall develop and implement a redetermination of eligibility, to the extent required by federal law, pursuant to Section 14005.37, for individuals referenced in paragraph (2) of subdivision (d) whose eligibility is suspended pursuant to this section.

(f) This section does not create a state-funded benefit or program. Health care services under this chapter and Chapter 8 (commencing with Section 14200) shall not be available to inmates of public institutions whose Medi-Cal benefits have been suspended under this section.

(g) This section shall be implemented only if and to the extent allowed by federal law. This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approval of state plan amendments or other federal approvals have been obtained.

(h) This section shall be implemented on January 1, 2010, or the date when all necessary federal approvals are obtained, whichever is later.

(i) By January 1, 2010, or the date when all necessary federal approvals are obtained, whichever is later, the department, in consultation with the Chief Probation Officers of California and the County Welfare Directors Association of California, shall establish the protocols and procedures necessary to implement this section, including any needed changes to the protocols and procedures previously established to implement Section 14029.5.

(j) The department shall determine whether federal financial participation will be jeopardized by implementing this section and shall implement this section only if and to the extent that federal financial participation is not jeopardized.

(k) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of all-county letters or similar instructions without taking regulatory action. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(l) Notwithstanding any other law, commencing no sooner than July 1, 2021, the department, in consultation with representatives of county welfare departments, the Statewide Automated Welfare Systems, and other interested stakeholders, shall initiate the planning process to prioritize the automation of Medi-Cal suspensions for incarcerated individuals into the California Healthcare Eligibility, Enrollment, and Retention System, as set forth in this section. This change shall be reflected in both the California Healthcare Eligibility, Enrollment, and Retention System 24-Month Roadmap Initiatives and the County Eligibility Worker Dashboard.

SEC. 367. Section 14021.37 of the Welfare and Institutions Code is repealed.

SEC. 368. Section 14042.1 of the Welfare and Institutions Code is amended to read:

14042.1. (a) No earlier than January 1, 2018, the State Department of Health Care Services shall establish a Medically Tailored Meals Pilot Program to operate for a period of four years from the date the program is established, or until funding is no longer available for the program, whichever date is earlier.

(1) The department shall determine the number of eligible participants and providers in the program and shall use data from the Medi-Cal program to identify eligible beneficiaries for participation in the program.

(2) The program shall provide medically tailored meal intervention services to Medi-Cal participants with one or more of the following health conditions: congestive heart failure, cancer, diabetes, chronic obstructive pulmonary disease, or renal disease.

(3) The department may establish additional eligibility requirements based on acuity and other selection criteria. Each participant in the program shall receive a standard intervention, as determined by the department, of up to 21 meals per week for 12 to 24 weeks. The provided meals shall be medically tailored and designed to meet the specific nutritional needs of the participant’s specific illness.

(4) The program shall be conducted in the Counties of Alameda, Los Angeles, Marin, San Diego, San Francisco, San Mateo, Santa Clara, and Sonoma.

(5) (A) At the conclusion of the program, the department shall use the data from the Medi-Cal program on the program participants to evaluate what impact, to the extent it can be determined, the program had on hospital readmissions, decreased admissions to long-term care facilities, and emergency room utilization.

(B) The department shall send a report containing its evaluation to the Legislature within 12 months after the end of the four-year program.

(C) The legislative report submitted pursuant to subparagraph (B) shall be submitted in compliance with Section 9795 of the Government Code.

(b) For the purposes of this section, “medically tailored meals” means a specifically tailored diet to address the participant’s specific medical condition and associated symptoms.

(c) The department shall develop a methodology for reimbursing contractors, or other entities, as applicable, for services or activities provided pursuant to this section based on, and not to exceed, the aggregate amount of funds allocated per year for purposes of the program. The department may use up to 20 percent of the funds allocated per year for the program to support its administration and evaluation.

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

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

(f) The department shall seek any federal approvals necessary to implement this section, including any waivers it deems necessary to obtain federal financial participation for the program, and shall claim federal financial participation to the full extent permitted by law. If federal financial participation is unavailable, the department shall implement the program using available state-only funds, subject to annual appropriation by the Legislature.

(g) (1) For the 2021–2022 fiscal year, in addition to the Medically Tailored Meals Pilot Program specified under subdivisions (a) to (f), inclusive, the department shall implement the Short-Term Medically Tailored Meals Intervention Services Program to award funds to qualified entities providing medically tailored meals intervention services to eligible Medi-Cal beneficiaries who reside in a county identified in paragraph (4) with one or more of the following health conditions described in subparagraphs (A) to (H), inclusive, when meal services are unavailable under the Medically Tailored Meals Pilot Program:

(A) Diabetes.

(B) Chronic obstructive pulmonary disease.

(C) Renal disease.

(D) Chronic kidney disease.

(E) Cancer.

(F) Malnutrition.

(G) Human immunodeficiency virus or acquired immune deficiency syndrome.

(H) Congestive heart failure.

(2) The Short-Term Medically Tailored Meals Intervention Services Program shall cease to be operative when the funding allocated under the Budget Act of 2021 has been exhausted, or on June 30, 2022, whichever is sooner.

(3) (A) To the extent funding is available, an eligible Medi-Cal beneficiary shall receive medically tailored meals intervention services as specified in subparagraph (B).

(B) (i) For the 2021–2022 fiscal year, medically tailored meals intervention services shall be available to an eligible Medi-Cal beneficiary, and they shall receive up to 21 meals per week for 12 to 52 weeks, for a maximum of 52 weeks, depending on the medical diagnosis and need. The meals shall be medically tailored and designed to meet the specific nutritional needs of the Medi-Cal beneficiary’s specific health condition.

(ii) To the extent funding is available, the medically tailored meals intervention services shall include medical nutrition therapy or counseling for the program’s participants.

(C) The department may implement, as specified in subdivision (d), and in consultation with medically tailored meals providers, additional eligibility requirements for individuals to receive services under the Short-Term Medically Tailored Meals Intervention Services Program, based on acuity and other selection criteria.

(4) Funds appropriated for the Short-Term Medically Tailored Meals Intervention Services Program shall be awarded based on a methodology developed by the department to nonprofit and community-based organizations that have expertise as medically tailored meals providers in the Counties of Alameda, Contra Costa, Fresno, Kings, Los Angeles, Madera, Marin, San Diego, San Francisco, San Mateo, Santa Clara, Santa Cruz, Sonoma, and Tulare.

(5) Providers that are awarded funding to provide short-term medically tailored meals intervention services shall monitor and document the impacts of the Short-Term Medically Tailored Meals Intervention Services Program, including, but not limited to, the effect of this program on hospital readmissions, emergency room utilization, and health outcomes, to the extent data is available, and shall provide that information to the department upon request, and in a form and manner specified by the department. This information shall not be included in the data considered in evaluating the Medically Tailored Meals Pilot Program, as described in paragraph (5) of subdivision (a).

(6) The department shall develop a methodology for reimbursing contractors or other entities, as applicable, for services or activities provided pursuant to this subdivision based on, and not to exceed, the aggregate amount of funds allocated for purposes of this subdivision. The department shall allocate 5 percent of the funds to a nonprofit organization fiscal sponsor that shall coordinate the program to support its administration. The fiscal sponsor shall work with nonprofit members in relevant regions.

(7) To the extent permitted under applicable federal and state law, the department may use data from the Medi-Cal program to identify Medi-Cal beneficiaries eligible to receive services under the Short-Term Medically Tailored Meals Intervention Services Program.

(8) This subdivision shall be implemented only to the extent the department determines that federal financial participation under the Medi-Cal program is not jeopardized.

(h) This section shall remain in effect until the department submits its report containing its evaluation of the Medically Tailored Meals Pilot Program to the Legislature pursuant to subparagraph (B) of paragraph (5) of subdivision (a), or 12 months after the end of the Medically Tailored Meals Pilot Program or the Short-Term Medically Tailored Meals Intervention Services Program, whichever occurs last, and as of that date is repealed.

SEC. 369. Section 14043.15 of the Welfare and Institutions Code is amended to read:

14043.15. (a) The department may adopt regulations for certification of each applicant and each provider in the Medi-Cal program. No certification shall be required for natural persons licensed or certificated under Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act.

(b) (1) An applicant or provider who is a natural person, and is licensed or certificated pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or is a professional corporation, as defined in subdivision (b) of Section 13401 of the Corporations Code, shall comply with Section 14043.26 and shall be enrolled in the Medi-Cal program as either an individual provider or as a rendering provider in a provider group for each application package submitted and approved pursuant to Section 14043.26, notwithstanding that the applicant or provider meets the requirements to qualify as exempt from clinic licensure under subdivision (a) or (m) of Section 1206 of the Health and Safety Code.

(2) A provider enrolled in the Medi-Cal program pursuant to paragraph (1), who has disclosed in the application package for enrollment that the provider's practice includes the rendering of services, goods, supplies, or merchandise solely at one, or at more than one, health facility, as defined in Section 1250 of the Health and Safety Code, or clinic, as defined in Section 1204 of the Health and Safety Code, or medical therapy unit, for purposes of Section 123950 of the Health and Safety Code, or residence of the provider's patient, or office of a physician and surgeon involved in the care and treatment of the provider's patients, shall not be required to enroll at each such health facility, clinic, medical therapy unit, patient's residence, or physician and surgeon's office location and may utilize the business addresses listed on the application for enrollment pursuant to paragraph (1) to claim reimbursement from the Medi-Cal program for services rendered by the provider to Medi-Cal beneficiaries at all of those health facilities, clinics, medical therapy units, residences, or physician offices.

(3) This subdivision shall not be interpreted to allow the violation of any state or federal law governing fiscal intermediaries or Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act. This subdivision does not remove the requirement that each claim for reimbursement from the Medi-Cal program identify the place of service and the rendering, ordering, referring, and prescribing provider, where applicable.

(c) An applicant or provider licensed as a clinic pursuant to Chapter 1 (commencing with Section 1200) of, or a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of, Division 2 of the Health and Safety Code may be enrolled in the Medi-Cal program as a clinic or a health facility and need not comply with Section 14043.26 if the clinic or health facility is certified by the department to participate in the Medi-Cal program.

(d) An applicant or provider that meets the requirements to qualify as exempt from clinic licensure under subdivisions (b) to (l), inclusive, or subdivisions (n) to (p), inclusive, of Section 1206 of the Health and Safety Code shall comply with Section 14043.26 and may be enrolled in the Medi-Cal program as either a clinic or within any other provider category for which the applicant or provider qualifies. An applicant or provider to which any of the clinic licensure exemptions specified in this subdivision apply shall identify the licensure exemption category and document in its application package the legal and factual basis for the clinic license exemption claimed.

(e) Notwithstanding subdivisions (a), (b), (c), and (d), an applicant or provider that meets the requirements to qualify as exempt from clinic licensure pursuant to subdivision (h) of Section 1206 of the Health and Safety Code, including an intermittent site that is operated by a licensed primary care clinic or an affiliated mobile health care unit licensed or approved under Chapter 9 (commencing with Section 1765.101) of Division 2 of the Health and Safety Code, and that is operated by a licensed primary care clinic, and for which intermittent site or mobile health unit the licensed primary care clinic directly or indirectly provides all staffing, protocols, equipment, supplies, and billing services, need not enroll in the Medi-Cal program as a separate provider and need not comply with Section 14043.26 if the licensed primary care clinic operating the applicant, provider clinic, or mobile health care unit has notified the department of its separate locations, premises, intermittent sites, or mobile health care units.

(f) A primary care clinic with (1) an additional physical plant added to its primary care clinic license under a consolidated license pursuant to subdivision (d) of Section 1212 of the Health and Safety Code, or (2) a physical plant that was added to an existing primary care clinic license by the State Department of Public Health, prior to January 1, 2017, whether by a regional district office or the centralized application unit, need not separately enroll the additional physical plant as a separate provider, and need not comply with Section 14043.26 if the primary care clinic has notified the department of its additional physical plant.

(g) Notwithstanding any other law and to the extent permitted by federal law, an applicant or provider that meets the requirements to qualify as a mobile optometric office pursuant to Section 3070.2 of the Business and Professions Code and Section 14043.26 may be enrolled in the Medi-Cal program as either a mobile optometric office or within any other provider category for which the applicant or provider qualifies.

(1) An applicant or provider to which Section 3070.2 of the Business and Professions Code applies shall demonstrate its compliance by providing proof of its nonprofit or charitable organization status pursuant to Section 501(c)(3) or 501(c)(4) of the Internal Revenue Code and a statement that it shall not accept payment for services other than those provided to Medi-Cal beneficiaries, even if the State Board of Optometry has not yet issued final regulations as required by Section 3070.2 of the Business and Professions Code or issued any registrations at the time of enrollment.

(2) A mobile optometric office shall use the address of the owner and operator of the mobile optometric office as registered with the State Board of Optometry for its place of business address and shall not be required to comply with Section 51000.60 of Title 22 of the California Code of Regulations.

(3) To the extent federal financial participation is available, a mobile optometric office shall be permitted to bill the Medi-Cal program for the professional optometry services provided by licensed optometrists. The licensed optometrists providing service at a mobile optometric office shall use the address of the owner and operator of the mobile optometric office as registered with the State Board of Optometry for its place of business address and shall not be required to comply with Section 51000.60 of Title 22 of the California Code of Regulations.

SEC. 370. Section 14043.51 is added to the Welfare and Institutions Code, to read:

14043.51. (a) For purposes of this section, the following definitions apply:

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

(2) “Electronic visit verification system” has the same meaning as that term is defined in subsection (l) of Section 1396b of Title 42 of the United States Code.

(3) “Partners” means governmental entities, including, but not limited to, the State Department of Social Services, the State Department of Developmental Services, the State Department of Public Health, the California Department of Aging, and the Office of Systems Integration.

(4) “Provider” means a provider who is enrolled in the Medi-Cal program, as specified in subdivision (h) of Section 14043.1.

(b) The department, as the single state agency for the Medicaid program in California, may undertake action, as determined by the director to be appropriate, to implement an electronic visit verification system for purposes of obtaining and maintaining federal approval or ensuring federal financial participation is available or not otherwise jeopardized.

(c) The department may collaborate and contract with other governmental entities, including its partners, to comply with federal requirements relating to electronic visit verification.

(d) (1) If a provider renders Medi-Cal services that are subject to electronic visit verification, they shall comply with requirements, as established by the department and its partners, relating to electronic verification of those services.

(2) Except as provided in paragraph (3), if the department determines a provider has failed to comply with the established requirements, the department and its partners, as may be appropriate under the circumstances, may take any of the following action to address the noncompliance of the provider:

(A) Provide technical assistance on compliance.

(B) Require an approved corrective action plan.

(C) Recover associated overpayments.

(D) Impose enrollment or monetary sanctions.

(E) Take any other remedial action, as deemed appropriate.

(3) Individual providers of in-home supportive services, and individual providers of waiver personal care services, who are not employed by an agency, are not subject to the actions described in paragraph (2) for purposes of noncompliance with requirements established pursuant to paragraph (1), and are instead subject to the electronic visit verification system development and implementation principles set forth in Section 10836 and the provisions of Sections 12305.82 and 12305.83.

(e) (1) The department and its partners may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis to implement this section and an electronic visit verification system.

(2) In developing and implementing electronic visit verification, the department and its partners may continue to utilize services performed under existing contracts if those services involve planning, developing, or establishing an electronic visit verification protocol or system.

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

SEC. 371. Section 14059.5 of the Welfare and Institutions Code is amended to read:

14059.5. (a) For individuals 21 years of age or older, a service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

(b) (1) For individuals under 21 years of age, a service is “medically necessary” or a “medical necessity” if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code.

(2) The department and its contractors shall update any model evidence of coverage documents, beneficiary handbooks, and related material to ensure the medical necessity standard for coverage for individuals under 21 years of age is accurately reflected in all materials.

(3) 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, and make specific this subdivision by means of all-county letters, plan letters, plan provider bulletins, manuals, plan contract amendments, or similar instructions until regulations are revised or adopted.

(4) By July 1, 2022, the department shall revise or adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. This paragraph shall not apply to a Medi-Cal behavioral health delivery system, as defined in subdivision (i) of Section 14184.101.

(c) This section shall not be construed to limit the application of subdivisions (a) and (b) of Section 51184 of Title 22 of the California Code of Regulations.

(d) Medical necessity for covered benefits provided in a Medi-Cal behavioral health delivery system, as defined in subdivision (i) of Section 14184.101, shall also be governed in accordance with Section 14184.402.

SEC. 372. Section 14087.46 of the Welfare and Institutions Code is amended to read:

14087.46. (a) The department shall implement a dental managed care program for Medi-Cal beneficiaries to achieve major cost savings, while ensuring access and quality of care, pursuant to this section.

(b) The department shall issue a request for proposals and award contracts on a competitive basis to one or more dental health care service contractors licensed pursuant to the Knox-Keene Health Care Service Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) in each county or region that the department determines to be feasible. The department may contract with county organized health systems.

(c) To ensure access and continuity of care, the department shall award contracts to plans that agree to negotiate in good faith and subcontract with any provider who agrees to provide dental services to Medi-Cal beneficiaries at a reimbursement rate comparable to that paid by the plan to other participating providers. A plan shall contract whenever feasible with traditional and safety net providers of dental services to Medi-Cal beneficiaries. In evaluating the plans, the department shall assign favorable weighting to contractors that include traditional and safety net providers.

(d) The department shall implement a process to inform each Medi-Cal beneficiary of their choice of participating dentists and to allow a beneficiary to choose or change their participating dentist.

(e) The department shall make every effort to achieve operational contracts to place Medi-Cal beneficiaries in dental managed care by October 1, 1995. The department may determine which counties or categories of Medi-Cal beneficiaries are to be included in the dental managed care program. If the department has achieved one or more operational managed care contracts in a county or region, fee-for-service dental services shall not be an option for selection by a beneficiary, except that the department may provide for fee-for-service dental care if needed to ensure adequate access in rural or underserved areas, or for unique populations.

(f) The department shall require a participating plan to provide, at a minimum, the full scope of dental benefits pursuant to state and federal law.

(g) In order to achieve maximum cost savings, the Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Therefore, contracts under this section shall be exempt from the Public Contract Code.

(h) A Medi-Cal beneficiary shall be able to receive their dental care from federally qualified health centers and rural health clinics certified pursuant to Public Law 95-210 that provide dental care in their service area. At the time of informing the Medi-Cal beneficiary of their choice of participating dentists, the beneficiary shall be informed of this option. Federally qualified health centers and rural health clinics shall continue to be reimbursed for dental services through the medical payment system in accordance with federal regulations.

(i) The department shall monitor the implementation of dental managed care, and for each of the first three years of implementation, shall annually evaluate the program on a county-by-county basis in terms of access, quality of care, and cost savings. The evaluation shall be provided to the Legislature within 120 days of the close of each of the three fiscal years.

(j) The department shall seek federal waivers necessary to allow for federal financial participation in the program implemented pursuant to this section. This article shall not be implemented unless and until the director has executed a declaration, to be retained by the director, that approval of all necessary federal waivers have been obtained by the department.

(k) Notwithstanding any other law, the department shall extend the dental managed care contracts, which are in effect on the effective date of the act that added this subdivision, for the provision of covered dental services authorized under this section pursuant to all of the following:

(1) These contracts shall be extended to December 31, 2022.

(2) Contract extensions shall be secured on a sole source basis.

(3) Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, 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.

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

SEC. 373. Section 14105.075 of the Welfare and Institutions Code is amended to read:

14105.075. (a) (1) Notwithstanding any other law, for dates of service on or after August 1, 2016, payments to intermediate care facilities for the developmentally disabled that are licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, and to facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20, as determined by the applicable methodology for setting reimbursement rates for those facilities, shall be the reimbursement rates that were applicable to those facilities in the 2008–09 rate year, increased by 3.7 percent. Payments to the facilities pursuant to this section shall also include the projected cost of complying with new state or federal mandates to the extent applicable to the reimbursement methodology associated with the type of facility.

(2) Notwithstanding paragraph (1) and Sections 14105.191 and 14105.192, and for dates of service on or after August 1, 2021, the reimbursement rates for intermediate care facilities for the developmentally disabled and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to Section 14132.20 shall be determined without applying to that rate any reduction, limitation, or increase, including the 3.7-percent increase, specified in paragraph (1), as described in this section or Sections 14105.191 and 14105.192.

(b) (1) For dates of service on or after August 1, 2021, and for each rate year thereafter, the department shall calculate and publish the reimbursement rates, as specified in paragraph (2) of subdivision (a), plus the projected cost of complying with new state or federal mandates.

(2) For the 2021–22 fiscal year, and for each fiscal year thereafter, the reimbursement rates for intermediate care facilities for the developmentally disabled or facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to Section 14132.20, or both, shall account for, and be inclusive of, supplemental payments, as described under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016, or Proposition 56, if the Budget Act of that fiscal year appropriates funds from the Healthcare Treatment Fund, as established pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code, to the department to make those supplemental payments to these facilities.

(3) For dates of service on or after August 1, 2021, to July 31, 2022, inclusive, the reimbursement rate established for an intermediate care facility for the developmentally disabled or a facility providing continuous skilled nursing care to developmentally disabled individuals pursuant to Section 14132.20 shall be the greater of that facility's reimbursement rate established pursuant to paragraphs (1) and (2), or the approved Medi-Cal State Plan reimbursement rate, inclusive of the temporary increased Medicaid payments associated with the COVID-19 Public Health Emergency, plus the Proposition 56 supplemental payment amount, in effect for that facility on July 31, 2021.

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

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

(e) (1) The department may modify any methodology or provision specified in this section to the extent it deems necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure federal financial participation is available or is not otherwise jeopardized, only if that modification does not violate the spirit, purposes, and intent of this section.

(2) If the department determines that a modification is necessary pursuant to paragraph (1), the department shall consult with affected providers and stakeholders to the extent practicable.

SEC. 374. Section 14105.192 of the Welfare and Institutions Code is amended to read:

14105.192. (a) The Legislature finds and declares all of the following:

(1) Costs within the Medi-Cal program continue to grow due to the rising cost of providing health care throughout the state and also due to increases in enrollment, which are more pronounced during difficult economic times.

(2) In order to minimize the need for drastically cutting enrollment standards or benefits during times of economic crisis, it is crucial to find areas within the Medi-Cal program that have reimbursement levels are higher than required under the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and may be reduced in accordance with federal law.

(3) The Medi-Cal program delivers its services and benefits to Medi-Cal beneficiaries through a wide variety of health care providers, some of which deliver care via managed care or other contract models while others do so through fee-for-service arrangements.

(4) The setting of rates within the Medi-Cal program is complex and subject to close supervision by the United States Department of Health and Human Services.

(5) As the single state agency for the Medicaid program in California, the department has unique expertise that can inform decisions that set or adjust reimbursement methodologies and levels consistent with the requirements of federal law.

(b) Therefore, it is the intent of the Legislature for the department to analyze and identify where reimbursement levels can be reduced consistent with the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and consistent with federal and state law and policies, including exemptions contained in the act that added this section, provided that the reductions in reimbursement shall not exceed 10 percent on an aggregate basis for all providers, services, and products.

(c) Notwithstanding any other law, the director shall adjust provider payments, as specified in this section.

(d) (1) Except as otherwise provided in this section, payments shall be reduced by 10 percent for Medi-Cal fee-for-service benefits for dates of service on and after June 1, 2011.

(2) For managed health care plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), except contracts with Senior Care Action Network and AIDS Healthcare Foundation, payments shall be reduced by the actuarial equivalent amount of the payment reductions specified in this section pursuant to contract amendments or change orders effective on July 1, 2011, or thereafter.

(3) Payments shall be reduced by 10 percent for non-Medi-Cal programs described in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after June 1, 2011. This paragraph shall not apply to inpatient hospital services provided in a hospital that is paid under contract pursuant to Article 2.6 (commencing with Section 14081).

(4) (A) Notwithstanding any other law, the director may adjust the payments specified in paragraphs (1) and (3) with respect to one or more categories of Medi-Cal providers, or for one or more products or services rendered, or any combination thereof, if the resulting reductions to any category of Medi-Cal providers, in the aggregate, total no more than 10 percent.

(B) The adjustments authorized in subparagraph (A) shall be implemented only if the director determines that, for each affected product, service, or provider category, the payments resulting from the adjustment comply with subdivision (m).

(e) Notwithstanding this section, payments to hospitals that are not under contract with the department pursuant to Article 2.6 (commencing with Section 14081) for inpatient hospital services provided to Medi-Cal beneficiaries and that are subject to former Section 14166.245 shall be governed by that section.

(f) Notwithstanding this section, both of the following apply:

(1) Payments to providers that are paid pursuant to Article 3.8 (commencing with Section 14126) shall be governed by that article.

(2) (A) Subject to subparagraph (B), for dates of service on and after June 1, 2011, Medi-Cal reimbursement rates for intermediate care facilities for the developmentally disabled licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20, as determined by the applicable methodology for setting reimbursement rates for these facilities, shall not exceed the reimbursement rates that were applicable to providers in the 2008–09 rate year.

(B) (i) If Section 14105.07 is added to the Welfare and Institutions Code during the 2011–12 Regular Session of the Legislature, subparagraph (A) shall become inoperative.

(ii) If Section 14105.07 is added to the Welfare and Institutions Code during the 2011–12 Regular Session of the Legislature, then for dates of service on and after June 1, 2011, payments to intermediate care facilities for the developmentally disabled licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20, shall be governed by the applicable methodology for setting reimbursement rates for these facilities and by Section 14105.07.

(g) The department may enter into contracts with a vendor for the purposes of implementing this section on a bid or nonbid basis. In order to achieve maximum cost savings, the Legislature declares that an expedited process for contracts under this subdivision is necessary. Therefore, contracts entered into to implement this section and all contract amendments and change orders shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 Division 2 of the Public Contract Code.

(h) To the extent applicable, all of the following services, facilities, and payments shall be exempt from the payment reductions specified in subdivision (d):

(1) Acute hospital inpatient services that are paid under contracts pursuant to Article 2.6 (commencing with Section 14081).

(2) Federally qualified health center services, including those facilities deemed to have federally qualified health center status pursuant to a waiver pursuant to subsection (a) of Section 1115 of the federal Social Security Act (42 U.S.C. Sec. 1315(a)).

(3) Rural health clinic services.

(4) Payments to facilities owned or operated by the State Department of State Hospitals or the State Department of Developmental Services.

(5) Hospice services.

(6) Contract services, as designated by the director pursuant to subdivision (k).

(7) Payments to providers to the extent that the payments are funded by means of a certified public expenditure or an intergovernmental transfer pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations. This paragraph shall apply to payments described in paragraph (3) of subdivision (d) only to the extent that they are also exempt from reduction pursuant to subdivision (l).

(8) Services pursuant to local assistance contracts and interagency agreements to the extent the funding is not included in the funds appropriated to the department in the annual Budget Act.

(9) Breast and cervical cancer treatment provided pursuant to Section 14007.71 and as described in paragraph (3) of subdivision (a) of Section 14105.18 or Article 1.5 (commencing with Section 104160) of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code.

(10) The Family Planning, Access, Care, and Treatment (Family PACT) Program pursuant to subdivision (aa) of Section 14132.

(11) (A) Effective for dates of service on or after July 1, 2015, or the effective date of any necessary federal approvals as required by subdivisions (n) and (o), whichever is later, dental services and applicable ancillary services.

(B) For dental managed care plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), payments pursuant to contract amendments or change orders effective on or after July 1, 2015, or the effective date of any necessary federal approvals as required by subdivisions (n) and (o), whichever is later.

(12) For dates of service on and after January 1, 2022, or the effective date of any necessary federal approvals as required by subdivisions (n) and (o), whichever is later, providers of complex rehabilitation technology and complex rehabilitation technology services, as described in Section 14132.85.

(i) Subject to the exception for services listed in subdivision (h), the payment reductions required by subdivision (d) shall apply to the benefits rendered by any provider who may be authorized to bill for the service, including, but not limited to, physicians, podiatrists, nurse practitioners, certified nurse-midwives, nurse anesthetists, and organized outpatient clinics.

(j) Notwithstanding any other law, for dates of service on and after June 1, 2011, Medi-Cal reimbursement rates applicable to the following classes of providers shall not exceed the reimbursement rates that were applicable to those classes of providers in the 2008–09 rate year, as described in subdivision (f) of Section 14105.191, reduced by 10 percent:

(1) Intermediate care facilities, excluding those facilities identified in paragraph (2) of subdivision (f). For purposes of this section, “intermediate care facility” has the same meaning as defined in Section 51118 of Title 22 of the California Code of Regulations.

(2) Skilled nursing facilities that are distinct parts of general acute care hospitals. For purposes of this section, “distinct part” has the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

(3) Rural swing-bed facilities.

(4) Subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this paragraph, “subacute care unit” has the same meaning as defined in Section 51215.5 of Title 22 of the California Code of Regulations.

(5) Pediatric subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this paragraph, “pediatric subacute care unit” has the same meaning as defined in Section 51215.8 of Title 22 of the California Code of Regulations.

(6) Adult day health care centers.

(7) Freestanding pediatric subacute care units, as defined in Section 51215.8 of Title 22 of the California Code of Regulations.

(k) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement and administer this section by means of provider bulletins or similar instructions, without taking regulatory action.

(l) The reductions described in this section shall apply only to payments for services when the General Fund share of the payment is paid with funds directly appropriated to the department in the annual Budget Act and shall not apply to payments for services paid with funds appropriated to other departments or agencies.

(m) Notwithstanding this section, the payment reductions and adjustments provided for in subdivision (d) shall be implemented only if the director determines that the payments that result from the application of this section comply with applicable federal Medicaid program requirements and that federal financial participation will be available.

(1) In determining whether federal financial participation is available, the director shall determine whether the payments comply with applicable federal Medicaid program requirements, including those set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code.

(2) To the extent that the director determines that the payments do not comply with the federal Medicaid program requirements or that federal financial participation is not available with respect to any payment that is reduced pursuant to this section, the director shall retain the discretion to not implement the particular payment reduction or adjustment and may adjust the payment as necessary to comply with federal Medicaid program requirements.

(n) The department shall seek any necessary federal approvals for the implementation of this section.

(o) (1) The payment reductions and adjustments set forth in this section shall not be implemented until federal approval is obtained.

(2) To the extent that federal approval is obtained for one or more of the payment reductions and adjustments in this section and Section 14105.07, the payment reductions and adjustments set forth in Section 14105.191 shall cease to be implemented for the same services provided by the same class of providers. If there is a conflict between this section and Section 14105.191, other than the provisions setting forth a payment reduction or adjustment, this section shall govern.

(3) When federal approval is obtained, the payments resulting from the application of this section shall be implemented retroactively to June 1, 2011, or on any other date or dates, as may be applicable.

(4) The director may clarify the application of this subdivision by means of provider bulletins or similar instructions, pursuant to subdivision (k).

(p) Adjustments to pharmacy drug product payment pursuant to this section shall no longer apply when the department determines that the average acquisition cost methodology pursuant to Section 14105.45 has been fully implemented and the department's pharmacy budget reduction targets, consistent with payment reduction levels pursuant to this section, have been met.

SEC. 375. Section 14105.194 is added to the Welfare and Institutions Code, to read:

14105.194. (a) (1) Notwithstanding Sections 14105.191, 14105.192, and 14105.193, and for dates of service on or after August 1, 2021, the reimbursement rates for freestanding pediatric subacute care units, as defined in Section 51215.8 of Title 22 of the California Code of Regulations, shall be determined without applying any reductions or limitations as set forth under Sections 14105.191, 14105.192, and 14105.193.

(2) For dates of service on or after August 1, 2021, and for each rate year thereafter, the department shall calculate and publish the reimbursement rates, as specified in paragraph (1), plus the projected cost of complying with new state or federal mandates.

(3) For the 2021–22 fiscal year, and for each fiscal year thereafter, the reimbursement rates for freestanding pediatric subacute care units shall account for, and be inclusive of, supplemental payments, as described under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016, or Proposition 56, if the Budget Act of that fiscal year appropriates funds from the Healthcare Treatment Fund, as established pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code, to the department to make those supplemental payments to the freestanding pediatric subacute care units.

(b) In implementing this section, the department shall seek any federal approvals it deems necessary. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available

and is not otherwise jeopardized.

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

(d) (1) The department may modify any methodology or provision specified in this section to the extent it deems necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure federal financial participation is available or is not otherwise jeopardized, only if that modification does not violate the spirit, purposes, and intent of this section.

(2) If the department determines that a modification is necessary pursuant to paragraph (1), the department shall consult with affected providers and stakeholders to the extent practicable.

SEC. 376. Section 14105.22 of the Welfare and Institutions Code is amended to read:

14105.22. (a) (1) It is the intent of the Legislature that the department develop reimbursement rates for clinical laboratory or laboratory services that are comparable to the payment amounts received from other payers for clinical laboratory or laboratory services. Development of these rates will enable the department to reimburse clinical laboratory or laboratory service providers in compliance with state and federal law.

(2) (A) The requirements specified in subdivision (a) of Section 51501 of Title 22 of the California Code of Regulations shall not apply to laboratory providers reimbursed under the new rate methodology developed for clinical laboratories or laboratory services pursuant to this subdivision.

(B) In addition to subparagraph (A), laboratory providers reimbursed under any payment reductions implemented pursuant to this section shall not be subject to the requirements specified in subdivision (a) of Section 51501 of Title 22 of the California Code of Regulations until July 1, 2015.

(3) Reimbursement to providers for clinical laboratory or laboratory services shall not exceed the lowest of the following:

(A) The amount billed.

(B) The charge to the general public.

(C) (i) For dates of service before July 1, 2022, 80 percent of the lowest maximum allowance established by the federal Medicare program for the same or similar services.

(ii) For dates of service on or after July 1, 2022, 100 percent of the lowest maximum allowance established by the federal Medicare program for the same or similar services.

(D) A reimbursement rate based on an average of the lowest amount that other payers and other state Medicaid programs are paying for similar clinical laboratory or laboratory services.

(4) (A) In addition to the payment reductions implemented pursuant to Section 14105.192, payments shall be reduced by up to 10 percent for clinical laboratory or laboratory services, as defined in Section 51137.2 of Title 22 of the California Code of Regulations, for dates of service on and after July 1, 2012. The payment reductions pursuant to this paragraph shall continue until the new rate methodology under this subdivision has been approved by the federal Centers for Medicare and Medicaid Services.

(B) Notwithstanding subparagraph (A), the Family Planning, Access, Care, and Treatment Program pursuant to subdivision (aa) of Section 14132 shall be exempt from the payment reduction specified in this section.

(5) (A) For purposes of establishing reimbursement rates for clinical laboratory or laboratory services pursuant to subparagraph (D) of paragraph (3), laboratory service providers shall submit data reports according to the following schedule:

(i) The data initially provided shall be for the 2018 calendar year. For each subsequent reporting year, the data shall be based on the previous calendar year.

(ii) For purposes of clause (i), “reporting year” means 2019 and every third year thereafter.

(B) A data report submitted pursuant to subparagraph (A) shall specify the provider’s lowest amounts other payers are paying, including other state Medicaid programs and private insurance, minus discounts and rebates. The specific data required for submission under this subparagraph and the format for the data submission shall be determined and specified by the department after receiving stakeholder input pursuant to paragraph (7).

(C) The data submitted pursuant to subparagraph (A) may be used to determine reimbursement rates by procedure code based on an average of the lowest amount other payers are paying providers for similar clinical laboratory or laboratory services, excluding significant deviations of cost or volume factors and with consideration to geographical areas. The department shall have the discretion to determine the specific methodology and factors used in the development of the lowest average amount under this subparagraph to ensure compliance with federal Medicaid law and regulations as specified in paragraph (9).

(D) For purposes of subparagraph (C), the department may contract with a vendor for the purposes of collecting payment data reports from clinical laboratories, analyzing payment information, and calculating a proposed rate.

(E) The proposed rates calculated by the vendor, as described in subparagraph (D), may be used in determining the lowest reimbursement rate for clinical laboratories or laboratory services in accordance with paragraph (3).

(F) Data reports submitted to the department shall be certified by the provider's certified financial officer or an authorized individual.

(G) Clinical laboratory providers that fail to submit data reports within 30 working days from the time requested by the department shall be subject to the suspension standards of subdivisions (a) and (c) of Section 14123.

(6) Data reports provided to the department pursuant to this section shall be confidential and shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(7) The department shall seek stakeholder input on the ratesetting methodology.

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

(9) (A) The department shall implement this section in a manner that is consistent with federal Medicaid law and regulations. The director shall seek any necessary federal approvals for the implementation of this section. This section shall be implemented only to the extent that federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(B) In determining whether federal financial participation is available, the director shall determine whether the rates and payments comply with applicable federal Medicaid requirements, including those set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code.

(C) To the extent that the director determines that the rates and payments do not comply with applicable federal Medicaid requirements or that federal financial participation is not available with respect to any reimbursement rate, the director retains the discretion not to implement that rate or payment and may revise the rate or payment as necessary to comply with federal Medicaid requirements. The department shall notify the Joint Legislative Budget Committee 10 days prior to revising the rate or payment to comply with federal Medicaid requirements.

(b) Reimbursement rates developed pursuant to subparagraph (D) of paragraph (3) of subdivision (a) and the changes made by the act that added this subdivision shall be effective beginning on July 1, 2020, and on July 1 of every third year thereafter.

(c) Notwithstanding subdivisions (a) and (b), for dates of service from July 1, 2021, to June 30, 2022, inclusive, the department shall establish the reimbursement rates for clinical laboratory or laboratory services at the rates in effect and approved in the Medi-Cal State Plan as of December 31, 2019, pursuant to Section 14105.222.

SEC. 377. Section 14105.222 is added to the Welfare and Institutions Code, to read:

14105.222. (a) Notwithstanding Section 14105.22, the department shall not seek to retroactively implement the reductions and limitations to the reimbursement for clinical laboratory or laboratory services set forth in Section 14105.22 for dates of service from January 1, 2020, to June 30, 2021, inclusive. The payment reductions implemented pursuant to Section 14105.192 shall continue to apply for clinical laboratory or laboratory services.

(b) The department shall not seek to recoup any overpayments for clinical laboratory or laboratory services resulting from the reductions and limitations to the reimbursement for clinical laboratory or laboratory services pursuant to Section 14105.22 for dates of service from January 1, 2020, to June 30, 2021, inclusive. Any overpayments for clinical laboratory or laboratory services resulting from the reductions implemented pursuant to Section 14105.192 shall continue to be recouped.

(c) For dates of service from July 1, 2021, to June 30, 2022, inclusive, the department shall establish the reimbursement rates for clinical laboratory or laboratory services at the rates in effect and approved in the Medi-Cal State Plan as of December 31, 2019.

(d) For dates of services on or after July 1, 2022, the department shall establish the reimbursement rates for clinical laboratory or laboratory services pursuant to Section 14105.22.

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

(f) The department shall implement this section in a manner that is consistent with federal Medicaid law and regulations. The department shall seek any necessary federal approvals for the implementation of this section. This section shall be implemented only to the extent that federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

SEC. 378. Section 14105.48 of the Welfare and Institutions Code is amended to read:

14105.48. (a) The department shall establish a list of covered services and maximum allowable reimbursement rates for durable medical equipment, as defined in Section 51160 of Title 22 of the California Code of Regulations, and the list shall be published in provider manuals. The list shall specify utilization controls to be applied to each type of durable medical equipment.

(b) Reimbursement for durable medical equipment, except wheelchairs, wheelchair accessories, and speech-generating devices and related accessories, shall be the lesser of (1) the amount billed pursuant to Section 51008.1 of Title 22 of the California Code of Regulations, (2) an amount that does not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare Program for the same or similar item or service, or (3) the guaranteed acquisition cost negotiated by means of the contracting process provided for pursuant to Section 14105.3 plus a percentage markup to be established by the department.

(c) Reimbursement for wheelchairs, wheelchair accessories, and speech-generating devices and related accessories shall be the lesser of (1) the amount billed pursuant to Section 51008.1 of Title 22 of the California Code of Regulations, (2) an amount that does not exceed 100 percent of the lowest maximum allowance for California established by the federal Medicare Program for the same or similar item or service, or (3) the guaranteed acquisition cost negotiated by means of the contracting process provided for pursuant to Section 14105.3 plus a percentage markup to be established by the department.

(d) Reimbursement for all durable medical equipment billed to the Medi-Cal program utilizing codes with no specified maximum allowable rate shall be the lesser of (1) the amount billed pursuant to Section 51008.1 of Title 22 of the California Code of Regulations, (2) the guaranteed acquisition cost negotiated by means of the contracting process provided for pursuant to Section 14105.3 plus a percentage markup to be established by the department, (3) the actual acquisition cost plus a markup to be established by the department, (4) the manufacturer's suggested retail purchase price on or prior to the date of service, and documented by a printed catalog or a hard copy of an electronic catalog page showing that price, reduced by a percentage discount not to exceed 20 percent, or not to exceed 15 percent for wheelchairs and wheelchair accessories if the provider employs or contracts with a qualified rehabilitation technology professional, as defined in Section 14132.85, or (5) a price established through targeted product-specific cost containment provisions developed with providers.

(e) Reimbursement for all durable medical equipment supplies and accessories billed to the Medi-Cal program shall be the lesser of (1) the amount billed pursuant to Section 51008.1 of Title 22 of the California Code of Regulations, or (2) the acquisition cost plus a 23 percent markup.

(f) Commencing January 1, 2007, reimbursement for oxygen delivery systems and oxygen contents shall utilize national HCPCS codes, and shall be the lesser of (1) the amount billed pursuant to Section 51008.1 of Title 22 of the California Code of Regulations, (2) an amount that does not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare Program for the same or a similar item or service, or (3) the guaranteed acquisition cost negotiated by means of the contracting process provided for pursuant to Section 14105.3, plus a percentage markup to be established by the department.

(g) Within six months of the effective date of the act that added this subdivision, the department shall review utilization of services and equipment resulting from the changes to this section made by that act, and shall assess whether the changes are contributing to inappropriate use of those services or equipment. If the department's review finds an increase in inappropriate use of those services or equipment, the Department of Finance shall notify the Joint Legislative Budget Committee of the State Department of Health Services' findings and recommended changes to ensure program integrity.

(h) Any regulation in Division 3 of Title 22 of the California Code of Regulations that contains provisions for reimbursement rates for durable medical equipment shall be amended or repealed effective for dates of service on or after the date of the act adding this section.

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

(j) The department shall consult with interested parties and appropriate stakeholders in implementing this section with respect to all of the following:

(1) Notifying the provider representatives of the proposed change.

(2) Scheduling at least one meeting to discuss the change.

(3) Allowing for written input regarding the change.

(4) Providing advance notice on the implementation and effective date of the change.

(k) The department may require providers of durable medical equipment to appeal Medicare denials for dually eligible beneficiaries as a condition of Medi-Cal payment.

SEC. 379. Section 14105.485 of the Welfare and Institutions Code is repealed.

