AB-177 Health. (2023-2024)

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Assembly Bill No. 177

CHAPTER 999

An act to amend Sections 1751.70 and 1753.1 of, and to add Chapter 6 (commencing with Section 131400) to Part 1 of Division 112 of, the Health and Safety Code, to amend Section 10144.53 of the Insurance Code, and to amend Sections 7295 and 14165.50 of, to add Section 14165.51 to, and to add Chapter 3.5 (commencing with Section 5964) to Part 7 of Division 5 of, the Welfare and Institutions Code, relating to health, and making an appropriation therefore, to take effect immediately, bill related to the budget.

[Approved by Governor September 30, 2024. Filed with Secretary of State September 30, 2024.]

LEGISLATIVE COUNSEL'S DIGEST

AB 177, Committee on Budget. Health.

(1) The California Hospice Licensure Act of 1990 requires a person, political subdivision of the state, or other governmental agency to obtain a license from the State Department of Public Health to provide hospice services to an individual who is experiencing the last phase of life due to a terminal disease, as defined, and their family, except as provided. Existing law requires the department, by January 1, 2025, to adopt emergency regulations to implement the recommendations in a specified report of the California State Auditor. Existing law requires the department to maintain the general moratorium on new hospice agency licenses until the department adopts the regulations. Existing law requires the moratorium to end the date the emergency regulations are adopted.

This bill would extend the deadline by which the department is required to adopt those regulations to January 1, 2026, and would require the moratorium to end January 1, 2027, or one year after the date the emergency regulations are adopted.

(2) Existing law requires a disability insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, to provide coverage for medically necessary treatment of mental health and substance use disorders and cover services identified in a fee-for-service reimbursement schedule published by the State Department of Health Care Services when those services are delivered at schoolsites, regardless of the network status of the local educational agency, institution of higher education, or health care provider. Existing law requires the Insurance Commissioner to issue guidance to disability insurers regarding compliance with these provisions. Existing law, as part of the Children and Youth Behavioral Health Initiative, requires the State Department of Health Care Services to develop and maintain a school-linked statewide provider network of schoolsite behavior health counselors and requires a health care service plan, insurer, or Medi-Cal managed care plan that covers necessary schoolsite services, as specified, to comply with all administrative requirements to cover and reimburse the services set forth by the network administrator.

This bill would require the commissioner to additionally issue guidance to disability insurers regarding compliance with provisions regarding administrative requirements to cover and reimburse services under the school-linked statewide behavioral health provider network.

(3) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides that Medi-Cal funding be made available to the Martin Luther King, Jr. Community Hospital, to serve the population of South Los Angeles, as specified.

This bill would, for dates of service commencing no later than January 1, 2026, and subject to an appropriation by the Legislature, require the department to establish a Medi-Cal managed care directed payment reimbursement methodology in accordance with federal regulations. The bill would specify the minimum requirements for the reimbursement methodology. The bill would authorize the department to adjust or modify the directed payment reimbursement methodology to meet applicable federal requirements. The bill would specify, for any dates of service for which these provisions are implemented, that a Medi-Cal managed care plan is not required to make payments pursuant to existing specified provisions. The bill would authorize the department to implement these provisions by means of all-county letters, plan letters, or other similar instructions.

This bill would make legislative findings and declarations as to the necessity of a special statute for the County of Los Angeles.

(4) Existing law provides for the licensure and regulation of certain health facilities, including general acute care hospitals, by the State Department of Public Health. Existing law requires health facilities to annually report certain information to the state, including the current inventory of beds and services.

This bill, upon appropriation or availability of funds, would authorize the State Department of Public Health, in collaboration with the State Department of Health Care Services, to contract, or develop and administer, a capacity data solution, as specified. The bill would require specified entities, as defined, to submit data to the capacity data solution, which would both collect data and enable searches to identify available behavioral health beds. The bill would authorize the State Department of Health Care Services to impose a plan of correction or assess civil money penalties against an entity licensed or certified by the State Department of Health Care Services that fails to submit data accurately, timely, or as required by the State Department of Public Health.

(5) Existing law authorizes a state hospital under the jurisdiction of the State Department of State Hospitals to develop a list of items that are deemed contraband and prohibited on hospital grounds and control and eliminate the contraband on hospital grounds.