SEC. 380. Section 14124.12 of the Welfare and Institutions Code is amended to read:

14124.12. (a) (1) Notwithstanding any other law, for the duration of the COVID-19 emergency period, the department shall implement any federal Medicaid program waiver or flexibility approved by the federal Centers for Medicare and Medicaid Services related to the COVID-19 public health emergency. This includes, but is not limited to, any waiver or flexibility approved pursuant to Sections 1315, 1320b-5, or 1396n of Title 42 of the United States Code, or the Medi-Cal state plan. Any request for a federal Medicaid program waiver or flexibility shall be subject to Department of Finance approval before the department submits that request to the federal Centers for Medicare and Medicaid Services.

(2) During the COVID-19 emergency period, and through December 31, 2022, for any extended waiver or flexibility described in subdivision (f), if there is a conflict between this chapter, Chapter 8 (commencing with Section 14200), Chapter 8.8 (commencing with Section 14600), or Chapter 8.9 (commencing with Section 14700), and any approved federal waiver or flexibility, as described in paragraph (1), the approved federal waiver or flexibility shall control over any conflict in the specified state law.

(b) (1) To the extent that federal financial participation is available, the department, subject to Department of Finance approval, shall exercise its option under Section 1396a(a)(10)(A)(ii)(XXIII) of Title 42 of the United States Code to extend the medical assistance, as described in Section 1396a(a)(10)(A)(ii)(XVIII) of Title 42 of the United States Code, to uninsured individuals, as defined in Section 1396a(ss) of Title 42 of the United States Code, for the duration of the COVID-19 emergency period.

(2) The department, subject to Department of Finance approval, may seek federal approval pursuant to Section 1315 of Title 42 of the United States Code to extend the medical assistance afforded to uninsured individuals pursuant to paragraph (1) to include COVID-19-related treatment services that are otherwise covered for full-scope Medi-Cal beneficiaries, as defined by the department. If federal financial participation is unavailable, the department, subject to Department of Finance approval, may elect to implement this paragraph on a state-only funding basis, and subject to an appropriation by the Legislature.

(c) Notwithstanding any other law, the department shall seek to maximize federal financial participation for Medi-Cal expenditures that it determines to be available for the COVID-19 public health emergency, and shall comply with any federal requirements and conditions for receipt of that federal financial participation. This includes, but is not limited to, the temporary increase in the federal medical assistance percentage made available pursuant to Section 6008 of the federal Families First Coronavirus Response Act (Public Law 116-127).

(d) Due to the impact of the COVID-19 public health emergency on the department's ongoing administration of the Medi-Cal program, the department may seek any federal approvals it deems necessary for any number of temporary extensions of all or select components of the California Medi-Cal 2020 Demonstration (No. 11-W-00193/9) pursuant to Article 5.5 (commencing with Section 14184), which is scheduled to expire on December 31, 2020. If the department elects to seek any extension, the department shall determine the length of time for the extension sought and whether to seek an extension for the entirety of the demonstration or select components of the demonstration. In implementing this subdivision, the department, to the extent practicable, shall consult with affected stakeholder entities before seeking a temporary extension.

(e) The department, subject to Department of Finance approval, shall seek any federal approvals it deems necessary to implement this section or to maintain sufficient access to covered benefits under the Medi-Cal program during the COVID-19 emergency period. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(f) (1) (A) The department shall seek any federal approvals it deems necessary to extend the approved waiver or flexibility implemented pursuant to subdivision (a), as of July 1, 2021, that are related to the delivery and reimbursement of services via telehealth modalities in the Medi-Cal program. Subject to subdivision (e), the department shall implement those extended waivers

or flexibilities for which federal approval is obtained, to commence on the first calendar day immediately following the last calendar day of the federal COVID-19 public health emergency period, and through December 31, 2022.

(B) Subject to subdivision (e), the department may authorize the use of remote patient monitoring as an allowable telehealth modality for covered health care services and provider types it deems appropriate for dates of service on or after July 1, 2021. The department may establish a fee schedule for applicable health care services delivered via remote patient monitoring.

(2) (A) For purposes of informing the 2022–23 proposed Governor's Budget, released in January 2022, the department shall convene an advisory group consisting of consultants, subject matter experts, and other affected stakeholders to provide recommendations to inform the department in establishing and adopting billing and utilization management protocols for telehealth modalities to increase access and equity and reduce disparities in the Medi-Cal program. The advisory group shall analyze the impact of telehealth in increased access for patients, changes in health quality outcomes and utilization, best practices for the appropriate mix of in-person visits and telehealth, and the benefits or liabilities of any practice or care model changes that have resulted from telephonic visits.

(B) The advisory group shall include representatives of the California Medical Association, the California Primary Care Association, the California Association of Public Hospitals, the County Behavioral Health Directors Association, Medi-Cal managed care plans, Planned Parenthood Affiliates of California, Essential Access Health, and other subject matter experts or other affected stakeholders as identified by the department.

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

(4) Nothing in this subdivision shall be construed to limit coverage of, and reimbursement for, telehealth modalities that are the type authorized by the department prior to the COVID-19 emergency period and described in the Medi-Cal State Plan, the Medi-Cal provider manual, or other departmental guidance.

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

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

(1) "COVID-19 emergency period" has the same meaning as "emergency period" as defined in Section 1320b-5(g)(1)(B) of Title 42 of the United States Code, unless otherwise defined in federal law or any federal approval obtained pursuant to this section.

(2) "COVID-19 public health emergency" means the Public Health Emergency declared by the Secretary of the United States Department of Health and Human Services on January 31, 2020, pursuant to Section 247d of Title 42 of the United States Code, and entitled "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus," including any subsequent renewal of that declaration.

SEC. 381. Section 14124.89 of the Welfare and Institutions Code is amended to read:

14124.89. (a) (1) This section applies to all of the following entities:

(A) Health insurer, or any health care entity licensed through the Department of Insurance.

(B) Self-insured plan.

(C) Group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974.

(D) Service benefit plan.

(E) Managed care organization, including a health care service plan as defined in subdivision (f) of Section 1345 of the Health and Safety Code, 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).

(F) Pharmacy benefit manager.

(G) Third-party administrator.

(H) Union trust.

(I) Other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

(2) The entities listed in paragraph (1) shall, upon request of the department for any records, or any information contained in records pertaining to an individual or group health insurance policy or plan issued by such insurer or plan against, or pertaining to the medical or dental benefits paid by or claims made against such insurer or plan under a policy or plan, make the requested records or information available upon a certification by the department that the individual is an applicant for or recipient of services under this chapter or is a person who is legally responsible for such an applicant or recipient.

(b) The entities listed in paragraph (1) of subdivision (a) shall enter into a cooperative agreement with the department setting forth mutually agreeable procedures for the provision of appropriate information, not inconsistent with any law pertaining to the confidentiality and privacy of medical records, at no cost to the department, within 90 days of the department's request.

(c) The information required to be made available pursuant to this section shall be limited to information necessary to determine whether health benefits have been or should have been claimed and paid pursuant to a health insurance policy or plan with respect to items of medical care and services received by a particular individual for which Medi-Cal coverage would otherwise be available.

(d) Not later than the date upon which the procedures agreed to pursuant to subdivision (b) become effective, the director shall establish guidelines to assure that information relating to an individual certified to be an applicant for or recipient of medical assistance, furnished to any insurer or plan pursuant to this section, is used only for the purpose of identifying the records or information requested in such manner so as not to violate the confidentiality of an applicant or recipient.

SEC. 382. Section 14124.90 of the Welfare and Institutions Code is repealed.

SEC. 383. Section 14124.90 is added to the Welfare and Institutions Code, to read:

14124.90. (a) (1) It is the intent of the Legislature to comply with federal law requiring that when a beneficiary has third-party health coverage or insurance, the State Department of Health Care Services shall be the payer of last resort.

(2) In order to assess overlapping or duplicate health coverage and adjudicate claims, all of the following entities shall maintain a centralized file of the eligibility and coverage information for each subscriber, policyholder, enrollee, or insured:

(A) Health insurer or any health care entity licensed through the Department of Insurance.

(B) Self-insured plan.

(C) Group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974.

(D) Service benefit plan.

(E) Managed care organization, including a health care service plan as defined in subdivision (f) of Section 1345 of the Health and Safety Code, 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).

(F) Pharmacy benefit manager.

(G) Third-party administrator.

(H) Union trust.

(I) Other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

(b) (1) The eligibility and coverage information shall include, at a minimum, all of the following information about a subscriber, policyholder, enrollee, or insured:

(A) Full name.

(B) Address.

(C) Date of birth.

(D) Social security number.

(E) Policy number.

(F) Group identification number.

(G) Policy or plan type.

(H) Types of covered services under the policy or plan.

(I) Effective dates of coverage.

(J) Policy or plan termination date.

(2) For any other persons covered under the policy or plan, if any, the eligibility and coverage information shall include, at a minimum, all of the following information:

(A) Full name.

(B) Social security number.

(C) Date of birth.

(D) Place of birth.

(E) Parents' names, if applicable.

(c) The information described in subdivision (b) shall be provided to the State Department of Health Care Services at least once a month, in a format provided by the department. The information shall also be provided to the department's agents and contracted Medi-Cal managed care plans, upon reasonable request, to perform cost avoidance on behalf of the department.

(d) An entity listed in subdivision (a) shall provide to the department access to real-time, electronic eligibility verification, at no cost, and in a form and manner specified by the department, as is necessary to conduct its coordination of benefits responsibilities pursuant to this section.

(e) Notwithstanding Section 20134 of the Government Code, the Board of Administration of the California Public Employees' Retirement System and affiliated systems or contract agencies shall permit data matches with the state department to identify Medi-Cal beneficiaries with third-party health coverage or insurance. A recipient's Medi-Cal identification card shall, where information is available, contain information advising providers of health care services of any third-party health coverage for the recipient. Providers shall seek reimbursement from available third-party health coverage before billing the Medi-Cal program.

(f) 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 policy letter, information notice, or other similar instruction, without taking any further regulatory action.

SEC. 384. Section 14126.029 is added to the Welfare and Institutions Code, immediately following Section 14126.028, to read:

14126.029. (a) For purposes of this section, the following definitions apply:

(1) "Long-term health care facility" means a skilled nursing facility or nursing facility as those terms are defined in paragraph (1) of subdivision (c) and subdivision (k) of Section 1250 of the Health and Safety Code, respectively.

(2) "Timely" means within three calendar days of a long-term health care facility being served a hearing decision.

(b) A long-term health care facility shall timely comply with a hearing decision, as issued by the department's Office of Administrative Hearings and Appeals pursuant to Section 1396r(e)(3) of Title 42 of the United States Code and Section 1599.1 of the Health and Safety Code, that finds that the long-term health care facility improperly transferred, discharged, or refused to readmit a resident.

(c) (1) Notwithstanding any other law, and in addition to any other remedial action available to the department, if a long-term health care facility fails to timely comply with a hearing decision issued by the department's Office of Administrative Hearings and Appeals, the department may assess penalties pursuant to this subdivision.

(2) Commencing on the fourth calendar day after the date of service of the hearing decision, the department may assess a penalty of seven hundred fifty dollars ($750) for each calendar day the facility fails to comply with the hearing decision.

(3) For each individual hearing decision, the department shall not assess aggregate penalties that exceed seventy-five thousand dollars ($75,000).

(d) To demonstrate compliance with a hearing decision, a long-term health care facility shall file a certification of compliance with the department within three calendar days of the date the hearing decision is served on that facility, in a form and manner as established by the department. The certification shall specify the date of service of the hearing decision and the date on which the resident was readmitted or the facility otherwise complied with the hearing decision. The department shall make a certificate of compliance available on its internet website.

(e) A long-term health care facility's failure to timely comply with the hearing decision, including, but not limited to, a failure to file the certification of compliance within three calendar days of service of the hearing decision, as described in subdivision (d), shall subject that facility to the issuance of penalties as specified in subdivision (c), except as provided in subdivision (g).

(f) (1) Notwithstanding any other law, the amount of the assessed penalties, as calculated pursuant to subdivision (c), for a long-term health care facility may be deducted by the department from any Medi-Cal payments to that facility until the penalties are paid in full. If the department deducts the penalties from the Medi-Cal payments to the facility, the department shall provide prior written notice to the facility, and, in taking into account the financial condition of the facility, may apply that deduction over a period of time.

(2) Notwithstanding any other law, if there is a merger, acquisition, or change of ownership involving a long-term health care facility that has outstanding penalties pursuant to this section, the successor long-term health care facility shall be responsible for paying to the department the full amount of outstanding penalties attributable to the facility for which it was assessed, upon the effective date of that transaction.

(g) The department may waive all or a portion of the penalties assessed under this section if a facility petitions for a waiver and the department determines, in its sole discretion, that the petitioning facility meets both of the following:

(1) The facility complied with the hearing decision or otherwise demonstrated to the department's satisfaction that sufficient corrective action has been taken to remediate the underlying improper conduct.

(2) The facility demonstrated to the department's satisfaction that imposing the full amount of penalties under this section has a high likelihood of creating an undue financial hardship for that facility or creates a significant difficulty in providing services to Medi-Cal beneficiaries.

(h) Any penalties collected by the department pursuant to this section shall be deposited into the General Fund, and, upon appropriation by the Legislature, shall be used to improve quality of long-term care services under the Medi-Cal program, and to fund the department's administrative costs associated with the hearings conducted pursuant to Section 1396r(e)(3) of Title 42 of the United States Code and Section 1599.1 of the Health and Safety Code for purposes of implementing this section.

(i) Any penalty the department assesses on a long-term health care facility pursuant to this section is appealable only to the superior court of the county where the facility is located.

(j) Any penalty issued pursuant to this section shall not prohibit any state or federal enforcement action, including, but not limited to, an enforcement action by the State Department of Public Health, for a violation of improper transfer or discharge or failure to readmit requirements.

(k) Notwithstanding the rulemaking provisions of 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 information notices, provider bulletins, or other similar instructions, without taking any further regulatory action.

(l) 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 not jeopardized.

(m) In the event that the long-term health care facility seeks judicial review of the hearing decision and the hearing decision is reversed through such review, the department, after being provided a copy of the final judicial order by the facility, shall refund to the facility any penalties paid by the facility associated with the reversed hearing decision.

(n) (1) A hearing decision for a hearing described in subdivision (b) shall be made by a hearing officer trained to consider and apply the procedural and substantive requirements of all applicable federal and state laws and regulations governing the transfer and discharge process.

(2) A hearing described in subdivision (b) shall afford the resident and facility due process, including, but not limited to, allowing the direct and cross-examination of witnesses under oath, allowing the presentation of documents as exhibits, and making a recording of all sessions of the proceedings of sufficient quality to allow for the preparation of a written transcript.

SEC. 385. Section 14127.6 of the Welfare and Institutions Code is amended to read:

14127.6. (a) The Health Home Program shall be implemented only if and to the extent federal financial participation is available and the federal Centers for Medicare and Medicaid Services approves any state plan amendments and any necessary waivers sought pursuant to this article.

(b) (1) Except as provided in paragraph (2) and subdivision (c), this article shall be implemented through the 2020–21 state fiscal year only if no additional General Fund moneys are used to fund the administration and costs of services.

(2) Notwithstanding any other law, for the 2021–22 state fiscal year and each state fiscal year thereafter, as applicable, this article may be implemented using General Fund moneys upon appropriation by the Legislature.

(c) Notwithstanding subdivision (b), if the department projects, based on analysis of current and projected expenditures for health home services before, during, or after the first eight quarters of implementation, that this article can be implemented in a manner that does not or will not result in a net increase in ongoing General Fund costs for the Medi-Cal program, the department may use state funds to fund any Health Home Program costs.

(d) The department may use new funding in the form of enhanced federal financial participation for health home services that are currently provided to fund additional costs for new Health Home Program services.

(e) Through the 2020–21 state fiscal year, the department shall seek to fund the creation, implementation, and administration of the program with funding other than state general funds.

(f) The department may revise or terminate the Health Home Program any time after the first eight quarters of implementation if the department finds that the program fails to result in reduced inpatient stays, hospital admission rates, and emergency department visits, or results in substantial General Fund expense without commensurate decreases in Medi-Cal costs among program participants.

(g) (1) Notwithstanding any law, the department shall cease to implement the Health Home Program on January 1, 2022, or the effective date reflected in any necessary federal approvals obtained by the department to implement the Enhanced Care Management benefit under the California Advancing and Innovating Medi-Cal initiative pursuant to Section 14184.205, whichever is later.

(2) The department shall conduct any necessary closeout activities associated with the Health Home Program, including, but not limited to, the evaluation required pursuant to subdivision (a) of Section 14127.5.

(3) This article shall remain in effect only until January 1, 2023, and as of that date is repealed.

SEC. 386. Section 14131.10 of the Welfare and Institutions Code is amended to read:

14131.10. (a) Notwithstanding this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591), in order to implement changes in the level of funding for health care services, specific optional benefits are excluded from coverage under the Medi-Cal program.

(b) (1) The following optional benefits are excluded from coverage under the Medi-Cal program:

(A) Adult dental services, except as specified in paragraph (2).

(i) This exclusion shall be in effect only through December 31, 2017, and adult dental services shall be covered under the Medi-Cal program as of January 1, 2018, or the effective date of any necessary federal approvals, whichever is later.

(ii) The restoration of adult dental services pursuant to clause (i) shall be effective only to the extent any necessary federal approvals are obtained as required by subdivision (f).

(B) Audiology services and speech therapy services.

(C) Chiropractic services.

(D) Optometric and optician services, including services provided by a fabricating optical laboratory, except as provided in subdivision (g).

(E) Podiatric services.

(F) Incontinence creams and washes.

(2) (A) Medical and surgical services provided by a doctor of dental medicine or dental surgery, which, if provided by a physician, would be considered physician services, and which services may be provided by either a physician or a dentist in this state, are covered.

(B) Emergency procedures are also covered in the categories of service specified in subparagraph (A). The director may adopt regulations for any of the services specified in subparagraph (A).

(C) Effective May 1, 2014, or the effective date of any necessary federal approvals as required by subdivision (f), whichever is later, for persons 21 years of age or older, adult dental benefits, subject to utilization controls, are limited to all the following medically necessary services:

(i) Examinations, radiographs/photographic images, prophylaxis, and fluoride treatments.

(ii) Amalgam and composite restorations.

(iii) Stainless steel, resin, and resin window crowns.

(iv) Anterior root canal therapy.

(v) Complete dentures, including immediate dentures.

(vi) Complete denture adjustments, repairs, and relines.

(D) Services specified in this paragraph shall be included as a covered medical benefit under the Medi-Cal program pursuant to Section 14132.89.

(3) Pregnancy-related services and services for the treatment of other conditions that might complicate the pregnancy are not excluded from coverage under this section.

(c) The optional benefit exclusions do not apply to either of the following:

(1) Beneficiaries under the Early and Periodic Screening, Diagnostic, and Treatment Program.

(2) Beneficiaries receiving long-term care in a nursing facility that is both:

(A) A skilled nursing facility or intermediate care facility as defined in subdivisions (c) and (d) of Section 1250 of the Health and Safety Code.

(B) Licensed pursuant to subdivision (k) of Section 1250 of the Health and Safety Code.

(d) This section shall only be implemented to the extent permitted by federal law.

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

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

(g) (1) Effective no sooner than January 1, 2020, or January 1 of the subsequent calendar year following the legislative action pursuant to paragraph (2), whichever is later, and subject to paragraph (2) and subdivision (f), optometric and optician services, including services provided by a fabricating optical laboratory, shall be covered benefits under the Medi-Cal program.

(2) The restoration of optometric and optician services pursuant to this subdivision is contingent upon the Legislature including funding for these services in the state budget process.

(h) Effective no sooner than January 1, 2020, all of the following optional benefits shall be covered benefits under the Medi-Cal program:

(1) Audiology services and speech therapy services.

(2) Podiatric services.

(3) Incontinence creams and washes.

SEC. 387. Section 14132 of the Welfare and Institutions Code is amended to read:

14132. The following is the schedule of benefits under this chapter:

(a) Outpatient services are covered as follows:

Physician, hospital or clinic outpatient, surgical center, respiratory care, optometric, chiropractic, psychology, podiatric, occupational therapy, physical therapy, speech therapy, audiology, acupuncture to the extent federal matching funds are provided for acupuncture, and services of persons rendering treatment by prayer or healing by spiritual means in the practice of any church or religious denomination insofar as these can be encompassed by federal participation under an approved plan, subject to utilization controls.

(b) (1) Inpatient hospital services, including, but not limited to, physician and podiatric services, physical therapy, and occupational therapy, are covered subject to utilization controls.

(2) For a Medi-Cal fee-for-service beneficiary, emergency services and care that are necessary for the treatment of an emergency medical condition and medical care directly related to the emergency medical condition. This paragraph does not change the obligation of Medi-Cal managed care plans to provide emergency services and care. For the purposes of this paragraph, “emergency services and care” and “emergency medical condition” have the same meanings as those terms are defined in Section 1317.1 of the Health and Safety Code.

(c) Nursing facility services, subacute care services, and services provided by any category of intermediate care facility for the developmentally disabled, including podiatry, physician, nurse practitioner services, and prescribed drugs, as described in subdivision (d), are covered subject to utilization controls. Respiratory care, physical therapy, occupational therapy, speech therapy, and audiology services for patients in nursing facilities and any category of intermediate care facility for the developmentally disabled are covered subject to utilization controls.

(d) (1) Purchase of prescribed drugs is covered subject to the Medi-Cal List of Contract Drugs and utilization controls.

(2) Purchase of drugs used to treat erectile dysfunction or any off-label uses of those drugs are covered only to the extent that federal financial participation is available.

(3) (A) To the extent required by federal law, the purchase of outpatient prescribed drugs, for which the prescription is executed by a prescriber in written, nonelectronic form on or after April 1, 2008, is covered only when executed on a tamper resistant prescription form. The implementation of this paragraph shall conform to the guidance issued by the federal Centers for Medicare and Medicaid Services but shall not conflict with state statutes on the characteristics of tamper resistant prescriptions for controlled substances, including Section 11162.1 of the Health and Safety Code. The department shall provide providers and beneficiaries with as much flexibility in implementing these rules as allowed by the federal government. The department shall notify and consult with appropriate stakeholders in implementing, interpreting, or making specific this paragraph.

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instructions without taking regulatory action.

(4) (A) (i) For the purposes of this paragraph, nonlegend has the same meaning as defined in subdivision (a) of Section 14105.45.

(ii) Nonlegend acetaminophen-containing products, with the exception of children’s acetaminophen-containing products, selected by the department are not covered benefits.

(iii) Nonlegend cough and cold products selected by the department are not covered benefits. This clause shall be implemented on the first day of the first calendar month following 90 days after the effective date of the act that added this clause, or on the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later.

(iv) A beneficiary under the Early and Periodic Screening Diagnostic, and Treatment Program shall be exempt from clauses (ii) and (iii).

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instruction without taking regulatory action.

(e) Outpatient dialysis services and home hemodialysis services, including physician services, medical supplies, drugs, and equipment required for dialysis, are covered, subject to utilization controls.

(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetist services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and x-ray services are covered, subject to utilization controls. This subdivision does not require prior authorization for anesthesiologist services provided as part of an outpatient medical procedure or for portable x-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses that are lost or destroyed due to circumstances beyond the beneficiary's control. Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions that preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children's Services program.

(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:

(A) Periodontal treatment is not a benefit.

(B) Endodontic therapy is not a benefit except for vital pulpotomy.

(C) Laboratory processed crowns are not a benefit.

(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.

(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

(F) Notwithstanding the conditions specified in subparagraphs (A) to (E), inclusive, the department may approve services for persons with special medical disorders subject to utilization review.

(3) Paragraph (2) shall become inoperative July 1, 1995.

(i) Medical transportation is covered, subject to utilization controls.

(j) Home health care services are covered, subject to utilization controls.

(k) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated is covered, subject to utilization controls. If there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.

Therapeutic shoes and inserts are covered when provided to a beneficiary with a diagnosis of diabetes, subject to utilization controls, to the extent that federal financial participation is available.

(l) Hearing aids are covered, subject to utilization controls. Utilization controls shall allow replacement of hearing aids necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls shall allow the replacement of durable medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary's control. The utilization controls shall allow authorization of durable medical equipment needed to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian, subject to the availability of federal financial participation. The department shall adopt emergency regulations to define and establish criteria for assistive durable medical equipment in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(n) Family planning services are covered, subject to utilization controls. However, for Medi-Cal managed care plans, utilization controls shall be subject to Section 1367.25 of the Health and Safety Code.

(o) Inpatient intensive rehabilitation hospital services, including respiratory rehabilitation services, in a general acute care hospital are covered, subject to utilization controls, when either of the following criteria are met:

(1) A patient with a permanent disability or severe impairment requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to develop function beyond the limited amount that would occur in the normal course of recovery.

(2) A patient with a chronic or progressive disease requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to maintain the patient's present functional level as long as possible.

(p) (1) Adult day health care is covered in accordance with Chapter 8.7 (commencing with Section 14520).

(2) Commencing 30 days after the effective date of the act that added this paragraph, and notwithstanding the number of days previously approved through a treatment authorization request, adult day health care is covered for a maximum of three days per week.

(3) As provided in accordance with paragraph (4), adult day health care is covered for a maximum of five days per week.

(4) As of the date that the director makes the declaration described in subdivision (g) of Section 14525.1, paragraph (2) shall become inoperative and paragraph (3) shall become operative.

(q) (1) Application of fluoride, or other appropriate fluoride treatment as defined by the department, and other prophylaxis treatment for children 17 years of age and under are covered.

(2) All dental hygiene services provided by a registered dental hygienist, registered dental hygienist in extended functions, and registered dental hygienist in alternative practice licensed pursuant to Sections 1753, 1917, 1918, and 1922 of the Business and Professions Code may be covered as long as they are within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental hygienist, registered dental hygienist in extended functions, or registered dental hygienist in alternative practice.

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under former Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of former Section 1482 of the article.

(2) A provider enrolled under this subdivision shall satisfy all applicable statutory and regulatory requirements for becoming a Medi-Cal provider.

(3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.

(s) (1) In-home medical care services are covered when medically appropriate and subject to utilization controls, for a beneficiary who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be provided to a patient placed in a shared or congregate living arrangement, if a home setting is not medically appropriate or available to the beneficiary.

(2) As used in this subdivision, "in-home medical care service" includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

(3) As used in this subdivision, in-home medical care services include, but are not limited to:

(A) Level-of-care and cost-of-care evaluations.

(B) Expenses, directly attributable to home care activities, for materials.

(C) Physician fees for home visits.

(D) Expenses directly attributable to home care activities for shelter and modification to shelter.

(E) Expenses directly attributable to additional costs of special diets, including tube feeding.

(F) Medically related personal services.

(G) Home nursing education.

(H) Emergency maintenance repair.

(I) Home health agency personnel benefits that permit coverage of care during periods when regular personnel are on vacation or using sick leave.

(J) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.

(K) Emergency and nonemergency medical transportation.

(L) Medical supplies.

(M) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.

(N) Utility use directly attributable to the requirements of home care activities that are in addition to normal utility use.

(O) Special drugs and medications.

(P) Home health agency supervision of visiting staff that is medically necessary, but not included in the home health agency rate.

(Q) Therapy services.

(R) Household appliances and household utensil costs directly attributable to home care activities.

(S) Modification of medical equipment for home use.

(T) Training and orientation for use of life-support systems, including, but not limited to, support of respiratory functions.

(U) Respiratory care practitioner services as defined in Sections 3702 and 3703 of the Business and Professions Code, subject to prescription by a physician and surgeon.

(4) A beneficiary receiving in-home medical care services is entitled to the full range of services within the Medi-Cal scope of benefits as defined by this section, subject to medical necessity and applicable utilization control. Services provided pursuant to this subdivision, which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with a home- and community-based services waiver.

(t) Home- and community-based services approved by the United States Department of Health and Human Services are covered to the extent that federal financial participation is available for those services under the state plan or waivers granted in accordance with Section 1315 or 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and community-based services approvable under Section 1315 or 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers.

(u) Comprehensive perinatal services, as provided through an agreement with a health care provider designated in Section 14134.5 and meeting the standards developed by the department pursuant to Section 14134.5, subject to utilization controls.

The department shall seek any federal waivers necessary to implement the provisions of this subdivision. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained or for which waivers are not required shall be implemented notwithstanding any inability to obtain federal waivers for the other provisions. No provision of this subdivision shall be implemented unless matching funds from Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are available.

(v) Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(w) Hospice service that is Medicare-certified hospice service is covered, subject to utilization controls. Coverage shall be available only to the extent that no additional net program costs are incurred.

(x) When a claim for treatment provided to a beneficiary includes both services that are authorized and reimbursable under this chapter, and services that are not reimbursable under this chapter, that portion of the claim for the treatment and services authorized and reimbursable under this chapter shall be payable.

(y) Home- and community-based services approved by the United States Department of Health and Human Services for a beneficiary with a diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex who requires intermediate care or a higher level of care.

Services provided pursuant to a waiver obtained from the Secretary of the United States Department of Health and Human Services pursuant to this subdivision, and that are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with the waiver, and subject to the terms, conditions, and duration of the waiver. These services shall be provided to a beneficiary in accordance with the client's needs as identified in the plan of care, and subject to medical necessity and applicable utilization control.

The director may under this section contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to an eligible beneficiary. Contracts or agreements entered into pursuant to this division shall not be subject

to the Public Contract Code.

(z) Respiratory care when provided in organized health care systems as defined in Section 3701 of the Business and Professions Code, and as an in-home medical service as outlined in subdivision (s).

(aa) (1) There is hereby established in the department a program to provide comprehensive clinical family planning services to any person who has a family income at or below 200 percent of the federal poverty level, as revised annually, and who is eligible to receive these services pursuant to the waiver identified in paragraph (2). This program shall be known as the Family Planning, Access, Care, and Treatment (Family PACT) Program.

(2) The department shall seek a waiver in accordance with Section 1315 of Title 42 of the United States Code, or a state plan amendment adopted in accordance with Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code, which was added to Section 1396a of Title 42 of the United States Code by Section 2303(a)(2) of the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), for a program to provide comprehensive clinical family planning services as described in paragraph (8). Under the waiver, the program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. Under the state plan amendment, which shall replace the waiver and shall be known as the Family PACT successor state plan amendment, the program shall be operated only in accordance with this subdivision and the statutes and regulations in paragraph (4). The state shall use the standards and processes imposed by the state on January 1, 2007, including the application of an eligibility discount factor to the extent required by the federal Centers for Medicare and Medicaid Services, for purposes of determining eligibility as permitted under Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code. To the extent that federal financial participation is available, the program shall continue to conduct education, outreach, enrollment, service delivery, and evaluation services as specified under the waiver. The services shall be provided under the program only if the waiver and, when applicable, the successor state plan amendment are approved by the federal Centers for Medicare and Medicaid Services and only to the extent that federal financial participation is available for the services. This section does not prohibit the department from seeking the Family PACT successor state plan amendment during the operation of the waiver.

(3) Solely for the purposes of the waiver or Family PACT successor state plan amendment and notwithstanding any other law, the collection and use of an individual's social security number shall be necessary only to the extent required by federal law.

(4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005, and 24013, and any regulations adopted under these statutes shall apply to the program provided for under this subdivision. No other law under the Medi-Cal program or the State-Only Family Planning Program shall apply to the program provided for under this subdivision.

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, without taking regulatory action, the provisions of the waiver after its approval by the federal Centers for Medicare and Medicaid Services and the provisions of this section by means of an all-county letter or similar instruction to providers. Thereafter, the department shall adopt regulations to implement this section and the approved waiver in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of the act adding this subdivision, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(6) If the Department of Finance determines that the program operated under the authority of the waiver described in paragraph (2) or the Family PACT successor state plan amendment is no longer cost effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no share of cost, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a share of cost or if they are otherwise eligible under Section 24003.

(8) For purposes of this subdivision, "comprehensive clinical family planning services" means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, natural family planning, abstinence methods, and basic, limited fertility management. Comprehensive clinical family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability,

medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Comprehensive clinical family planning services shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that is not incident to the diagnosis of pregnancy. Comprehensive clinical family planning services shall be subject to utilization control and include all of the following:

(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

(B) All United States Department of Agriculture, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.

(C) Culturally and linguistically appropriate health education and counseling services, including informed consent, that include all of the following:

(i) Psychosocial and medical aspects of contraception.

(ii) Sexuality.

(iii) Fertility.

(iv) Pregnancy.

(v) Parenthood.

(vi) Infertility.

(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

(x) Use of contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies.

(xi) Possible contraceptive consequences and followup.

(xii) Interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(D) A comprehensive health history, updated at the next periodic visit (between 11 and 24 months after initial examination) that includes a complete obstetrical history, gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.

(E) A complete physical examination on initial and subsequent periodic visits.

(F) Services, drugs, devices, and supplies deemed by the federal Centers for Medicare and Medicaid Services to be appropriate for inclusion in the program.

(9) In order to maximize the availability of federal financial participation under this subdivision, the director shall have the discretion to implement the Family PACT successor state plan amendment retroactively to July 1, 2010.

(ab) (1) Purchase of prescribed enteral nutrition products is covered, subject to the Medi-Cal list of enteral nutrition products and utilization controls.

(2) Purchase of enteral nutrition products is limited to those products to be administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube. A beneficiary under the Early and Periodic Screening, Diagnostic, and Treatment Program shall be exempt from this paragraph.

(3) Notwithstanding paragraph (2), the department may deem an enteral nutrition product, not administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube, a benefit for patients with diagnoses, including, but not limited to, malabsorption and inborn errors of metabolism, if the product has been shown to be neither investigational nor experimental when used as part of a therapeutic regimen to prevent serious disability or death.

(4) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement the amendments to this subdivision made by the act that added this paragraph by means of all-county letters, provider bulletins, or similar instructions, without taking regulatory action.

(5) The amendments made to this subdivision by the act that added this paragraph shall be implemented June 1, 2011, or on the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later.

(ac) Diabetic testing supplies are covered when provided by a pharmacy, subject to utilization controls.

(ad) (1) Nonmedical transportation is covered, subject to utilization controls and permissible time and distance standards, for a beneficiary to obtain covered Medi-Cal services.

(2) (A) (i) Nonmedical transportation includes, at a minimum, round trip transportation for a beneficiary to obtain covered Medi-Cal services by passenger car, taxicab, or any other form of public or private conveyance, and mileage reimbursement when conveyance is in a private vehicle arranged by the beneficiary and not through a transportation broker, bus passes, taxi vouchers, or train tickets.

(ii) Nonmedical transportation does not include the transportation of a sick, injured, invalid, convalescent, infirm, or otherwise incapacitated beneficiary by ambulance, litter van, or wheelchair van licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations.

(B) Nonmedical transportation shall be provided for a beneficiary who can attest in a manner to be specified by the department that other currently available resources have been reasonably exhausted. For a beneficiary enrolled in a managed care plan, nonmedical transportation shall be provided by the beneficiary's managed care plan. For a Medi-Cal fee-for-service beneficiary, the department shall provide nonmedical transportation when those services are not available to the beneficiary under Sections 14132.44 and 14132.47.

(3) Nonmedical transportation shall be provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the beneficiary and consistent with applicable state and federal disability rights laws.

(4) It is the intent of the Legislature in enacting this subdivision to affirm the requirement under Section 431.53 of Title 42 of the Code of Federal Regulations, in which the department is required to provide necessary transportation, including nonmedical transportation, for recipients to and from covered services. This subdivision shall not be interpreted to add a new benefit to the Medi-Cal program.

(5) The department shall seek any federal approvals that may be required to implement this subdivision, including, but not limited to, approval of revisions to the existing state plan that the department determines are necessary to implement this subdivision.

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

(7) Prior to the effective date of any necessary federal approvals, nonmedical transportation was not a Medi-Cal managed care benefit with the exception of when provided as an Early and Periodic Screening, Diagnostic, and Treatment service.

(8) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. By July 1, 2018, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Commencing January 1, 2018, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(9) This subdivision shall not be implemented until July 1, 2017.

(ae) This section shall become inoperative on July 1, 2021, and, as of January 1, 2022, is repealed.

SEC. 388. Section 14132 is added to the Welfare and Institutions Code, to read:

14132. The following is the schedule of benefits under this chapter:

(a) Outpatient services are covered as follows:

Physician, hospital or clinic outpatient, surgical center, respiratory care, optometric, chiropractic, psychology, podiatric, occupational therapy, physical therapy, speech therapy, audiology, acupuncture to the extent federal matching funds are provided for acupuncture, and services of persons rendering treatment by prayer or healing by spiritual means in the practice of any church or religious denomination insofar as these can be encompassed by federal participation under an approved plan, subject to utilization controls.

(b) (1) Inpatient hospital services, including, but not limited to, physician and podiatric services, physical therapy, and occupational therapy, are covered subject to utilization controls.

(2) For a Medi-Cal fee-for-service beneficiary, emergency services and care that are necessary for the treatment of an emergency medical condition and medical care directly related to the emergency medical condition. This paragraph does not change the obligation of Medi-Cal managed care plans to provide emergency services and care. For the purposes of this paragraph, “emergency services and care” and “emergency medical condition” have the same meanings as those terms are defined in Section 1317.1 of the Health and Safety Code.

(c) Nursing facility services, subacute care services, and services provided by any category of intermediate care facility for the developmentally disabled, including podiatry, physician, nurse practitioner services, and prescribed drugs, as described in subdivision (d), are covered subject to utilization controls. Respiratory care, physical therapy, occupational therapy, speech therapy, and audiology services for patients in nursing facilities and any category of intermediate care facility for the developmentally disabled are covered subject to utilization controls.

(d) (1) Purchase of prescribed drugs is covered subject to the Medi-Cal List of Contract Drugs and utilization controls.

(2) Purchase of drugs used to treat erectile dysfunction or any off-label uses of those drugs are covered only to the extent that federal financial participation is available.

(3) (A) To the extent required by federal law, the purchase of outpatient prescribed drugs, for which the prescription is executed by a prescriber in written, nonelectronic form on or after April 1, 2008, is covered only when executed on a tamper resistant prescription form. The implementation of this paragraph shall conform to the guidance issued by the federal Centers for Medicare and Medicaid Services but shall not conflict with state statutes on the characteristics of tamper resistant prescriptions for controlled substances, including Section 11162.1 of the Health and Safety Code. The department shall provide providers and beneficiaries with as much flexibility in implementing these rules as allowed by the federal government. The department shall notify and consult with appropriate stakeholders in implementing, interpreting, or making specific this paragraph.

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instructions without taking regulatory action.

(4) (A) (i) For the purposes of this paragraph, nonlegend has the same meaning as defined in subdivision (a) of Section 14105.45.

(ii) Nonlegend acetaminophen-containing products, including children’s acetaminophen-containing products, selected by the department are covered benefits.

(iii) Nonlegend cough and cold products selected by the department are covered benefits.

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instruction without taking regulatory action.

(e) Outpatient dialysis services and home hemodialysis services, including physician services, medical supplies, drugs, and equipment required for dialysis, are covered, subject to utilization controls.

(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetist services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and x-ray services are covered, subject to utilization controls. This subdivision does not require prior authorization for anesthesiologist services provided as part of an outpatient medical procedure or for portable x-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are

necessary to prevent a significant disability or to replace previously furnished prostheses that are lost or destroyed due to circumstances beyond the beneficiary's control. Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions that preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children's Services program.

(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:

(A) Periodontal treatment is not a benefit.

(B) Endodontic therapy is not a benefit except for vital pulpotomy.

(C) Laboratory processed crowns are not a benefit.

(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.

(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

(F) Notwithstanding the conditions specified in subparagraphs (A) to (E), inclusive, the department may approve services for persons with special medical disorders subject to utilization review.

(3) Paragraph (2) shall become inoperative July 1, 1995.

(i) Medical transportation is covered, subject to utilization controls.

(j) Home health care services are covered, subject to utilization controls.

(k) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated is covered, subject to utilization controls. If there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.

Therapeutic shoes and inserts are covered when provided to a beneficiary with a diagnosis of diabetes, subject to utilization controls, to the extent that federal financial participation is available.

(l) Hearing aids are covered, subject to utilization controls. Utilization controls shall allow replacement of hearing aids necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls shall allow the replacement of durable medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary's control. The utilization controls shall allow authorization of durable medical equipment needed to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian, subject to the availability of federal financial participation. The department shall adopt emergency regulations to define and establish criteria for assistive durable medical equipment in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(n) Family planning services are covered, subject to utilization controls. However, for Medi-Cal managed care plans, utilization controls shall be subject to Section 1367.25 of the Health and Safety Code.

(o) Inpatient intensive rehabilitation hospital services, including respiratory rehabilitation services, in a general acute care hospital are covered, subject to utilization controls, when either of the following criteria are met:

(1) A patient with a permanent disability or severe impairment requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to develop function beyond the limited amount that would occur in the normal course of recovery.

(2) A patient with a chronic or progressive disease requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to maintain the patient's present functional level as long as possible.

(p) (1) Adult day health care is covered in accordance with Chapter 8.7 (commencing with Section 14520).

(2) Commencing 30 days after the effective date of the act that added this paragraph, and notwithstanding the number of days previously approved through a treatment authorization request, adult day health care is covered for a maximum of three days per week.

(3) As provided in accordance with paragraph (4), adult day health care is covered for a maximum of five days per week.

(4) As of the date that the director makes the declaration described in subdivision (g) of Section 14525.1, paragraph (2) shall become inoperative and paragraph (3) shall become operative.

(q) (1) Application of fluoride, or other appropriate fluoride treatment as defined by the department, and other prophylaxis treatment for children 17 years of age and under are covered.

(2) All dental hygiene services provided by a registered dental hygienist, registered dental hygienist in extended functions, and registered dental hygienist in alternative practice licensed pursuant to Sections 1753, 1917, 1918, and 1922 of the Business and Professions Code may be covered as long as they are within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental hygienist, registered dental hygienist in extended functions, or registered dental hygienist in alternative practice.

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under former Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of former Section 1482 of the article.

(2) A provider enrolled under this subdivision shall satisfy all applicable statutory and regulatory requirements for becoming a Medi-Cal provider.

(3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.

(s) (1) In-home medical care services are covered when medically appropriate and subject to utilization controls, for a beneficiary who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be provided to a patient placed in a shared or congregate living arrangement, if a home setting is not medically appropriate or available to the beneficiary.

(2) As used in this subdivision, "in-home medical care service" includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

(3) As used in this subdivision, in-home medical care services include, but are not limited to:

(A) Level-of-care and cost-of-care evaluations.

(B) Expenses, directly attributable to home care activities, for materials.

(C) Physician fees for home visits.

(D) Expenses directly attributable to home care activities for shelter and modification to shelter.

(E) Expenses directly attributable to additional costs of special diets, including tube feeding.

(F) Medically related personal services.

(G) Home nursing education.

(H) Emergency maintenance repair.

(I) Home health agency personnel benefits that permit coverage of care during periods when regular personnel are on vacation or using sick leave.

(J) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.

(K) Emergency and nonemergency medical transportation.

(L) Medical supplies.

(M) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.

(N) Utility use directly attributable to the requirements of home care activities that are in addition to normal utility use.

(O) Special drugs and medications.

(P) Home health agency supervision of visiting staff that is medically necessary, but not included in the home health agency rate.

(Q) Therapy services.

(R) Household appliances and household utensil costs directly attributable to home care activities.

(S) Modification of medical equipment for home use.

(T) Training and orientation for use of life-support systems, including, but not limited to, support of respiratory functions.

(U) Respiratory care practitioner services as defined in Sections 3702 and 3703 of the Business and Professions Code, subject to prescription by a physician and surgeon.

(4) A beneficiary receiving in-home medical care services is entitled to the full range of services within the Medi-Cal scope of benefits as defined by this section, subject to medical necessity and applicable utilization control. Services provided pursuant to this subdivision, which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with a home- and community-based services waiver.

(t) Home- and community-based services approved by the United States Department of Health and Human Services are covered to the extent that federal financial participation is available for those services under the state plan or waivers granted in accordance with Section 1315 or 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and community-based services approvable under Section 1315 or 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers.

(u) Comprehensive perinatal services, as provided through an agreement with a health care provider designated in Section 14134.5 and meeting the standards developed by the department pursuant to Section 14134.5, subject to utilization controls.

The department shall seek any federal waivers necessary to implement the provisions of this subdivision. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained or for which waivers are not required shall be implemented notwithstanding any inability to obtain federal waivers for the other provisions. No provision of this subdivision shall be implemented unless matching funds from Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are available.

(v) Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(w) Hospice service that is Medicare-certified hospice service is covered, subject to utilization controls. Coverage shall be available only to the extent that no additional net program costs are incurred.

(x) When a claim for treatment provided to a beneficiary includes both services that are authorized and reimbursable under this chapter, and services that are not reimbursable under this chapter, that portion of the claim for the treatment and services authorized and reimbursable under this chapter shall be payable.

(y) Home- and community-based services approved by the United States Department of Health and Human Services for a beneficiary with a diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex who requires intermediate care or a higher level of care.

Services provided pursuant to a waiver obtained from the Secretary of the United States Department of Health and Human Services pursuant to this subdivision, and that are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with the waiver, and subject to the terms, conditions, and duration of the waiver. These services shall be provided to a beneficiary in accordance with the client's needs as identified in the plan of care, and subject to medical necessity and applicable utilization control.

The director may under this section contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to an eligible beneficiary. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract Code.

(z) Respiratory care when provided in organized health care systems as defined in Section 3701 of the Business and Professions Code, and as an in-home medical service as outlined in subdivision (s).

(aa) (1) There is hereby established in the department a program to provide comprehensive clinical family planning services to any person who has a family income at or below 200 percent of the federal poverty level, as revised annually, and who is eligible to receive these services pursuant to the waiver identified in paragraph (2). This program shall be known as the Family Planning, Access, Care, and Treatment (Family PACT) Program.

(2) The department shall seek a waiver in accordance with Section 1315 of Title 42 of the United States Code, or a state plan amendment adopted in accordance with Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code, which was added to Section 1396a of Title 42 of the United States Code by Section 2303(a)(2) of the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), for a program to provide comprehensive clinical family planning services as described in paragraph (8). Under the waiver, the program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. Under the state plan amendment, which shall replace the waiver and shall be known as the Family PACT successor state plan amendment, the program shall be operated only in accordance with this subdivision and the statutes and regulations in paragraph (4). The state shall use the standards and processes imposed by the state on January 1, 2007, including the application of an eligibility discount factor to the extent required by the federal Centers for Medicare and Medicaid Services, for purposes of determining eligibility as permitted under Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code. To the extent that federal financial participation is available, the program shall continue to conduct education, outreach, enrollment, service delivery, and evaluation services as specified under the waiver. The services shall be provided under the program only if the waiver and, when applicable, the successor state plan amendment are approved by the federal Centers for Medicare and Medicaid Services and only to the extent that federal financial participation is available for the services. This section does not prohibit the department from seeking the Family PACT successor state plan amendment during the operation of the waiver.

(3) Solely for the purposes of the waiver or Family PACT successor state plan amendment and notwithstanding any other law, the collection and use of an individual's social security number shall be necessary only to the extent required by federal law.

(4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005, and 24013, and any regulations adopted under these statutes shall apply to the program provided for under this subdivision. No other law under the Medi-Cal program or the State-Only Family Planning Program shall apply to the program provided for under this subdivision.

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, without taking regulatory action, the provisions of the waiver after its approval by the federal Centers for Medicare and Medicaid Services and the provisions of this section by means of an all-county letter or similar instruction to providers. Thereafter, the department shall adopt regulations to implement this section and the approved waiver in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of the act adding this subdivision, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(6) If the Department of Finance determines that the program operated under the authority of the waiver described in paragraph (2) or the Family PACT successor state plan amendment is no longer cost effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no share of cost, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a share of cost or if they are otherwise eligible under Section 24003.

(8) For purposes of this subdivision, "comprehensive clinical family planning services" means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, natural family planning, abstinence methods, and basic, limited fertility management. Comprehensive clinical family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Comprehensive clinical family planning services shall not include abortion, pregnancy testing solely for

the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that is not incident to the diagnosis of pregnancy. Comprehensive clinical family planning services shall be subject to utilization control and include all of the following:

(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

(B) All United States Department of Agriculture, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.

(C) Culturally and linguistically appropriate health education and counseling services, including informed consent, that include all of the following:

(i) Psychosocial and medical aspects of contraception.

(ii) Sexuality.

(iii) Fertility.

(iv) Pregnancy.

(v) Parenthood.

(vi) Infertility.

(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

(x) Use of contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies.

(xi) Possible contraceptive consequences and followup.

(xii) Interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(D) A comprehensive health history, updated at the next periodic visit (between 11 and 24 months after initial examination) that includes a complete obstetrical history, gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.

(E) A complete physical examination on initial and subsequent periodic visits.

(F) Services, drugs, devices, and supplies deemed by the federal Centers for Medicare and Medicaid Services to be appropriate for inclusion in the program.

(9) In order to maximize the availability of federal financial participation under this subdivision, the director shall have the discretion to implement the Family PACT successor state plan amendment retroactively to July 1, 2010.

(ab) (1) Purchase of prescribed enteral nutrition products is covered, subject to the Medi-Cal list of enteral nutrition products and utilization controls.

(2) Purchase of enteral nutrition products is limited to those products to be administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube. A beneficiary under the Early and Periodic Screening, Diagnostic, and Treatment Program shall be exempt from this paragraph.

(3) Notwithstanding paragraph (2), the department may deem an enteral nutrition product, not administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube, a benefit for patients with diagnoses, including, but not limited to, malabsorption and inborn errors of metabolism, if the product has been shown to be neither investigational nor experimental when used as part of a therapeutic regimen to prevent serious disability or death.

(4) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement the amendments to this subdivision made by the act that added this paragraph by means of all-county letters, provider bulletins, or similar instructions, without taking regulatory action.

(5) The amendments made to this subdivision by the act that added this paragraph shall be implemented June 1, 2011, or on the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later.

(ac) Diabetic testing supplies are covered when provided by a pharmacy, subject to utilization controls.

(ad) (1) Nonmedical transportation is covered, subject to utilization controls and permissible time and distance standards, for a beneficiary to obtain covered Medi-Cal services.

(2) (A) (i) Nonmedical transportation includes, at a minimum, round trip transportation for a beneficiary to obtain covered Medi-Cal services by passenger car, taxicab, or any other form of public or private conveyance, and mileage reimbursement when conveyance is in a private vehicle arranged by the beneficiary and not through a transportation broker, bus passes, taxi vouchers, or train tickets.

(ii) Nonmedical transportation does not include the transportation of a sick, injured, invalid, convalescent, infirm, or otherwise incapacitated beneficiary by ambulance, litter van, or wheelchair van licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations.

(B) Nonmedical transportation shall be provided for a beneficiary who can attest in a manner to be specified by the department that other currently available resources have been reasonably exhausted. For a beneficiary enrolled in a managed care plan, nonmedical transportation shall be provided by the beneficiary's managed care plan. For a Medi-Cal fee-for-service beneficiary, the department shall provide nonmedical transportation when those services are not available to the beneficiary under Sections 14132.44 and 14132.47.

(3) Nonmedical transportation shall be provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the beneficiary and consistent with applicable state and federal disability rights laws.

(4) It is the intent of the Legislature in enacting this subdivision to affirm the requirement under Section 431.53 of Title 42 of the Code of Federal Regulations, in which the department is required to provide necessary transportation, including nonmedical transportation, for recipients to and from covered services. This subdivision shall not be interpreted to add a new benefit to the Medi-Cal program.

(5) The department shall seek any federal approvals that may be required to implement this subdivision, including, but not limited to, approval of revisions to the existing state plan that the department determines are necessary to implement this subdivision.

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

(7) Prior to the effective date of any necessary federal approvals, nonmedical transportation was not a Medi-Cal managed care benefit with the exception of when provided as an Early and Periodic Screening, Diagnostic, and Treatment service.

(8) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. By July 1, 2018, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Commencing January 1, 2018, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(9) This subdivision shall not be implemented until July 1, 2017.

(ae) (1) No sooner than January 1, 2022, Rapid Whole Genome Sequencing, including individual sequencing, trio sequencing for a parent or parents and their baby, and ultra-rapid sequencing, is a covered benefit for any Medi-Cal beneficiary who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit.

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

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

(af) This section shall become operative on July 1, 2021.

SEC. 389. Section 14132.275 of the Welfare and Institutions Code is amended to read:

14132.275. (a) The department shall seek federal approval to establish the demonstration project described in this section pursuant to a Medicare or a Medicaid demonstration project or waiver, or a combination of those. Under a Medicare demonstration, the department may contract with the federal Centers for Medicare and Medicaid Services (CMS) and demonstration sites to operate the Medicare and Medicaid benefits in a demonstration project that is overseen by the state as a delegated Medicare benefit administrator, and may enter into financing arrangements with CMS to share in any Medicare Program savings generated by the demonstration project.

(b) After federal approval is obtained, the department shall establish the demonstration project that enables dual eligible beneficiaries to receive a continuum of services that maximizes access to, and coordination of, benefits between the Medi-Cal and Medicare programs and access to the continuum of long-term services and supports and behavioral health services, including mental health and substance use disorder treatment services. The purpose of the demonstration project is to integrate services authorized under the federal Medicaid program (Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.)) and the federal Medicare Program (Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.)). The demonstration project may also include additional services as approved through a demonstration project or waiver, or a combination of those.

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

(1) “Behavioral health” means Medi-Cal services provided pursuant to Section 51341 of Title 22 of the California Code of Regulations and Drug Medi-Cal substance abuse services provided pursuant to Section 51341.1 of Title 22 of the California Code of Regulations, and any mental health benefits available under the Medicare Program.

(2) “Capitated payment model” means an agreement entered into between CMS, the state, and a managed care health plan, in which the managed care health plan receives a capitation payment for the comprehensive, coordinated provision of Medi-Cal services and benefits under Medicare Part C (42 U.S.C. Sec. 1395w-21 et seq.) and Medicare Part D (42 U.S.C. Sec. 1395w-101 et seq.), and CMS shares the savings with the state from improved provision of Medi-Cal and Medicare services that reduces the cost of those services. Medi-Cal services include long-term services and supports as defined in Section 14186.1, behavioral health services, and any additional services offered by the demonstration site.

(3) “Demonstration site” means a managed care health plan that is selected to participate in the demonstration project under the capitated payment model.

(4) “Dual eligible beneficiary” means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) and Medicare Part B (42 U.S.C. Sec. 1395j et seq.) and is eligible for medical assistance under the Medi-Cal State Plan.

(d) No sooner than March 1, 2011, the department shall identify health care models that may be included in the demonstration project, shall develop a timeline and process for selecting, financing, monitoring, and evaluating the demonstration sites, and shall provide this timeline and process to the appropriate fiscal and policy committees of the Legislature. The department may implement these demonstration sites in phases.

(e) The department shall provide the fiscal and appropriate policy committees of the Legislature with a copy of any report submitted to CMS to meet the requirements under the demonstration project.

(f) Goals for the demonstration project shall include all of the following:

(1) Coordinate Medi-Cal and Medicare benefits across health care settings and improve the continuity of care across acute care, long-term care, behavioral health, including mental health and substance use disorder services, and home- and community-based services settings using a person-centered approach.

(2) Coordinate access to acute and long-term care services for dual eligible beneficiaries.

(3) Maximize the ability of dual eligible beneficiaries to remain in their homes and communities with appropriate services and supports in lieu of institutional care.

(4) Increase the availability of and access to home- and community-based services.

(5) Coordinate access to necessary and appropriate behavioral health services, including mental health and substance use disorder services.

(6) Improve the quality of care for dual eligible beneficiaries.

(7) Promote a system that is both sustainable and person and family centered by providing dual eligible beneficiaries with timely access to appropriate, coordinated health care services and community resources that enable them to attain or maintain personal health goals.

(g) No sooner than March 1, 2013, demonstration sites shall be established in up to eight counties, and shall include at least one county that provides Medi-Cal services through a two-plan model pursuant to Article 2.7 (commencing with Section 14087.3) and at least one county that provides Medi-Cal services under a county organized health system pursuant to Article 2.8 (commencing with Section 14087.5). The director shall consult with the Legislature, CMS, and stakeholders when determining the implementation date for this section. In determining the counties in which to establish a demonstration site, the director shall consider both of the following:

(1) Local support for integrating medical care, long-term care, and home- and community-based services networks.

(2) A local stakeholder process that includes health plans, providers, mental health representatives, community programs, consumers, designated representatives of in-home supportive services personnel, and other interested stakeholders in the development, implementation, and continued operation of the demonstration site.

(h) In developing the process for selecting, financing, monitoring, and evaluating the health care models for the demonstration project, the department shall enter into a memorandum of understanding with CMS. Upon completion, the memorandum of understanding shall be provided to the fiscal and appropriate policy committees of the Legislature and posted on the department's internet website.

(i) The department shall negotiate the terms and conditions of the memorandum of understanding, which shall address, but are not limited to, all of the following:

(1) Reimbursement methods for a capitated payment model. Under the capitated payment model, the demonstration sites shall meet all of the following requirements:

(A) Have Medi-Cal managed care health plan and Medicare dual eligible-special needs plan contract experience, or evidence of the ability to meet these contracting requirements.

(B) Be in good financial standing and meet licensure requirements under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), except for county organized health system plans that are exempt from licensure pursuant to Section 14087.95.

(C) Meet quality measures, which may include Medi-Cal and Medicare Healthcare Effectiveness Data and Information Set measures and other quality measures determined or developed by the department or CMS.

(D) Demonstrate a local stakeholder process that includes dual eligible beneficiaries, managed care health plans, providers, mental health representatives, county health and human services agencies, designated representatives of in-home supportive services personnel, and other interested stakeholders that advise and consult with the demonstration site in the development, implementation, and continued operation of the demonstration project.

(E) Pay providers reimbursement rates sufficient to maintain an adequate provider network and ensure access to care for beneficiaries.

(F) Follow final policy guidance determined by CMS and the department with regard to reimbursement rates for providers pursuant to paragraphs (4) to (7), inclusive, of subdivision (o).

(G) To the extent permitted under the demonstration, pay noncontracted hospitals prevailing Medicare fee-for-service rates for traditionally Medicare covered benefits and prevailing Medi-Cal fee-for-service rates for traditionally Medi-Cal covered benefits.

(2) Encounter data reporting requirements for both Medi-Cal and Medicare services provided to beneficiaries enrolling in the demonstration project.

(3) Quality assurance withholding from the demonstration site payment, to be paid only if quality measures developed as part of the memorandum of understanding and plan contracts are met.

(4) Provider network adequacy standards developed by the department and CMS, in consultation with the Department of Managed Health Care, the demonstration site, and stakeholders.

(5) Medicare and Medi-Cal appeals and hearing process.

(6) Unified marketing requirements and combined review process by the department and CMS.

(7) Combined quality management and consolidated reporting process by the department and CMS.

(8) Procedures related to combined federal and state contract management to ensure access, quality, program integrity, and financial solvency of the demonstration site.

(9) To the extent permissible under federal requirements, implementation of the provisions of Sections 14182.16 and 14182.17 that are applicable to beneficiaries simultaneously eligible for full-scope benefits under Medi-Cal and the Medicare Program.

(10) (A) In consultation with the hospital industry, CMS approval to ensure that Medicare supplemental payments for direct graduate medical education and Medicare add-on payments, including indirect medical education and disproportionate share hospital adjustments continue to be made available to hospitals for services provided under the demonstration.

(B) The department shall seek CMS approval for CMS to continue these payments either outside the capitation rates or, if contained within the capitation rates, and to the extent permitted under the demonstration project, shall require demonstration sites to provide this reimbursement to hospitals.

(11) To the extent permitted under the demonstration project, the default rate for noncontracting providers of physician services shall be the prevailing Medicare fee schedule for services covered by the Medicare Program and the prevailing Medi-Cal fee schedule for services covered by the Medi-Cal program.

(j) (1) The department shall comply with and enforce the terms and conditions of the memorandum of understanding with CMS, as specified in subdivision (i). To the extent that the terms and conditions do not address the specific selection, financing, monitoring, and evaluation criteria listed in subdivision (i), the department:

(A) Shall require the demonstration site to do all of the following:

(i) Comply with additional site readiness criteria specified by the department.

(ii) Comply with long-term services and supports requirements in accordance with Article 5.7 (commencing with Section 14186).

(iii) To the extent permissible under federal requirements, comply with the provisions of Sections 14182.16 and 14182.17 that are applicable to beneficiaries simultaneously eligible for full-scope benefits under both Medi-Cal and the Medicare Program.

(iv) Comply with all transition of care requirements for Medicare Part D benefits as described in Chapters 6 and 14 of the Medicare Managed Care Manual, published by CMS, including transition timeframes, notices, and emergency supplies.

(B) May require the demonstration site to forgo charging premiums, coinsurance, copayments, and deductibles for Medicare Part C and Medicare Part D services.

(2) The department shall notify the Legislature within 30 days of the implementation of the requirements in paragraph (1).

(k) The director may enter into exclusive or nonexclusive contracts on a bid or negotiated basis and may amend existing managed care contracts to provide or arrange for services provided under this section. Contracts entered into or amended pursuant to this section shall be exempt from the provisions of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code.

(l) (1) (A) Except for the exemptions provided for in this section and in Section 14132.277, the department shall enroll dual eligible beneficiaries into a demonstration site unless the beneficiary makes an affirmative choice to opt out of enrollment or is already enrolled on or before June 1, 2013, in a managed care organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has previously contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS or in any entity with a contract with the department pursuant to Chapter 8.75 (commencing with Section 14591).

(B) Dual eligible beneficiaries who opt out of enrollment into a demonstration site may choose to remain enrolled in fee-for-service Medicare or a Medicare Advantage plan for their Medicare benefits, but shall be mandatorily enrolled into a Medi-Cal managed care health plan pursuant to Section 14182.16, except as exempted under subdivision (c) of Section 14182.16.

(C) (i) Persons meeting requirements for the Program of All-Inclusive Care for the Elderly (PACE) pursuant to Chapter 8.75 (commencing with Section 14591) or a managed care organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has

previously contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) of Chapter 7 to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS may select either of these managed care health plans for their Medicare and Medi-Cal benefits if one is available in that county.

(ii) In areas where a PACE plan is available, the PACE plan shall be presented as an enrollment option, included in all enrollment materials, enrollment assistance programs, and outreach programs related to the demonstration project, and made available to beneficiaries whenever enrollment choices and options are presented. Persons meeting the age qualifications for PACE and who choose PACE shall remain in the fee-for-service Medi-Cal and Medicare programs, and shall not be assigned to a managed care health plan for the lesser of 60 days or until they are assessed for eligibility for PACE and determined not to be eligible for a PACE plan. Persons enrolled in a PACE plan shall receive all Medicare and Medi-Cal services from the PACE program pursuant to the three-way agreement between the PACE program, the department, and the Centers for Medicare and Medicaid Services.

(2) To the extent that federal approval is obtained, the department may require that any beneficiary, upon enrollment in a demonstration site, remain enrolled in the Medicare portion of the demonstration project on a mandatory basis for six months from the date of initial enrollment. After the sixth month, a dual eligible beneficiary may elect to enroll in a different demonstration site, a different Medicare Advantage plan, fee-for-service Medicare, PACE, or a managed care organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has previously contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS, for their Medicare benefits.

(A) During the six-month mandatory enrollment in a demonstration site, a beneficiary may continue receiving services from an out-of-network Medicare provider for primary and specialty care services only if all of the following criteria are met:

(i) The dual eligible beneficiary demonstrates an existing relationship with the provider before enrollment in a demonstration site.

(ii) The provider is willing to accept payment from the demonstration site based on the current Medicare fee schedule.

(iii) The demonstration site would not otherwise exclude the provider from its provider network due to documented quality of care concerns.

(B) The department shall develop a process to inform providers and beneficiaries of the availability of continuity of services from an existing provider and ensure that the beneficiary continues to receive services without interruption.

(3) (A) Notwithstanding subparagraph (A) of paragraph (1), a dual eligible beneficiary shall be excluded from enrollment in the demonstration project if the beneficiary meets any of the following:

(i) The beneficiary has a prior diagnosis of end-stage renal disease. This clause does not apply to beneficiaries diagnosed with end-stage renal disease subsequent to enrollment in the demonstration project. The director may, with stakeholder input and federal approval, authorize beneficiaries with a prior diagnosis of end-stage renal disease in specified counties to voluntarily enroll in the demonstration project.

(ii) The beneficiary has other health coverage, as defined in paragraph (5) of subdivision (b) of Section 14182.16.

(iii) The beneficiary is enrolled in a home- and community-based waiver that is a Medi-Cal benefit under Section 1915(c) of the federal Social Security Act (42 U.S.C. Sec. 1396n et seq.), except for persons enrolled in Multipurpose Senior Services Program services or beneficiaries receiving services through a regional center who resides in the County of San Mateo.

(iv) The beneficiary is receiving services through a regional center or state developmental center. However, a beneficiary receiving services through a regional center who resides in the County of San Mateo, by making an affirmative choice to opt in, may voluntarily enroll in the demonstration project, upon receipt of all legal notifications required pursuant to this section and applicable federal requirements.

(v) The beneficiary resides in a geographic area or ZIP Code not included in managed care, as determined by the department and CMS.

(vi) The beneficiary resides in one of the Veterans' Homes of California, as described in Chapter 1 (commencing with Section 1010) of Division 5 of the Military and Veterans Code.

(B) (i) Beneficiaries who have been diagnosed with HIV/AIDS may opt out of the demonstration project at the beginning of any month. The State Department of Public Health may share relevant data relating to a beneficiary's enrollment in the AIDS Drug Assistance Program with the department, and the department may share relevant data relating to HIV-positive beneficiaries with the State Department of Public Health.

(ii) The information provided by the State Department of Public Health pursuant to this subparagraph shall not be further disclosed by the State Department of Health Care Services, and shall be subject to the confidentiality protections of subdivisions (d) and (e) of Section 121025 of the Health and Safety Code, except this information may be further disclosed as follows:

(I) To the person to whom the information pertains or the designated representative of that person.

(II) To the Office of AIDS within the State Department of Public Health.

(C) Beneficiaries who are Indians receiving Medi-Cal services in accordance with Section 55110 of Title 22 of the California Code of Regulations may opt out of the demonstration project at the beginning of any month.

(D) The department, with stakeholder input, may exempt specific categories of dual eligible beneficiaries from enrollment requirements in this section based on extraordinary medical needs of specific patient groups or to meet federal requirements.

(4) For the 2013 calendar year, the department shall offer federal Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275) compliant contracts to existing Medicare Advantage Dual Special Needs Plans (D-SNP) to continue to provide Medicare benefits to their enrollees in their service areas as approved on January 1, 2012. In the 2013 calendar year, beneficiaries in Medicare Advantage and D-SNP plans shall be exempt from the enrollment requirements of subparagraph (A) of paragraph (1), but may voluntarily choose to enroll in the demonstration project. Enrollment into the demonstration project's managed care health plans shall be reassessed in 2014 depending on federal reauthorization of the D-SNP model and the department's assessment of the demonstration plans.

(5) For the 2013 calendar year, demonstration sites shall not offer to enroll dual eligible beneficiaries eligible for the demonstration project into the demonstration site's D-SNP.

(6) The department shall not terminate contracts in a demonstration site with a managed care organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has previously contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) to provide services to beneficiaries who are HIV positive beneficiaries or who have been diagnosed with AIDS and with any entity with a contract pursuant to Chapter 8.75 (commencing with Section 14591), except as provided in the contract or pursuant to state or federal law.

(m) Notwithstanding Section 10231.5 of the Government Code, the department shall conduct an evaluation, in partnership with CMS, to assess outcomes and the experience of dual eligibles in these demonstration sites and shall provide a report to the Legislature after the first full year of demonstration operation, and annually thereafter. A report submitted to the Legislature pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code. The department shall consult with stakeholders regarding the scope and structure of the evaluation.

(n) This section shall be implemented only if and to the extent that federal financial participation or funding is available.

(o) It is the intent of the Legislature that:

(1) In order to maintain adequate provider networks, demonstration sites shall reimburse providers at rates sufficient to ensure access to care for beneficiaries.

(2) Savings under the demonstration project are intended to be achieved through shifts in utilization, and not through reduced reimbursement rates to providers.

(3) Reimbursement policies shall not prevent demonstration sites and providers from entering into payment arrangements that allow for the alignment of financial incentives and provide opportunities for shared risk and shared savings in order to promote appropriate utilization shifts, which encourage the use of home- and community-based services and quality of care for dual eligible beneficiaries enrolled in the demonstration sites.

(4) To the extent permitted under the demonstration project, and to the extent that a public entity voluntarily provides an intergovernmental transfer for this purpose, both of the following shall apply:

(A) The department shall work with CMS in ensuring that the capitation rates under the demonstration project are inclusive of funding currently provided through certified public expenditures supplemental payment programs that would otherwise be impacted by the demonstration project.

(B) Demonstration sites shall pay to a public entity voluntarily providing intergovernmental transfers that previously received reimbursement under a certified public expenditures supplemental payment program, rates that include the additional funding under the capitation rates that are funded by the public entity's intergovernmental transfer.

(5) The department shall work with CMS in developing other reimbursement policies and shall inform demonstration sites, providers, and the Legislature of the final policy guidance.

(6) The department shall seek approval from CMS to permit the provider payment requirements contained in subparagraph (G) of paragraph (1) and paragraphs (10) and (11) of subdivision (i), and Section 14132.276.

(7) Demonstration sites that contract with hospitals for hospital services on a fee-for-service basis that otherwise would have been traditionally Medicare services will achieve savings through utilization changes and not by paying hospitals at rates lower than prevailing Medicare fee-for-service rates.

(p) The department shall enter into an interagency agreement with the Department of Managed Health Care to perform some or all of the department's oversight and readiness review activities specified in this section. These activities may include providing consumer assistance to beneficiaries affected by this section and conducting financial audits, medical surveys, and a review of the adequacy of provider networks of the managed care health plans participating in this section. The interagency agreement shall be updated, as necessary, on an annual basis in order to maintain functional clarity regarding the roles and responsibilities of the Department of Managed Health Care and the department. The department shall not delegate its authority under this section as the single state Medicaid agency to the Department of Managed Health Care. Notwithstanding any other law, this subdivision shall be operative only through June 30, 2017.

(q) (1) Beginning with the May Revision to the 2013–14 Governor's Budget, and annually thereafter, the department shall report to the Legislature on the enrollment status, quality measures, and state costs of the actions taken pursuant to this section.

(2) (A) By January 1, 2013, or as soon thereafter as practicable, the department shall develop, in consultation with CMS and stakeholders, quality and fiscal measures for health plans to reflect the short- and long-term results of the implementation of this section. The department shall also develop quality thresholds and milestones for these measures. The department shall update these measures periodically to reflect changes in this program due to implementation factors and the structure and design of the benefits and services being coordinated by managed care health plans.

(B) The department shall require health plans to submit Medicare and Medi-Cal data to determine the results of these measures. If the department finds that a health plan is not in compliance with one or more of the measures set forth in this section, the health plan shall, within 60 days, submit a corrective action plan to the department for approval. The corrective action plan shall, at a minimum, include steps that the health plan shall take to improve its performance based on the standard or standards with which the health plan is out of compliance. The plan shall establish interim benchmarks for improvement that shall be expected to be met by the health plan in order to avoid a sanction pursuant to Section 14197.7. This subparagraph is not intended to limit Section 14197.7.

(C) The department shall publish the results of these measures, including by posting on the department's internet website, on a quarterly basis.

(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 and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. Before issuing any letter or similar instrument authorized pursuant to this section, the department shall notify and consult with stakeholders, including advocates, providers, and beneficiaries. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

(s) (1) Notwithstanding any other law, the demonstration project described in this section shall remain operative only through December 31, 2022, subject to subdivision (f) of Section 14184.102.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 390. Section 14132.276 of the Welfare and Institutions Code is amended to read:

14132.276. For nursing facility services provided under the demonstration project as established in Section 14132.275, to the extent these provisions are authorized under the memorandum of understanding specified in subdivision (j) of Section 14132.275, the following shall apply:

(a) The demonstration site shall not combine the rates of payment for post-acute skilled and rehabilitation care provided by a nursing facility and long-term and chronic care provided by a nursing facility in order to establish a single payment rate for dual eligible beneficiaries requiring skilled nursing services.

(b) The demonstration site shall pay nursing facilities providing post-acute skilled and rehabilitation care or long-term and chronic care rates that reflect the different level of services and intensity required to provide these services.

(c) For the purposes of determining the appropriate rate for the type of care identified in subdivision (b), the demonstration site shall pay no less than the recognized rates under Medicare and Medi-Cal for these service types.

(d) With respect to services under this section, the demonstration site shall not offer, and the nursing facility shall not accept, any discounts, rebates, or refunds as compensation or inducements for the referral of patients or residents.

(e) It is the intent of the Legislature that savings under the demonstration project be achieved through shifts in utilization, and not through reduced reimbursement rates to providers.

(f) In order to encourage quality improvement and promote appropriate utilization incentives, including reduced rehospitalization and shorter lengths of stay, for nursing facilities providing the services under this section, the demonstration sites may do any of the following:

(1) Utilize incentive or bonus payment programs that are in addition to the rates identified in subdivisions (b) and (c).

(2) Opt to direct beneficiaries to facilities that demonstrate better performance on quality or appropriate utilization factors.

(g) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(h) (1) Notwithstanding any other law, this section shall remain operative only through December 31, 2022.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 391. Section 14132.277 of the Welfare and Institutions Code is amended to read:

14132.277. (a) For purposes of this section, the following definitions apply:

(1) “Alternate health care service plan” means a prepaid health plan that is a nonprofit health care service plan with at least 3.5 million enrollees statewide, that owns or operates its own pharmacies, and that provides 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 operates to provide services to enrollees.

(2) “Cal MediConnect plan” means a health plan or other qualified entity jointly selected by the state and CMS for participation in the demonstration project.

(3) “CMS” means the federal Centers for Medicare and Medicaid Services.

(4) “Coordinated Care Initiative county” means the Counties of Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara, and any other county identified in Appendix 3 of the Memorandum of Understanding Between the Centers for Medicare and Medicaid Services and the State of California, Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees, inclusive of all amendments, as authorized by Section 14132.275.

(5) “D-SNP plan” means a Medicare Advantage Dual Special Needs Plan.

(6) “D-SNP contract” means a federal Medicare Improvements for Patients and Provider Act of 2008 (Public Law 110-275) compliant contract between the department and a D-SNP plan.

(7) “Demonstration project” means the demonstration project authorized by Section 14132.275.

(8) “Excluded beneficiaries” means those beneficiaries who are ineligible to participate in the demonstration project pursuant to subdivision (l) of Section 14132.275.

(9) “FIDE-SNP plan” means a Medicare Advantage Fully-Integrated Dual Eligible Special Needs Plan.

(10) “Non-Coordinated Care Initiative counties” means counties not participating in the demonstration project.

(b) For the 2014 calendar year, the department shall offer D-SNP contracts to existing D-SNP plans to continue to provide benefits to their enrollees in their service areas as approved on January 1, 2013. The director may include in any D-SNP contract provisions requiring that the D-SNP plan do the following:

(1) Submit to the department a complete and accurate copy of the bid submitted by the plan to CMS for its D-SNP contract.

(2) Submit to the department copies of all utilization and quality management reports submitted to CMS.

(c) In Coordinated Care Initiative counties, Medicare Advantage plans and D-SNP plans may continue to enroll beneficiaries in 2014. In the 2014 calendar year, beneficiaries enrolled in a Medicare Advantage or D-SNP plan operating in a Coordinated Care Initiative county shall be exempt from the enrollment provisions of subparagraph (A) of paragraph (1) of subdivision (l) of Section 14132.275. Those beneficiaries may at any time voluntarily choose to disenroll from their Medicare Advantage or D-SNP plan and enroll in a demonstration site operating pursuant to subdivision (g) of Section 14132.275. If a beneficiary chooses to do so, that beneficiary may subsequently disenroll from the demonstration site and return to fee-for-service Medicare or to a D-SNP plan or Medicare Advantage plan.

(d) (1) For the 2015 calendar year and the remainder of the demonstration project, in Coordinated Care Initiative counties, the department shall offer D-SNP contracts to D-SNP plans that were approved for the D-SNP plan's service areas as of January 1, 2013. In Coordinated Care Initiative counties, the department shall enter into D-SNP contracts with D-SNP plans only for excluded beneficiaries and for those beneficiaries identified in paragraphs (2) and (5) of subdivision (g).

(2) For the 2022 contract year and the remainder of the demonstration project, in Coordinated Care Initiative counties, Medi-Cal managed care plans, or their subcontracted delegate health plans, as defined in paragraph (6) of subdivision (h) of Section 14184.208, may transition beneficiaries enrolled in their affiliated non-D-SNP Medicare Advantage plans on or before January 1, 2022, into their affiliated D-SNP plan, if the D-SNP plan was approved for that service area as of January 1, 2013.

(e) For the 2015 calendar year and the remainder of the demonstration project, in non-Coordinated Care Initiative counties, the department may offer D-SNP contracts to D-SNP plans, in accordance with Section 14184.208.

(f) The director may include in a D-SNP contract offered pursuant to subdivision (d) or (e) provisions requiring that the D-SNP plan do the following:

(1) Submit to the department a complete and accurate copy of the bid submitted by the plan to CMS for its D-SNP contract.

(2) Submit to the department copies of all utilization and quality management reports submitted to CMS.

(g) For the 2015 calendar year and the remainder of the demonstration project, in Coordinated Care Initiative counties, the enrollment provisions of subdivision (l) of Section 14132.275 shall apply subject to the following:

(1) Beneficiaries enrolled in a FIDE-SNP plan or a Medicare Advantage plan, other than a D-SNP plan, shall be exempt from the enrollment provisions of subparagraph (A) of paragraph (1) of subdivision (l) of Section 14132.275.

(2) If the D-SNP plan is not a Cal MediConnect plan, beneficiaries enrolled as of December 31, 2014, in a D-SNP plan shall be exempt from the enrollment provisions of subparagraph (A) of paragraph (1) of subdivision (l) of Section 14132.275. Those beneficiaries may at any time voluntarily choose to disenroll from their D-SNP plan and enroll in a demonstration site operating pursuant to subdivision (g) of Section 14132.275. A dual eligible beneficiary who is enrolled as of December 31, 2014, in a D-SNP plan that is not a Cal MediConnect plan and who opts out of a demonstration site during the course of the demonstration project may choose to reenroll in that D-SNP plan.

(3) If the D-SNP is a Cal MediConnect plan, beneficiaries enrolled in a D-SNP plan who are eligible for the demonstration project shall be subject to the enrollment provisions of subparagraph (A) of paragraph (1) of subdivision (l) of Section 14132.275.

(4) For FIDE-SNP plans serving beneficiaries in Coordinated Care Initiative counties, the department shall require the following provisions:

(A) After December 31, 2014, enrollment in the County of Los Angeles shall not exceed 6,000 additional beneficiaries at any point during the term of the demonstration project. After December 31, 2014, enrollment in the combined Counties of Riverside and San Bernardino shall not exceed 1,500 additional beneficiaries at any point during the term of the demonstration project. This subparagraph shall be inoperative on July 1, 2021.

(B) Any necessary data or information requirements provided by the FIDE-SNP to ensure contract compliance.

(5) Beneficiaries enrolled in an alternate health care service plan (AHCSP) who become dually eligible for Medicare and Medicaid benefits while enrolled in that AHCSP may elect to enroll in the AHCSP's D-SNP plan subject to the following

requirements:

(A) The beneficiary was a member of the AHCSP immediately before becoming dually eligible for Medicare and Medicaid benefits.

(B) Upon mutual agreement between a Cal MediConnect Plan operated by a health authority or commission contracting with the department and the AHCSP, the AHCSP shall take full financial and programmatic responsibility for certain long-term supports and services of the D-SNP enrollee, including, but not limited to, certain long-term skilled nursing care, community-based adult services, multipurpose senior services program services, and other applicable Medi-Cal benefits offered in the demonstration project.

(6) Before assigning a beneficiary in a Medi-Cal managed care health plan pursuant to Section 14182.16, the department shall determine whether the beneficiary is already a member of the AHCSP. If so, the beneficiary shall be assigned to a Medi-Cal managed care health plan operated by a health authority or commission contracting with the department and subcontracting with the AHCSP.

(h) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(i) (1) Notwithstanding any other law, this section shall remain operative only through December 31, 2022.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 392. Section 14132.755 is added to the Welfare and Institutions Code, to read:

14132.755. (a) Commencing no sooner than July 1, 2022, dyadic behavioral health visits shall be a covered benefit under the Medi-Cal program, subject to utilization controls.

(b) The dyadic services benefit is a family- and caregiver-focused model of care intended to address developmental and behavioral health conditions of children as soon as they are identified, and that fosters access to preventive care for children, rates of immunization completion, coordination of care, child social-emotional health and safety, developmentally appropriate parenting, and maternal mental health. Dyadic behavioral health visits are provided for the child and caregiver or parent at medical visits, providing screening for behavioral health problems, interpersonal safety, tobacco and substance misuse and social determinants of health, such as food insecurity and housing instability, and referrals for appropriate followup care.

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

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

SEC. 393. Section 14132.85 is added to the Welfare and Institutions Code, to read:

14132.85. (a) For purposes of this section, the following definitions apply:

(1) “Complex needs patient” means an individual with a diagnosis or medical condition that results in significant physical impairment or functional limitation. “Complex needs patient” includes, but is not limited to, individuals with spinal cord injury, traumatic brain injury, cerebral palsy, muscular dystrophy, spina bifida, osteogenesis imperfecta, arthrogryposis, amyotrophic lateral sclerosis, multiple sclerosis, demyelinating disease, myelopathy, myopathy, progressive muscular atrophy, anterior horn cell disease, post-polio syndrome, cerebellar degeneration, dystonia, Huntington’s disease, spinocerebellar disease, and the types of amputation, paralysis, or paresis that result in significant physical impairment or functional limitation. “Complex needs patient” does not negate the requirement that an individual meet medical necessity requirements under authority rules to qualify for receiving complex rehabilitation technology.

(2) “Complex rehabilitation technology” means items classified within the federal Medicare Program as of January 1, 2021, as durable medical equipment that are individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living identified as medically necessary. These items include, but are not limited to, complex rehabilitation manual and power wheelchairs, power seat elevation or power standing components of power wheelchairs, seating and positioning items, other specialized equipment such as adaptive bath equipment, standing frames, gait trainers, and specialized strollers, and related options and accessories.

(3) “Complex rehabilitation technology services” includes the application of enabling systems designed and assembled to meet the needs of a patient experiencing any permanent or long-term loss or abnormality of physical or anatomical structure or function with respect to mobility or other function or need. These services include, but are not limited to, all of the following:

(A) Evaluating the needs of a patient with a disability, including an assessment of the patient for the purpose of ensuring that the proposed equipment is appropriate.

(B) Documenting medical necessity.

(C) Selecting, fitting, customizing, maintaining, assembling, repairing, replacing, picking up and delivering, and testing equipment and parts.

(D) Training the patient who will use the technology or any individual who assists the patient in using the complex rehabilitation technology.

(4) “Qualified health care professional” means an individual who has no financial relationship to the provider of complex rehabilitation technology and is any of the following:

(A) A physical therapist licensed pursuant to Chapter 5.7 (commencing with Section 2600) of Division 2 of the Business and Professions Code.

(B) An occupational therapist licensed pursuant to Chapter 5.6 (commencing with Section 2570) of Division 2 of the Business and Professions Code.

(C) Other licensed health care professional, approved by the department, and who performs specialty evaluations within the professional’s scope of practice.

(5) “Qualified rehabilitation technology professional” means an individual who meets either of the following:

(A) Holds the credential of Assistive Technology Professional (ATP) from the Rehabilitation Engineering and Assistive Technology Society of North America.

(B) Holds the credential of Certified Complex Rehabilitation Technology Supplier (CRTS) from the National Registry of Rehabilitation Technology Suppliers.

(b) A provider of complex rehabilitation technology to a Medi-Cal beneficiary shall comply with all of the following:

(1) Meet the supplier and quality standards established for a durable medical equipment supplier under the federal Medicare Program and be enrolled as a provider in the Medi-Cal program.

(2) Be accredited by a recognized accrediting organization as a supplier of complex rehabilitation technology.

(3) Employ at least one qualified rehabilitation technology professional as a W-2 employee (receiving a W-2 tax form from the provider) for each distribution location.

(4) Have the qualified rehabilitation technology professional physically present for the evaluation, either in person or remotely if necessary, directly involved in determining the specific complex rehabilitation technology appropriate for the patient, and directly involved with, or closely supervised in, the final fitting and delivery of the complex rehabilitation technology.

(5) Maintain a reasonable supply of parts, adequate physical facilities, and qualified service or repair technicians, and provide patients with prompt services and repair for all complex rehabilitation technology supplied.

(6) Provide written information at the time of delivery of complex rehabilitation technology regarding how the patient may receive services and repair.

(c) For complex needs patients receiving a complex rehabilitation manual wheelchair, power wheelchair, or seating component, the patient shall be evaluated, either in person or remotely if necessary, by both of the following:

(1) A qualified health care professional.

(2) A qualified rehabilitation technology professional.

(d) A medical provider shall conduct a physical examination of an individual, either in person or remotely if necessary, before prescribing a power wheelchair or scooter for a Medi-Cal beneficiary. The medical provider shall complete a certificate of medical necessity that documents the medical condition that necessitates the power wheelchair or scooter, and verifies that the patient is capable of using the wheelchair or scooter safely.

(e) The department may adopt utilization controls, including a specialty evaluation by a qualified health care professional, as defined in paragraph (4) of subdivision (a). The department may adopt any other additional utilization controls for complex rehabilitation technology, as appropriate.