This bill would authorize the department to adopt emergency regulations related to the management, inspection, and disposition of contraband identified by the department pursuant to these provisions until June 30, 2026.

(6) The bill would also reappropriate specified funds from the Budget Act of 2021 related to the CalHOPE Student Support Program.

(7) This bill would declare that it is to take effect immediately as a bill providing for appropriations related to the Budget Bill.
Vote: majority Appropriation: yes Fiscal Committee: yes Local Program: no

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

SECTION 1. Section 1751.70 of the Health and Safety Code is amended to read:

1751.70. (a) Notwithstanding any other law and except as provided in Section 1751.75, on and after January 1, 2022, and until January 1, 2027, or one year after the date emergency regulations are adopted pursuant to Section 1753.1, the department shall not issue a new license to operate a hospice agency pursuant to this chapter.

(b) Hospice facilities licensed under subdivision (n) of Section 1250 are exempt from the moratorium established under subdivision (a).

SEC. 2. Section 1753.1 of the Health and Safety Code is amended to read:

1753.1. On or before January 1, 2026, the department shall adopt emergency regulations to implement the recommendations in California State Auditor Report 2021-123 on the California Hospice Licensure and Oversight (March 29, 2022). The department shall maintain the general moratorium on new hospice agency licenses until the department adopts the regulations. The emergency regulations shall do all of the following:

(a) Establish time and distance standards that define the maximum time and distance hospice agency staff may travel to reach patients, taking into consideration typical traffic conditions and whether the hospice agency is serving patients in rural or urban areas.

(b) Establish standards for a hospice agency’s ratio of nurses to patients.

(c) Establish a limit for the number of hospice agencies that hospice agency management personnel can be involved with concurrently.

(d) Require hospice agency management personnel to meet minimum standards of training and experience, including, but not limited to, hospice-specific training or experience.

(e) Establish specific requirements for hospice agency office space.

(f) Establish timelines for reporting changes to application information, including, but not limited to, change of mailing address, change of location, and change of name.

SEC. 3. Chapter 6 (commencing with Section 131400) is added to Part 1 of Division 112 of the Health and Safety Code, to read:

CHAPTER 6. Hospital, Emergency Medical Services, and Behavioral Health Facilities Bed Capacity Data Solution
Article 1. General Provisions

131400. For purposes of this chapter:

(a) “Department” means the State Department of Public Health.

(b) “Emergency department” has the same meaning as defined in subdivision (b) of Section 128700.

(c) “General acute care hospital” has the same meaning as defined in subdivision (a) of Section 1250.

(d) “Local health department” has the same meaning as defined in Section 101185.

(e) “Personal information” means any information that is maintained by an agency that identifies or describes an individual, including, but not limited to, the individual’s name, social security number, physical description, home address, home telephone number, education, financial matters, and medical or employment history.

(f) “Protected health information” means any health information that can identify an individual that is in possession of or transmitted by a covered entity or its business associate that relates to a patient’s past, present, or future health.

(g) “Specified entities” means general acute care hospitals, emergency departments, and behavioral health facilities determined to be included in the capacity data solution pursuant to paragraphs (1) and (2) of subdivision (a) of Section 131405.

131405. (a) The department, in collaboration with the State Department of Health Care Services, may contract, or develop and administer a capacity data solution to collect, aggregate, and display information about the availability of beds in specified entities. The development of the capacity data solution shall be subject to state information technology policies, as applicable.

(1) The department may determine entities in addition to subdivision (g) of Section 131400 to be included in the capacity data solution.

(2) The State Department of Health Care Services shall determine the behavioral health facilities to be included in the capacity data solution to comply with the Special Terms and Conditions of the federal Centers for Medicare and Medicaid Services for the purposes of the Medicaid demonstration project pursuant to subdivision (c) of Section 14184.400 of the Welfare and Institutions Code, including, but not limited to:

(A) Acute psychiatric hospitals.

(B) General acute care hospitals with psychiatric units.

(C) Psychiatric health facilities.

(D) Provider sites certified to provide crisis stabilization services by the State Department of Health Care Services or a mental health plan.

(E) Psychiatric residential treatment facilities.

(b) (1) The determination of additional specified entities, list of data elements, electronic transmission standards, the data transmission schedule, and instructions pertaining to the capacity data solution may be modified by the department, in collaboration with the State Department of Health Care Services and in consultation with stakeholders, at any time. The list of data elements to be collected or disclosed shall not, at any time, include personal information or personal health information.