(f) The department shall seek any necessary federal approvals for the implementation of 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.

SEC. 394. Section 14132.968 of the Welfare and Institutions Code is amended to read:

14132.968. (a) (1) Pharmacist services are a benefit under the Medi-Cal program, subject to approval by the federal Centers for Medicare and Medicaid Services.

(2) The department shall establish a fee schedule for the list of pharmacist services.

(3) The rate of reimbursement for pharmacist services shall be at 85 percent of the fee schedule for physician services under the Medi-Cal program, except for medication therapy management (MTM) pharmacist services as described in Section 14132.969.

(b) (1) The following services are covered pharmacist services that may be provided to a Medi-Cal beneficiary:

(A) Furnishing travel medications, as authorized in clause (3) of subparagraph (A) of paragraph (10) of subdivision (a) of Section 4052 of the Business and Professions Code.

(B) Furnishing naloxone hydrochloride, as authorized in Section 4052.01 of the Business and Professions Code.

(C) Furnishing self-administered hormonal contraception, as authorized in subdivision (a) of Section 4052.3 of the Business and Professions Code.

(D) Initiating and administering immunizations, as authorized in Section 4052.8 of the Business and Professions Code.

(E) Providing tobacco cessation counseling and furnishing nicotine replacement therapy, as authorized in Section 4052.9 of the Business and Professions Code.

(F) Initiating and furnishing preexposure prophylaxis, as authorized in Section 4052.02 of the Business and Professions Code, limited to no more than a 60-day supply of preexposure prophylaxis to a single patient once every two years.

(G) Initiating and furnishing postexposure prophylaxis, as authorized in Section 4052.03 of the Business and Professions Code.

(H) Providing MTM pharmacist services in conjunction with the dispensing of qualified specialty drugs, as described in Section 14132.969.

(2) Covered pharmacist services shall be subject to department protocols and utilization controls.

(c) A pharmacist shall be enrolled as an ordering, referring, and prescribing provider under the Medi-Cal program prior to rendering a pharmacist service that is submitted by a Medi-Cal pharmacy provider for reimbursement pursuant to this section.

(d) (1) The director shall seek any necessary federal approvals to implement this section. This section shall not be implemented until the necessary federal approvals are obtained and shall be implemented only to the extent that federal financial participation is available.

(2) This section neither restricts nor prohibits any services currently provided by pharmacists as authorized by law, including, but not limited to, this chapter, or the Medicaid state plan.

(e) 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, and any applicable federal waivers and state plan amendments, by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. By July 1, 2021, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Commencing July 1, 2017, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

SEC. 395. Section 14132.969 is added to the Welfare and Institutions Code, to read:

14132.969. (a) Subject to an annual appropriation for this express purpose, the department shall implement a medication therapy management (MTM) reimbursement methodology for covered pharmacist services related to the dispensing of qualified specialty drugs by an eligible pharmacy contracted with the department pursuant to subdivision (c). MTM reimbursement pursuant to this section is intended to supplement Medi-Cal payments made to eligible pharmacies for MTM pharmacist services provided in conjunction with certain specialty drug therapy categories, as identified by the department pursuant to paragraph (2) of subdivision (b).

(b) In implementing this section, the department shall do all of the following:

(1) Establish and maintain protocols and utilization controls for covered MTM pharmacist services.

(2) Establish and maintain a list of covered specialty drug therapy categories for which MTM pharmacist services reimbursement is available.

(3) Establish and maintain rates of reimbursement for covered MTM pharmacist services under contracts with participating pharmacies pursuant to subdivision (c).

(4) Establish and maintain the eligibility criteria and conditions for receipt of MTM pharmacist services reimbursement pursuant to this section.

(c) (1) MTM pharmacist services reimbursement pursuant to this section shall only be available to a Medi-Cal enrolled pharmacy that enters into an MTM pharmacist services contract with the department.

(2) For purposes of implementing this section, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, 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.

(d) (1) This section shall apply to dates of service on or after July 1, 2021, or to dates of service on or after the effective date reflected in any necessary federal approvals obtained by the department pursuant to paragraph (2), whichever is later.

(2) The department shall seek any necessary federal approvals to implement this section.

(3) 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) This section neither restricts nor prohibits any services currently provided by pharmacists as authorized by law, including, but not limited to, this chapter, or the Medicaid state plan.

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

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

(1) “Medication therapy management” or “MTM” means a distinct service or group of services, as determined by the department, that are provided by pharmacists to improve health outcomes of beneficiaries who are at risk of treatment failure due to noncompliance, nonadherence, or other factors found to negatively affect drug therapy outcomes.

(2) “Specialty drugs” has the same meaning as set forth in paragraph (13) of subdivision (a) of Section 14105.45.

SEC. 396. Section 14182.16 of the Welfare and Institutions Code is amended to read:

14182.16. (a) The department shall require Medi-Cal beneficiaries who have dual eligibility in Medi-Cal and the Medicare Program to be assigned as mandatory enrollees into new or existing Medi-Cal managed care health plans for their Medi-Cal benefits in Coordinated Care Initiative counties.

(b) For the purposes of this section and Section 14182.17, the following definitions shall apply:

(1) “Coordinated Care Initiative counties” means the Counties of Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

(2) “Dual eligible beneficiary” means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or both, and is eligible for medical assistance under the Medi-Cal State Plan.

(3) “Full-benefit dual eligible beneficiary” means an individual 21 years of age or older who is eligible for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.), Medicare Part B (42 U.S.C. Sec. 1395j et seq.), and Medicare Part D (42 U.S.C. Sec. 1395w-101), and is eligible for medical assistance under the Medi-Cal State Plan.

(4) “Managed care health plan” means an individual, organization, or entity that enters into a contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.81 (commencing with Section 14087.96), or Article 2.91 (commencing with Section 14089), of this chapter, or Chapter 8 (commencing with Section 14200).

(5) “Other health coverage” means health coverage providing the same full or partial benefits as the Medi-Cal program, health coverage under another state or federal medical care program except for the Medicare Program (Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.)), or health coverage under a contractual or legal entitlement, including, but not limited to, a private group or indemnification insurance program.

(6) “Out-of-network Medi-Cal provider” means a health care provider that does not have an existing contract with the beneficiary’s managed care health plan or its subcontractors.

(7) “Partial-benefit dual eligible beneficiary” means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.), but not Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or who is eligible for Medicare Part B (42 U.S.C. Sec. 1395j et seq.), but not Medicare Part A (42 U.S.C. Sec. 1395c et seq.), and is eligible for medical assistance under the Medi-Cal State Plan.

(c) (1) Notwithstanding subdivision (a), a dual eligible beneficiary is exempt from mandatory enrollment in a managed care health plan if the dual eligible beneficiary meets any of the following:

(A) Except in counties with county organized health systems operating pursuant to Article 2.8 (commencing with Section 14087.5), the beneficiary has other health coverage.

(B) The beneficiary receives services through a foster care program, including the program described in Article 5 (commencing with Section 11400) of Chapter 2.

(C) The beneficiary is under 21 years of age.

(D) The beneficiary is ineligible for enrollment in managed care health plans for medically necessary reasons determined by the department.

(E) The beneficiary resides in one of the Veterans Homes of California, as described in Chapter 1 (commencing with Section 1010) of Division 5 of the Military and Veterans Code.

(F) The beneficiary is enrolled in any entity with a contract with the department pursuant to Chapter 8.75 (commencing with Section 14591).

(G) The beneficiary is enrolled in a managed care organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has previously contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) of Chapter 7.

(2) A beneficiary who has been diagnosed with HIV/AIDS is not exempt from mandatory enrollment, but may opt out of managed care enrollment at the beginning of any month.

(d) Implementation of this section shall incorporate the provisions of Section 14182.17 that are applicable to beneficiaries eligible for benefits under Medi-Cal and the Medicare Program.

(e) At the director’s sole discretion, in consultation with stakeholders, the department may determine and implement a phased-in enrollment approach that may include Medi-Cal beneficiary enrollment into managed care health plans immediately upon implementation of this section in a specific county, over a 12-month period, or other phased approach. The phased-in enrollment shall commence no sooner than March 1, 2013, and not until all necessary federal approvals have been obtained.

(f) To the extent that mandatory enrollment is required by the department, an enrollee’s access to fee-for-service Medi-Cal shall not be terminated until the enrollee has selected or been assigned to a managed care health plan.

(g) Except in a county where Medi-Cal services are provided by a county organized health system, and notwithstanding any other law, in any county in which fewer than two existing managed health care plans contract with the department to provide Medi-Cal services under this chapter that are available to dual eligible beneficiaries, including long-term services and supports, the department may contract with additional managed care health plans to provide Medi-Cal services.

(h) For partial-benefit dual eligible beneficiaries, the department shall inform these beneficiaries of their rights to continuity of care from out-of-network Medi-Cal providers pursuant to subparagraph (G) of paragraph (5) of subdivision (d) of Section 14182.17, and that the need for medical exemption criteria applied to counties operating under Chapter 4.1 (commencing with Section 53800) of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations may not be necessary to continue receiving Medi-Cal services from an out-of-network provider.

(i) The department may contract with existing managed care health plans to provide or arrange for services under this section. Notwithstanding any other law, the department may enter into the contract without the need for a competitive bid process or other contract proposal process, provided that the managed care health plan provides written documentation that it meets all of the qualifications and requirements of this section and Section 14182.17.

(j) The development of capitation rates for managed care health plan contracts shall include the analysis of data specific to the dual eligible population. For the purposes of developing capitation rates for payments to managed care health plans, the department shall require all managed care health plans, including existing managed care health plans, to submit financial, encounter, and utilization data in a form, at a time, and including substance as deemed necessary by the department. Failure to submit the required data shall result in the imposition of penalties pursuant to Section 14182.1.

(k) Persons meeting participation requirements for the Program of All-Inclusive Care for the Elderly (PACE) pursuant to Chapter 8.75 (commencing with Section 14591) may select a PACE plan if one is available in that county. Except in counties with county organized health systems operating pursuant to Article 2.8 (commencing with Section 14087.5), the department or its enrollment contractor shall notify a dual eligible beneficiary who is subject to mandatory enrollment in a managed care plan and who is potentially eligible for PACE that they may alternatively request to be assessed for eligibility for PACE, and, if eligible, may enroll in a PACE plan. The department or its enrollment contractor shall not enroll a dual eligible beneficiary who requests to be assessed for PACE in a managed care plan until the earlier of 60 days or the time that they are assessed and determined to be ineligible for a PACE plan, unless the beneficiary subsequently chooses to enroll in a managed care plan.

(l) Except for dual eligible beneficiaries participating in the demonstration project pursuant to Section 14132.275, persons meeting the participation requirements in effect on January 1, 2010, for a Medi-Cal primary case management plan in operation on that date, may select that primary care case management plan or a successor health care plan that 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) to provide services within the same geographic area that the primary care case management plan served on January 1, 2010.

(m) The department may implement an intergovernmental transfer arrangement with a public entity that elects to transfer public funds to the state to be used solely as the nonfederal share of Medi-Cal payments to managed care health plans for the provision of services to dual eligible beneficiaries pursuant to Section 14182.15.

(n) To implement this section, the department may contract with public or private entities. Contracts or amendments entered into under this section may be on an exclusive or nonexclusive basis and on a noncompetitive bid basis and shall be exempt from all of the following:

(1) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part.

(2) Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code.

(3) Review or approval of contracts by the Department of General Services.

(o) Any otherwise applicable provisions of this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) not in conflict with this section or with the Special Terms and Conditions of the waiver shall apply to this section.

(p) The department shall, in coordination with and consistent with an interagency agreement with the Department of Managed Health Care, at a minimum, monitor on a quarterly basis the adequacy of provider networks of the managed care health plans. Notwithstanding any other law, this subdivision shall remain operative only through June 30, 2017.

(q) The department shall suspend new enrollment of dual eligible beneficiaries into a managed care health plan if it determines that the managed care health plan does not have sufficient primary or specialty care providers and long-term service and supports to meet the needs of its enrollees.

(r) Managed care health plans shall pay providers in accordance with Medicare and Medi-Cal coordination of benefits.

(s) This section shall be implemented only to the extent that all federal approvals and waivers are obtained and only if and to the extent that federal financial participation is available.

(t) 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 and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. Before issuing any letter or similar instrument authorized pursuant to this section, the department shall notify and consult with stakeholders, including advocates, providers, and beneficiaries. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

(u) A managed care health plan that contracts with the department for the provision of services under this section shall ensure that beneficiaries have access to the same categories of licensed providers that are available under fee-for-service Medicare. Nothing in this section shall prevent a managed care health plan from contracting with selected providers within a category of licensure.

(v) The department shall, commencing August 1, 2013, convene stakeholders, at least quarterly, to review progress on the Coordinated Care Initiative and make recommendations to the department and the Legislature for the duration of the Coordinated Care Initiative. The stakeholders shall include beneficiaries, counties, and health plans, and representatives from primary care providers, specialists, hospitals, nursing facilities, MSSP programs, CBAS programs, other social service providers, the IHSS program, behavioral health providers, and substance use disorders stakeholders.

(w) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(x) (1) Notwithstanding any other law, this section shall remain operative only through December 31, 2022.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 397. Section 14182.17 of the Welfare and Institutions Code is amended to read:

14182.17. (a) For the purposes of this section, the definitions in subdivision (b) of Section 14182.16 apply.

(b) The department shall ensure and improve the care coordination and integration of health care services for Medi-Cal beneficiaries residing in Coordinated Care Initiative counties who are either of the following:

(1) Dual eligible beneficiaries, as defined in subdivision (b) of Section 14182.16, who receive Medi-Cal benefits and services through the demonstration project established pursuant to Section 14132.275 or through mandatory enrollment in managed care health plans pursuant to Section 14182.16.

(2) Medi-Cal beneficiaries who receive long-term services and supports pursuant to Article 5.7 (commencing with Section 14186).

(c) The department shall develop an enrollment process to be used in Coordinated Care Initiative counties to do the following:

(1) Except in a county that provides Medi-Cal services under a county organized health system pursuant to Article 2.8 (commencing with Section 14087.5), provide a choice of Medi-Cal managed care plans to a dual eligible beneficiary who has opted for Medicare fee-for-service, and establish an algorithm to assign beneficiaries who do not make a choice.

(2) Ensure that only beneficiaries required to make a choice or affirmatively opt out are sent enrollment materials.

(3) Establish enrollment timelines, developed in consultation with health plans and stakeholders, and approved by CMS, for each demonstration site. The timeline may provide for combining or phasing in enrollment for Medicare and Medi-Cal benefits.

(d) Before the department contracts with managed care health plans or Medi-Cal providers to furnish Medi-Cal benefits and services pursuant to subdivision (b), the department shall do all of the following:

(1) Ensure timely and appropriate communications with beneficiaries as follows:

(A) At least 90 days before enrollment, inform dual eligible beneficiaries through a notice written at not more than a sixth grade reading level that includes, at a minimum, how the Medi-Cal system of care will change, when the changes will occur, and who they can contact for assistance with choosing a managed care health plan or with problems they encounter.

(B) Develop and implement an outreach and education program for beneficiaries to inform them of their enrollment options and rights, including specific steps to work with consumer and beneficiary community groups.

(C) Develop, in consultation with consumers, beneficiaries, and other stakeholders, an overall communications plan that includes all aspects of developing beneficiary notices.

(D) Ensure that managed care health plans and their provider networks are able to provide communication and services to dual eligible beneficiaries in alternative formats that are culturally, linguistically, and physically appropriate through means, including, but not limited to, assistive listening systems, sign language interpreters, captioning, written communication, plain language, and written translations.

(E) Ensure that managed care health plans have prepared materials to inform beneficiaries of procedures for obtaining Medi-Cal benefits, including grievance and appeals procedures, that are offered by the plan or are available through the Medi-Cal program.

(F) Ensure that managed care health plans have policies and procedures in effect to address the effective transition of beneficiaries from Medicare Part D plans not participating in the demonstration project. These policies shall include, but not be limited to, the transition of care requirements for Medicare Part D benefits as described in Chapters 6 and 14 of the Medicare Managed Care Manual, published by CMS, including a determination of which beneficiaries require information about their transition supply, and, within the first 90 days of coverage under a new plan, provide for a temporary fill when the beneficiary requests a refill of a nonformulary drug.

(G) Contingent upon available private or public funds other than moneys from the General Fund, contract with community-based, nonprofit consumer, or health insurance assistance organizations with expertise and experience in assisting dual eligible beneficiaries in understanding their health care coverage options.

(H) Develop, with stakeholder input, informing and enrollment materials and an enrollment process in the demonstration site counties. The department shall ensure all of the following before implementing enrollment:

(i) Enrollment materials shall be made public at least 60 days before the first mailing of notices to dual eligible beneficiaries, and the department shall work with stakeholders to incorporate public comment into the materials.

(ii) The materials shall be in a not more than sixth grade reading level and shall be available in all the Medi-Cal threshold languages, as well as in alternative formats that are culturally, linguistically, and physically appropriate. For in-person enrollment assistance, disability accommodation shall be provided, when appropriate, through means including, but not limited to, assistive listening systems, sign language interpreters, captioning, and written communication.

(iii) The materials shall plainly state that the beneficiary may choose fee-for-service Medicare or Medicare Advantage, but must return the form to indicate this choice, and that if the beneficiary does not return the form, the state shall assign the beneficiary to a plan and all Medicare and Medi-Cal benefits shall only be available through that plan.

(iv) The materials shall plainly state that the beneficiary shall be enrolled in a Medi-Cal managed care health plan even if the beneficiary chooses to stay in fee-for-service Medicare.

(v) The materials shall plainly explain all of the following:

(I) The plan choices.

(II) Continuity of care provisions.

(III) How to determine which providers are enrolled in each plan.

(IV) How to obtain assistance with the choice forms.

(vi) The enrollment contractor recognizes, in compliance with existing statutes and regulations, authorized representatives, including, but not limited to, a caregiver, family member, conservator, or a legal services advocate, who is recognized by any of the services or programs that the person is already receiving or participating in.

(I) Make available to the public and to all Medi-Cal providers copies of all beneficiary notices in advance of the date the notices are sent to beneficiaries. These copies shall be available on the department's internet website.

(2) Require that managed care health plans perform an assessment process that, at a minimum, does all of the following:

(A) Assesses each new enrollee's risk level and needs by performing a risk assessment process using means, including telephonic, web-based, or in-person communication, or review of utilization and claims processing data, or by other means as determined by the department, with a particular focus on identifying those enrollees who may need long-term services and supports. The risk assessment process shall be performed in accordance with all applicable federal and state laws.

(B) Assesses the care needs of dual eligible beneficiaries and coordinates their Medi-Cal benefits across all settings, including coordination of necessary services within, and, when necessary, outside of the managed care health plan's provider network.

(C) Uses a mechanism or algorithm developed by the managed care health plan pursuant to paragraph (7) of subdivision (b) of Section 14182 for risk stratification of members.

(D) At the time of enrollment, applies the risk stratification mechanism or algorithm approved by the department to determine the health risk level of members.

(E) Reviews historical Medi-Cal fee-for-service utilization data and Medicare data, to the extent either is accessible to and provided by the department, for dual eligible beneficiaries upon enrollment in a managed care health plan so that the managed care health plans are better able to assist dual eligible beneficiaries and prioritize assessment and care planning.

(F) Analyzes Medicare claims data for dual eligible beneficiaries upon enrollment in a demonstration site pursuant to Section 14132.275 to provide an appropriate transition process for newly enrolled beneficiaries who are prescribed Medicare Part D drugs that are not on the demonstration site's formulary, as required under the transition of care requirements for Medicare Part D benefits as described in Chapters 6 and 14 of the Medicare Managed Care Manual, published by CMS.

(G) Assesses each new enrollee's behavioral health needs and historical utilization, including mental health and substance use disorder treatment services.

(H) Follows timeframes for reassessment and, if necessary, circumstances or conditions that require redetermination of risk level, which shall be set by the department.

(3) Ensure that the managed care health plans arrange for primary care by doing all of the following:

(A) Except for beneficiaries enrolled in the demonstration project pursuant to Section 14132.275, forgo interference with a beneficiary's choice of primary care physician under Medicare, and not assign a full-benefit dual eligible beneficiary to a primary care physician unless it is determined through the risk stratification and assessment process that assignment is necessary, in order to properly coordinate the care of the beneficiary or upon the beneficiary's request.

(B) Assign a primary care physician to a partial-benefit dual eligible beneficiary receiving primary or specialty care through the Medi-Cal managed care plan.

(C) Provide a mechanism for partial-benefit dual eligible enrollees to request a specialist or clinic as a primary care provider if these services are being provided through the Medi-Cal managed care health plan. A specialist or clinic may serve as a primary care provider if the specialist or clinic agrees to serve in a primary care provider role and is qualified to treat the required range of conditions of the enrollees.

(4) Ensure that the managed care health plans perform, at a minimum, and in addition to, other statutory and contractual requirements, care coordination, and care management activities as follows:

(A) Reflect a member-centered, outcome-based approach to care planning, consistent with the CMS model of care approach and with federal Medicare requirements and guidance.

(B) Adhere to a beneficiary's determination about the appropriate involvement of the beneficiary's medical providers and caregivers, according to the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(C) Develop care management and care coordination for the beneficiary across the medical and long-term services and supports care system, including transitions among levels of care and between service locations.

(D) Develop individual care plans for higher risk beneficiaries based on the results of the risk assessment process with a particular focus on long-term services and supports.

(E) Use nurses, social workers, the beneficiary's primary care physician, if appropriate, and other medical professionals to provide care management and enhanced care management, as applicable, particularly for beneficiaries in need of or receiving long-term services and supports.

(F) Consider behavioral health needs of beneficiaries and coordinate those services with the county mental health department as part of the beneficiary's care management plan when appropriate.

(G) Facilitate a beneficiary's ability to access appropriate community resources and other agencies, including referrals as necessary and appropriate for behavioral services, such as mental health and substance use disorders treatment services.

(H) Monitor skilled nursing facility utilization and develop care transition plans and programs that move beneficiaries back into the community to the extent possible. Plans shall monitor and support beneficiaries in the community to avoid further institutionalization.

(5) Ensure that the managed care health plans comply with, at a minimum, and in addition to other statutory and contractual requirements, network adequacy requirements as follows:

(A) Provide access to providers that comply with applicable state and federal law, including, but not limited to, physical accessibility and the provision of health plan information in alternative formats.

(B) Meet provider network adequacy standards for long-term services and supports that the department shall develop.

(C) Maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients, which shall be made available to beneficiaries, at a minimum, by phone, written material, and the internet, and in accessible formats, upon request.

(D) Monitor an appropriate provider network that includes an adequate number of accessible facilities within each service area.

(E) Contract with and assign patients to safety net and traditional providers as defined in subdivisions (hh) and (jj), respectively, of Section 53810 of Title 22 of the California Code of Regulations, including small and private practice providers who have traditionally treated dual eligible patients, based on available medical history to ensure access to care and services. A managed care health plan shall establish participation standards to ensure participation and broad representation of traditional and safety net providers within a service area.

(F) Maintain a liaison to coordinate with each regional center operating within the plan's service area to assist dual eligible beneficiaries with developmental disabilities in understanding and accessing services and act as a central point of contact for questions, access and care concerns, and problem resolution.

(G) Maintain a liaison and provide access to out-of-network providers, for up to 12 months, for new members enrolled under Sections 14132.275 and 14182.16 who have an ongoing relationship with a provider, if the provider will accept the health plan's rate for the service offered, or for nursing facilities and Community-Based Adult Services, or the applicable Medi-Cal fee-for-service rate, whichever is higher, and the managed care health plan determines that the provider meets applicable professional standards and has no disqualifying quality of care issues in accordance with guidance from the department, including all-plan letters. A partial-benefit dual eligible beneficiary enrolled in Medicare Part A who only receives primary and specialty care services through a Medi-Cal managed care health plan shall be able to receive these Medi-Cal services from an out-of-network Medi-Cal provider for 12 months after enrollment. This subparagraph shall not apply to out-of-network providers that furnish ancillary services.

(H) Assign a primary care physician who is the primary clinician for the beneficiary and who provides core clinical management functions for partial-benefit dual eligible beneficiaries who are receiving primary and specialty care through the Medi-Cal managed care health plan.

(I) Employ care managers directly or contract with nonprofit or proprietary organizations in sufficient numbers to provide coordinated care services for long-term services and supports as needed for all members.

(6) Ensure that the managed care health plans address medical and social needs as follows:

(A) Offer services beyond those required by Medicare and Medi-Cal at the managed care health plan's discretion.

(B) Refer beneficiaries to community resources or other agencies for needed medical or social services or items outside the managed care health plan's responsibilities.

(C) Facilitate communication among a beneficiary's health care and personal care providers, including long-term services and supports and behavioral health providers when appropriate.

(D) Engage in other activities or services needed to assist beneficiaries in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve health status.

(E) Facilitate timely access to primary care, specialty care, medications, and other health services needed by the beneficiary, including referrals to address any physical or cognitive barriers to access.

(F) Utilize the most recent common procedure terminology (CPT) codes, modifiers, and correct coding initiative edits.

(7) (A) Ensure that the managed care health plans provide, at a minimum, and in addition to other statutory and contractual requirements, a grievance and appeal process that does both of the following:

(i) Provides a clear, timely, and fair process for accepting and acting upon complaints, grievances, and disenrollment requests, including procedures for appealing decisions regarding coverage or benefits, as specified by the department.

Each managed care health plan shall have a grievance process that complies with Section 14450, and Sections 1368 and 1368.01 of the Health and Safety Code.

(ii) Complies with a Medicare and Medi-Cal grievance and appeal process, as applicable. The appeals process shall not diminish the grievance and appeals rights of IHSS recipients pursuant to Section 10950.

(B) In no circumstance shall the process for appeals be more restrictive than what is required under the Medi-Cal program.

(e) The department shall do all of the following:

(1) Monitor the managed care health plans' performance and accountability for provision of services, in addition to all other statutory and contractual monitoring and oversight requirements, by doing all of the following:

(A) Develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care health plan and for the dual eligible subset of enrollees. These performance measures may include measures from the Healthcare Effectiveness Data and Information Set or measures indicative of performance in serving special needs populations, such as the National Committee for Quality Assurance structure and process measures, or other performance measures identified or developed by the department.

(B) Implement performance measures that are required as part of the contract to provide quality assurance indicators for long-term services and supports in quality assurance plans required under the plans' contracts. These indicators shall include factors such as affirmative member choice, increased independence, avoidance of institutional care, and positive health outcomes. The department shall develop these quality assurance indicators in consultation with stakeholder groups.

(C) Effective January 10, 2014, and for each subsequent year of the demonstration project authorized under Section 14132.275, provide a report to the Legislature describing the degree to which Medi-Cal managed care health plans in counties participating in the demonstration project have fulfilled the quality requirements, as set forth in the health plan contracts.

(D) Effective June 1, 2014, and for each subsequent year of the demonstration project authorized by Section 14132.275, provide a report from the department to the Legislature summarizing information from both of the following:

(i) The independent audit report required to be submitted annually to the department by managed care health plans participating in the demonstration project authorized by Section 14132.275.

(ii) Any routine financial examinations of managed care health plans operating in the demonstration project authorized by Section 14132.275 that have been conducted and completed for the previous calendar year by the department.

(2) Monitor on a quarterly basis the utilization of covered services of beneficiaries enrolled in the demonstration project pursuant to Section 14132.275 or receiving long-term services and supports pursuant to Article 5.7 (commencing with Section 14186).

(3) Develop requirements for managed care health plans to solicit stakeholder and member participation in advisory groups for the planning and development activities relating to the provision of services for dual eligible beneficiaries.

(4) Submit to the Legislature the following information:

(A) Provide, to the fiscal and appropriate policy committees of the Legislature, a copy of any report submitted to CMS pursuant to the approved federal waiver described in Section 14180.

(B) The department, together with the State Department of Social Services, the California Department of Aging, and the Department of Managed Health Care, convene and consult with stakeholders at least twice during the period following production of a draft of the implementation plan and before submission of the plan to the Legislature. Continued consultation with stakeholders shall occur on an ongoing basis for the implementation of the provisions of this section.

(C) No later than 90 days before the initial plan enrollment date of the demonstration project pursuant to the provisions of Sections 14132.275, 14182.16, and of Article 5.7 (commencing with Section 14186), assess and report to the fiscal and appropriate policy committees of the Legislature on the readiness of the managed care health plans to address the unique needs of dual eligible beneficiaries and Medi-Cal only seniors and persons with disabilities pursuant to the applicable readiness evaluation criteria and requirements set forth in paragraphs (1) to (8), inclusive, of subdivision (b) of Section 14087.48. The report shall also include an assessment of the readiness of the managed care health plans in each county participating in the demonstration project to have met the requirements set forth in paragraphs (1) to (9), inclusive.

(D) The department shall submit two reports to the Legislature, with the first report submitted five months before the commencement date of enrollment and the second report submitted three months before the commencement date of

enrollment, that describe the status of all of the following readiness criteria and activities that the department shall complete:

(i) Enter into contracts, either directly or by funding other agencies or community-based, nonprofit, consumer, or health insurance assistance organizations with expertise and experience in providing health plan counseling or other direct health consumer assistance to dual eligible beneficiaries, in order to assist these beneficiaries in understanding their options to participate in the demonstration project specified in Section 14132.275 and to exercise their rights and address barriers regarding access to benefits and services.

(ii) Develop a plan to ensure timely and appropriate communications with beneficiaries as follows:

(I) Develop a plan to inform beneficiaries of their enrollment options and rights, including specific steps to work with consumer and beneficiary community groups described in clause (i), consistent with the provisions of paragraph (1).

(II) Design, in consultation with consumers, beneficiaries, and stakeholders, all enrollment-related notices, including, but not limited to, summary of benefits, evidence of coverage, prescription formulary, and provider directory notices, as well as all appeals and grievance-related procedures and notices produced in coordination with existing federal Centers for Medicare and Medicaid Services (CMS) guidelines.

(III) Design a comprehensive plan for beneficiary and provider outreach, including specific materials for persons in nursing and group homes, family members, conservators, and authorized representatives of beneficiaries, as appropriate, and providers of services and supports.

(IV) Develop a description of the benefits package available to beneficiaries in order to assist them in plan selection and how they may select and access services in the demonstration project's assessment and care planning process.

(V) Design uniform and plain language materials and a process to inform seniors and persons with disabilities of copays and covered services so that beneficiaries can make informed choices.

(VI) Develop a description of the process, except in those demonstration counties that have a county operated health system, of automatically assigning beneficiaries into managed care health plans that shall include a requirement to consider Medicare service utilization, provider data, and consideration of plan quality.

(iii) Finalize rates and comprehensive contracts between the department and participating health plans to facilitate effective outreach, enroll network providers, and establish benefit packages. To the extent permitted by CMS, the plan rates and contract structure shall be provided to the appropriate fiscal and policy committees of the Legislature and posted on the department's internet website so that they are readily available to the public.

(iv) Ensure that contracts have been entered into between plans and providers including, but not limited to, agreements with county agencies as necessary.

(v) Develop network adequacy standards for medical care and long-term supports and services that reflect the provisions of paragraph (5).

(vi) Identify dedicated department or contractor staff with adequate training and availability during business hours to address and resolve issues between health plans and beneficiaries, and establish a requirement that health plans have similar points of contact and are required to respond to state inquiries when continuity of care issues arise.

(vii) Develop a tracking mechanism for inquiries and complaints for quality assessment purposes, and post publicly on the department's internet website information on the types of issues that arise and data on the resolution of complaints.

(viii) Prepare scripts and training for the department and plan customer service representatives on all aspects of the program, including training for enrollment brokers and community-based organizations on rules of enrollment and counseling of beneficiaries.

(ix) Develop continuity of care procedures.

(x) Adopt quality measures to be used to evaluate the demonstration projects. Quality measures shall be detailed enough to enable measurement of the impact of automatic plan assignment on quality of care.

(xi) Develop reporting requirements for the plans to report to the department, including data on enrollments and disenrollments, appeals and grievances, and information necessary to evaluate quality measures and care coordination models. The department shall report this information to the appropriate fiscal and policy committees of the Legislature, and this information shall be posted on the department's internet website.

(f) This section shall be implemented only to the extent that all federal approvals and waivers are obtained and only if and to the extent that federal financial participation is available.

(g) To implement this section, the department may contract with public or private entities. Contracts or amendments entered into under this section may be on an exclusive or nonexclusive basis and a noncompetitive bid basis and shall be exempt from the following:

(1) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part.

(2) Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code.

(3) Review or approval of contracts by the Department of General Services.

(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 and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. Before issuing any letter or similar instrument authorized pursuant to this section, the department shall notify and consult with stakeholders, including advocates, providers, and beneficiaries. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

(i) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(j) (1) Notwithstanding any other law, this section shall remain operative only through December 31, 2022.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 398. Section 14182.18 of the Welfare and Institutions Code is amended to read:

14182.18. (a) It is the intent of the Legislature that both the managed care plans participating in and providing long-term services and supports under Sections 14182.16 and 14186.2 and the state have protections against either significant overpayment or significant underpayments. Risk corridors are one method of risk sharing that may limit the financial risk of misaligning the payments associated with a contract to furnish long-term services and supports pursuant to a contract under the Coordinated Care Initiative on an at-risk basis.

(b) In Coordinated Care Initiative counties, as defined in paragraph (1) of subdivision (b) of Section 14182.16, for managed care health plans providing long-term services and supports, the department shall include in its contract with those plans risk corridors designed with the following parameters:

(1) Risk corridors shall apply only to the costs of the individuals and services identified below:

(A) Health care service costs for full-benefit dual eligible beneficiaries, as defined in paragraph (3) of subdivision (b) of Section 14182.16, for whom both of the following are true:

(i) The beneficiary is enrolled in the managed care health plan and the plan's contract covers all Medi-Cal long-term services and supports.

(ii) The beneficiary is not enrolled in the demonstration project.

(B) Long-term services and supports costs for partial-benefit dual eligible beneficiaries, as defined in paragraph (7) of subdivision (b) of Section 14182.16, and non-dual-eligible beneficiaries who are enrolled in the managed care health plan if the plan's contract covers all Medi-Cal long-term services and supports.

(2) Risk corridors applied to costs of beneficiary services identified in subparagraph (A) of paragraph (1) shall only be in place for a period of 24 months starting with the first month in which both mandatory enrollment of full-benefit dual eligible beneficiaries pursuant to Section 14182.16 and mandatory coverage of all Medi-Cal long-term services and supports pursuant to Section 14186.2 have occurred.

(3) Risk corridors applied to costs of beneficiary services identified in subparagraph (B) of paragraph (1) shall only be in place for a period of 24 months starting with the first month in which mandatory coverage of all Medi-Cal long-term services and supports pursuant to Section 14186.2 has occurred.

(4) The risk sharing of the costs of the individuals and services under this subdivision shall be constructed by the department so that it is symmetrical with respect to risk and profit, and so that all of the following apply:

(A) The managed care health plan is fully responsible for all costs in excess of the capitated rate of the plan up to 1 percent.

(B) The managed care health plan shall fully retain the revenues paid through the capitated rate in excess of the costs incurred up to 1 percent.

(C) The managed care health plan and the department shall share responsibility for costs in excess of the capitated rate of the plan that are greater than 1 percent above the rate but less than 2.5 percent above the rate.

(D) The managed care health plan and the department shall share the benefit of revenues in excess of the costs incurred that are greater than 1 percent below the capitated rate of the plan but less than 2.5 percent below the capitated rate of the plan.

(E) The department shall be fully responsible for all costs in excess of the capitated rate of the plan that are more than 2.5 percent above the capitated rate of the plan.

(F) The department shall fully retain the revenues paid through the capitated rate in excess of the costs incurred greater than 2.5 percent below the capitated rate of the plan.

(c) The department shall develop specific contractual language implementing the requirements of this section and corresponding details that shall be incorporated into the managed care health plan's contract.

(d) This section shall be implemented only to the extent that any necessary federal approvals or waivers are obtained.

(e) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(f) (1) Notwithstanding any other law, this section shall remain operative only through December 31, 2022.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 399. Section 14184.10 of the Welfare and Institutions Code is amended to read:

14184.10. For purposes of this article, the following definitions shall apply:

(a) "Demonstration project" means the California Medi-Cal 2020 Demonstration Project, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services, effective for the period from December 30, 2015, to December 31, 2020, inclusive, and any applicable extension period.

(b) "Demonstration term" means the entire period during which the demonstration project is in effect, as approved by the federal Centers for Medicare and Medicaid Services, including any applicable extension period.

(c) "Demonstration year" means the demonstration year as identified in the Special Terms and Conditions that corresponds to a specific period of time as set forth in paragraphs (1) to (6), inclusive. Individual programs under the demonstration project may be operated on program years that differ from the demonstration years identified in paragraphs (1) to (6), inclusive.

(1) Demonstration year 11 corresponds to the period of January 1, 2016, to June 30, 2016, inclusive.

(2) Demonstration year 12 corresponds to the period of July 1, 2016, to June 30, 2017, inclusive.

(3) Demonstration year 13 corresponds to the period of July 1, 2017, to June 30, 2018, inclusive.

(4) Demonstration year 14 corresponds to the period of July 1, 2018, to June 30, 2019, inclusive.

(5) Demonstration year 15 corresponds to the period of July 1, 2019, to June 30, 2020, inclusive.

(6) Demonstration year 16 corresponds to the period of July 1, 2020, to December 31, 2020, inclusive.

(d) "Dental Transformation Initiative" or "DTI" means the waiver program intended to improve oral health services for children, as authorized under the Special Terms and Conditions and described in Section 14184.70.

(e) "Designated state health program" has the same meaning as set forth in the Special Terms and Conditions.

(f) (1) "Designated public hospital" means any one of the following hospitals, and any successor, including any restructured, reorganized, or differently named hospital, which is operated by a county, a city and county, the University of California, or special hospital authority described in Chapter 5 (commencing with Section 101850) or Chapter 5.5 (commencing with Section 101852) of Part 4 of Division 101 of the Health and Safety Code, or any additional public hospital, to the extent identified as a "designated

public hospital" in the Special Terms and Conditions or, effective July 1, 2021, the CalAIM Terms and Conditions, as defined in Section 14184.101. Unless otherwise provided for in law, in the Medi-Cal State Plan, or in the Special Terms and Conditions, all references in law to a designated public hospital as defined in subdivision (d) of Section 14166.1 shall be deemed to refer to a hospital described in this section effective as of January 1, 2016, except as provided in paragraph (2):

(A) UC Davis Medical Center.

(B) UC Irvine Medical Center.

(C) UC San Diego Medical Center.

(D) UC San Francisco Medical Center.

(E) UCLA Medical Center.

(F) Santa Monica/UCLA Medical Center, also known as the Santa Monica-UCLA Medical Center and Orthopaedic Hospital.

(G) LA County Health System Hospitals:

(i) LA County Harbor/UCLA Medical Center.

(ii) LA County Olive View UCLA Medical Center.

(iii) LA County Rancho Los Amigos National Rehabilitation Center.

(iv) LA County University of Southern California Medical Center.

(H) Alameda Health System Hospitals, including the following:

(i) Highland Hospital, including the Fairmont and John George Psychiatric facilities.

(ii) Alameda Hospital.

(iii) San Leandro Hospital.

(I) Arrowhead Regional Medical Center.

(J) Contra Costa Regional Medical Center.

(K) Kern Medical Center.

(L) Natividad Medical Center.

(M) Riverside University Health System-Medical Center.

(N) San Francisco General Hospital.

(O) San Joaquin General Hospital.

(P) San Mateo Medical Center.

(Q) Santa Clara Valley Medical Center.

(R) Ventura County Medical Center.

(2) For purposes of the following reimbursement methodologies, the hospitals identified in clauses (ii) and (iii) of subparagraph (H) of paragraph (1) shall be deemed to be a designated public hospital as of the following effective dates:

(A) For purposes of the fee-for-service payment methodologies established and implemented under Section 14166.4, the effective date shall be the date described in paragraph (3) of subdivision (a) of Section 14184.30.

(B) For purposes of Article 5.230 (commencing with Section 14169.50), the effective date shall be January 1, 2017.

(g) "Disproportionate share hospital provisions of the Medi-Cal State Plan" means those applicable provisions contained in Attachment 4.19-A of the California Medicaid state plan, approved by the federal Centers for Medicare and Medicaid Services, that implement the payment adjustment program for disproportionate share hospitals.

(h) "Federal disproportionate share hospital allotment" means the amount specified for California under Section 1396r-4(f) of Title 42 of the United States Code for a federal fiscal year.

(i) “Federal medical assistance percentage” means the federal medical assistance percentage applicable for federal financial participation purposes for medical services under the Medi-Cal State Plan pursuant to Section 1396b(a)(1) of Title 42 of the United States Code.

(j) “Global Payment Program” or “GPP” means the payment program authorized under the demonstration project and described in Section 14184.40 that assists participating public health care systems that provide health care for the uninsured and that promotes the delivery of more cost-effective, higher-value health care services and activities.

(k) “Nondesignated public hospital” means a public hospital as that term is defined in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(l) “Nonfederal share percentage” means the difference between 100 percent and the federal medical assistance percentage.

(m) “PRIME” means the Public Hospital Redesign and Incentives in Medi-Cal program authorized under the demonstration project and described in Section 14184.50.

(n) “Total computable disproportionate share hospital allotment” means the federal disproportionate share hospital allotment for a federal fiscal year, divided by the applicable federal medical assistance percentage with respect to that same federal fiscal year.

(o) “Special Terms and Conditions” means those terms and conditions issued by the federal Centers for Medicare and Medicaid Services, including all attachments to those terms and conditions and any subsequent amendments approved by the federal Centers for Medicare and Medicaid Services, that apply to the demonstration project.

(p) “Uninsured” means an individual for whom there is no source of third-party coverage for the health care services the individual receives, as determined pursuant to the Special Terms and Conditions.

(q) “Whole Person Care pilot program” means a local collaboration among local governmental agencies, Medi-Cal managed care plans, health care and behavioral health providers, or other community organizations, as applicable, that are approved by the department to implement strategies to serve one or more identified target populations, pursuant to Section 14184.60 and the Special Terms and Conditions.

SEC. 400. Section 14184.30 of the Welfare and Institutions Code is amended to read:

14184.30. The following payment methodologies and requirements implemented pursuant to Article 5.2 (commencing with Section 14166) shall be applicable as set forth in this section.

(a) (1) (A) For purposes of Section 14166.4, the references to “project year” and “successor demonstration year” shall include references to the demonstration term, as defined under this article, and to any extensions of the prior federal Medicaid demonstration project entitled “California Bridge to Reform Demonstration (Waiver No. 11-W-00193/9).”

(B) For purposes of Section 14166.4, the references to “project year” and “successor demonstration year” shall include references to the CalAIM term, as defined in subdivision (b) of Section 14184.101, and to any extensions of the demonstration project pursuant to this article.

(2) The fee-for-service payment methodologies established and implemented under Section 14166.4 shall continue to apply with respect to designated public hospitals approved under the Medi-Cal State Plan.

(3) For the hospitals identified in clauses (ii) and (iii) of subparagraph (H) of paragraph (1) of subdivision (f) of Section 14184.10, the department shall seek any necessary federal approvals to apply the fee-for-service payment methodologies established and implemented under Section 14166.4 to these identified hospitals effective no earlier than the 2016–17 state fiscal year. This paragraph shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and not otherwise jeopardized. Before the effective date of any necessary federal approval obtained pursuant to this paragraph, these identified hospitals shall continue to be considered nondesignated public hospitals for purposes of the fee-for-service methodology authorized pursuant to Section 14105.28 and the applicable provisions of the Medi-Cal State Plan.

(4) The department shall continue to make reimbursement available to qualifying hospitals that meet the eligibility requirements for participation in the supplemental reimbursement program for hospital facility construction, renovation, or replacement pursuant to Section 14085.5 and the applicable provisions of the Medi-Cal State Plan. The department shall continue to make inpatient hospital payments for services that were historically excluded from a hospital’s contract under the Selective Provider Contracting Program established under Article 2.6 (commencing with Section 14081) in accordance with the applicable provisions of the Medi-Cal State Plan. These payments shall not duplicate or supplant any other payments made under this article.

(b) During the 2015–16 state fiscal year, and subsequent state fiscal years that commence during the demonstration term or the CalAIM term, payment adjustments to disproportionate share hospitals shall not be made pursuant to Section 14105.98, except as otherwise provided in this article or Article 5.51 (commencing with Section 14184.100). Payment adjustments to disproportionate share hospitals shall be made solely in accordance with this article or Article 5.51 (commencing with Section 14184.100).

(1) Except as otherwise provided in this article or Article 5.51(commencing with Section 14184.100), the department shall continue to make all eligibility determinations and perform all payment adjustment amount computations under the disproportionate share hospital payment adjustment program pursuant to Section 14105.98 and pursuant to the disproportionate share hospital provisions of the Medi-Cal State Plan. For purposes of these determinations and computations, which include those made pursuant to Sections 14166.11 and 14166.16, all of the following shall apply:

(A) The federal Medicaid DSH reductions pursuant to Section 1396r-4(f)(7) of Title 42 of the United States Code shall be reflected as appropriate, including, but not limited to, the calculations set forth in subparagraph (B) of paragraph (2) of subdivision (am) of Section 14105.98.

(B) Services that were rendered under the Low Income Health Program authorized pursuant to Part 3.6 (commencing with Section 15909) shall be included.

(2) (A) Notwithstanding Section 14105.98, the federal disproportionate share hospital allotment specified for California under Section 1396r-4(f) of Title 42 of the United States Code for each of federal fiscal years 2016 to 2021, inclusive, shall be aligned with the state fiscal year in which the applicable federal fiscal year commences, and shall be distributed solely for the following purposes:

(i) As disproportionate share hospital payments under the methodology set forth in applicable disproportionate share hospital provisions of the Medi-Cal State Plan, which, to the extent permitted under federal law and the Special Terms and Conditions, or the CalAIM Terms and Conditions, shall be limited to the following hospitals:

(I) Eligible hospitals, as determined pursuant to Section 14105.98 for each state fiscal year in which the particular federal fiscal year commences, that meet the definition of a public hospital, as specified in paragraph (25) of subdivision (a) of Section 14105.98, and that are not participating as GPP systems under the Global Payment Program.

(II) Hospitals that are licensed to the University of California, which meet the requirements set forth in Section 1396r-4(d) of Title 42 of the United States Code.

(ii) As a funding component for payments under the Global Payment Program, as described in subparagraph (A) of paragraph (1) of subdivision (c) of Section 14184.40, or paragraph (1) of subdivision (c) of Section 14184.300, and the Special Terms and Conditions or the CalAIM Terms and Conditions.

(B) The distribution of the federal disproportionate share hospital allotment to hospitals described in this paragraph shall satisfy the state's payment obligations, if any, with respect to those hospitals under Section 1396r-4 of Title 42 of the United States Code.

(3) (A) During the 2015–16 state fiscal year and subsequent state fiscal years that commence during the demonstration term or the CalAIM term, a public entity shall not be obligated to make any intergovernmental transfer pursuant to Section 14163, and all transfer amount determinations for those state fiscal years shall be suspended. However, intergovernmental transfers shall be made with respect to the disproportionate share hospital payment adjustments made in accordance with clause (ii) of subparagraph (B) of paragraph (6), as applicable.

(B) During the 2015–16 state fiscal year and subsequent state fiscal years that commence during the demonstration term or the CalAIM term, transfer amounts from the Medi-Cal Inpatient Payment Adjustment Fund to the Health Care Deposit Fund, as described in paragraph (2) of subdivision (d) of Section 14163, are hereby reduced to zero. Unless otherwise specified in this article or the applicable provisions of Article 5.2 (commencing with Section 14166), this subparagraph shall be disregarded for purposes of the calculations made under Section 14105.98 during the 2015–16 state fiscal year and subsequent state fiscal years that commence during the demonstration term or the CalAIM term.

(4) (A) During the state fiscal years for which the Global Payment Program under Section 14184.40, or Section 14184.300, is in effect, designated public hospitals that are participating GPP systems shall not be eligible to receive disproportionate share hospital payments pursuant to otherwise applicable disproportionate share hospital provisions of the Medi-Cal State Plan.

(B) Eligible hospitals described in clause (i) of subparagraph (A) of paragraph (2) that are nondesignated public hospitals shall continue to receive disproportionate share hospital payment adjustments as set forth in Section 14166.16.

(C) Hospitals described in clause (i) of subparagraph (A) of paragraph (2) that are licensed to the University of California, except as provided in paragraph (4) of subdivision (b) of Section 14184.300, shall receive disproportionate share hospital payments as follows:

(i) Subject to clause (iii), each hospital licensed to the University of California may draw and receive federal Medicaid funding from the applicable federal disproportionate share hospital allotment on the amount of certified public expenditures for the hospital's expenditures that are eligible for federal financial participation as reported in accordance with Section 14166.8 and the applicable disproportionate share hospital provisions of the Medi-Cal State Plan.

(ii) Subject to clause (iii) and to the extent the hospital meets the requirement in Section 1396r-4(b)(1)(A) of Title 42 of the United States Code regarding the Medicaid inpatient utilization rate or Section 1396r-4(b)(1)(B) of Title 42 of the United States Code regarding the low-income utilization rate, each hospital shall receive intergovernmental transfer-funded direct disproportionate share hospital payments as provided for under the applicable disproportionate share hospital provisions of the Medi-Cal State Plan. The total amount of these payments to the hospital, consisting of the federal and nonfederal components, shall in no case exceed that amount equal to 75 percent of the hospital's uncompensated Medi-Cal and uninsured costs of hospital services as reported in accordance with Section 14166.8.

(iii) Unless the provisions of subparagraph (D) apply, the aggregate amount of the federal disproportionate share hospital allotment with respect to payments for an applicable state fiscal year to hospitals licensed to the University of California shall be limited to an amount calculated as follows:

(I) The maximum amount of federal disproportionate share hospital allotment for the state fiscal year, less the amounts of federal disproportionate share hospital allotment associated with payments to nondesignated public hospitals under subparagraph (B) and other payments, if any, required to be made from the federal disproportionate share hospital allotment, shall be determined.

(II) For the 2015–16 state fiscal year, the amount determined in subclause (I) shall be multiplied by 26.296 percent, resulting in the maximum amount of the federal disproportionate share hospital allotment available as disproportionate share hospital payments for the state fiscal year to hospitals that are licensed to the University of California.

(III) For the 2016–17 state fiscal year, the amount determined in subclause (I) shall be multiplied by 24.053 percent, resulting in the maximum amount of the federal disproportionate share hospital allotment available as disproportionate share hospital payments for the state fiscal year to hospitals that are licensed to the University of California.

(IV) For the 2017–18 state fiscal year, the amount determined in subclause (I) shall be multiplied by 23.150 percent, resulting in the maximum amount of the federal disproportionate share hospital allotment available as disproportionate share hospital payments for the state fiscal year to hospitals that are licensed to the University of California.

(V) For each of the 2018–19 and 2019–20 state fiscal years, the amount determined in subclause (I) shall be multiplied by 21.896 percent, resulting in the maximum amount of the federal disproportionate share hospital allotment available as disproportionate share hospital payments for the state fiscal year to hospitals that are licensed to the University of California.

(VI) For the 2020–21 state fiscal year, and subsequent state fiscal years or portions thereof during the CalAIM Term, the amount determined in subclause (I) shall be multiplied by a percentage as determined by the department, in consultation with designated public hospitals and consistent with the applicable federal terms and conditions, that will be used to determine the maximum amount of the federal disproportionate share hospital allotment available as disproportionate share hospital payments for the state fiscal year to hospitals that are licensed to the University of California. The percentage shall be communicated in writing to all of the designated public hospitals.

(VII) To the extent the limitations set forth in this clause result in payment reductions for the applicable year, those reductions shall be applied pro rata, subject to clause (vii).

(iv) Each hospital licensed to the University of California shall receive quarterly interim payments of its disproportionate share hospital allocation during the applicable state fiscal year. The determinations set forth in clauses (i) to (iii), inclusive, shall be made on an interim basis before the start of each state fiscal year, except that the determinations for the 2015–16 state fiscal year shall be made as soon as practicable. The department shall use the same cost and statistical data used in determining the interim payments for Medi-Cal inpatient hospital services under Section 14166.4, and available payments and uncompensated and uninsured cost data, including data from the Medi-Cal paid claims file

and the hospital's books and records, for the corresponding period, to the extent permitted under the Medi-Cal State Plan.

(v) No later than April 1 following the end of the relevant reporting period for the applicable state fiscal year, the department shall undertake an interim reconciliation of payments based on Medi-Cal, Medicare, and other cost, payment, discharge, and statistical data submitted by the hospital for the applicable state fiscal year, and shall adjust payments to the hospital accordingly.

(vi) Except as otherwise provided in this article or Article 5.51 (commencing with Section 14184.100), each hospital licensed to the University of California shall receive disproportionate share hospital payments subject to final audits of all applicable Medi-Cal, Medicare, and other cost, payment, discharge, and statistical data submitted by the hospital for the applicable state fiscal year.

(vii) Before the interim and final distributions of payments pursuant to clauses (iv) to (vi), inclusive, the department shall consult with the University of California, and implement any adjustments to the payment distributions for the hospitals as requested by the University of California, so long as the aggregate net effect of the requested adjustments for the affected hospitals is zero.

(D) With respect to any state fiscal year commencing during the demonstration term or the CalAIM term for which the Global Payment Program pursuant to Section 14184.40 or 14184.300 is not in effect, designated public hospitals that are eligible hospitals as determined pursuant to Section 14105.98, and hospitals described in clause (i) of subparagraph (A) of paragraph (2) that are licensed to the University of California, shall claim disproportionate share hospital payments in accordance with the applicable disproportionate share hospital provisions of the Medi-Cal State Plan. The allocation of federal Medicaid funding from the applicable federal disproportionate share hospital allotment shall be made in accordance with the methodology set forth in Section 14166.61.

(5) For each applicable state fiscal year during the demonstration term or the CalAIM term, eligible hospitals, as determined pursuant to Section 14105.98, which are nonpublic hospitals, nonpublic-converted hospitals, and converted hospitals, as those terms are defined in paragraphs (26), (27), and (28), respectively, of subdivision (a) of Section 14105.98, shall continue to receive Medi-Cal disproportionate share hospital replacement payment adjustments pursuant to Section 14166.11 and other provisions of this article or Article 5.51 (commencing with Section 14184.100) and applicable provisions of the Medi-Cal State Plan. The payment adjustments so provided shall satisfy the state's payment obligations, if any, with respect to those hospitals under Section 1396r-4 of Title 42 of the United States Code. The provisions of subdivision (j) of Section 14166.11 shall continue to apply with respect to the 2015–16 state fiscal year and subsequent state fiscal years commencing during the demonstration term or the CalAIM term. Except as may otherwise be required by federal law, the federal share of these payments shall not be claimed from the federal disproportionate share hospital allotment.

(6) The nonfederal share of disproportionate share hospital payments and disproportionate share hospital replacement payment adjustments described in paragraphs (4) and (5) shall be derived from the following sources:

(A) With respect to the payments described in subparagraph (B) of paragraph (4) that are made to nondesignated public hospitals, the nonfederal share shall consist solely of state General Fund appropriations.

(B) With respect to the payments described in subparagraph (C) or (D), as applicable, of paragraph (4) that are made to designated public hospitals, the nonfederal share shall consist of both of the following:

(i) Certified public expenditures incurred by the hospitals for hospital expenditures eligible for federal financial participation as reported in accordance with Section 14166.8.

(ii) Intergovernmental transfer amounts for direct disproportionate share hospital payments provided for under subparagraph (C) or (D) of paragraph (4) and the applicable disproportionate share hospital provisions of the Medi-Cal State Plan. A transfer amount shall be determined for each hospital that is eligible for these payments, equal to the nonfederal share of the payment amount established for the hospital. The transfer amount determined shall be paid by the hospital, or the public entity with which the hospital is affiliated, and deposited into the Medi-Cal Inpatient Payment Adjustment Fund established pursuant to subdivision (b) of Section 14163, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws.

(C) With respect to the payments described in paragraph (5), the nonfederal share shall consist of state General Fund appropriations.

(7) The Demonstration Disproportionate Share Hospital Fund established in the State Treasury pursuant to subdivision (d) of Section 14166.9 shall be retained during the demonstration term and the CalAIM term. All federal funds received by the department with respect to the certified public expenditures claimed pursuant to subparagraph (C), and, as applicable in

subparagraph (D), of paragraph (4) shall be transferred to the fund and disbursed to the eligible designated public hospitals pursuant to those applicable provisions. Notwithstanding Section 13340 of the Government Code, moneys deposited in the fund shall be continuously appropriated, without regard to fiscal year, to the department solely for the purposes specified in this article and Article 5.51 (commencing with Section 14184.100).

(c) (1) Disproportionate share hospital payment allocations under Sections 14166.3 and 14166.61, and safety net care pool payment allocations under Section 14166.71, that were paid to designated public hospitals with respect to the period July 1, 2015, through October 31, 2015, or for subsequent periods pursuant to Section 14166.253, shall be reconciled to amounts payable to the hospitals under this article as set forth in this subdivision.

(2) The disproportionate share hospital payments and safety net care pool payments described in paragraph (1) that were paid to a designated public hospital participating in a GPP system under Section 14184.40 shall be deemed to be interim payments under the Global Payment Program for GPP program year 2015–16, and will be reconciled to and offset against the interim payment amount due to the GPP system under subparagraph (B) of paragraph (4) of subdivision (d) of Section 14184.40, consistent with the Special Terms and Conditions.

(3) The disproportionate share hospital payments described in paragraph (1) that were paid to designated public hospitals licensed to the University of California shall be reconciled to and offset against the disproportionate share hospital payments payable to the hospitals under subparagraph (C) of paragraph (4) of subdivision (b) for the 2015–16 state fiscal year.

(4) The safety net care pool payments described in paragraph (1) that were paid to designated public hospitals licensed to the University of California shall be recouped and included as available funding under the Global Payment Program for the 2015–16 GPP program year described in subparagraph (B) of paragraph (1) of subdivision (c) of Section 14184.40.

(d) During the 2015–16 state fiscal year, and subsequent state fiscal years that commence during the demonstration term or the CalAIM term, costs shall continue to be determined and reported for designated public hospitals in accordance with Sections 14166.8 and 14166.24, except as follows:

(1) (A) The provisions of subdivision (c) of Section 14166.8 shall not apply.

(B) Notwithstanding subparagraph (A), the department may require the reporting of any data the department deems necessary to satisfy reporting requirements pursuant to the Special Terms and Conditions or the CalAIM Terms and Conditions.

(2) The provisions of Sections 14166.221 and 15916 shall not apply with respect to any costs reported for the demonstration term or the CalAIM term pursuant to Section 14166.8.

(e) (1) Notwithstanding subdivision (h) of Section 14166.61 and subdivision (c) of Section 14166.71, the disproportionate share hospital allocation and safety net care pool payment determinations and payments for the 2013–14 and 2014–15 state fiscal years shall be deemed final as of the April 30 that is 22 months following the close of the respective state fiscal year, to the extent permitted under federal law and subject to recoupment pursuant to subdivision (f) if it is later determined that federal financial participation is unavailable for any portion of the applicable payments.

(2) The determinations and payments shall be finalized using the best available data, including unaudited data, and reasonable current estimates and projections submitted by the designated public hospitals. The department shall accept all appropriate revisions to the data, estimates, and projections previously submitted, including revised cost reports, for purposes of this subdivision, to the extent these revisions are submitted in a timely manner as determined by the department.

(f) Upon receipt of a notice of disallowance or deferral from the federal government related to the certified public expenditures or intergovernmental transfers of a designated public hospital or governmental entity with which it is affiliated for disproportionate share hospital payments or safety net care pool payments claimed and distributed pursuant to Section 14166.61, 14166.71, or 15916 for the 2013–14 or 2014–15 state fiscal year, the department shall promptly notify the designated public hospitals and proceed as follows:

(1) To the extent there are additional certified public expenditures for the applicable state fiscal year for which federal funds have not been received, but for which federal funds could have been received had additional federal funds been available, including any subsequently allowable expenditures for designated state health programs, the department shall first respond to the deferral or disallowance by substituting the additional certified public expenditures or allowable expenditures for those deferred or disallowed, consistent with the claiming optimization priorities set forth in Section 14166.9, in consultation with the designated public hospitals, but only to the extent that any necessary federal approvals are obtained or these actions are otherwise permitted by federal law.

(2) The department shall consult with the designated public hospitals and proceed in accordance with paragraphs (2) and (3) of subdivision (d) of Section 14166.24.

(3) If the department elects to appeal pursuant to paragraph (3) of subdivision (d) of Section 14166.24, the department shall not implement any recoupment of payments from the affected designated public hospitals, until a final disposition has been made regarding the deferral or disallowance, including the conclusion of applicable administrative and judicial review, if any.

(4) (A) Upon final disposition of the federal deferral or disallowance, the department shall determine the resulting aggregate repayment amount of federal funds for each affected state fiscal year.

(B) The department shall determine the ratio of the aggregate repayment amount to the total amount of the federal share of payments finalized and distributed pursuant to Sections 14166.61 and 14166.71 and subdivision (e) for each affected state fiscal year, expressed as a percentage.

(5) Notwithstanding paragraph (1) of subdivision (d) of Section 14166.24, the responsibility for repayment of the federal portion of any deferral of disallowance for each affected year shall be determined as follows:

(A) The provisions of subdivision (g) of Section 15916 shall be applied to determine the department's repayment responsibility amount with respect to any deferral or disallowance related to safety net care pool payments, which shall be in addition to amounts determined under subparagraph (E).

(B) Using the most recent data for the applicable fiscal year, and reflecting modifications to the applicable initial DSH claiming ability and initial SNCP claiming ability for individual hospitals resulting from the deferral or disallowance, the department shall perform the calculations and determinations for each designated public hospital as set forth in Sections 14166.61 and 14166.71. For this purpose, the calculations and determinations shall assume no reduction in the available federal disproportionate share hospital allotment or in the amount of available safety net care pool payments as a result of the deferral or disallowance.

(C) For each designated public hospital, the revised determinations of disproportionate share hospital and safety net care pool payment amounts under subparagraph (B) shall be combined and compared to the combined disproportionate share hospital and safety net care pool payment amounts determined and received by the hospital pursuant to subdivision (e). For this purpose and purposes of subparagraph (D), the applicable data for designated public hospitals described in subparagraph (G) of paragraph (1) of subdivision (f) of Section 14184.10 shall be combined, and the applicable data for designated public hospitals described in subparagraphs (E) and (F) of paragraph (1) of subdivision (f) of Section 14184.10 shall be combined.

(D) (i) Subject to subparagraph (E), the repayment of the federal portion of the deferral of disallowance, less the department's responsibility amount for safety net care pool payments, if any, determined in subparagraph (A), shall be first allocated among each of those designated public hospitals for which the combined revised disproportionate share hospital and safety net care pool payments as determined in subparagraph (B) are less than the combined disproportionate share hospital and safety net care pool payment amounts determined and received pursuant to subdivision (e). Repayment shall be allocated under this initial stage among these hospitals pro rata on the basis of each hospital's relative reduction as reflected in the revised calculations performed under subparagraph (B), but in no case shall the allocation to a hospital exceed the limit in clause (iii). Repayment amounts that are not allocated due to this limitation shall be allocated pursuant to clause (ii).

(ii) Subject to subparagraph (E), any repayment amounts that were unallocated to hospitals due to the limitation in clause (iii) shall be allocated in a second stage among each of the remaining designated public hospitals that has not reached its applicable repayment limit, including the hospitals that were not subject to the allocations under clause (i), based pro rata on the amounts determined and received by the hospital pursuant to subdivision (e), except that no repayment amount for a hospital shall exceed the limitation under clause (iii). The pro rata allocation process will be repeated in subsequent stages with respect to any repayment amounts that cannot be allocated in a prior stage to hospitals due to the limitation under clause (iii), until the entire federal repayment amount has been allocated among the hospitals.

(iii) The repayment amount allocated to a designated public hospital pursuant to this subparagraph shall not exceed an amount equal to the percentage of the combined payments determined and received by the hospital pursuant to subdivision (e) that is twice the percentage computed in subparagraph (B) of paragraph (4).

(E) Notwithstanding any other law, if the affiliated governmental entity for the designated public hospital is a county subject to the provisions of Article 12 (commencing with Section 17612.1) of Chapter 6 of Part 5, the department, in consultation with the affected designated public hospital, and the Department of Finance, shall determine how to account for whether any repayment amount determined for the designated public hospital pursuant to subparagraph (D) for the 2013–14 and

2014–15 state fiscal years would otherwise have affected, if at all, the applicable county's redirection obligation for the applicable state fiscal year pursuant to paragraphs (4) and (5) of subdivision (a) of Section 17612.3 and shall determine what adjustments, if any, are necessary to either the repayment amount or the applicable county's redirection obligation. For purposes of this subparagraph, the provisions of subdivision (f) of Section 17612.2 and paragraph (7) of subdivision (e) of Section 101853 of the Health and Safety Code shall apply.

(g) The provisions of Article 5.2 (commencing with Section 14166) shall remain in effect until all payments authorized pursuant to that article have been paid, finalized, and settled, and to the extent its provisions are retained for purposes of this article or Article 5.51 (commencing with Section 14184.100).

(h) For purposes of this article, commencing January 1, 2021, and thereafter, any references to "Designated Public Hospital," "CalAIM term," or "CalAIM Terms and Conditions" have the same meanings as set forth in Section 14184.101.

SEC. 401. Section 14184.40 of the Welfare and Institutions Code is amended to read:

14184.40. (a) (1) The department shall implement the Global Payment Program authorized under the demonstration project to support participating public health care systems that provide health care services for the uninsured. Under the Global Payment Program, GPP systems receive global payments based on the health care they provide to the uninsured, in lieu of traditional disproportionate share hospital payments and safety net care pool payments previously made available pursuant to Article 5.2 (commencing with Section 14166).

(2) The Global Payment Program is intended to streamline funding sources for care for California's remaining uninsured population, creating a value-based mechanism to increase incentives to provide primary and preventive care services and other high-value services. The Global Payment Program supports GPP systems for their key role providing and promoting effective, higher value services to California's remaining uninsured. Promoting more cost-effective and higher value care means that the payment structure rewards the provision of care in more appropriate venues for patients, and will support structural changes to the care delivery system that will improve the options for treating both Medi-Cal and uninsured patients.

(3) Under the Global Payment Program, GPP systems will receive Global Payment Program payments calculated using an innovative value-based point methodology that incorporates measures of value for the patient in conjunction with the recognition of costs. To receive the full amount of Global Payment Program payments, a GPP system shall provide a threshold level of services, as measured in the point methodology described in paragraph (2) of subdivision (c), and based on the GPP system's historical volume, cost, and mix of services. This payment methodology is intended to support GPP systems that continue to provide services to the uninsured, while incentivizing the GPP systems to shift the overall delivery of services for the uninsured to provide more cost-effective, higher value care.

(4) The department shall implement and oversee the operation of the Global Payment Program in accordance with the Special Terms and Conditions and the requirements of this section, to maximize the amount of federal financial participation available to participating GPP systems.

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

(1) "GPP system" means a public health care system that consists of a designated public hospital, as defined in subdivision (f) of Section 14184.10 but excluding the hospitals operated by the University of California, except as provided in paragraph (4) of subdivision (b) of Section 14184.300, and its affiliated and contracted providers. Multiple designated public hospitals operated by a single legal entity may belong to the same GPP system, to the extent set forth in the Special Terms and Conditions.

(2) "GPP program year" means a state fiscal year beginning on July 1 and ending on June 30 during which the Global Payment Program is authorized under the demonstration project, beginning with state fiscal year 2015–16, and, as applicable, each state fiscal year thereafter through 2019–20, and any years or partial years during which the Global Payment Program is authorized under an extension or successor to the demonstration project.

(c) (1) For each GPP program year, the department shall determine the Global Payment Program's aggregate annual limit, which is the maximum amount of funding available under the demonstration project for the Global Payment Program and which is the sum of the components described in subparagraphs (A) and (B). To the extent feasible, the aggregate annual limit shall be determined and made available by the department before the implementation of a GPP program year, and shall be updated and adjusted as necessary to reflect changes or adjustments to the amount of funding available for the Global Payment Program.

(A) A portion of the federal disproportionate share allotment specified for California under Section 1396r-4(f) of Title 42 of the United States Code shall be included as a component of the aggregate annual limit for each GPP program year. The amount of this portion shall equal the state's total computable disproportionate share allotment reduced by the maximum amount of funding projected for payments pursuant to subparagraphs (B) and (C) of paragraph (4) of subdivision (b) of Section 14184.30 to disproportionate share hospitals that are not participating in the Global Payment Program. For

purposes of this determination, the federal disproportionate share allotment shall be aligned with the GPP program year in which the applicable federal fiscal year commences.

(B) The aggregate annual limit shall also include the amount authorized under the demonstration project for the uncompensated care component of the Global Payment Program for the applicable GPP program year, as determined pursuant to the Special Terms and Conditions.

(2) The department shall develop a methodology for valuing health care services and activities provided to the uninsured that achieves the goals of the Global Payment Program, including those values set forth in subdivision (a) and as expressed in the Special Terms and Conditions. The points assigned to a particular service or activity shall be the same across all GPP systems. Points for specific services or activities may be increased or decreased over time as the Global Payment Program progresses, to incentivize appropriate changes in the mix of services provided to the uninsured. To the extent necessary, the department shall obtain federal approval for the methodology and any applicable changes to the methodology.

(3) For each GPP system, the department shall perform a baseline analysis of the GPP system's historical volume, cost, and mix of services to the uninsured to establish an annual threshold for purposes of the Global Payment Program. The annual threshold shall be measured in points established through the methodology developed pursuant to paragraph (2) and as set forth in the Special Terms and Conditions.

(4) The department shall determine a pro rata allocation percentage for each GPP system by dividing the GPP system's annual threshold determined in paragraph (3) by the sum of all GPP systems' thresholds.

(5) For each GPP system, the department shall determine an annual budget the GPP system will receive if it achieves its threshold. A GPP system's annual budget shall equal the allocation percentage determined in paragraph (4) for the GPP system, multiplied by the Global Payment Program's aggregate annual limit determined in paragraph (1).

(6) If there is a change in the aggregate annual limit, the department shall adjust and recalculate each GPP system's annual threshold or the annual budget in proportion to changes in the aggregate annual limit calculated in paragraph (1) in accordance with the Special Terms and Conditions.

(d) The amount of Global Payment Program funding payable to a GPP system for a GPP program year shall be calculated as follows, subject to the Special Terms and Conditions:

(1) The full amount of a GPP system's annual budget shall be payable to the GPP system if the services it provided to the uninsured during the GPP program year, as measured and scored using the point methodology described under paragraph (2) of subdivision (c), meets or exceeds its threshold for a given year. For GPP systems that do not achieve their threshold, the amount payable to the GPP system shall equal its annual budget reduced by the proportion by which it fell short of its threshold.

(2) The department shall develop a methodology to redistribute unearned Global Payment Program funds for a given GPP program year to those GPP systems that exceeded their respective threshold for that same year. To the extent sufficient funds are available for all qualifying GPP systems, the GPP system's redistributed amount shall equal the GPP system's annual budget multiplied by the percentage by which the GPP system exceeded its threshold, and any remaining amounts of unearned funds will remain undistributed. If sufficient funds are unavailable to make all these payments to qualifying GPP systems, the amounts of these additional payments will be reduced for all qualifying GPP systems by the same proportion, so that the full amount of unearned Global Payment Program funds are redistributed. Redistributed payment amounts calculated pursuant to this paragraph shall be added to the amounts payable to a GPP system calculated pursuant to paragraph (1).

(3) The department shall specify a reporting schedule for participating GPP systems to submit an interim yearend report and a final reconciliation report for each GPP program year. The interim yearend report and the final reconciliation report shall identify the services the GPP system provided to the uninsured during the GPP program year, the associated point calculation, and the amount of payments earned by the GPP system before any redistribution. The method and format of the reporting shall be established by the department, consistent with the approved Special Terms and Conditions.

(4) Payments shall be made in the manner and within the timeframes as follows, except if one or more GPP systems fail to provide the intergovernmental transfer amount determined pursuant to subdivision (g) by the date specified in this paragraph, the timeframe for the associated payments shall be extended to the extent necessary to allow the department to timely process the payments. In no event, however, shall payment be delayed beyond 21 days after all the necessary intergovernmental transfers have been made.

(A) Except as provided in subparagraph (B), for each of the first three quarters of a GPP program year the department shall notify GPP systems of their payment amounts and intergovernmental transfer amounts and make a quarterly interim payment equal to 25 percent of each GPP system's annual global budget to the GPP system.

(i) For quarters ending September 30, the payment amount and intergovernmental transfer amount notice shall be sent by September 15, intergovernmental transfers shall be due by September 22, and payments shall be made by October 15.

(ii) For quarters ending December 31, the payment amount and intergovernmental transfer amount notice shall be sent by December 15, intergovernmental transfers shall be due by December 22, and payments shall be made by January 15.

(iii) For quarters ending March 31, the payment amount and intergovernmental transfer amount notice shall be sent by March 15, intergovernmental transfers shall be due by March 22, and payments shall be made by April 15.

(B) For the 2015–16 GPP program year, the department shall make the quarterly interim payments described in subdivision (a) in a single interim payment for the first three quarters as soon as practicable following approval of the Global Payment Program protocols as part of the Special Terms and Conditions and receipt of the associated intergovernmental transfers. The amount of this interim payment that is otherwise payable to a GPP system shall be reduced by the payments described in paragraph (2) of subdivision (c) of Section 14184.30 that were received by a designated public hospital affiliated with the GPP system.

(C) By September 15 following the end of each GPP program year, the department shall determine and notify each GPP system of the amount the GPP system earned for the GPP program year pursuant to paragraph (1) based on its interim yearend report, the amount of additional interim payments necessary to bring the GPP system's aggregate interim payments for the GPP program year to that amount, and the transfer amounts calculated pursuant to subdivision (g). If the GPP system has earned less than 75 percent of its annual budget, no additional interim payment will be made for the GPP program year. Intergovernmental transfer amounts shall be due by September 22 following the end of the GPP program year, and interim payments shall be made by October 15 following the end of each GPP program year. All interim payments shall be subject to reconciliation after the submission of the final reconciliation report.

(D) By June 30 following the end of each GPP program year, the department shall review the final reconciliation reports and determine and notify each GPP system of the final amounts earned by the GPP system for the GPP program year pursuant to paragraph (1), as well as the redistribution amounts, if any, pursuant to paragraph (2), the amount of the payment adjustments or recoupments necessary to reconcile interim payments to those amounts, and the transfer amount pursuant to subdivision (g). Intergovernmental transfer amounts shall be due by July 14 following the notification, and final reconciliation payments for the GPP program year shall be made no later than August 15 following this notification.

(e) The Global Payment Program provides a source of funding for GPP systems to support their ability to make health care activities and services available to the uninsured, and shall not constitute or offer health care coverage for individuals receiving services. Global Payment Program payments are not paid on behalf of specific individuals, and participating GPP systems may determine the scope, type, and extent to which services are available, to the extent consistent with the Special Terms and Conditions. The operation of the Global Payment Program shall not decrease, expand, or otherwise alter the scope of a county's obligations to the medically indigent pursuant to Part 5 (commencing with Section 17000) of Division 9.

(f) The nonfederal share of any payments under the Global Payment Program shall consist of voluntary intergovernmental transfers of funds provided by designated public hospitals or affiliated governmental agencies or entities, in accordance with this section or Section 14184.300.

(1) The Global Payment Program Special Fund is hereby established in the State Treasury. Notwithstanding Section 13340 of the Government Code, moneys deposited in the Global Payment Program Special Fund shall be continuously appropriated, without regard to fiscal years, to the department for the purposes specified in this section or Section 14184.300. All funds derived pursuant to this section or Section 14184.300 shall be deposited in the State Treasury to the credit of the Global Payment Program Special Fund.

(2) The Global Payment Program Special Fund shall consist of moneys that a designated public hospital or affiliated governmental agency or entity elects to transfer to the department for deposit into the fund as a condition of participation in the Global Payment Program, to the extent permitted under Section 433.51 of Title 42 of the Code of Federal Regulations, the Special Terms and Conditions, and any other applicable federal Medicaid laws. Except as otherwise provided in paragraph (3), moneys derived from these intergovernmental transfers in the Global Payment Program Special Fund shall be used as the source for the nonfederal share of Global Payment Program payments authorized under the demonstration project. Any intergovernmental transfer of funds provided for purposes of the Global Payment Program shall be made as specified in this section or Section 14184.300. 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 the Special Terms and Conditions, and in the form and manner as required by the department.

(3) The department shall claim federal financial participation for GPP payments using moneys derived from intergovernmental transfers made pursuant to this section or Section 14184.300, and deposited in the Global Payment Program Special Fund to the full extent permitted by law. The moneys disbursed from the fund, and all associated federal financial participation, shall be distributed only to GPP systems and the governmental agencies or entities to which they are affiliated, as applicable. If federal financial participation is unavailable with respect to a payment under this section or Section 14184.300 and either is not obtained, or results in a recoupment of payments already made, the department shall return any intergovernmental transfer fund amounts associated with the payment for which federal financial participation is unavailable to the applicable transferring entities within 14 days from the date of the associated recoupment or other determination, as applicable.

(4) As a condition of participation in the Global Payment Program, each designated public hospital or affiliated governmental agency or entity, agrees to provide intergovernmental transfer of funds necessary to meet the nonfederal share obligation as calculated under subdivision (g) for Global Payment Program payments made pursuant to this section or Section 14184.300 and the Special Terms and Conditions. Any intergovernmental transfer of funds made pursuant to this section or Section 14184.300 shall be considered voluntary for purposes of all federal laws. No state General Fund moneys shall be used to fund the nonfederal share of any Global Payment Program payment.

(g) For each scheduled quarterly interim payment, interim yearend payment, and final reconciliation payment pursuant to subdivision (d), the department shall determine the intergovernmental transfer amount for each GPP system as follows:

(1) The department shall determine the amount of the quarterly interim payment, interim yearend payment, or final reconciliation payment, as applicable, that is payable to each GPP system pursuant to subdivision (d). For purposes of these determinations, the redistributed amounts described in paragraph (2) of subdivision (d) shall be disregarded.

(2) The department shall determine the aggregate amount of intergovernmental transfers necessary to fund the nonfederal share of the quarterly interim payment, interim yearend payment, or final reconciliation payment, as applicable, identified in paragraph (1) for all the GPP systems.

(3) With respect to each quarterly interim payment, interim yearend payment, or final yearend reconciliation payment, as applicable, an initial transfer amount shall be determined for each GPP system, calculated as the amount for the GPP system determined in paragraph (1), multiplied by the nonfederal share percentage, as defined in Section 14184.10, and multiplied by the applicable GPP system-specific IGT factor as follows:

(A) Los Angeles County Health System: 1.100.

(B) Alameda Health System: 1.137.

(C) Arrowhead Regional Medical Center: 0.923.

(D) Contra Costa Regional Medical Center: 0.502.

(E) Kern Medical Center: 0.581.

(F) Natividad Medical Center: 1.183.

(G) Riverside University Health System-Medical Center: 0.720.

(H) San Francisco General Hospital: 0.507.

(I) San Joaquin General Hospital: 0.803.

(J) San Mateo Medical Center: 1.325.

(K) Santa Clara Valley Medical Center: 0.706.

(L) Ventura County Medical Center: 1.401.

(4) The initial transfer amount for each GPP system determined under paragraph (3) shall be further adjusted as follows to ensure that sufficient intergovernmental transfers are available to make payments to all GPP systems:

(A) With respect to each quarterly interim payment, interim yearend payment, or final reconciliation payment, as applicable, the initial transfer amounts for all GPP systems determined under paragraph (3) shall be added together.

(B) The sum of the initial transfer amounts in subparagraph (A) shall be subtracted from the aggregate amount of intergovernmental transfers necessary to fund the payments as determined in paragraph (2). The resulting positive or negative amount shall be the aggregate positive or negative intergovernmental transfer adjustment.

(C) Each GPP system-specific IGT factor, as specified in subparagraphs (A) to (L), inclusive, of paragraph (3) shall be subtracted from 2.000, yielding an IGT adjustment factor for each GPP system.

(D) The IGT adjustment factor calculated in subparagraph (C) for each GPP system shall be multiplied by the positive or negative amount in subparagraph (B), and multiplied by the allocation percentage determined for the GPP system in paragraph (4) of subdivision (c), yielding the amount to be added or subtracted from the initial transfer amount determined in paragraph (3) for the applicable GPP system.

(E) The transfer amount to be paid by each GPP system with respect to the applicable quarterly interim payment, interim yearend payment, or final reconciliation payment, shall equal the initial transfer amount determined in paragraph (3) as adjusted by the amount determined in subparagraph (D).

(5) Upon the determination of the redistributed amounts described in paragraph (2) of subdivision (d) for the final reconciliation payment, the department shall, with respect to each GPP system that exceeded its respective threshold, determine the associated intergovernmental transfer amount equal to the nonfederal share that is necessary to draw down the additional payment, and shall include this amount in the GPP system's transfer amount.

(h) The department may initiate audits of GPP systems' data submissions and reports, and may request supporting documentation. Any audits conducted by the department shall be complete within 22 months of the end of the applicable GPP program year to allow for the appropriate finalization of payments to the participating GPP system, but subject to recoupment if it is later determined that federal financial participation is unavailable for any portion of the applicable payments.

(i) If the department determines, during the course of the demonstration term and in consultation with participating GPP systems, that the Global Payment Program should be terminated for subsequent years, the department shall terminate the Global Payment Program by notifying the federal Centers for Medicare and Medicaid Services in accordance with the timeframes specified in the Special Terms and Conditions. In the event of this type of termination, the department shall issue a declaration terminating the Global Payment Program and shall work with the federal Centers for Medicare and Medicaid Services to finalize all remaining payments under the Global Payment Program. Subsequent to the effective date for any termination accomplished pursuant to this subdivision, the designated public hospitals that participated in the Global Payment Program shall claim and receive disproportionate share hospital payments, if eligible, as described in subparagraph (D) of paragraph (4) of subdivision (b) of Section 14184.30, but only to the extent that any necessary federal approvals are obtained and federal financial participation is available and not otherwise jeopardized.

(j) Commencing January 1, 2021, the Global Payment Program shall be continued as modified pursuant to Section 14184.300.

SEC. 402. Article 5.51 (commencing with Section 14184.100) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 5.51. California Advancing and Innovating Medi-Cal Act

14184.100. (a) This article shall be known, and may be cited, as the California Advancing and Innovating Medi-Cal (CalAIM) Act.

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

(1) Identify and manage the risk and needs of Medi-Cal beneficiaries through whole-person-care approaches and addressing social determinants of health.

(2) Transition and transform the Medi-Cal program to a more consistent and seamless system by reducing complexity and increasing flexibility.

(3) Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

14184.101. For purposes of this article, and elsewhere in law where specified, the following definitions shall apply:

(a) "CalAIM" or "CalAIM initiative" means the respective components of the California Advancing and Innovating Medi-Cal initiative authorized by this article and approved by the federal Centers for Medicare and Medicaid Services in the CalAIM Terms and Conditions.

(b) "CalAIM term" means the entire period during which an applicable component of the CalAIM initiative is in effect, as approved by the federal Centers for Medicare and Medicaid Services, including any applicable extension period.

(c) "CalAIM Terms and Conditions" means those terms and conditions issued and approved by the federal Centers for Medicare and Medicaid Services, including any attachments, appendices, or similar documents, and subsequent amendments thereto, that

govern implementation of the respective components of the CalAIM initiative pursuant to this article. CalAIM Terms and Conditions shall include, at a minimum, any terms and conditions specified in the following:

(1) California Advancing and Innovating Medi-Cal Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services pursuant to Section 1315 of Title 42 of the United States Code, effective for the period from January 1, 2022, to December 31, 2026, inclusive, and any applicable extension period, or for any period otherwise approved therein.

(2) Any associated Medicaid Waivers as approved by the federal Centers for Medicare and Medicaid Services pursuant to Section 1396n of Title 42 of the United States Code that are necessary to implement a CalAIM component, effective for the period from January 1, 2022, to December 31, 2026, inclusive, and any applicable extension period, or for any period otherwise specified in the CalAIM Terms and Conditions.

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

(4) Any provision of a comprehensive risk contract, nonrisk contract, or other similar managed care arrangement, including an intergovernmental agreement, approved by the federal Centers for Medicare and Medicaid Services to implement the authorities described in paragraph (1), (2), or (3).

(d) “CalAIM year” or “Initiative Year” means the applicable effective period identified in the CalAIM Terms and Conditions that corresponds to a specific period of time as set forth in paragraphs (1) to (5), inclusive. Individual programs or components under the CalAIM Initiative may be operated on program years that differ from the CalAIM years identified in paragraphs (1) to (5), inclusive, or may be operated without regard to program years, as applicable.

(1) Initiative year 1 corresponds to the period of January 1, 2022, to December 31, 2022, inclusive.

(2) Initiative year 2 corresponds to the period of January 1, 2023, to December 31, 2023, inclusive.

(3) Initiative year 3 corresponds to the period of January 1, 2024, to December 31, 2024, inclusive.

(4) Initiative year 4 corresponds to the period of January 1, 2025, to December 31, 2025, inclusive.

(5) Initiative year 5 corresponds to the period of January 1, 2026, to December 31, 2026, inclusive.

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

(f) “Designated public hospital” means any one of the hospitals identified in subdivision (f) of Section 14184.10, and any successor, including any restructured, reorganized, or differently named hospital, that is operated by a county, a city and county, the University of California, or a special hospital authority described in Chapter 5 (commencing with Section 101850) or Chapter 5.5 (commencing with Section 101852) of Part 4 of Division 101 of the Health and Safety Code, or any additional public hospital to the extent identified as a “designated public hospital” in the CalAIM Terms and Conditions.

(g) “Federal disproportionate share hospital allotment” means the amount specified for California under Section 1396r-4(f) of Title 42 of the United States Code for a federal fiscal year.

(h) “Federal medical assistance percentage” means the federal medical assistance percentage applicable for federal financial participation purposes for medical assistance under the Medi-Cal State Plan pursuant to Section 1396b(a)(1) of Title 42 of the United States Code.

(i) “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 Article 3.2 (commencing with Section 14124.20), or 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).

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

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

(l) “Nonfederal share percentage” means the difference between 100 percent and the applicable federal medical assistance percentage.

(m) “Total computable disproportionate share hospital allotment” means the federal disproportionate share hospital allotment for a federal fiscal year, divided by the applicable federal medical assistance percentage with respect to that same federal fiscal year.

14184.102. (a) Consistent with federal law, the department shall seek federal approval for, and implement, the CalAIM initiative, including, but not limited to, all of the following components:

(1) Continuation of the Medi-Cal Managed Care program, described in part in Sections 14184.200 to 14184.208, inclusive, and, elsewhere in this chapter and Chapter 8 (commencing with Section 14200), and which includes any comprehensive risk contract between the department and an individual, organization, or entity to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries pursuant to any provision of this chapter or Chapter 8 (commencing with Section 14200).

(2) Continuation of the Global Payment Program, described in Section 14184.40, as amended by the act that added this section, and Section 14184.300.

(3) Continuation of the Medi-Cal Specialty Mental Health Services Program, as described in part in Section 14184.400.

(4) Continuation of the Drug Medi-Cal organized delivery system program, as described in part in Section 14184.401.

(5) Behavioral Health Medical Necessity Changes, Payment Reform, Administrative Simplification, and Behavioral Health Quality Improvement Program, as described in Sections 14184.402, 14184.403, 14184.404, and 14184.405.

(6) The State Plan Dental Improvement Program, as described in Section 14184.500.

(7) Enhancing County Oversight and Monitoring, as described in Section 14184.600.

(8) Providing Access and Transforming Health (PATH) Supports, as described in Section 14184.700.

(9) Targeted Pre-Release Medi-Cal Benefits for Qualified Inmates, as described in Section 14184.800.

(b) The department shall report to the Legislature any conflicts between this article and the CalAIM Terms and Conditions, including identification of the specific conflicts and recommendations for conforming language.

(c) The department, as appropriate and to the extent practicable, shall consult with interested stakeholders with regard to implementation of applicable components of CalAIM under subdivision (a) in which they will participate, including, but not limited to, the issuance of departmental guidance pursuant to subdivision (d). Interested stakeholders may include, but need not be limited to, designated public hospitals, district and municipal public hospitals, other local governmental agencies, consumer representatives, and Medi-Cal managed care plans.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this article or the CalAIM Terms and Conditions, in whole or in part, by means of all-county letters, plan letters, provider bulletins, information notices, or other similar instructions, without taking any further regulatory action. The department shall make use of appropriate processes to ensure that affected stakeholders are timely informed of, and have access to, applicable guidance issued pursuant to this authority, and that this guidance remains publicly available until all payments related to the applicable CalAIM component are finalized.

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

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

(g) Consistent with subdivision (b), the director shall report to the Legislature on any recommended amendments to any provision, process, or methodology specified in this article, Article 5.4 (commencing with Section 14180), Article 5.5 (commencing with Section 14184), or other sections of law amended by the act that added this subdivision, to the extent necessary to comply with federal law or the CalAIM Terms and Conditions, to obtain or maintain federal approval, or to ensure federal financial participation is available and not otherwise jeopardized, if the amendment is consistent with the goals set forth in this article and its individual

components, and does not significantly alter the relative level of support for participating entities. If the director, after consulting with those entities participating in the applicable CalAIM component and that would be affected by that amendment, determines that the potential amendment would be consistent with the goals set forth in this article and would not significantly alter the relative level of support for affected participating entities, the amendment shall be submitted to the Legislature for its consideration.

(h) During the course of the CalAIM term, the department may develop and implement successor payment methodologies or programs to continue to support entities participating in one or more components of CalAIM following the expiration of the CalAIM term and that further the goals set forth in this article. The department shall consult with the entities participating in the payment methodologies or program components under CalAIM, affected stakeholders, and the Legislature in the development of any successor payment methodologies or program components pursuant to this subdivision.

(i) The department may seek to extend the payment methodologies or programs described in this article, or in the CalAIM Terms and Conditions, including modification thereto, through the CalAIM term or to subsequent time periods by way of amendment or extension of the relevant CalAIM Terms and Conditions, amendment to the Medi-Cal State Plan, or any combination thereof, consistent with the applicable federal requirements. This subdivision shall only be implemented after consultation with the entities participating in, or affected by, those methodologies or programs, and only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(j) Notwithstanding any other state or local law, including, but not limited to, Section 5328 of this code, and Sections 11812 and 11845.5 of the Health and Safety Code, the sharing of health, social services, housing, and criminal justice information, records, and other data with and among the department, other state departments, including the State Department of Public Health and the State Department of Social Services, Medi-Cal managed care plans, Medi-Cal behavioral health delivery systems, counties, health care providers, social services organizations, care coordination and case management teams, and other authorized provider or plan entities, and contractors of all of those entities, shall be permitted to the extent necessary to implement applicable CalAIM components described in this article and the CalAIM Terms and Conditions, and to the extent consistent with federal law. The department shall issue guidance identifying permissible data-sharing arrangements to implement CalAIM.

(k) (1) Notwithstanding any other law, and to the extent authorized by the CalAIM Terms and Conditions, the department may claim federal financial participation for expenditures associated with the designated state health care programs identified in the CalAIM Terms and Conditions for use solely by the department as specified in this subdivision.

(2) Any federal financial participation claimed pursuant to paragraph (1) shall be used to offset applicable General Fund expenditures. These amounts are hereby appropriated to the department and shall be available for transfer to the General Fund for this purpose.

(3) An amount of General Fund moneys equal to the federal financial participation that may be claimed pursuant to paragraph (1) is hereby appropriated to the Health Care Deposit Fund for use by the department for purposes of implementing this article.

14184.200. (a) Notwithstanding any other law, the department may standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, subject to a Medi-Cal managed care plan readiness, continuity of care transition plan, and disenrollment process developed in consultation with stakeholders, in accordance with the CalAIM Terms and Conditions and as described in this section.

(1) (A) The department shall ensure the Medi-Cal managed care plan's readiness for network adequacy includes a geographic access review of rural ZIP Codes to ensure time or distance standards are met, or alternative access standard requests are approved, as applicable, and the plan's ability to meet existing federal and state mandatory provider type requirements, where available.

(B) The department shall not require a population to enroll in managed care if Medi-Cal managed care plans fail to meet the Medi-Cal managed care plan readiness requirements detailed in this paragraph for that population.

(2) The Medi-Cal managed care plan shall comply with the continuity of care requirements in Section 1373.96 of the Health Safety Code and shall be consistent with and no more restrictive than existing policy and guidance, including All Plan Letter 18-008 and Duals Plan Letter 16-002.

(3) The disenrollment process for an enrollee in any county shall be consistent with and no more restrictive than existing federal and state statutes and regulations, including Section 53889 and subdivision (c) of Section 53891 of Title 22 of the California Code of Regulations. The beneficiary may request a medical exemption from mandatory enrollment in a Medi-Cal managed care plan in accordance with Section 53887 of Title 22 of the California Code of Regulations and may disenroll or be exempted from mandatory enrollment under the limited circumstances set forth in subdivision (c) of Section 53891 of Title 22 of the California Code of Regulations. That disenrollment or exemption from mandatory enrollment in a Medi-Cal managed care plan

shall be consistent with subsection (c) of Section 438.56 of Title 42 of the Code of Federal Regulations and applicable state law.

(b) (1) Notwithstanding any other law, if the department standardizes those populations subject to mandatory enrollment in a Medi-Cal managed care plan pursuant to subdivision (a), commencing January 1, 2022, and subject to subdivision (f) of Section 14184.102, a non-dual-eligible beneficiary, except a beneficiary identified in paragraph (2), shall be required to enroll, or shall continue to be required to enroll, in a Medi-Cal managed care plan for purposes of their receipt of covered Medi-Cal benefits.

(2) Notwithstanding any other law, if the department standardizes those populations subject to mandatory enrollment in a Medi-Cal managed care plan pursuant to subdivision (a), commencing January 1, 2022, subject to subdivision (f) of Section 14184.102, the following dual and non-dual beneficiary groups, as identified by the department, shall be exempt from mandatory enrollment in a Medi-Cal managed care plan:

(A) A beneficiary eligible for only restricted-scope Medi-Cal benefits, as described in subdivision (d) of Section 14007.5.

(B) A beneficiary made eligible on the basis of a share of cost, including, but not limited to, a non-dual-eligible beneficiary residing in a county that is authorized to operate a county organized health system (COHS), as described in Article 2.8 (commencing with Section 14087.5), except for a non-dual-eligible beneficiary that is eligible on the basis of their need for long-term care services with a share of cost, as identified by the department.

(C) A beneficiary made eligible on the basis of a federally approved Medi-Cal Presumptive Eligibility program, as determined by the department, but only during the relevant period of presumptive eligibility.

(D) An eligible beneficiary who is an inmate of a public institution, or who is released pursuant to Section 26605.6 or 26605.7 of the Government Code.

(E) A beneficiary with satisfactory immigration status, including a noncitizen that is lawfully present, who is eligible for only pregnancy-related Medi-Cal coverage and who received services through the Medi-Cal fee-for-service delivery system prior to January 1, 2022, as identified by the department, but only through the end of the postpartum period.

(F) A beneficiary without satisfactory immigration status or who is unable to establish satisfactory immigration status as required by Section 14011.2, who is eligible for only pregnancy-related Medi-Cal coverage, excluding a beneficiary enrolled in the Medi-Cal Access Program described in Chapter 2 (commencing Section 15810) of Part 3.3.

(G) A non-dual-eligible beneficiary who is an Indian, as defined in subdivision (a) of Section 438.14 of Title 42 of the Code of Federal Regulations, and who elects to forego voluntary enrollment in a Medi-Cal managed care plan.

(H) A non-dual-eligible beneficiary eligible on the basis of their receipt of services through a state foster care program, or eligible pursuant to Section 14005.28, who elects to forego voluntary enrollment in a Medi-Cal managed care plan, except for a non-dual beneficiary described in this subparagraph who resides in a county that is authorized to operate COHS, as described in Article 2.8 (commencing with Section 14087.5).

(I) A non-dual-eligible beneficiary enrolled with an entity with a contract with the department pursuant to the Program of All-Inclusive Care for the Elderly (PACE), as described in Chapter 8.75 (commencing with Section 14591).

(J) Any other non-dual-eligible beneficiary, as identified by the department, for whom federal law prohibits mandatory enrollment in a Medi-Cal managed care plan.

(K) A beneficiary residing in one of the Veterans' Homes of California, as described in Chapter 1 (commencing with Section 1010) of Division 5 of the Military and Veterans Code.

(c) (1) Notwithstanding any other law, if the department standardizes those populations subject to mandatory enrollment in a Medi-Cal managed care plan pursuant to subdivision (a), commencing January 1, 2023, and subject to subdivision (f) of Section 14184.102, a dual eligible beneficiary, except as provided in paragraph (2) of subdivision (b) or paragraph (2) of this subdivision, shall be required to enroll, or shall continue to be required to enroll, in a Medi-Cal managed care plan for purposes of their receipt of covered Medi-Cal benefits.

(2) The following dual eligible beneficiary groups, as identified by the department, shall be exempt from mandatory enrollment in Medi-Cal managed care as described in paragraph (1):

(A) A dual eligible beneficiary made eligible on the basis of a share of cost, including, but not limited to, a dual eligible beneficiary residing in a county that is authorized to operate COHS, as described in Article 2.8 (commencing with Section 14087.5), except for a dual eligible beneficiary who is eligible on the basis of their need for long-term care services with a share of cost, as determined by the department.

(B) A dual eligible beneficiary enrolled with an entity with a contract with the department pursuant to PACE as described in Chapter 8.75 (commencing with Section 14591).

(C) A dual eligible beneficiary enrolled with an entity with a Senior Care Action Network (SCAN) contract with the department.

(D) A dual eligible beneficiary who is an Indian, as defined in subsection (a) of Section 438.14 of Title 42 of the Code of Federal Regulations, and who elects to forego voluntary enrollment in a Medi-Cal managed care plan.

(E) A dual eligible beneficiary with HIV/AIDS who elects to forego voluntary enrollment in a Medi-Cal managed care plan.

(F) A dual eligible beneficiary eligible on the basis of their receipt of services through a state foster care program, or eligible pursuant to Section 14005.28, who elects to forego voluntary enrollment in a Medi-Cal managed care plan, except for a dual beneficiary described in this subparagraph who resides in a county that is authorized to operate COHS, as described in Article 2.8 (commencing with Section 14087.5).

(G) A dual eligible beneficiary residing in one of the Veterans' Homes of California, as described in Chapter 1 (commencing with Section 1010) of Division 5 of the Military and Veterans Code.

(H) Any other dual eligible beneficiary, as identified by the department, for whom federal law prohibits mandatory enrollment in a Medi-Cal managed care plan.

(d) (1) This section shall not prohibit a Medi-Cal beneficiary from receiving covered benefits on a temporary basis through the Medi-Cal fee-for-service delivery system pending enrollment into an individual Medi-Cal managed care plan in accordance with this section and the CalAIM Terms and Conditions.

(2) This section shall not prohibit certain Medi-Cal beneficiaries eligible for full-scope benefits under the Medi-Cal State plan, as identified by the department, from voluntarily enrolling in a Medi-Cal managed care plan, in accordance with the CalAIM Terms and Conditions.

(e) (1) No later than January 1, 2023, in all non-County Organized Health System counties, in areas where a PACE plan is available, the PACE plan shall be presented as an enrollment option, included in enrollment materials, and made available to an applicable beneficiary whenever enrollment choices and options are presented. Outreach and enrollment materials shall enable a Medi-Cal beneficiary to understand what PACE provides, that, if eligible, they may be assessed for PACE eligibility and enroll in PACE, and how they can receive additional information and request to be assessed for PACE eligibility. A person meeting the age qualifications for PACE and who chooses PACE shall not be assigned to a Medi-Cal managed care plan for the lesser of 60 days or until they are assessed for eligibility for PACE and determined not to be eligible for PACE. A person enrolled in a PACE plan shall receive all Medicare and Medi-Cal services from the PACE plan pursuant to the three-way agreement between the PACE plan, the department, and the federal Centers for Medicare and Medicaid Services.

(2) In areas of the state where a presentation on Medi-Cal managed care plan enrollment options is unavailable, the department, or its contracted vendor, shall provide informational, outreach, and enrollment materials about the PACE program.

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

(1) "Dual eligible beneficiary" means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or both, and is eligible for medical assistance under the Medi-Cal State Plan. For purposes of this article, "dual eligible beneficiary" shall include both a "full-benefit dual eligible beneficiary" and a "partial-benefit dual eligible beneficiary," as those terms are defined in this subdivision.

(2) "Full-benefit dual eligible beneficiary" means an individual 21 years or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.), Medicare Part B (42 U.S.C. Sec. 1395j et seq.), and Medicare Part D (42 U.S.C. Sec. 1395w-101), and is eligible for medical assistance under the Medi-Cal State Plan.

(3) "Non-dual-eligible beneficiary" means an individual eligible for medical assistance under the Medi-Cal State plan, as determined by the department, that is not eligible for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.).

(4) "Partial-benefit dual eligible beneficiary" means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.), but not Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or who is enrolled for Medicare Part B (42 U.S.C. Sec. 1395j et seq.), but not Medicare Part A (42 U.S.C. Sec. 1395c et seq.), and is eligible for medical assistance under the Medi-Cal State Plan.

14184.201. (a) Notwithstanding any other law, the department shall standardize those applicable covered Medi-Cal benefits provided by Medi-Cal managed care plans under comprehensive risk contracts with the department on a statewide basis and across all models of Medi-Cal managed care in accordance with this section and the CalAIM Terms and Conditions.

(b) (1) Notwithstanding any other law, commencing January 1, 2023, subject to subdivision (f) of Section 14184.102, the department shall include, or continue to include, institutional long-term care services as capitated benefits in the comprehensive risk contract with each Medi-Cal managed care plan.

(2) For contract periods from January 1, 2023, to December 31, 2025, inclusive, during which paragraph (1) is implemented, each Medi-Cal managed care plan shall reimburse a network provider furnishing institutional long-term care services to a Medi-Cal beneficiary enrolled in that plan, and each network provider of institutional long-term care services shall accept the payment amount the network provider of institutional long-term care services would be paid for those services in the Medi-Cal fee-for-service delivery system, as defined by the department in the Medi-Cal State Plan and guidance issued pursuant to subdivision (d) of Section 14184.102. For contract periods commencing on or after January 1, 2026, during which paragraph (1) is implemented, the department may elect to continue the payment requirement described in this paragraph, subject to subdivision (f) of Section 14184.102.

(3) For contract periods during which paragraph (1) is implemented, capitation rates paid by the department to a Medi-Cal managed care plan shall be actuarially sound and shall account for the payment levels described in paragraph (2) as applicable. The department may require Medi-Cal managed care plans and network providers of institutional long-term care services to submit information the department deems necessary to implement this subdivision, at the times and in the form and manner specified by the department.

(4) The department shall convene, in collaboration with the State Department of Developmental Services (DDS), a workgroup to address transition of intermediate care facility/developmentally disabled (ICF/DD) facilities, and Intermediate Care Facility for the Developmentally Disabled-Nursing (ICF/DD-N) and Intermediate Care Facility for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes from the Medi-Cal fee-for-service delivery system to the Medi-Cal managed care delivery system to ensure a smooth transition to CalAIM.

(c) (1) Notwithstanding any other law, commencing January 1, 2022, the department shall include donor and recipient organ transplant surgeries, as described in Section 14132.69 and in the CalAIM Terms and Conditions, and donor and recipient bone marrow transplants, as described in Section 14133.8 and in the CalAIM Terms and Conditions, as capitated benefits in the comprehensive risk contract with each Medi-Cal managed care plan.

(2) For contract periods from January 1, 2022, to December 31, 2024, inclusive, during which paragraph (1) is implemented, each applicable Medi-Cal managed care plan shall reimburse a provider furnishing organ or bone marrow transplant surgeries to a Medi-Cal beneficiary enrolled in that plan, and each provider of organ or bone marrow transplant surgeries shall accept the payment amount the provider of organ or bone marrow transplant surgeries would be paid for those services in the Medi-Cal fee-for-service delivery system, as defined by the department in the Medi-Cal State Plan and guidance issued pursuant to subdivision (d) of Section 14184.102. For contract periods commencing on or after January 1, 2025, during which paragraph (1) is implemented, the department may elect to continue the payment requirement described in this paragraph, subject to subdivision (f) of Section 14184.102.

(3) For contract periods during which paragraph (1) is implemented, capitation rates paid by the department to a Medi-Cal managed care plan shall be actuarially sound and shall account for the payment levels described in paragraph (2) as applicable. The department may require Medi-Cal managed care plans and providers of organ or bone marrow transplant surgeries to submit information the department deems necessary to implement this subdivision, at the times and in the form and manner specified by the department.

(d) (1) Notwithstanding any other law, commencing January 1, 2022, Community-Based Adult Services (CBAS), as described in Section 14186.3, shall continue to be available as a capitated benefit for a qualified Medi-Cal beneficiary under a comprehensive risk contract with an applicable Medi-Cal managed care plan, in accordance with the CalAIM Terms and Conditions.

(2) CBAS shall only be available as a covered Medi-Cal benefit for a qualified Medi-Cal beneficiary under a comprehensive risk contract with an applicable Medi-Cal managed care plan. Medi-Cal beneficiaries who are eligible for CBAS shall enroll in an applicable Medi-Cal managed care plan in order to receive those services, except for beneficiaries exempt from mandatory enrollment in a Medi-Cal managed care plan pursuant to the CalAIM Terms and Conditions and Section 14184.200.

(3) CBAS shall be delivered in accordance with applicable state and federal law, including, but not limited to, the federal home and community-based settings regulations set forth in Sections 441.301(c)(4), 441.530(a)(1), and 441.710(a)(1) of Title 42 of the Code of Federal Regulations, and related subregulatory guidance and any amendment issued thereto.

(4) For contract periods during which paragraph (1) is implemented, each applicable Medi-Cal managed care plan shall reimburse a network provider furnishing CBAS to a Medi-Cal beneficiary enrolled in that plan, and each network provider of CBAS shall accept the payment amount the network provider of CBAS would be paid for the service in the Medi-Cal fee-for-service delivery system, as defined by the department in guidance issued pursuant to subdivision (d) of Section 14184.102, unless the Medi-Cal managed plan and network provider mutually agree to reimbursement in a different amount.

(5) For contract periods during which paragraph (1) is implemented, capitation rates paid by the department to an applicable Medi-Cal managed care plan shall be actuarially sound and shall account for the payment levels described in paragraph (4) as applicable. The department may require applicable Medi-Cal managed care plans and network providers of CBAS to submit information the department deems necessary to implement this subdivision, at the times and in the form and manner specified by the department.

(e) Notwithstanding any other law, including, but not limited to, subdivision (a), the department may not transfer responsibility for specialty mental health services in the Counties of Sacramento and Solano from the Medi-Cal managed care plan responsible for those services on July 1, 2022, in those counties until no sooner than all of the following requirements have been met:

(1) The requirements of Section 14184.403 have been implemented.

(2) Each county and Medi-Cal managed care plan has submitted to the department a transition plan that contains provisions for continuity of care or the transfer of care.

(3) Notice has been provided to affected beneficiaries, including the ability of beneficiaries to request continuity of care pursuant to mental health and substance use disorder information notices issued by the department.

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

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

(2) “Institutional long-term care services” has the same meaning as set forth in the CalAIM Terms and Conditions and, subject to subdivision (f) of Section 14184.102, includes at a minimum all of the following:

(A) Skilled nursing facility services.

(B) Subacute facility services.

(C) Pediatric subacute facility services.

(D) Intermediate care facility services.

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

14184.203. (a) For contract periods commencing on or after January 1, 2026, the department may require each Medi-Cal managed care plan and each health plan subcontractor of a Medi-Cal managed care plan to be accredited by the National Committee for Quality Assurance, or an alternative entity pursuant to subdivision (c), in accordance with this section and the CalAIM Terms and Conditions.

(b) The department shall not use findings from the accreditation pursuant to subdivision (a) to certify or deem a Medi-Cal managed care plan’s compliance with applicable state and federal Medicaid requirements, except in the area of credentialing.

(c) If the department determines that a Medi-Cal managed care plan or an applicable health plan subcontractor thereof is unable to receive accreditation from the National Committee for Quality Assurance due to population size, the department may authorize alternate accreditation if the requirements applied are substantially similar to those applied pursuant to subdivision (a), as determined by the department.

(d) For purposes of this section, “subcontractor” has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

14184.204. (a) Commencing January 1, 2023, subject to subdivision (f) of Section 14184.102, the department shall implement the Population Health Management Program under the Medi-Cal managed care delivery system to improve health outcomes, care coordination, and efficiency through application of standardized health management requirements, in accordance with the CalAIM Terms and Conditions.

(b) The department shall require each Medi-Cal managed care plan, after consultation with counties and other affected stakeholders, to develop and maintain a beneficiary-centered population health management program, which is a model of care

and plan of action designed to address member health needs at all points along the continuum of care, as described in the CalAIM Terms and Conditions.

(c) Each Medi-Cal managed care plan in the population health management program shall, at a minimum, do all of the following:

(1) Prioritize preventive and wellness services.

(2) Identify and assess beneficiary member risks and needs on an ongoing basis.

(3) Manage beneficiary member safety and outcomes during care transitions, across all applicable delivery systems and settings, through effective care coordination.

(4) Identify and mitigate social determinants of health and reduce health disparities or inequities.

(d) To support implementation of this section, the department shall develop and implement a Medi-Cal Population Health Management service that expands access to available medical, behavioral, and social service data and provides authorized entities access to necessary administrative and clinical data and information with respect to Medi-Cal beneficiaries across Medi-Cal delivery systems and other applicable public programs, as identified by the department. Data will be available at the individual member level and include the ability for bulk downloads for the purposes of population health analytics and clinical management by Medi-Cal managed care plans in support of the population health management activities described in subdivision (f).

(e) Population health management program components shall be developed in consultation with appropriate stakeholders, including, but not limited to, the State Department of Public Health, Medi-Cal managed care plans, Medi-Cal behavioral health delivery systems, county public health and social services, providers, community-based organizations, and consumer advocates.

(f) The Population Health Management Program shall include, but is not limited to, all of the following:

(1) Appropriate use of preventive services for children and adults, and other interventions, including chronic disease management, referrals for behavioral and oral health care services, housing, nutrition, and other health-related social needs.

(2) Risk assessment is comparable and consistent between Medi-Cal managed care plans.

(3) Any algorithm used to conduct member risk assessment is comparable, standardized, and mitigated for racial and other biases through consideration of disease burden relative to utilization and other patient risk factors beyond cost and historical utilization. The department shall report the underlying measures it uses in its algorithm.

(4) Any screening tool used to assess beneficiaries is age appropriate and comparable across Medi-Cal managed care plans.

(5) Each Medi-Cal managed care plan incorporates the findings of its Population Needs Assessment in its population health management program.

(6) Each Medi-Cal managed care plan describes how it will incorporate preventive and wellness services in partnership with Medi-Cal behavioral health delivery systems, county public health and social services, providers, community-based organizations, and consumer advocates.

(g) Beginning no later than January 1, 2024, the department shall annually post an analysis of the Population Health Management Program on its internet website.

14184.205. (a) Subject to subdivision (f) of Section 14184.102, the department shall implement an enhanced care management (ECM) benefit designed to address the clinical and nonclinical needs on a whole-person-care basis for certain target populations of Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans, in accordance with this section and the CalAIM Terms and Conditions.

(b) (1) Subject to the effective dates listed in subdivision (c), the ECM benefit shall be available on a statewide basis to an eligible Medi-Cal beneficiary who is enrolled in an applicable Medi-Cal managed care plan and who meets the criteria in the CalAIM Terms and Conditions for one or more target populations, as determined by the department. A Medi-Cal beneficiary is excluded from ECM while enrolled in a 1915(c) waiver or the Family Mosaic Project, or while receiving California Community Transitions (CCT) Money Follows the Person (MFTP) services. ECM shall be available to a qualifying dual eligible beneficiary, as described under Section 14184.200, except for a dual eligible beneficiary enrolled in a fully integrated program for members who are dually eligible for Medicare and Medicaid, including Cal MediConnect during the duration of the demonstration authorized in Section 14132.275, Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), and the Programs of All-Inclusive Care for the Elderly (PACE).

(2) ECM only shall be available as a covered Medi-Cal benefit under a comprehensive risk contract with a Medi-Cal managed care plan. A Medi-Cal beneficiary who is eligible for ECM shall enroll in a Medi-Cal managed care plan in order to receive those

services.

(c) (1) A Medi-Cal managed care plan operating in counties in which either the Whole Person Care pilot program, pursuant to Section 14184.60, or the Health Home Program, pursuant to Article 3.9 (commencing with Section 14127), or both, were implemented, as determined by the department, shall be required to cover ECM under its comprehensive risk contract as follows:

(A) Commencing January 1, 2022, a Medi-Cal managed care plan described in this paragraph shall be required to cover ECM for existing target populations under either the Whole Person Care pilot program or the Health Home Program, or both, as identified by the department.

(B) (i) Commencing January 1, 2023, a Medi-Cal managed care plan described in this paragraph shall be required to cover ECM for other select target populations described in subdivision (d), as identified by the department and in accordance with the CalAIM Terms and Conditions.

(ii) Commencing July 1, 2023, a Medi-Cal managed care plan described in this paragraph shall be required to cover ECM for all target populations described in subdivision (d) and in accordance with the CalAIM Terms and Conditions.

(2) A Medi-Cal managed care plan operating in counties in which neither the Whole Person Care pilot program, pursuant to Section 14184.60, or the Health Home Program, pursuant to Article 3.9 (commencing with Section 14127), was implemented, as determined by the department, shall be required to cover select ECM target populations, as identified by the department, under its comprehensive risk contract, commencing July 1, 2022. All other target populations, including the target population described in paragraph (7) of subdivision (d), shall be covered commencing January 1, 2023, or July 1, 2023, in accordance with the CalAIM Terms and Conditions.

(d) Target populations shall include the following, consistent with the department's eligibility criteria, and to the extent approved in the CalAIM Terms and Conditions:

(1) Children or youth with complex physical, behavioral, developmental, or oral health needs, including, but not limited to, those eligible for California Children's Services, those involved or with a history of involvement in child welfare or the juvenile justice system, or youth with clinical high-risk syndrome or a first episode of psychosis.

(2) Individuals experiencing homelessness.

(3) High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.

(4) Individuals at risk for institutionalization and eligible for long-term care services.

(5) Nursing facility residents who want to transition to the community.

(6) Individuals with serious mental illness (SMI), and children with serious emotional disturbance (SED) or substance use disorder (SUD).

(7) Individuals transitioning from incarceration requiring immediate transition of services to the community.

(e) Notwithstanding any other law, for any time period in which a Medi-Cal beneficiary is eligible to receive ECM services through enrollment in their Medi-Cal managed care plan, the beneficiary shall not receive duplicative targeted case management services as described in Section 14132.44 or otherwise authorized in the Medi-Cal State Plan, as determined by the department.

(f) Medi-Cal managed plans shall consult and collaborate with Medi-Cal behavioral health delivery systems for the delivery of ECM for beneficiaries with an SMI, SED, or SUD.

(g) If a Medi-Cal managed care plan proposes to keep some level of ECM in house instead of contracting with direct providers, the Medi-Cal managed care plan shall demonstrate to the state that its ECM benefit is appropriately community based and shall provide a rationale for not contracting with existing providers.

(h) The department shall develop, in consultation with Medi-Cal managed care plans and other appropriate stakeholders, a monitoring plan and reporting template for the implementation of ECM pursuant to this section. The department shall annually publish a public report on reported ECM utilization data, populations served, and demographic data, stratified by age, sex, race, ethnicity, and languages spoken, to the extent statistically reliant data is available.

14184.206. (a) Commencing January 1, 2022, and subject to subdivision (f) of Section 14184.102, a Medi-Cal managed care plan may elect to cover those services or settings approved by the department as cost effective and medically appropriate in the comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services, in accordance with the CalAIM Terms and Conditions.

(b) (1) Approved in lieu of services or settings pursuant to this section shall be available only to beneficiaries enrolled in a Medi-Cal managed care plan under a comprehensive risk contract, subject to paragraph (2).

(2) Approved in lieu of services or settings shall not supplant other covered Medi-Cal benefits that are not the responsibility of the Medi-Cal managed care plan under the comprehensive risk contract, including, but not limited to, in-home supportive services provided pursuant to Article 7 (commencing with Section 12300) of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.

(3) An enrolled Medi-Cal beneficiary shall not be required by their Medi-Cal managed care plan to use the in lieu of service or setting.

(c) Subject to subdivision (f) of Section 14184.102, in lieu of services or settings the department may approve include, but need not be limited to, all of the following when authorized by the department in the comprehensive risk contract with each Medi-Cal managed care plan and to the extent the department determines that the in lieu of service or setting is a cost-effective and medically appropriate substitute for the applicable covered Medi-Cal benefit under the comprehensive risk contract:

(1) Housing transition navigation services.

(2) Housing deposits.

(3) Housing tenancy and sustaining services.

(4) Short-term post-hospitalization housing.

(5) Recuperative care or medical respite.

(6) Respite.

(7) Day habilitation programs.

(8) Nursing facility transition or diversion to assisted living facilities, including, but not limited to, residential care facilities for the elderly or adult residential facilities.

(9) Nursing facility transition to a home.

(10) Personal care and homemaker services.

(11) Environmental accessibility adaptations or home modifications.

(12) Medically supportive food and nutrition services, including medically tailored meals.

(13) Sobering centers.

(14) Asthma remediation.

(d) The department shall publically post on its internet website a list of which in lieu of services are offered to enrollees by each Medi-Cal managed care plan.

(e) A Medi-Cal managed care plan shall provide information on the available in lieu of services in its member handbook and plan website, including any limitations on in lieu of services on the plan website.

(f) The department shall develop, in consultation with Medi-Cal managed care plans and other appropriate stakeholders, a monitoring plan and reporting template for the implementation of in lieu of services pursuant to this section. The department shall annually publish a public report on reported in lieu of services utilization data, populations served, and demographic data, stratified by age, sex, race, ethnicity, and languages spoken, to the extent statistically reliant data is available.

(g) Beginning no later than January 1, 2024, the department shall conduct an independent evaluation of the effectiveness of in lieu of services.

(h) The department shall take into account the utilization and actual cost of in lieu of services in developing capitation rates.

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

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

(2) “In lieu of services” has the same meaning as set forth in paragraph (2) of subsection (e) of Section 438.3 of Title 42 of the Code of Federal Regulations.

14184.207. (a) Commencing January 1, 2022, subject to appropriation by the Legislature in an applicable fiscal year and subdivision (f) of section 14184.102, the department shall make incentive payments available to qualifying Medi-Cal managed care plans that meet predefined milestones and metrics associated with implementation of applicable components of CalAIM, including, but not limited to, Sections 14184.205 and 14184.206, as determined by the department and in accordance with the CalAIM Terms and Conditions.

(b) The department, in consultation with Medi-Cal managed care plans, consumer advocates, the Medi-Cal behavioral health delivery system, and other stakeholder representatives, shall establish the methodology, parameters, and eligibility criteria for incentive payments pursuant to this section. This shall include, but is not limited to, the milestones and metrics that Medi-Cal managed care plans must meet in order to receive an incentive payment pursuant to this section and the CalAIM Terms and Conditions.

(c) The department, in accordance with the CalAIM Terms and Conditions, shall determine if a Medi-Cal managed care plan has earned an incentive payment, and the amount of that payment, for any relevant time period in which this section is implemented.

(d) Incentive payments pursuant to this section shall be made in accordance with the requirements for incentive arrangements described in Section 438.6(b)(2) of Title 42 of the Code of Federal Regulations and any associated federal guidance.

(e) (1) Notwithstanding subdivision (a), the department may make additional or augmented incentive payments available to Medi-Cal managed care plans, subject to subdivision (f) of Section 14184.102 and to the extent sufficient nonfederal share funds are available for this purpose in each applicable CalAIM year.

(2) The nonfederal share of additional or augmented incentive payments pursuant to this subdivision may consist of voluntary intergovernmental transfers of funds provided by eligible governmental agencies or other public entities, pursuant to Section 14164. Upon providing any intergovernmental transfer of funds, a transferring entity shall certify that the transferred funds qualify for federal financial participation pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations and any other applicable Medicaid laws, and in the form and manner specified by the department. An intergovernmental transfer of funds made pursuant to this subdivision shall be considered voluntary for purposes of all state and federal laws. Notwithstanding any other law, the department shall not assess the fee described in subdivision (d) of Section 14301.4 or any other similar fee on the intergovernmental transfers made pursuant to this subdivision.

14184.208. (a) To promote more integrated care for dual eligible beneficiaries, the department shall seek to align the enrollment of dual eligible beneficiaries in affiliated Medi-Cal managed care plans and Medicare plans, including Medicare Advantage Dual Special Needs Plans (D-SNP), as described in this section and in accordance with the CalAIM Terms and Conditions. A dual eligible beneficiary shall not be required to enroll in a D-SNP for purposes of receiving their Medi-Cal benefits.

(b) (1) Commencing January 1, 2023, subject to subdivision (f) of Section 14184.102, the department shall require each Medi-Cal managed care plan operating in Coordinated Care Initiative counties to operate, or continue to operate, a D-SNP in accordance with the CalAIM Terms and Conditions, and in accordance with federal requirements for each D-SNP, to have an executed contract with the department, referred to as a State Medicaid Agency Contract (SMAC). The requirements described in this paragraph shall not be applicable to a subcontracted delegate health plan.

(2) In Coordinated Care Initiative counties, beginning in contract year 2023, the department may only contract with a proposed D-SNP that is affiliated with a Medi-Cal managed care plan or a subcontracted delegate health plan, or was contracted with the department for a D-SNP in contract year 2022 in the proposed D-SNP service area.

(3) In Coordinated Care Initiative counties, beginning with contract year 2023, dual eligible beneficiaries that are not already enrolled in a D-SNP for contract year 2022 may only enroll in a D-SNP that is affiliated with a Medi-Cal managed care plan or a subcontracted delegate health plan in the beneficiary’s service area.

(4) In Coordinated Care Initiative counties, beginning with contract year 2023, a dual eligible beneficiary shall be assigned to a Medi-Cal managed care plan, or subcontracted delegate health plan, that is affiliated with the Medicare Advantage plan, including a D-SNP, in which the dual eligible beneficiary is enrolled. The department may approve exceptions to this policy, to support beneficiary enrollment choice.

(c) (1) Commencing January 1, 2026, subject to subdivision (f) of Section 14184.102 and paragraph (5) of this subdivision, the department may require each Medi-Cal managed care plan to operate, or continue to operate, a D-SNP in accordance with the CalAIM Terms and Conditions, and in accordance with federal requirements for each D-SNP to have an executed contract with

the department, referred to as an SMAC. The requirements described in this paragraph shall not be applicable to a subcontracted delegate health plan.

(2) In non-Coordinated Care Initiative counties, beginning no later than contract year 2025, the department shall only contract with a proposed D-SNP that is affiliated with a Medi-Cal managed care plan or subcontracted delegate health plan, or was contracted with the department for a D-SNP in the proposed D-SNP service area in the contract year that immediately precedes the contract year in which this paragraph is implemented with respect to an individual county.

(3) In non-Coordinated Care Initiative counties, beginning no later than contract year 2026, a dual eligible beneficiary shall be assigned to a Medi-Cal managed care plan or a subcontracted delegate health plan that is affiliated with the Medicare Advantage plan, including a D-SNP, in which the dual eligible beneficiary is enrolled. The department may approve exceptions to the requirement described in this subparagraph when it determines necessary to support beneficiary enrollment choice.

(4) In non-Coordinated Care Initiative counties, beginning no later than contract year 2025, dual eligible beneficiaries not already enrolled in a D-SNP, in the contract year that immediately precedes the contract year in which this paragraph is implemented with respect to an individual county, may only enroll in a D-SNP that is affiliated with a Medi-Cal managed care plan, or a subcontracted delegate health plan, in the beneficiary's service area. Beginning no later than contract year 2025, D-SNPs that are not affiliated with a Medi-Cal managed care plan or a subcontracted delegate health plan shall not accept new enrollment of dual eligible beneficiaries.

(5) The department shall conduct a feasibility study of D-SNPs, in specific non-Coordinated Care Initiative counties as determined by the department, to be completed no later than July 1, 2022. As a result of the study findings, or evidence provided by a Medi-Cal managed care plan of the potential for significant financial losses that may be incurred by a Medi-Cal managed care plan as a result of operating a D-SNP, and evidence provided by a Medi-Cal managed care plan that the plan has made a good faith effort but is not able to develop a partnership with a D-SNP for coordinated care across Medicare and Medi-Cal, the department may provide, in its sole discretion, an exemption from the requirements in paragraph (1) of this subdivision on an individual plan basis for a period of three years. The department may renew this exemption for successive three-year periods based on study findings or evidence of potential losses, and evidence of a good faith effort, as specified in this paragraph.

(d) To ensure dual eligible beneficiaries are fully informed regarding aligned enrollment, the department or the Med-Cal managed care plan, as applicable, shall provide informing notices to affected beneficiaries regarding Medi-Cal plan enrollment changes related to aligned enrollment. The notices shall be developed in consultation with consumer advocates.

(e) Beginning in contract year 2023, the department shall include requirements for network adequacy, aligned networks, and continuity of care in the SMAC. The requirements shall be developed in consultation with affected stakeholders.

(f) The department shall contract with public or private entities in assisting dual eligible beneficiaries in understanding their health care coverage options, overcoming access to care barriers, and addressing eligibility and enrollment barriers.

(g) The department shall convene a workgroup including plans, providers, and consumer stakeholders to discuss transition to a statewide Managed Long-Term Services and Supports and D-SNP structure.

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

(1) "Coordinated Care Initiative counties" means the Counties of Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

(2) "Dual eligible beneficiary" means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or both, and is eligible for medical assistance under the Medi-Cal State Plan. For purposes of this section, "dual eligible beneficiary" shall include both "full-benefit dual eligible beneficiaries" and "partial-benefit dual eligible beneficiaries," as those terms are defined in this subdivision.

(3) "Full-benefit dual eligible beneficiary" means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.), Medicare Part B (42 U.S.C. Sec. 1395j et seq.), and Medicare Part D (42 U.S.C. Sec. 1395w-101), and is eligible for medical assistance under the Medi-Cal State Plan.

(4) "Medicare Advantage Dual Special Needs Plan" or "D-SNP" shall have the same meaning as set forth in Section 1395w-28(b)(6) of Title 42 of the United States Code.

(5) "Partial-benefit dual eligible beneficiary" means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.), but not Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or who is enrolled for Medicare Part B (42 U.S.C. Sec. 1395j et seq.), but not Medicare Part A (42 U.S.C. Sec. 1395c et seq.), and is eligible medical assistance under the Medi-Cal State Plan.

(6) “Subcontracted delegate health plan” means a health care service plan that is a subcontractor of a Medi-Cal managed care plan that the department determines to have assumed the entire financial risk for all Medi-Cal services provided to a dual eligible beneficiary that are covered under the applicable comprehensive risk contract of the Medi-Cal managed care plan.

(7) “Subcontractor” shall have the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(i) For purposes of this section, “Medi-Cal managed care plan” shall not include a managed care plan contract with the AIDS Healthcare Foundation.

14184.300. (a) (1) To the extent federal financial participation is available, the department shall continue to implement the Global Payment Program (GPP) as described in Section 14184.40 during the CalAIM term. The department shall continue to administer the GPP in accordance with Section 14184.40, except to the extent changes are approved in the CalAIM Terms and Conditions and except as provided in subdivision (b).

(b) (1) Commencing January 1, 2021, the GPP program year shall be aligned with the calendar year. The department shall provide to the GPP systems a revised schedule for the reporting, notification, intergovernmental transfer, and payment set forth in paragraphs (3) and (4) of subdivision (d) of Section 14184.40, which shall maintain the same conditions and timeline, adjusted by six months to align with the calendar year, and consistent with the CalAIM Terms and Conditions.

(2) Commencing January 1, 2021, the GPP system-specific IGT factors identified in paragraph (3) of subdivision (g) of Section 14184.40 shall be inapplicable and the initial transfer amount calculated for each GPP system shall be identified by the department and communicated in writing to each GPP system for each applicable GPP program year.

(3) Commencing January 1, 2021, for purposes of determining the applicable GPP’s aggregate annual limit, applicable portions of the federal disproportionate share allotment for the federal fiscal year that ends in the GPP program year, and for the federal fiscal year that commences in the applicable GPP program year, shall be appropriately aligned with the GPP program year.

(4) Subject to subdivision (f) of Section 14184.102, a hospital that is operated by the University of California, and its affiliated and contracted providers, may elect to participate as a GPP system during the CalAIM terms by providing written notice to the department no later than June 1 of the calendar year immediately preceding the subject GPP program year.

(A) A University of California hospital that is approved to participate as a GPP system shall continue to participate as a GPP system for all remaining GPP program years during the CalAIM term, and shall be subject to all other provisions, requirements, and restrictions applicable to GPP systems in accordance with the CalAIM Terms and Conditions.

(B) A University of California hospital that is approved to participate as a GPP system shall be ineligible to receive disproportionate share hospital payments through the termination of GPP.

(C) If a University of California hospital is approved to participate as a GPP system, the department shall make all appropriate funding and program adjustments necessary to account for the additional participating GPP system in the subject GPP program years, including, but not limited to, the determinations of the federal disproportionate share hospital allotment funding available to nonparticipating University of California hospitals and the resulting GPP aggregate annual limits.

(5) Subject to the availability of sufficient nonfederal share funds for this purpose, the department may seek federal approval for, and implement, additional funding and program components for GPP systems that support and further the objectives of CalAIM and GPP.

(c) Before implementing any of the modifications described in subdivision (b), the department shall consult with the GPP systems.

(d) Except as otherwise provided in the CalAIM Terms and Conditions or in this section, and without limiting the authority in subdivision (g) of Section 14184.102, the rights, obligations, and limitations set forth in Section 14184.40 shall apply to the GPP as continued pursuant to this section.

14184.301. The payment methodologies and requirements described in Section 14184.30, as amended by the act that added this section, shall continue to apply during the entirety of the CalAIM term and any extension periods in which the Global Payment Program pursuant to Section 14184.300 is authorized.

14184.400. (a) Commencing January 1, 2022, subject to subdivision (f) of Section 14184.102, the department shall continue to implement the Specialty Mental Health Services Program described in part in Chapter 8.9 (commencing with Section 14700), as a component of CalAIM and in accordance with this article and the CalAIM Terms and Conditions.

(b) Each mental health plan contracting with the department to provide specialty mental health services pursuant to Chapter 8.9 (commencing with Section 14700) shall comply with all applicable CalAIM Terms and Conditions and any guidance issued by the department pursuant to subdivision (d) of Section 14184.102.

14184.401. (a) Commencing January 1, 2022, subject to subdivision (f) of Section 14184.102, the department shall continue to implement the Drug Medi-Cal organized delivery system (DMC-ODS) program, previously authorized under the California Medi-Cal 2020 Demonstration pursuant to Article 5.5 (commencing with Section 14184), as a component of CalAIM and in accordance with this article and the CalAIM Terms and Conditions.

(b) A county, or consortium of counties in a regional model, that elects to administer, or elects to continue to administer, a DMC-ODS pilot shall enter into and maintain an intergovernmental agreement with the department. Those counties shall comply with all applicable CalAIM Terms and Conditions and any guidance issued by the department pursuant to subdivision (d) of Section 14184.102 as a condition of participation.

(c) An election by a county, or consortium of counties in a regional model, to participate as a DMC-ODS pilot shall be considered voluntary for purposes of all state and federal laws.

14184.402. (a) Notwithstanding any other law, including, but not limited to, the applicable provisions of Chapter 11 (commencing with Section 1810.100) of Division 1 of Title 9, and Chapter 3 (commencing with Section 51000) of Subdivision 1 of Division 3 of Title 22, of the California Code of Regulations, commencing no sooner than January 1, 2022, all medically necessary determinations for covered specialty mental health services and substance use disorder services provided by a Medi-Cal behavioral health delivery system shall be made in accordance with Section 14059.5, except as provided in this section and any written instructions issued by the department pursuant to subdivision (j) until such time that regulations are promulgated or amended.

(b) (1) Subject to subdivision (f) of Section 14184.102, the following nonspecialty mental health services shall be covered by a Medi-Cal managed care plan, or available through the Medi-Cal fee-for-service delivery system for beneficiaries not enrolled in a Medi-Cal managed care plan or for services that are carved out from a Medi-Cal managed care plan's comprehensive risk contract:

(A) Individual and group mental health evaluation and treatment, including psychotherapy, family therapy, and dyadic services.

(B) Psychological testing, when clinically indicated to evaluate a mental health condition.

(C) Outpatient services for the purposes of monitoring drug therapy.

(D) Psychiatric consultation.

(E) Outpatient laboratory, drugs, supplies, and supplements.

(2) Covered nonspecialty mental health services for adult beneficiaries with mild-to-moderate distress or mild-to-moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current edition of the Diagnostic and Statistical Manual of Mental Disorders, shall be provided by a Medi-Cal managed care plan or through the Medi-Cal fee-for-service delivery system. A Medi-Cal managed care plan shall provide medically necessary nonspecialty mental health services to enrolled beneficiaries under 21 years of age as required pursuant to Section 1396d(r) of Title 42 of the United States Code. A Medi-Cal managed care plan shall also be responsible for providing covered nonspecialty mental health services to enrolled beneficiaries with potential mental health disorders not yet diagnosed.

(c) For enrolled beneficiaries 21 years of age or older, a county mental health plan shall provide covered specialty mental health services for beneficiaries who meet both of the following criteria:

(1) The beneficiary has one or both of the following:

(A) Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

(B) A reasonable probability of significant deterioration in an important area of life functioning.

(2) The beneficiary's condition as described in paragraph (1) is due to either of the following:

(A) A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.

(B) A suspected mental disorder that has not yet been diagnosed.

(d) For enrolled beneficiaries under 21 years of age, a county mental health plan shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria:

(1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experiencing trauma evidenced by scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

(2) The beneficiary meets both of the following requirements:

(A) The beneficiary has at least one of the following:

(i) A significant impairment.

(ii) A reasonable probability of significant deterioration in an important area of life functioning.

(iii) A reasonable probability of not progressing developmentally as appropriate.

(iv) A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

(B) The beneficiary's condition as described in subparagraph (A) is due to one of the following:

(i) A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.

(ii) A suspected mental health disorder that has not yet been diagnosed.

(iii) Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

(e) (1) Covered services provided under a county Drug Medi-Cal Treatment Program or a Drug Medi-Cal organized delivery system shall use criteria adopted by the American Society of Addiction Medicine to determine the appropriate level of care for substance use disorder treatment services.

(2) Covered services provided under a county Drug Medi-Cal Treatment Program or a Drug Medi-Cal organized delivery system shall include all medically necessary substance use disorder services for an individual under 21 years of age as required pursuant to Section 1396d(r) of Title 42 of the United States Code.

(3) A full assessment utilizing the criteria adopted by the American Society of Addiction Medicine shall not be required for a beneficiary to begin receiving services through a Drug Medi-Cal Treatment Program or a Drug Medi-Cal organized delivery system.

(f) (1) This section and Section 14059.5 shall not be construed to exclude coverage for, or reimbursement of, a clinically appropriate and covered mental health or substance use disorder prevention, screening, assessment, treatment, or recovery service under any of the following circumstances:

(A) Services were provided prior to determining a diagnosis.

(B) The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.

(C) The treated Medi-Cal beneficiary has a co-occurring mental health condition and substance use disorder.

(D) For a provider who provides specialty mental health services to a Medi-Cal beneficiary under a contract between the department and a county mental health plan when that beneficiary concurrently receives nonspecialty mental health services from a Medi-Cal managed care plan or under the Medi-Cal fee-for-service delivery system, if those services are coordinated between the specialty and nonspecialty delivery systems and those services are not duplicative.

(E) For a provider who provides nonspecialty mental health services to a Medi-Cal beneficiary pursuant to a comprehensive risk contract with a Medi-Cal managed care plan or under the Medi-Cal fee-for-service delivery system when that beneficiary concurrently receives specialty mental health services from a county mental health plan, if those services are coordinated between the nonspecialty and specialty delivery systems and those services are not duplicative.

(2) This section and Section 14059.5 shall not be construed to exclude clinically appropriate and covered mental health or substance use disorder services during the assessment process.

(g) A dispute between a county mental health plan and a Medi-Cal managed care plan shall not delay the provision of medically necessary services by the county mental health plan or the Medi-Cal managed care plan.

(h) (1) The department shall develop, in consultation with county behavioral health directors, consumer advocates, labor organizations representing county behavioral health workers, mental health and substance use disorder treatment providers, and Medi-Cal managed care plans, standardized screening tools to guide a referral to a Medi-Cal behavioral health delivery system. The department shall develop a standardized screening tool for Medi-Cal beneficiaries who are under 21 years of age and a separate standardized screening tool for those who are 21 years of age or older. The department may require the use of these standardized screening tools by Medi-Cal behavioral health delivery systems and Medi-Cal managed care plans.

(2) The department shall develop, in consultation with county behavioral health directors, consumer advocates, labor organizations representing county behavioral health workers, mental health and substance use disorder treatment providers, and Medi-Cal managed care plans, standardized statewide transition tools to ensure that Medi-Cal beneficiaries requiring transition between delivery systems receive timely coordinated care. The department shall develop a standardized statewide transition tool for Medi-Cal beneficiaries who are under 21 years of age and a separate standardized statewide transition tool for those who are 21 years of age or older. The department may require the use of these standardized statewide transition tools.

(3) The department shall develop, in consultation with county behavioral health directors, consumer advocates, labor organizations representing county behavioral health workers, and mental health and substance use disorders treatment providers, documentation standards and changes to the department's clinical auditing standards. The department may require the use of these documentation standards by Medi-Cal behavioral health delivery systems, including, but not limited to, restrictions developed in consultation with representatives of Medi-Cal behavioral health delivery systems on what Medi-Cal behavioral health delivery systems impose on their contract providers, consistent with Medi-Cal managed care plans and taking into account the need to ensure quality and program integrity and to address equity and disparities.

(i) (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, and make specific this section and the associated CalAIM terms and conditions by means of all-county letters, plan letters, information notices, or similar instructions, until regulations are promulgated or amended in accordance with paragraph (2).

(2) Notwithstanding subdivision (d) of Section 14184.102, the department shall promulgate or amend regulations, as necessary, to implement, interpret, and make specific this section and the associated CalAIM terms and conditions 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 by July 1, 2024.

14184.403. (a) Notwithstanding any other law, commencing no sooner than July 1, 2022, subject to subdivision (f) of Section 14184.102, each Medi-Cal behavioral health delivery system shall comply with the behavioral health payment reform provisions approved in the CalAIM Terms and Conditions and any associated instruction issued by the department pursuant to subdivision (d) of Section 14184.102.

(b) As a component of Behavioral Health Payment Reform under CalAIM, the department shall, at a minimum, design and implement an intergovernmental transfer-based reimbursement methodology to replace the use of certified public expenditures for claims associated with covered Specialty Mental Health and Drug Medi-Cal services provided through Medi-Cal behavioral health delivery systems.

(c) Notwithstanding any other law, commencing no sooner than July 1, 2022, the nonfederal share of any payments associated with each Medi-Cal behavioral health delivery system shall consist of voluntary intergovernmental transfers of funds provided by eligible governmental agencies or public entities associated with a respective Medi-Cal behavioral health delivery system. Upon providing any intergovernmental transfer of funds, each transferring entity shall certify that the transferred funds qualify for federal financial participation pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations, any other applicable federal Medicaid laws, and the CalAIM Terms and Conditions, and in the form and manner specified by the department. Any intergovernmental transfer of funds made pursuant to this section shall be considered voluntary for purposes of all state and federal laws. Notwithstanding any other law, the department shall not assess the fee described in subdivision (d) of Section 14301.4 or any other similar fee on the intergovernmental transfers made pursuant to this section. The total intergovernmental transfer-funded payment amount, which includes the federal and nonfederal share, paid to a Medi-Cal behavioral health delivery system shall be for the support of behavioral health-related services and activities that benefit patients served by the Medi-Cal behavioral health delivery system, consistent with federal law.

(d) (1) The department shall establish and implement prospective reimbursement rate methodologies utilizing past county cost experience for covered Specialty Mental Health and Drug Medi-Cal services provided by Medi-Cal behavioral health delivery systems. Those methodologies shall make use of peer groups whereby counties are grouped according to past cost experience, where the department determines appropriate. The department shall determine the frequency of payments and intergovernmental transfers made pursuant to this section. The department shall consult with the representatives of Medi-Cal behavioral health delivery systems in the development of the rate methodologies, peer groups, and the payment schedule.

(2) The department, in consultation with the representatives of Medi-Cal behavioral health delivery systems, shall review and may modify the methodologies annually, including, but not limited to, adjustments to the peer groups or to rates.

14184.404. (a) Notwithstanding any other law, commencing January 1, 2027, subject to subdivision (f) of Section 14184.102, an individual county, or counties acting jointly, shall provide and administer covered behavioral health Medi-Cal benefits under a single Medi-Cal behavioral health delivery system contract, in accordance with the CalAIM Terms and Conditions.

(b) During the CalAIM term, the department, in consultation with counties, shall conduct any planning activities it deems necessary and issue related guidance pursuant to subdivision (d) of Section 14184.102 to facilitate implementation of subdivision (a).

(c) The department may authorize a noncounty organization that it contracts with pursuant to Section 14712 or Section 14124.21 to provide and administer covered behavioral health Medi-Cal benefits under a single Medi-Cal behavioral health delivery system contract, in accordance with the CalAIM Terms and Conditions.

14184.405. (a) Subject to an appropriation, the department shall establish, implement, and administer the Behavioral Health Quality Improvement Program to provide grants to qualified Medi-Cal behavioral health delivery systems for purposes of preparing those entities and their contracting health care providers for implementation of CalAIM behavioral health components described in this article and for the purposes of implementing changes to the behavioral health delivery system in the Children and Youth Behavioral Health Initiative.

(b) The department shall, in consultation with representatives of the Medi-Cal behavioral health delivery systems, determine the eligibility criteria, grant application process, and methodology for distribution of the moneys appropriated to the department for the purposes described in this section to Medi-Cal behavioral health delivery systems that the department deems qualified and for the purposes of implementing changes to the behavioral health delivery system in the Children and Youth Behavioral Health Initiative.

(c) The section shall be implemented only if, and to the extent that, the department determines that federal financial participation is not jeopardized.

14184.500. (a) The department shall implement the State Plan Dental Improvement Program in accordance with the CalAIM Terms and Conditions and as described in this section, with the goal of further improving accessibility of Medi-Cal dental services and oral health outcomes for statewide and targeted populations, as a successor program to the Dental Transformation Initiative described in Section 14184.70.

(b) Commencing no sooner than January 1, 2022, subject to subdivision (f) of Section 14184.102, both of the following shall be covered Medi-Cal benefits for the specified populations, when medically necessary and subject to utilization controls:

(1) Caries Risk Assessment bundle for eligible children 0 to 6 years of age, inclusive.

(2) Silver diamine fluoride for eligible children 0 to 6 years of age, inclusive, and for eligible beneficiaries residing in skilled nursing facilities or intermediate care facilities or that receive services in facilities overseen by the State Department of Developmental Services, as determined by the department.

(c) (1) Commencing no sooner than January 1, 2022, subject to subdivision (f) of Section 14184.102, the department shall make supplemental payments to qualified dental providers for increased utilization of certain preventive dental services, and for the establishment or maintenance of beneficiary continuity of care through a dental home.

(2) The department shall develop the methodology for making supplemental payments pursuant to this subdivision, including, but not limited to, the eligibility criteria for receiving payments, the amount of payments, and the applicable preventive dental services that are eligible for payments.

(A) For payments for increased utilization of certain preventive services, the department shall make a supplemental payment to a qualified dental service office location for each eligible paid claim made for those Current Dental Terminology codes specified by the department and approved in the CalAIM Terms and Conditions. To the extent the department deems practicable, the supplemental payment shall be applied at the same time as the underlying eligible paid claim is made.

(B) For payments for the establishment or maintenance of beneficiary continuity of care through a dental home, the department shall make a supplemental payment to each eligible service office location statewide based on the number of Medi-Cal beneficiaries for which eligible paid claims were submitted using at least one of Current Dental Terminology exam codes, as specified by the department, in two or more consecutive calendar years.

(d) To the extent permissible under federal law and authorized under the CalAIM Terms and Conditions, for purposes of eligibility for payments described in this section, qualified dental providers may include safety net clinics that provide services defined under subdivision (a) or (b) of Section 14132.100. Supplemental payments made pursuant to this section to safety net clinics shall be considered separate and apart from either the Prospective Payment Service reimbursement for federally qualified health centers or rural health clinics, or Memorandum of Agreement reimbursement for Tribal Health Centers.

(e) The department shall seek federal approval of any state plan amendments it deems necessary to implement subdivisions (b) and (c).

14184.600. (a) As a component of the CalAIM initiative, on and after July 1, 2022, the department, in consultation with representatives of county welfare departments and other affected stakeholders, shall develop and make publicly available a dashboard that reflects each county's performance in meeting the measures established pursuant to subdivision (d) of Section 14154 and Section 14154.5.

(b) During the CalAIM term, subject to subdivision (f) of Section 14184.102, the department, in consultation with counties and other affected stakeholders, shall develop and implement all of the following initiatives to enhance oversight and monitoring of county administration of the California Children's Services (CCS) program, pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code:

(1) Establish statewide performance, reporting, and budgetary standards, and accompanying audit tools, used to assess county compliance with federal and state requirements applicable to the CCS program.

(2) Conduct periodic CCS quality assurance reviews and audits to assess compliance with the standards established in paragraph (1).

(3) Assess each CCS program to ensure appropriate allocation of resources necessary for compliance with standards, policies, guidelines, performance, and compliance requirements.

(4) Determine and implement a process to inform each CCS program of, and make available on its internet website, the latest standards, policies, guidelines, and new performance and compliance requirements imposed pursuant to this section.

(5) Establish a statewide, tiered enforcement framework to ensure prompt corrective action for counties that do not meet standards established in paragraph (1), including providing technical assistance to counties on measures where performance is consistently below expectations and on any issues that may be identified to create a continuous quality improvement process prior to the imposition of fiscal penalties.

(6) Require each county to enter into memoranda of understanding with the department to document each county's obligations in administering the CCS program.

(c) During the CalAIM term, the department shall convene a workgroup consisting of counties and other applicable stakeholders to develop and implement one or more initiatives designed to improve the collection and use of beneficiary demographic and contact information in administering the Medi-Cal program and other applicable public assistance programs.

14184.700. (a) Subject to subdivision (f) of section 14184.102 and the availability of sufficient nonfederal share funds for this purpose in each CalAIM year, the department may make incentive payments, grants, or other financial support available to qualified entities or providers under the Providing Access and Transforming Health (PATH) program to support services, infrastructure, and capacity building in advancing and complimenting select goals and components of CalAIM as described in this article.

(b) The department, in consultation with affected entities and providers, shall establish the methodologies, parameters, and eligibility criteria for PATH payments pursuant to this section, in accordance with the CalAIM Terms and Conditions.

(c) For purposes of PATH payments made pursuant to this section, qualified entities or providers may include, but need not be limited to, counties, Medi-Cal managed care plans, designated public hospital systems, community-based organizations, county sheriffs, adult and juvenile correctional facilities, or chief probation officers, to the extent approved in the CalAIM Terms and Conditions.

(d) The nonfederal share of PATH payments may consist of voluntary intergovernmental transfers of funds provided by eligible governmental agencies 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 Section 433.51 of Title 42 of the Code of Federal Regulations, any other applicable federal Medicaid laws, and the CalAIM Terms and Conditions, and in the form and manner specified by the department. Any intergovernmental transfer of funds made pursuant to this section shall be considered voluntary for purposes of all state and federal laws. Notwithstanding any other law, the department shall not assess the fee described in subdivision (d) of Section 14301.4 or any other similar fee on the intergovernmental transfers made pursuant to this section.

14184.800. (a) Notwithstanding any other law, commencing no sooner than January 1, 2023, a qualifying inmate of a public institution shall be eligible to receive targeted Medi-Cal services for 90 days, or the number of days approved in the CalAIM Terms and Conditions if fewer than 90 days, prior to the date they are released from a public institution, if otherwise eligible for those services under this chapter and subject to subdivision (f) of Section 14184.102.

(b) Targeted Medi-Cal services made available to qualifying inmates pursuant to subdivision (a) shall be limited to those services approved in the CalAIM Terms and Conditions.

(c) To the extent federal approval is obtained to implement this section, the department shall arrange for an independent, third-party evaluation of the hypotheses and outcomes associated with providing targeted Medi-Cal services to qualifying inmates as described in the CalAIM Terms and Conditions. The department shall post the evaluation report on its internet website following submission to the federal Centers for Medicare and Medicaid Services.

SEC. 403. Section 14186 of the Welfare and Institutions Code is amended to read:

14186. (a) It is the intent of the Legislature that long-term services and supports (LTSS) be covered through managed care health plans in Coordinated Care Initiative counties.

(b) It is further the intent of the Legislature that all of the following occur:

(1) Persons receiving health care services through Medi-Cal receive these services through a coordinated health care system that reduces the unnecessary use of emergency and hospital services.

(2) Coordinated health care services, including medical, long-term services and supports, and enhanced care management be covered through Medi-Cal managed care health plans in order to eliminate system inefficiencies and align incentives with positive health care outcomes.

(3) Managed care health plans shall, in coordination with LTSS care management providers, develop and expand care coordination practices in consultation with counties, nursing facilities, area agencies on aging, and other home- and community-based providers, and share best practices. Unless the consumer objects, managed care health plans may establish care coordination teams as needed. If the consumer is an IHSS recipient, their participation and the participation of their provider shall be subject to the consumer’s consent. These care coordination teams shall include the consumer, and their authorized representative, health plan, Community-Based Adult Services (CBAS) case manager for CBAS clients, Multipurpose Senior Services Program (MSSP) case manager for MSSP clients, and, if an IHSS recipient, may include others, including, but not limited to, the recipient’s IHSS provider or a representative of the county social services agency.

(4) To the extent possible, for Medi-Cal beneficiaries also enrolled in the Medicare program, that the department work with the federal government to coordinate financing and incentives and permit managed care health plans to coordinate health care provided under both health care systems.

(5) The health care choices made by Medi-Cal beneficiaries be considered with regard to all of the following:

(A) Receiving care in a home- and community-based setting to maintain independence and quality of life.

(B) Selecting their health care providers in the managed care plan network.

(C) Controlling care planning, decisionmaking, and coordination with their health care providers.

(D) Gaining access to services that are culturally, linguistically, and operationally sensitive to meet their needs or limitations and that improve their health outcomes, enhance independence, and promote living in home- and community-based settings.

(E) Self-directing their care by being able to hire, fire, and supervise their IHSS provider.

(F) Being assured by the department and coordinating departments of their oversight of the quality of these coordinated health care services.

(6) Counties continue to perform functions necessary for the administration of the IHSS program, including conducting assessments and determining authorized hours for recipients, pursuant to Article 7 (commencing with Section 12300) of Chapter 3. Counties and the State Department of Social Services may share recipient and provider data, as legally authorized, related to the IHSS program with managed care health plans for members who are receiving IHSS benefits to support care coordination when applicable.

(7) (A) No sooner than December 31, 2019, or on the date the managed care health plans and MSSP providers jointly satisfy the readiness criteria developed pursuant to subparagraph (D) of paragraph (4) of subdivision (b) of Section 14186.3, whichever is earlier, MSSP services shall transition from a federal waiver pursuant to Section 1915(c) under the federal Social Security Act (42 U.S.C. Sec. 1396n(c)) to a benefit administered and allocated by managed care health plans in Coordinated Care Initiative counties.

(B) Notwithstanding Chapter 8 (commencing with Section 9560) of Division 8.5, it is also the intent of the Legislature that the provisions of this article shall apply to dual eligible and Medi-Cal-only beneficiaries enrolled in MSSP. It is the further intent of the Legislature that the department and managed care health plans shall work in collaboration with MSSP providers to begin development of standards that create a model of care of an integrated, person-centered care management and care coordination model that works within the context of managed care, and explore which portions of the MSSP program model may be adapted to managed care while maintaining the integrity and efficacy of the MSSP model to use as the basis of transition planning.

(C) At least 30 days before the MSSP services transition to a benefit administered and allocated by managed care health plans in Coordinated Care Initiative counties, the department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to transition the MSSP services to managed care health plans.

(D) Notwithstanding any other law, this paragraph shall be operative only through December 31, 2021.

(8) In lieu of providing nursing facility services, managed care health plans may authorize home- and community-based services plan benefits, as defined in subdivision (d) of Section 14186.1, which managed care health plans shall be responsible for paying at no share of cost to the county.

(9) Managed care health plans shall share confidential beneficiary data as legally authorized and as appropriate to improve care coordination, promote shared understanding of the consumer's needs, and provide appropriate coordination to the IHSS program and other long-term services and supports.

(10) Managed care health plans may authorize Care Plan Option services, which may include assistance with activities of daily living and instrumental activities of daily living, for which managed care health plans shall be solely responsible for paying. The grievance process for these benefits shall be the same process as used for other benefits authorized by managed care health plans, and shall comply with Section 14450 of this code and Sections 1368 and 1368.1 of the Health and Safety Code.

(c) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(d) (1) Notwithstanding any other law, this section shall remain operative only through December 31, 2022.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 404. Section 14186.1 of the Welfare and Institutions Code is amended to read:

14186.1. For purposes of this article, the following definitions shall apply unless otherwise specified:

(a) "Coordinated Care Initiative counties" has the same meaning as that term is defined in paragraph (1) of subdivision (b) of Section 14182.16.

(b) "Home- and community-based services" means services provided pursuant to paragraphs (1), (2), and (3) of subdivision (c).

(c) "Long-term services and supports" or "LTSS" means all of the following:

(1) In-home supportive services (IHSS) provided pursuant to Article 7 (commencing with Section 12300) of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956. Notwithstanding any other law, this paragraph shall be operative only through December 31, 2017.

(2) Community-Based Adult Services (CBAS).

(3) Multipurpose Senior Services Program (MSSP) services, which include those services approved under a federal home- and community-based services waiver or, beginning no sooner than January 1, 2020, or on the date the managed care health plans and MSSP providers jointly satisfy the readiness criteria developed pursuant to subparagraph (D) of paragraph (4) of subdivision (b) of Section 14186.3, whichever is earlier, equivalent services. Notwithstanding any other law, this paragraph shall be operative only through December 31, 2021.

(4) Skilled nursing facility services and subacute care services established under subdivision (c) of Section 14132, including those services described in Sections 51511 and 51511.5 of Title 22 of the California Code of Regulations, regardless of whether the service is included in the basic daily rate or billed separately, and any leave of absence or bed hold provided consistent with Section 72520 of Title 22 of the California Code of Regulations or the state plan. However, services provided by any category of intermediate care facility for the developmentally disabled shall not be considered long-term services and supports.

(d) "Home- and community-based services (HCBS) plan benefits" may include in-home and out-of-home respite, nutritional assessment, counseling, and supplements, minor home or environmental adaptations, habilitation, and other services that may be deemed necessary by the managed care health plan, including its care coordination team. The department, in consultation with stakeholders, may determine whether health plans shall be required to include these benefits in their scope of service, and may establish guidelines for the scope, duration, and intensity of these benefits. The grievance process for these benefits shall be the same process as used for other benefits authorized by managed care health plans, and shall comply with Section 14450, and Sections 1368 and 1368.1 of the Health and Safety Code.

(e) "Managed care health plan" means an individual, organization, or entity that enters into a contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), or Article 2.91 (commencing with Section 14089), of this chapter, or Chapter 8 (commencing with Section 14200). For purposes of this article, "managed care health plan" shall not include an individual, organization, or entity that enters into a contract with the department to provide services pursuant to Chapter 8.75 (commencing with Section 14591) or the Senior Care Action Network.

(f) "Other health coverage" means health coverage providing the same full or partial benefits as the Medi-Cal program, health coverage under another state or federal medical care program except for the Medicare Program (Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.)), or health coverage under a contractual or legal entitlement, including, but not limited to, a private group or indemnification insurance program.

(g) "Recipient" means a Medi-Cal beneficiary eligible for In-Home Supportive Services provided pursuant to Article 7 (commencing with Section 12300) of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.

(h) "Stakeholder" shall include, but not be limited to, area agencies on aging and independent living centers.

(i) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(j) (1) Notwithstanding any other law, this section shall remain operative only through December 31, 2022.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 405. Section 14186.2 of the Welfare and Institutions Code is amended to read:

14186.2. (a) (1) Not sooner than March 1, 2013, all Medi-Cal long-term services and supports (LTSS) described in subdivision (c) of Section 14186.1 shall be services that are covered under managed care health plan contracts and shall be available only through managed care health plans to beneficiaries residing in Coordinated Care Initiative counties, except for the exemptions provided for in subdivision (c). The director shall consult with the Legislature, CMS, and stakeholders when determining the implementation date for this section. The department shall pay managed care health plans using a capitation ratesetting methodology that pays for all Medi-Cal benefits and services, including all LTSS, covered under the managed care health plan contract. In order to receive any LTSS through Medi-Cal, Medi-Cal beneficiaries shall mandatorily enroll in a managed care health plan for the provision of Medi-Cal benefits.

(2) HCBS plan benefits may be covered services that are provided under managed care health plan contracts for beneficiaries residing in Coordinated Care Initiative counties, except for the exemptions provided for in subdivision (c).

(3) Beneficiaries who are not mandatorily enrolled in a managed care health plan pursuant to paragraph (15) of subdivision (b) of Section 14182 shall not be required to receive LTSS through a managed care health plan.

(4) The transition of the provision of LTSS through managed care health plans shall occur after the department obtains any federal approvals through necessary federal waivers or amendments, or state plan amendments.

(5) Counties where LTSS are not covered through managed care health plans shall not be subject to this article.

(6) Beneficiaries residing in counties not participating in the dual eligible demonstration project pursuant to Section 14132.275 shall not be subject to this article.

(b) (1) The provisions of this article shall be applicable to a Medi-Cal beneficiary enrolled in a managed care health plan in a county where this article is effective.

(2) At the director's sole discretion, in consultation with coordinating departments and stakeholders, the department may determine and implement a phased-in enrollment approach that may include the addition of Medi-Cal long-term services and supports in a beneficiary's Medi-Cal managed care benefits immediately upon implementation of this article in a specific county, over a 12-month period, or other phased approach, but no sooner than March 1, 2013.

(c) (1) The provisions of this article shall not apply to any of the following individuals:

(A) Medi-Cal beneficiaries who meet any of the following and shall, therefore, continue to receive any medically necessary Medi-Cal benefits, including LTSS, through fee-for-service Medi-Cal:

(i) Except in counties with county organized health systems operating pursuant to Article 2.8 (commencing with Section 14087.5), have other health coverage.

(ii) Receive services through any state foster care program including the program described in Article 5 (commencing with Section 11400) Chapter 2, unless the beneficiary is already receiving services through a managed care health plan.

(iii) Are ineligible for enrollment in managed care health plans for medically necessary reasons determined by the department.

(iv) Reside in one of the Veterans' Homes of California, as described in Chapter 1 (commencing with Section 1010) of Division 5 of the Military and Veterans Code.

(B) Persons enrolled in the Program of All-Inclusive Care for the Elderly (PACE) pursuant to Chapter 8.75 (commencing with Section 14591), or a managed care organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has previously contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) of Chapter 7 to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS.

(C) Persons who are under 21 years of age.

(D) Other specific categories of beneficiaries specified by the department based on extraordinary medical needs of specific patient groups or to meet federal requirements, in consultation with stakeholders.

(2) Beneficiaries who have been diagnosed with HIV/AIDS are not exempt from mandatory enrollment, but may opt out of managed care enrollment at the beginning of any month.

(d) Except in counties with county organized health systems operating pursuant to Article 2.8 (commencing with Section 14087.5), the department or its enrollment contractor shall notify a beneficiary who is required to receive Medi-Cal long-term care services and supports through a managed care plan and who is potentially eligible for PACE that they may alternatively request to be assessed for eligibility for PACE, and, if eligible, may enroll in PACE. The department or its enrollment contractor shall not enroll a beneficiary who requests to be assessed for PACE in a managed care plan until the earlier of 60 days or the time that they are assessed and determined to be ineligible for a PACE plan, unless the beneficiary subsequently chooses to enroll in a managed care plan. During the time that the beneficiary is being assessed, they shall remain in fee-for-service Medi-Cal, or, if applicable, the managed care plan in which they are enrolled.

(e) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(f) (1) Notwithstanding any other law, this section shall remain operative only through December 31, 2022.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 406. Section 14186.3 of the Welfare and Institutions Code is amended to read:

14186.3. (a) (1) No sooner than July 1, 2012, Community-Based Adult Services (CBAS) shall be a Medi-Cal benefit covered under every managed care health plan contract and available only through managed care health plans. Medi-Cal beneficiaries who are eligible for CBAS shall enroll in a managed care health plan in order to receive those services, except for beneficiaries

exempt under subdivision (c) of Section 14186.2 or in counties or geographic regions where Medi-Cal benefits are not covered through managed care health plans. Notwithstanding subdivision (a) of Section 14186.2 and pursuant to the provisions of an approved federal waiver or plan amendment, the provision of CBAS as a Medi-Cal benefit through a managed care health plan shall not be limited to Coordinated Care Initiative counties.

(2) Managed care health plans shall determine a member's medical need for CBAS using the assessment tool and eligibility criteria established pursuant to the provisions of an approved federal waiver or amendments and shall approve the number of days of attendance and monitor treatment plans of their members. Managed care health plans shall reauthorize CBAS in compliance with criteria established pursuant to the provisions of the approved federal waiver or amendment requirements.

(3) CBAS shall be delivered in accordance with applicable state and federal law including, but not limited to, the federal Home and Community-Based Settings regulations described in Sections 441.301(c)(4), 441.530(a)(1), and 441.710(a)(1) of Title 42 of the Code of Federal Regulations, and related subregulatory guidance and any amendment issued thereto.

(4) Commencing January 1, 2022, subject to subdivision (f) of Section 14184.102, CBAS shall continue to be available as a Medi-Cal benefit only through managed care health plans in accordance with subdivision (f) of Section 14184.201.

(b) (1) Beginning in the 2012 calendar year, managed care health plans shall collaborate with MSSP providers to begin development of an integrated, person-centered care management and care coordination model and explore how the MSSP program model may be adapted to managed care while maintaining the efficacy of the MSSP model. The California Department of Aging and the department shall work with the MSSP site association and managed care health plans to develop a template contract to be used by managed care health plans contracting with MSSP sites in Coordinated Care Initiative counties.

(2) Notwithstanding the implementation date authorized in paragraph (1) of subdivision (a) of Section 14186.2, no later than December 31, 2017, or on the date the managed care health plans and MSSP providers jointly satisfy the readiness criteria developed pursuant to subparagraph (D) of paragraph (4), whichever is earlier:

(A) Multipurpose Senior Services Program (MSSP) services shall be a Medi-Cal benefit available only through managed care health plans, except for beneficiaries exempt under subdivision (c) of Section 14186.2 in Coordinated Care Initiative counties.

(B) Managed care health plans shall contract with all county and nonprofit organizations that are designated providers of MSSP services for the provision of MSSP case management and waiver services. These contracts shall provide for all of the following:

(i) Managed care health plans shall allocate to the MSSP providers the same level of funding they would have otherwise received under their MSSP contract with the California Department of Aging.

(ii) MSSP providers shall continue to meet all existing federal waiver standards and program requirements, which include maintaining the contracted service levels.

(iii) Managed care plans and MSSP providers shall share confidential beneficiary data with one another, as necessary to implement the provisions of this section.

(C) The California Department of Aging shall continue to contract with all designated MSSP sites, including those in the counties participating in the demonstration project, and perform MSSP waiver oversight and monitoring.

(D) The California Department of Aging and the department, in consultation with MSSP providers, managed care health plans, and stakeholders, shall develop service fee structures, services, and person-centered care coordination models that shall be effective June 2013, for the provision of care coordination and home- and community-based services to beneficiaries who are enrolled in managed care health plans but not enrolled in MSSP, and who may have care coordination and service needs that are similar to MSSP participants. The service fees for MSSP providers and MSSP services for any additional beneficiaries and additional services for existing MSSP beneficiaries shall be based upon, and consistent with, the rates and services delivered in MSSP.

(3) In the 2014 calendar year, the provisions of paragraph (2) shall continue. In addition, managed care health plans shall work in collaboration with MSSP providers to begin development of an integrated, person-centered care management and care coordination model that works within the context of managed care and explore which portions of the MSSP program model may be adapted to managed care while maintaining the integrity and efficacy of the MSSP model.

(4) (A) No sooner than December 31, 2019, or on the date the managed care health plans and MSSP providers jointly satisfy the readiness criteria developed pursuant to subparagraph (D) of this paragraph, whichever is earlier, MSSP services in Coordinated Care Initiative counties shall transition from a federal waiver pursuant to Section 1915(c) under the federal Social Security Act (42 U.S.C. Sec. 1396n(c)) to a benefit administered and allocated by managed care health plans.

(B) No later than January 1, 2014, the department, in consultation with the California Department of Aging and the Department of Managed Health Care, and with stakeholder input, shall submit a transition plan to the Legislature to describe how subparagraph (A) shall be implemented. The plan shall incorporate the principles of the MSSP in the managed care benefit, and shall include provisions to ensure seamless transitions and continuity of care. Managed care health plans shall, in partnership with local MSSP providers, conduct a local stakeholder process to develop recommendations that the department shall consider when developing the transition plan.

(C) No later than 90 days before the implementation of subparagraph (A), the department, in consultation with the California Department of Aging and the Department of Managed Health Care, and with stakeholder input, shall submit a transition plan to the Legislature that includes steps to address concerns, if any, raised by stakeholders subsequent to the plan developed pursuant to subparagraph (B).

(D) Before MSSP services transition to a benefit administered and allocated by managed care health plans pursuant to subparagraph (A) of paragraph (2), the California Department of Aging and the department, in consultation with MSSP providers, managed care health plans, and stakeholders, shall develop readiness criteria for the transition. The readiness criteria shall include, but are not limited to, the mutual agreement of the affected managed care health plans and MSSP providers to the transition date. The department shall evaluate the readiness of the managed care health plans and MSSP providers to commence the transition of MSSP services to managed care health plans.

(E) At least 30 days before the MSSP services transition to a benefit administered and allocated by managed care health plans in Coordinated Care Initiative counties, the department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to transition the MSSP services to managed care health plans.

(5) Notwithstanding any other law, this subdivision shall be operative only through December 31, 2021.

(c) (1) Not sooner than March 1, 2013, or on the date that any necessary federal approvals or waivers are obtained, whichever is later, nursing facility services and subacute facility services shall be Medi-Cal benefits available only through managed care health plans.

(2) Managed care health plans shall authorize utilization of nursing facility services or subacute facility services for their members when medically necessary. The managed care health plan shall maintain the standards for determining levels of care and authorization of services for both Medicare and Medi-Cal services that are consistent with policies established by the federal Centers for Medicare and Medicaid Services and consistent with the criteria for authorization of Medi-Cal services specified in Section 51003 of Title 22 of the California Code of Regulations, which includes utilization of the “Manual of Criteria for Medi-Cal Authorization,” published by the department in January 1982, last revised April 11, 2011.

(3) The managed care health plan shall maintain continuity of care for beneficiaries by recognizing any prior treatment authorization made by the department for not less than six months following enrollment of a beneficiary into the health plan.

(4) When a managed care health plan has authorized services in a facility and there is a change in the beneficiary’s condition under which the facility determines that the facility may no longer meet the needs of the beneficiary, the beneficiary’s health has improved sufficiently so the resident no longer needs the services provided by the facility, or the health or safety of individuals in the facility is endangered by the beneficiary, the managed care health plan shall arrange and coordinate a discharge of the beneficiary and continue to pay the facility the applicable rate until the beneficiary is successfully discharged and transitioned into an appropriate setting.

(5) The managed care health plan shall pay providers, including institutional providers, in accordance with the prompt payment provisions contained in each health plan’s contracts with the department, including the ability to accept and pay electronic claims.

(d) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(e) (1) Notwithstanding any other law, this section shall remain operative only through December 31, 2022.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 407. Section 14186.4 of the Welfare and Institutions Code is amended to read:

14186.4. (a) This article shall be implemented only to the extent that all necessary federal approvals and waivers have been obtained and only if and to the extent that federal financial participation is available.

(b) To implement this article, the department may contract with public or private entities. Contracts, or amendments to current contracts, entered into under this article may be on a noncompetitive bid basis and shall be exempt from all of the following:

(1) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part.

(2) Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code.

(3) Review or approval of contracts by the Department of General Services.

(4) Review or approval of feasibility study reports and the requirements of Sections 4819.35 to 4819.37, inclusive, and Sections 4920 to 4928, inclusive, of the State Administrative Manual.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department and State Department of Social Services may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. Before issuing any letter or similar instrument authorized pursuant to this section, the departments shall notify and consult with stakeholders, including beneficiaries, providers, area agencies on aging, independent living centers, and advocates.

(d) Beginning July 1, 2012, the department shall provide the fiscal and appropriate policy committees of the Legislature with a copy of any report submitted to the federal Centers for Medicare and Medicaid Services (CMS) that is required under an approved federal waiver or waiver amendments or any state plan amendment for any long-term services and supports.

(e) The department shall enter into an interagency agreement with the Department of Managed Health Care to perform some or all of the department's oversight and readiness review activities specified in this article. These activities may include providing consumer assistance to beneficiaries affected by this article, and conducting financial audits, medical surveys, and a review of the provider networks of the managed care health plans participating in this article. The interagency agreement shall be updated, as necessary, on an annual basis in order to maintain functional clarity regarding the roles and responsibilities of the Department of Managed Health Care and the department. The department shall not delegate its authority as the single state Medicaid agency under this article to the Department of Managed Health Care. Notwithstanding any law, this subdivision shall be operative only through June 30, 2017.

(f) (1) Beginning with the May Revision to the 2013–14 Governor's Budget, and annually thereafter, the department shall report to the Legislature on the enrollment status, quality measures, and state costs of the actions taken pursuant to this article.

(2) (A) By January 1, 2013, or as soon thereafter as practicable, the department shall develop, in consultation with CMS and stakeholders, quality and fiscal measures for managed care health plans to reflect the short- and long-term results of the implementation of this article. The department shall also develop quality thresholds and milestones for these measures. The department shall update these measures periodically to reflect changes in this program due to implementation factors and the structure and design of the benefits and services being coordinated by the health plans.

(B) The department shall require managed care health plans to submit Medicare and Medi-Cal data to determine the results of these measures. If the department finds that a health plan is noncompliant with one or more of the measures set forth in this section, the health plan shall submit, within 60 days, a corrective action plan to the department for approval. The corrective action plan shall include, at a minimum, steps that the health plan shall take to improve its performance based on the standard or standards with which the health plan is out of compliance. The corrective action plan shall establish interim benchmarks for improvement that shall be expected to be met by the health plan in order to avoid a sanction pursuant to Section 14197.7. This paragraph does not limit the application of Section 14197.7.

(C) The department shall publish the results of these measures, including via posting on the department's internet website, on a quarterly basis.

(g) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(h) (1) Notwithstanding any other law, this section shall remain operative only through December 31, 2022.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 408. Section 14188.1 of the Welfare and Institutions Code is amended to read:

14188.1. Subject to Section 14188, the department shall develop all of the following VBP programs:

(a) A VBP program that is aimed at improving behavioral health integration in Medi-Cal managed care.

(1) Designated Medi-Cal managed care plans may earn incentive payments for achieving milestones and measures through partnerships with qualified network providers that adopt a team-based care approach for individuals with serious mental health conditions or other chronic health conditions.

(2) Different levels of incentive payments may be available depending on the level of integration, using either a coordination or collocation approach. Partial incentive payments may be available for meeting above-minimum standards.

(3) The requirements for receiving an incentive payment and the methodology for determining the value of the payment shall be determined by the department, in accordance with this article.

(b) A VBP program that is aimed at improving prenatal and postpartum care in Medi-Cal managed care.

(1) Designated Medi-Cal managed care plans shall make incentive payments to qualified network primary care or appropriate specialist providers that meet achievement levels on selected prenatal and postpartum care measures, as determined by the department.

(2) Qualified network primary care or appropriate specialist providers may be eligible for maximum incentive payments if they meet the designated high-performance standards, and partial incentive payments for meeting above-minimum standards.

(3) The requirements for receiving an incentive payment and the methodology for determining the value of the payment shall be determined by the department, in accordance with this article.

(c) A VBP program that is aimed at improving chronic disease management in Medi-Cal managed care.

(1) Designated Medi-Cal managed care plans shall make incentive payments to qualified network providers that meet achievement levels on selected chronic disease care measures, as determined by the department. The measures shall be in chronic disease care areas, including, but not limited to, diabetes care and control of hypertension, using measures currently recognized for those areas in the Healthcare Effectiveness Data and Information Set (HEDIS) or other nationally recognized measures that the department deems appropriate.

(2) Qualified network providers may be eligible for maximum incentive payments if they meet the designated high-performance standards, and partial incentive payments for meeting above-minimum standards.

(3) The requirements for receiving an incentive payment and the methodology for determining the value of the payment shall be determined by the department, in accordance with this article.

(d) A VBP program that is aimed at improving quality and outcomes for children in Medi-Cal managed care.

(1) Designated Medi-Cal managed care plans shall make incentive payments to qualified network providers that meet achievement levels on selected childhood health care quality measures, as determined by the department. The measures shall be developed using measures currently recognized for those areas in HEDIS or other nationally recognized measures that the department deems appropriate.

(2) Qualified network providers may be eligible for maximum incentive payments if they meet the designated high-performance standards, and partial incentive payments for meeting above-minimum standards.

(3) The requirements for receiving an incentive payment and the methodology for determining the value of the payment shall be determined by the department, in accordance with this article.

SEC. 409. Section 14188.4 of the Welfare and Institutions Code is repealed.

SEC. 410. Section 14188.4 is added to the Welfare and Institutions Code, to read:

14188.4. (a) Notwithstanding any other law, the department shall only implement the payments described under Section 14188.1 for a service period during a state fiscal year subject to appropriation by the Legislature for that state fiscal year.

(b) This section shall be implemented only to the extent that the department obtains any necessary federal approvals and determines that federal financial participation is not otherwise jeopardized.

(c) Notwithstanding any other law, this section shall supersede any law suspending authority for any program described in Section 14188.1. The law on suspending authority includes, but is not limited to, provisions under the Budget Act of 2019, the Budget Act of 2020, and enacted legislation providing for appropriations related to those acts.

(d) The Legislature finds and declares that this section complies with all of the following:

(1) Made in accordance with the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Article 2.5 (commencing with Section 30130.50) of Chapter 2 of Part 13 of Division 2 of the Revenue and Taxation Code).

(2) Based on criteria developed and periodically updated as part of the annual state budget process, in accordance with subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

(3) Consistent with the purposes and conditions of expenditures described in subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

SEC. 411. Section 14196.2 of the Welfare and Institutions Code is amended to read:

14196.2. (a) (1) The Legislature finds and declares that in order to reduce the risk of transmission of COVID-19 during the current pandemic and to further the objectives of the Money Follows the Person Rebalancing Demonstration, a temporary program is hereby established to facilitate the transition of individuals from an inpatient facility who have resided in that setting for fewer than 60 days.

(2) The department shall provide services consistent with the Money Follows the Person Rebalancing Demonstration Program, pursuant to Section 6071 of Public Law 109-171, and subsequent amendments, for transitioning eligible individuals out of inpatient facilities.

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

(c) Commencing January 1, 2023, the department shall cease to enroll beneficiaries pursuant to this article and commencing January 1, 2024, the department shall cease to provide services pursuant to this article.

SEC. 412. Section 14196.4 of the Welfare and Institutions Code is amended to read:

14196.4. The following definitions apply for purposes of this article:

(a) “Eligible individual” means a Medi-Cal beneficiary who meets both of the following requirements:

(1) The individual meets the definition of an “eligible individual” under Section 6071(b)(2) of Public Law 109-171, and subsequent amendments, except that the individual is not required to have resided for at least 60 consecutive days in an inpatient facility.

(2) The individual is targeted to receive assistance in transitioning from an inpatient facility to a qualified residence, identified in the agreement between the department and the federal Centers for Medicare and Medicaid Services for the Money Follows the Person Rebalancing Demonstration, except the individual shall not be required to have resided for at least 60 consecutive days in an inpatient facility.

(b) “Inpatient facility” has the same meaning as that term is defined in Section 6071(b)(3) of Public Law 109-171, and subsequent amendments.

SEC. 413. Section 14196.5 of the Welfare and Institutions Code is amended to read:

14196.5. (a) A Medi-Cal beneficiary who has resided for at least 60 consecutive days in an inpatient facility, as required by the Money Follows the Person Rebalancing Demonstration, is ineligible for services under this article unless the department determines that any necessary federal approvals have been obtained and federal financial participation is available for this purpose.

(b) Services shall not be provided pursuant to this article during any period that the department has obtained any necessary federal approvals under the Money Follows the Person Rebalancing Demonstration to not apply the eligibility requirement that the beneficiary has resided for at least 60 consecutive days in an inpatient facility.

SEC. 414. Section 14197.4 of the Welfare and Institutions Code is amended to read:

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

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

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

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

(b) Commencing with the 2017–18 state fiscal year, 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 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 a uniform percentage increase, or other basis, 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. The department, in consultation with the designated public hospital systems, shall establish the classes of designated public hospital systems consistent with the objectives set forth in subdivisions (a) and (d) and that take into account differences in services provided, service delivery systems, and in the level of risk assumed from managed care plans. 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 or Medi-Cal managed care plans, or both, as follows:

(A) The department, in consultation with the designated public hospital systems, shall annually determine on a prospective basis the aggregate amount of payments that will be directed to each class of designated public hospital systems pursuant to this subdivision and the classification of each designated public hospital system. Once the department determines the classification for each designated public hospital system 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, shall develop the methodologies for determining the required directed payments for each designated public hospital system.

(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, adjust or modify the amounts of the aggregate directed payments for any class of designated public hospital systems, the method for determining the distribution of the directed payment amounts within any class of designated public hospital systems, and may modify, consolidate, or subdivide the classes of designated public hospital systems established pursuant to paragraph (1).

(D) After the aggregate amounts and the distribution methodology of directed payments for each designated public hospital system class have been established, the department shall consult with the designated public hospital systems 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.

(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.

(4) The directed payments required under this subdivision shall be implemented and documented by each Medi-Cal managed care plan and designated public hospital system 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 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 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 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 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 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 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 it contracts with, including both contract rates and the directed payments, to demonstrate compliance with this subdivision. To the extent 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 in accordance with this subdivision. The department may require Medi-Cal managed care plans and the designated public hospital systems 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. 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.

(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 they contract with 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.

(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 hospitals established pursuant to subparagraph (A) may earn in quality incentive payments for an applicable state fiscal 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. 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 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) The nonfederal share of the portion of the capitation rates specifically associated with directed payments to designated public hospital systems required under subdivision (b) and for the quality incentive payments established pursuant to subdivision (c), or associated with quality incentive payments to district and municipal public hospital systems pursuant to paragraph (4) of 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. Notwithstanding any other law, the department shall not assess the fee described in subdivision (d) of Section 14301.4 or any other similar fee.

(2) (A) When applicable for voluntary intergovernmental transfers described in paragraph (1), 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 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 quality incentive 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 pursuant to paragraph (4) of subdivision (c). 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 with regard to the development of the directed payment levels established pursuant to subdivision (b) of this section, with designated public hospital systems and district and municipal public hospitals with regard to the size of the quality incentive payments established pursuant to subdivision (c) of this section, and shall consult with designated public hospital systems, district and municipal 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 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 system, the district and municipal public hospital, 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 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 and programmatically supportive of the Medi-Cal program. This determination shall be based solely on both of 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) Quality incentive payments to district and municipal public hospitals pursuant to subdivision (c) shall cease to be operative on the first day of the state fiscal 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 and programmatically supportive of the Medi-Cal program. This determination shall be based solely on both of the following factors:

(i) The projected amount of nonfederal share funds available is insufficient to support implementation of the quality incentive payments to district and municipal hospitals pursuant to subdivision (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.

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

(k) The department, in consultation with the designated public hospital systems and the Medi-Cal managed care plans, shall provide the Legislature with the federally approved evaluation plan required in Section 438.6(c)(2)(i)(D) of Title 42 of the Code of Federal Regulations to measure the degree to which the payments authorized under this section advance at least one of the goals and objectives of the department's managed care quality strategy. The department, in consultation with the designated public hospital systems and the Medi-Cal managed care plans, shall report to the Legislature the results of this evaluation once the department determines that the evaluation is finalized and complete according to the terms of any applicable federal approval and no earlier than January 1, 2021.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) “Network provider” has the same meaning as that term is defined in Section 438.2 of Title 42 of the Code of Federal Regulations, and does not include arrangements where a designated public hospital system or a district and municipal public hospital provides or arranges for services under an agreement intended to cover a specific range of services for a single identified patient for a single inpatient admission, including any directly related followup care, outpatient visit or service, or other similar patient specific nonnetwork contractual arrangement, such as a letter of agreement or single case agreement, with a Medi-Cal managed care plan or subcontractor of a Medi-Cal managed care plan.

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

SEC. 415. Section 14197.9 is added to the Welfare and Institutions Code, to read:

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).

SEC. 416. Section 14301.1 of the Welfare and Institutions Code is amended to read:

14301.1. (a) For rates established on or after August 1, 2007, the department shall pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods and may establish health-plan- and county-specific rates. Notwithstanding any other law, this section shall apply to any managed care organization, licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), that has contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) of Chapter 7 to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS for rates established on or after July 1, 2012. The department shall utilize a county- and model-specific rate methodology to develop Medi-Cal managed care capitation rates for contracts entered into between the department and any entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 that includes, but is not limited to, all of the following:

(1) Health-plan-specific encounter and claims data.

(2) Supplemental utilization and cost data submitted by the health plans.

(3) Fee-for-service data for the underlying county of operation or other appropriate counties as deemed necessary by the department.

(4) Department of Managed Health Care financial statement data specific to Medi-Cal operations.

(5) Other demographic factors, such as age, gender, or diagnostic-based risk adjustments, as the department deems appropriate.

(b) To the extent that the department is unable to obtain sufficient actual plan data, it may substitute plan model, similar plan, or county-specific fee-for-service data.

(c) The department shall develop rates that include administrative costs, and may apply different administrative costs with respect to separate aid code groups.

(d) The department shall develop rates that shall include, but are not limited to, assumptions for underwriting, return on investment, risk, contingencies, changes in policy, and a detailed review of health plan financial statements to validate and reconcile costs for use in developing rates.

(e) The department may develop rates that pay plans based on performance incentives, including quality indicators, access to care, and data submission.

(f) The department may develop and adopt condition-specific payment rates for health conditions, including, but not limited to, childbirth delivery.

(g) (1) Before finalizing Medi-Cal managed care capitation rates, the department shall provide health plans with information on how the rates were developed, including rate sheets for that specific health plan, and provide the plans with the opportunity to provide additional supplemental information.

(2) For contracts entered into between the department and any entity pursuant to Article 2.8 (commencing with Section 14087.5) of Chapter 7, the department, by June 30 of each year, or, if the budget has not passed by that date, no later than five working days after the budget is signed, shall provide preliminary rates for the upcoming fiscal year.

(h) For the purposes of developing capitation rates through implementation of this ratesetting methodology, Medi-Cal managed care health plans shall provide the department with financial and utilization data in a form and substance as deemed necessary by the department to establish rates. These data shall be considered proprietary and shall be exempt from disclosure as official information pursuant to subdivision (k) of Section 6254 of the Government Code as contained in the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(i) Notwithstanding any other law, on and after the effective date of the act adding this subdivision, the department may apply this section to the capitation rates it pays under any managed care health plan contract.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may set and implement managed care capitation rates, and interpret or make specific this section and any applicable federal waivers and state plan amendments by means of plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action.

(k) (1) The department shall report, upon request, to the fiscal and policy committees of the respective houses of the Legislature regarding implementation of this section.

(2) The department shall publish on its public internet website a description of the rate methodology, data used for rate development, and core actuarial assumptions and adjustments in each year that the department develops rates pursuant to this section.

(l) Before October 1, 2011, the risk-adjusted countywide capitation rate shall comprise no more than 20 percent of the total capitation rate paid to each Medi-Cal managed care plan.

(m) (1) It is the intent of the Legislature to preserve the policy goal to support and strengthen traditional safety net providers who treat high volumes of uninsured and Medi-Cal patients when Medi-Cal enrollees are defaulted into Medi-Cal managed care plans.

(2) As the department adds additional factors, such as managed care plan costs, to the Medi-Cal managed care plan default assignment algorithm, it shall consult with the Auto Assignment Performance Incentive Program stakeholder workgroup to develop cost factor disregards related to intergovernmental transfers and required wraparound payments that support safety net providers.

(n) (1) The department shall develop and pay capitation rates to entities contracted pursuant to Chapter 8.75 (commencing with Section 14591), using actuarial methods and in a manner consistent with this section, except as provided in this subdivision.

(2) (A) The department may develop capitation rates using a standardized rate methodology across managed care plan models for comparable populations. The specific rate methodology applied to PACE organizations shall address features of PACE that distinguishes it from other managed care plan models.

(B) The rate methodology shall be consistent with actuarial rate development principles and shall provide for all reasonable, appropriate, and attainable costs for each PACE organization within a region.

(3) The department may develop statewide rates and apply geographic adjustments, using available data sources deemed appropriate by the department. Consistent with actuarial methods, the primary source of data used to develop rates for each PACE organization shall be its Medi-Cal cost and utilization data or other data sources as deemed necessary by the department.

(4) Rates developed pursuant to this subdivision shall reflect the level of care associated with the specific populations served under the contract.

(5) The rate methodology developed pursuant to this subdivision shall contain a mechanism to account for the costs of high-cost drugs and treatments.

(6) Rates developed pursuant to this subdivision shall be actuarially certified before implementation.

(7) The department shall consult with those entities contracted pursuant to Chapter 8.75 (commencing with Section 14591) in developing a rate methodology according to this subdivision.

(8) Consistent with the requirements of federal law, the department shall calculate an upper payment limit for payments to PACE organizations. In calculating the upper payment limit, the department shall correct the applicable data as necessary and shall consider the risk of nursing home placement for the comparable population when estimating the level of care and risk of PACE participants.

(9) The department shall pay the entity at a rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements and subject to paragraph (11), as necessary to mitigate the impact to the entity of the methodology developed pursuant to this subdivision.

(10) During the first two years in which a new PACE organization or existing PACE organization enters a previously unserved area, the department shall pay at a rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements and subject to paragraph (11), to reflect the lower enrollment and higher

operating costs associated with a new PACE organization relative to a PACE organization with higher enrollment and more experience providing managed care interventions to its beneficiaries.

(11) This subdivision shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available.

(12) This subdivision shall apply for rates implemented no earlier than January 1, 2017.

(o) (1) Notwithstanding any other law, as a component of the CalAIM Initiative authorized pursuant to Article 5.51 (commencing with Section 14184.100) of Chapter 7, and any successor waiver, demonstration, or state plan amendment authorizing the Medi-Cal managed care program, the department may establish capitation rates to contracted health plans on a regional basis in lieu of health plan and county-specific rates.

(2) Before initially implementing regional-based capitation rates under this subdivision, the department shall report to the Legislature on the process for developing those regional rates and determining the regional groups.

(3) The department shall provide a briefing to providers and stakeholders, including, but not limited to, physicians, hospitals, and consumer advocates, that describes the actuarial assumptions and rate methodologies used by the department following submission of rates to the federal government for approval that initially implement regional-based capitation rates under this subdivision. This publicly noticed meeting to providers and other stakeholders shall occur no more than 60 days after submission of the capitation rates to the federal government for approval. The meeting shall be for explanatory purposes and shall not otherwise impact the methodology and data provided to the federal government for approval.

(4) The department shall consult with affected contracted health plans in developing the regional groups and rate methodologies, consistent with applicable federal requirements, actuarial methods, and the CalAIM Terms and Conditions as defined in subdivision (c) of Section 14184.101 prior to implementing this subdivision. In developing and implementing any methodology pursuant to this subdivision, the department shall seek to incentivize improved quality and outcomes for Medi-Cal managed care enrollees.

(5) This subdivision shall be implemented only to the extent that the department obtains any necessary federal approvals, and that federal financial participation is available and not otherwise jeopardized.

(p) (1) It is the intent of the Legislature that both affected contracted health plans and the state have appropriate actuarial protections against the risk of either significant overpayments or significant underpayments in capitation rates developed and paid pursuant to this section that are associated with the changes to the Medi-Cal managed care program described in Article 5.51 (commencing with Section 14184.100) of Chapter 7, as identified by the department.

(2) (A) Notwithstanding any other law, as a component of the CalAIM initiative authorized pursuant to Article 5.51 (commencing with Section 14184.100) of Chapter 7, and any successor waiver, demonstration, or state plan amendment authorizing the Medi-Cal managed care program, the department may develop and implement appropriate actuarial methods to prevent significant overpayments or significant underpayments as described in paragraph (1), subject to paragraph (4). This may include, but need not be limited to, one or more of the following:

(i) A medical or profit and loss risk corridor.

(ii) Blended capitation rates based on projected member risk.

(iii) Other prospective or retrospective shared savings or risk models.

(B) The methods or models described in subparagraph (A) shall seek to encourage quality improvement and promote appropriate utilization incentives, including, but not limited to, reduced rehospitalization and shorter lengths of institutional stay.

(3) The department shall consult with affected contracted health plans in implementing this subdivision.

(4) This subdivision shall be implemented only to the extent that the department obtains any necessary federal approvals, and that federal financial participation is available and not otherwise jeopardized.

SEC. 417. Section 15840 of the Welfare and Institutions Code is amended to read:

15840. (a) (1) At a minimum, coverage provided pursuant to this chapter shall be provided to subscribers during one pregnancy, and until the end of the month in which the 60th day after pregnancy occurs, and to eligible children less than two years of age who were born of a pregnancy covered under this program or the Access for Infants and Mothers program under former Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code to a woman enrolled in the Access for Infants and Mothers program.

(2) (A) Upon the effective date reflected in any necessary federal approvals obtained by the department pursuant to subdivision (c) of Section 14005.185, a subscriber described in paragraph (1) shall be eligible for an additional 10-month period following the 60-day postpartum period, for a total of 12 months of continuous eligibility after the end of pregnancy.

(B) This paragraph shall be implemented only if, and to the extent that, any necessary federal approvals are obtained pursuant to Section 14005.185 and federal financial participation is available, and subject to an annual appropriation by the Legislature for this purpose.

(b) Coverage provided pursuant to this chapter shall include, at a minimum, those services required to be provided by health care service plans approved by the Secretary of Health and Human Services as a federally qualified health care service plan pursuant to Section 417.101 of Title 42 of the Code of Federal Regulations.

(c) Medically necessary prescription drugs shall be a required benefit in the coverage provided pursuant to this chapter.

(d) To the extent required pursuant to Section 15818 to comply with paragraph (1) of subdivision (b) of Section 30122 of the Revenue and Taxation Code, health education services related to tobacco use shall be a benefit in the coverage provided under this chapter.

SEC. 418. Section 17601 of the Welfare and Institutions Code is amended to read:

17601. On or before the 27th day of each month, the Controller shall allocate to the mental health account of each local health and welfare trust fund the amounts deposited and remaining unexpended and unreserved on the 15th day of the month in the Mental Health Subaccount of the Sales Tax Account in the Local Revenue Fund in accordance with the following schedules:

(a) (1) Schedule A—State Hospital and Community Mental Health Allocations.

Jurisdiction	Allocation Percentage
Alameda	4.882
Alpine	0.018
Amador	0.070
Butte	0.548
Calaveras	0.082
Colusa	0.073
Contra Costa	2.216
Del Norte	0.088
El Dorado	0.285
Fresno	2.045
Glenn	0.080
Humboldt	0.465
Imperial	0.342
Inyo	0.104
Kern	1.551
Kings	0.293
Lake	0.167
Lassen	0.087
Los Angeles	28.968
Madera	0.231
Marin	0.940
Mariposa	0.054
Mendocino	0.332
Merced	0.546

Modoc	0.048
Mono	0.042
Monterey	0.950
Napa	0.495
Nevada	0.191
Orange	4.868
Placer	0.391
Plumas	0.068
Riverside	2.394
Sacramento	3.069
San Benito	0.090
San Bernardino	3.193
San Diego	5.603
San Francisco	4.621
San Joaquin	1.655
San Luis Obispo	0.499
San Mateo	2.262
Santa Barbara	0.949
Santa Clara	4.112
Santa Cruz	0.558
Shasta	0.464
Sierra	0.026
Siskiyou	0.137
Solano	1.027
Sonoma	1.068
Stanislaus	1.034
Sutter/Yuba	0.420
Tehama	0.181
Trinity	0.055
Tulare	0.941
Tuolumne	0.121
Ventura	1.472
Yolo	0.470
Berkeley	0.190
Tri-City	0.165

The amounts allocated in accordance with Schedule A for the 1991–92 fiscal year shall be considered the base allocations for the 1992–93 fiscal year.

(2) The funds allocated pursuant to Schedule B shall be increased to reflect the addition of percentages for the institutions for mental disease allocation pursuant to paragraph (1) of subdivision (c).

(3) The Controller shall allocate three million seven hundred thousand dollars ($3,700,000) to the counties pursuant to a percentage schedule developed by the Director of Health Care Services as specified in subdivision (c) of Section 4095. The funds allocated pursuant to Schedule A shall be increased to reflect the addition of this schedule.

(4) (A) The State Department of Health Care Services may amend Schedule A in order to restore counties funds associated with multicounty regional programs.

(B) Notwithstanding any other provision of law, the State Department of Health Care Services shall amend Schedule A for the purpose of establishing mental health base allocations for each county for the 1994–95 fiscal year and fiscal years thereafter, in order to ensure that mental health base allocations for each county do not fall below 75 percent of the allocations for the 1989–90 fiscal year. The money specified in subdivision (c) of former Section 17605.05 shall be used for this purpose.

(b) (1) Schedule B—State Hospital Payment Schedule.

From the amounts allocated in accordance with Schedule A, each county and city shall reimburse the Controller for reimbursement to the State Department of Mental Health, or its successor, the State Department of State Hospitals, for the 1991–92 fiscal year only, an amount equal to one-ninth of the amount identified in Schedule B as modified to reflect adjustments pursuant to paragraph (2) of subdivision (a) of Section 4330, subparagraph (C) of paragraph (1) of subdivision (b) of, and subparagraph (B) of paragraph (2) of subdivision (c) of, Section 1370 of the Penal Code, and subparagraph (C) of paragraph (3) of subdivision (a) of, and subdivision (f) of, Section 1372 of the Penal Code. The reimbursements shall be due the 24th day of each month and the first payment shall be due on October 24, 1991. During the 1992–93 fiscal year and fiscal years thereafter, each monthly reimbursement shall be one-twelfth of the total amount of the county's contract with the State Department of Mental Health, or its successor, the State Department of State Hospitals, for state hospital services. If a county has not contracted with the State Department of State Hospitals by July 1 of any given fiscal year, each monthly reimbursement shall be an amount equal to one-twelfth the number of beds provided to the county the previous fiscal year multiplied by the current state rate as determined by the State Department of State Hospitals.

Jurisdiction	First Year State Hospital Withholding
Alameda	$ 15,636,372
Berkeley City	0
Alpine	95,379
Amador	148,915
Butte	650,238
Calaveras	100,316
Colusa	189,718
Contra Costa	8,893,339
Del Norte	94,859
El Dorado	236,757
Fresno	1,429,379
Glenn	51,977
Humboldt	727,684
Imperial	259,887
Inyo	363,842
Kern	4,024,613
Kings	266,904
Lake	292,373
Lassen	167,367
Los Angeles	102,458,700
Tri-City	0
Madera	131,243
Marin	3,248,590

Mariposa	117,989
Mendocino	471,955
Merced	404,125
Modoc	94,859
Mono	94,859
Monterey	2,079,097
Napa	2,338,985
Nevada	493,786
Orange	14,066,133
Placer	847,232
Plumas	130,463
Riverside	4,891,077
Sacramento	4,547,506
San Benito	259,887
San Bernardino	5,587,574
San Diego	6,734,976
San Francisco	23,615,688
San Joaquin	927,018
San Luis Obispo	719,887
San Mateo	6,497,179
Santa Barbara	2,168,758
Santa Clara	7,106,095
Santa Cruz	1,403,391
Shasta	1,169,492
Sierra	94,859
Siskiyou	129,944
Solano	5,332,885
Sonoma	2,669,041
Stanislaus	1,740,205
Sutter/Yuba	363,842
Tehama	363,842
Trinity	94,859
Tulare	675,707
Tuolumne	304,328
Ventura	3,378,533
Yolo	1,169,492

(2) (A) (i) During the 1992–93 fiscal year, in lieu of making the reimbursement required by paragraph (1), a county may elect to authorize the Controller to reimburse the State Hospital Account of the Mental Health Facilities Fund a pro rata share each month computed by multiplying the ratio of the reimbursement amount owed by the county as specified in Schedule B to the total amount of money projected to be allocated to the county pursuant to Schedule A by the funds available for deposit in the mental health account of the county's health and welfare trust fund.

(ii) The reimbursement shall be made monthly on the same day the Controller allocates funds to the local health and welfare trust funds.

(B) During the 1992–93 fiscal year and thereafter, the amount to be reimbursed each month shall be computed by multiplying the ratio of the county's contract for state hospital services to the amount of money projected to be allocated to the county pursuant to Schedule A by the funds available for deposit in the mental health account of the county's health and welfare trust fund.

(C) All reimbursements, deposits, and transfers made to the Mental Health Facilities Fund pursuant to a county election shall be deemed to be deposits to the local health and welfare trust fund.

(3) (A) Counties shall notify the Controller, in writing, by October 15, 1991, upon making the election pursuant to paragraph (2). The election shall be binding for the fiscal year. The pro rata share of allocations made prior to the election by the county shall be withheld from allocations in subsequent months until paid.

(B) For the 1992–93 fiscal year and fiscal years thereafter, counties shall notify the Controller, in writing, by July 1 of the fiscal year for which the election is made, upon making the election pursuant to paragraph (2).

(4) Regardless of the reimbursement option elected by a county, no county shall be required to reimburse the Mental Health Facilities Fund by an amount greater than the amount identified in Schedule B as modified to reflect adjustments pursuant to paragraph (2) of subdivision (a) of Section 4330.

(c) (1) For the 1991–92 fiscal year, the Controller shall distribute monthly beginning in October from the Mental Health Subaccount of the Sales Tax Account of the Local Revenue Fund to the mental health account of each local health and welfare trust fund one-ninth of the amount allocated to the county in accordance with the institutions for mental disease allocation schedule established by the State Department of Mental Health.

(2) Each county shall forward to the Controller, monthly, an amount equal to one-ninth of the amount identified in the schedule established by the State Department of Mental Health. The reimbursements shall be due by the 24th day of the month to which they apply, and the first payment shall be due October 24, 1991. These amounts shall be deposited in the Institutions for Mental Disease Account in the Mental Health Facilities Fund.

(3) (A) (i) During the 1991–92 fiscal year, in lieu of making the reimbursement required by paragraph (1), a county may elect to authorize the Controller to reimburse the Institutions for Mental Disease Account of the Mental Health Facilities Fund a pro rata share each month computed by multiplying the ratio of the reimbursement amount owed by the county as specified in Schedule B to the total amount of money projected to be allocated to the county pursuant to Schedule A by the funds available for deposit in the mental health account of the county's health and welfare trust fund.

(ii) The reimbursement shall be made monthly on the same day the Controller allocates funds to the local health and welfare trust funds.

(B) During the 1992–93 fiscal year and thereafter, the amount to be reimbursed each month shall be computed by multiplying the ratio of the county's contract for mental health services to the amount of money projected to be allocated to the county pursuant to Schedule A by the funds available for deposit in the mental health account of the county's health and welfare trust fund.

(C) All reimbursements, deposits, and transfers made to the Mental Health Facilities Fund pursuant to a county election shall be deemed to be deposits to the local health and welfare trust fund.

(4) (A) Counties shall notify the Controller, in writing, by October 15, 1991, upon making the election pursuant to paragraph (3). The election shall be binding for the fiscal year. The pro rata share of allocations made prior to the election by the county shall be withheld from allocations in subsequent months until paid.

(B) For the 1992–93 fiscal year and fiscal years thereafter, counties shall notify the Controller, in writing, by July 1 of the fiscal year for which the election is made, upon making the election pursuant to paragraph (2).

(5) Regardless of the reimbursement option elected by a county, no county shall be required to reimburse the Institutions for Mental Disease Account in the Mental Health Facilities Fund an amount greater than the amount identified in the schedule developed by the State Department of Mental Health pursuant to paragraph (1).

(d) The Controller shall withhold the allocation of funds pursuant to subdivision (a) in any month a county does not meet the requirements of paragraph (1) of subdivision (b) or paragraph (2) of subdivision (c), in the amount of the obligation and transfer the funds withheld to the State Department of State Hospitals and the State Department of Health Care Services for deposit in the State Hospital Account or the Institutions for Mental Disease Account in the Mental Health Facilities Fund, as appropriate.

SEC. 419. Section 69 of Chapter 12 of the Statutes of 2020 is repealed.

SEC. 420. Item 4265-001-0001 of Section 2.00 of the Budget Act of 2019 is amended to read:

4265-001-0001—For support of State Department of Public Health 105,029,000

Schedule:

(1) 4040-Public Health Emergency Preparedness 779,000

(2) 4045-Public and Environmental Health 183,699,000

(3) 4050-Licensing and Certification 12,800,000

(4) 9900100-Administration 50,734,000

(5) 9900200-Administration—Distributed ..... −50,734,000

(6) Reimbursements to 4045-Public and Environmental Health ..... −80,062,000

(7) Reimbursements to 4050-Licensing and Certification ..... −12,187,000

Provisions:

1. Except as otherwise prohibited by law, the State Department of Public Health shall promulgate emergency regulations to adjust the public health fees set by regulation to an amount such that, if the new fees were effective throughout the 2019–20 fiscal year, the estimated revenues would be sufficient to offset at least 95 percent of the approved program level intended to be supported by those fees. The General Fund fees of the department that are subject to the annual fee adjustment pursuant to subdivision (a) of Section 100425 of the Health and Safety Code shall be increased by 14.6 percent. The special fund fees of the department that are subject to the annual fee adjustment pursuant to subdivision (a) of Section 100425 of the Health and Safety Code may be increased by 14.6 percent only if the fund condition statement for a fund projects a reserve less than 10 percent of estimated expenditures and the revenues projected for the 2019–20 fiscal year are less than the appropriation contained in this act.

2. Notwithstanding subdivision (b) of Section 100450 of the Health and Safety Code, departmental fees that are subject to the annual fee adjustment pursuant to subdivision (a) of Section 100450 of the Health and Safety Code shall not be increased for the 2019–20 fiscal year. This adjustment shall not be applied to fees established by subdivisions (f), (g), (m), and (s) of Section 1300 of the Business and Professions Code.

3. The State Department of Public Health shall limit expenditures in this item to implement the Uniform Anatomical Gift Act (Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7 of the Health and Safety Code) to the amount of actual fees collected from tissue banks.

4. (a) Of the funds appropriated in Schedule (2), $2,965,000 shall be available for encumbrance or expenditure until June 30,

2024, for the State Department of Public Health to support activities that address lesbian, bisexual, and queer women's health disparities.

(b) Contracts entered into or amended pursuant to this provision are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, the State Administrative Manual, and the State Contracting Manual, and are exempt from the review or approval of any division of the Department of General Services.

5. Of the funds appropriated in Schedule (2), $4,000,000 shall be available for encumbrance or expenditure until June 30, 2023, for the State Department of Public Health to support infectious diseases prevention and control activities.

6. Of the funds appropriated in Schedule (2), $500,000 shall support sexually transmitted disease prevention and control activities pursuant to Section 120511 of the Health and Safety Code, $500,000 shall support human immunodeficiency virus prevention and control activities pursuant to Section 120780.5 of the Health and Safety Code, and $500,000 shall support hepatitis C virus prevention and control activities pursuant to Section 122440 of the Health and Safety Code. The funds shall be available for encumbrance or expenditure until June 30, 2022.

7. Of the funds appropriated in Schedule (2), $500,000 shall be available for encumbrance or expenditure until June 30, 2022, for the State Department of Public Health to administer grants to up to six local health jurisdictions to support activities that are consistent with the United States Centers for Disease Control and Prevention published Healthy Brain Initiative: State and Local Public Health Partnerships to Address Dementia, The 2018-2023 Road Map.

8. (a) Of the funds appropriated in Schedule (2), $3,000,000 shall be available for the State Department of Public Health to provide technical assistance to county behavioral health departments in reducing mental health disparities and $500,000 shall be available for the department to administer grants for community-based organizations to support community-defined mental health equity programs in partnership with county behavioral health departments. The funds shall be available for expenditure or encumbrance until June 30, 2022.

(b) Contracts entered into or amended pursuant to this provision are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section

10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and are exempt from the review or approval of any division of the Department of General Services.

9. (a) Of the funds appropriated in Schedule (2), $60,000 shall be available for encumbrance or expenditure until June 30, 2022, for State Department of Public Health administrative activities to allocate funds to the Public Health Institute to support sickle cell disease surveillance and monitoring activities.

(b) Of the funds appropriated in Schedule (2), $600,000 shall be available for encumbrance or expenditure until June 30, 2022, for the State Department of Public Health to allocate funds to the Public Health Institute to support sickle cell disease surveillance and monitoring.

(c) Contracts entered into or amended pursuant to this provision are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and are exempt from the review or approval of any division of the Department of General Services.

10. Of the funds appropriated in Schedule (2), $2,600,000 shall be available for encumbrance or expenditure until June 30, 2023, to support and provide technical assistance for Substance Use Disorder Response Navigator related activities by the State Department of Public Health.

11. (a) Of the funds appropriated in Schedule (2), $500,000 available to support the Black Infant Health Program may also support the California Perinatal Equity Initiative.

(b) Of the funds appropriated in Schedule (6), $500,000 available to support the Black Infant Health Program may also support the California Perinatal Equity Initiative.

12. Of the funds appropriated in Schedule (2), $1,500,000 shall be available for encumbrance or expenditure until June 30, 2022, to support a study on the health of farmworkers.

SEC. 421. Item 4265-111-0001 of Section 2.00 of the Budget Act of 2019 is amended to read:

4265-111-0001—For local assistance, State Department of Public Health 190,146,000

Schedule:

(1)	4040-Public Health Emergency Preparedness	4,960,000
(2)	4045-Public and Environmental Health	331,472,000
(3)	Reimbursements to 4045-Public and Environmental Health	−146,286,000

Provisions:

1. The Office of AIDS in the State Department of Public Health, in allocating and processing contracts and grants, shall comply with the same requirements that are established for contracts and grants for other public health programs. Notwithstanding any other provision of law, the contracts or grants administered by the Office of AIDS shall be exempt from the Public Contract Code and shall be exempt from approval by the Department of General Services prior to their execution.

2. The appropriation in this item for the Alzheimer's Research Centers shall be used for direct services, including, but not limited to, diagnostic screening, case management, disease management, support for caregivers, and related services necessary for positive client outcomes.

3. (a) Of the funds appropriated in Schedule (2), $2,000,000 shall be available for encumbrance of expenditure until June 30, 2021, and may be allocated to the Valley Fever Institute at Kern Medical to support valley fever research.

   (b) Contracts entered into or amended pursuant to this provision are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and are exempt from the review or approval of any division of the Department of General Services.

4. (a) Of the funds appropriated in Schedule (2), up to $14,535,000 shall be available for encumbrance or expenditure until June 30, 2024, for activities that address lesbian, bisexual, and queer women's health disparities.

   (b) Contracts entered into or amended pursuant to this provision are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, the State Administrative Manual, and the State Contracting Manual, and are exempt from the review or approval of any division of the Department of General Services.

5. (a) Of the funds appropriated in Schedule (2), $36,000,000 shall be available for encumbrance or expenditure until June 30, 2023, and are available for the State Department of Public Health to issue grants to local health jurisdictions and tribal communities for the prevention and control of infectious diseases.

   (b) Of the funding available in subdivision (a), the department shall allocate up to $1,000,000 in grants to tribal communities.

(c) Of the funding available in subdivision (a), the department shall allocate at least $35,000,000 in grants to local health jurisdictions. Funding shall be provided to local health jurisdictions in a lump sum amount in the 2019–20 fiscal year.

(d) The department shall consult with the County Health Executives Association of California, California Conference of Local Health Officers, community-based organizations, and other stakeholders to determine a funding allocation methodology based on factors that may include disease burden, population impact, and geographical area.

(e) Funds shall be allocated in a manner that balances the need to spread funding to as many local health jurisdictions as possible and the need to provide meaningful services to each funded local health jurisdiction.

(f) The funds identified in this provision shall not supplant existing services at the local level.

6. Of the funds appropriated in Schedule (2), $4,500,000 shall support sexually transmitted disease prevention and control activities pursuant to Section 120511 of the Health and Safety Code, $4,500,000 shall support human immunodeficiency virus prevention and control activities pursuant to Section 120780.5 of the Health and Safety Code, and $4,500,000 shall support hepatitis C virus prevention and control activities pursuant to Section 122440 of the Health and Safety Code. The funds shall be available for encumbrance or expenditure until June 30, 2022.

7. Of the funds appropriated in Schedule (2), $4,500,000 shall be available for encumbrance or expenditure until June 30, 2022, for the State Department of Public Health to allocate grants to up to six local health jurisdictions to support activities that are consistent with the United States Centers for Disease Control and Prevention published Healthy Brain Initiative: State and Local Public Health Partnerships to Address Dementia, The 2018-2023 Road Map. The State Department of Public Health shall allocate funds under this provision after consideration of the following:

(a) Local health jurisdictions that receive funds pursuant to this provision shall include up to two rural counties and at least one coastal county.

(b) Local health jurisdiction activities shall include one or more of the following:

(1) Education and empowerment of the public with regard to brain health and cognitive aging.

(2) Mobilizing public and private partnerships to engage local stakeholders in effective community-based interventions and best practices.

(3) Ensuring a competent workforce by strengthening the knowledge, skills, and abilities of health care professionals who

deliver care and services to people with Alzheimer's disease and other dementias and their family caregivers.

(4) Monitoring data and evaluating programs to contribute to evidence-based practice.

(c) In conducting activities, local health jurisdictions receiving funds pursuant to this provision shall incorporate the following fundamental principles: eliminating health disparities, collaborating across multiple sectors, and leveraging public and private resources for sustained impact.

8. (a) Of the funds appropriated in Schedule (2), $4,500,000 shall be available for encumbrance or expenditure until June 30, 2022, for the State Department of Public Health to provide grants to community-based organizations to develop and implement community-defined mental health equity programs in partnership with county behavioral health departments.

(b) Contracts entered into or amended pursuant to this provision are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and are exempt from the review or approval of any division of the Department of General Services.

9. (a) Of the funds appropriated in Schedule (2), $14,340,000 shall be available for encumbrance or expenditure until June 30, 2022, and may be allocated to the Center for Inherited Blood Disorders to establish a network of sickle cell disease centers in the local health jurisdictions of Alameda, Fresno, Kern, Los Angeles, Sacramento, San Bernardino, and San Diego to provide access to specialty care and improve quality of care for adults with sickle cell disease; support workforce expansion for coordinated health services; conduct surveillance to monitor disease incidence, prevalence, and other metrics; create a public awareness campaign; and provide fiscal oversight of the resources.

(b) Contracts entered into or amended pursuant to this provision are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and are exempt from the review or approval of any division of the Department of General Services.

10. Of the funds appropriated in Schedule (2), $12,600,000 shall be available for encumbrance or expenditure until June 30, 2023, for the State Department of Public Health to support Substance Use Disorder Response Navigator activities through grants to local health jurisdictions and community-

based organizations for the purpose of supporting syringe exchange and disposal program activities, including treatment navigators.

11. (a) Of the funds appropriated in Schedule (2), $7,000,000 available to support the Black Infant Health Program may also support the California Perinatal Equity Initiative upon approval by the State Department of Public Health.

(b) Of the funds appropriated in Schedule (3), $5,250,000 available to support the Black Infant Health Program may also support the California Perinatal Equity Initiative upon approval by the State Department of Public Health.

12. (a) Of the funds appropriated in Schedule (2), up to $2,000,000 shall be available for encumbrance or expenditure until June 30, 2022, and may be allocated to the City and County of San Francisco and the City of Oakland to support the 23rd Biennial International AIDS Conference.

(b) Contracts entered into or amended pursuant to this provision are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and are exempt from the review or approval of any division of the Department of General Services.

SEC. 422. The Legislature finds and declares that this act is a state law within the meaning of Section 1621(d) of Title 8 of the United States Code.

SEC. 423. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application. The Legislature hereby declares that it would have enacted this act and each and every provision thereof not declared invalid or unconstitutional without regard to whether any other provision of this act or application thereof would be subsequently declared invalid or unconstitutional.

SEC. 424. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.

SEC. 425. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 426. The Legislature finds and declares that Section 2 of this act, which adds Section 502 of the Business and Professions Code, and Section 17 of this act, which adds Section 103871.1 of the Health and Safety Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to protect the privacy of licensees, while also gathering useful workforce data, it is necessary that some information collected from licensees only be released in aggregate form. In order to protect private and confidential medical information, it is necessary for that information to remain confidential.