(2) The determination of additional specified entities, list of data elements, electronic transmission standards, the data transmission schedule, and instructions pertaining to the capacity data solution for behavioral health facilities may be modified by the State Department of Health Care Services, in collaboration with the department and in consultation with stakeholders, at

any time. The list of data elements to be collected or disclosed shall not, at any time, include personal information or personal health information.

(c) The lists, standards, schedules, and instructions implemented pursuant to this section and any subsequent modifications shall be exempt from the administrative regulation and rulemaking requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code and shall be implemented without being adopted as a regulation, except that the revisions shall be filed with the Secretary of State and printed and published in Title 17 of the California Code of Regulations.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department and the State Department of Health Care Services may implement, interpret, or make specific this chapter, 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.

(e) A civil penalty, fine, sanction, or finding, or a denial, suspension, or revocation of licensure for a person or facility, shall not be imposed based upon a failure to provide the data elements required under this chapter, unless the required data elements, electronic transmission standards, and data transmission schedule submissions by specified entities were published in the California Code of Regulations and the department notified the person or facility of the data reporting requirements at least six months before the date of the claimed failure to report or submit.

(f) Notwithstanding subdivision (e), the State Department of Health Care Services may impose a plan of correction or assess civil money penalties for specified entities licensed or certified by the State Department of Health Care Services pursuant to subdivision (a) of Section 5964 of the Welfare and Institutions Code.

131410. (a) The department may contract for any purpose to implement this chapter.

(b) This chapter shall be implemented subject to an appropriation and the availability of funds for this purpose.

Article 2. Capacity Data Solution

131420. (a) Subject to appropriation or upon availability of funds, the department, in collaboration with the State Department of Health Care Services, shall implement a capacity data solution. The development of the capacity data solution shall be subject to state information technology policies, as applicable.

(b) The purpose of the capacity data solution is to monitor bed capacity in near real time in specified entities during normal operations and emergencies, with the goal of reducing morbidity and mortality by facilitating patient transfers and placement, and to support response to public health and medical emergencies affecting or impacting the health of California residents.

(c) The capacity data solution shall not include any information relating to state hospitals under the jurisdiction of the State Department of State Hospitals.

131425. (a) Subject to appropriation or upon availability of funds, the department, in collaboration with the State Department of Health Care Services, shall designate and administer a capacity data solution to which the specified entities shall submit data.

(b) The department, in collaboration with the State Department of Health Care Services, shall identify the data elements that shall be submitted by the specified entities and the schedule and format for data submission.

(1) The data elements to be submitted by behavioral health facilities that are specified entities shall include, but not be limited to, the following:

(A) Number of available beds.

(B) For each available bed, the age ranges for which the bed is appropriate.

(C) For each available bed, whether the bed is secure for individuals who have been determined to be a danger to themselves or others or are gravely disabled.

(D) Other data elements the State Department of Health Care Services identifies, in consultation with interested organizations representing behavioral health facilities and other relevant stakeholders, as necessary for effective implementation of the capacity data solution.

(2) The data elements to be submitted by general acute care hospitals and emergency departments that are specified entities shall include, but not be limited to, the following:

(A) Hospital bed census.

(B) Bed availability by level of care, unit, and hospital.

(C) Other data elements the department identifies, in consultation with interested organizations representing general acute care hospitals and emergency departments and other relevant stakeholders, as necessary for effective implementation of the capacity data solution.

(c) The capacity data solution shall have both of the following capabilities, at a minimum:

(1) Collecting data.

(2) Enabling searches by authorized users to identify available behavioral health beds that are appropriate for individuals in need of treatment provided by the specified entities.

(d) The capacity data solution shall be subject to all applicable state and federal privacy laws.

(e) The specified entities shall submit the required data electronically in accordance with the schedule established by the department.

SEC. 4. Section 10144.53 of the Insurance Code is amended 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) The commissioner shall issue guidance to disability insurers regarding compliance with this section, as well as requirements necessary to comply with Section 5961.4 of the Welfare and Institutions Code. 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. 5. Chapter 3.5 (commencing with Section 5964) is added to Part 7 of Division 5 of the Welfare and Institutions Code, to read:

CHAPTER 3.5. Hospital, Emergency Medical Services, and Behavioral Health Facilities Bed Capacity Data Solution

5964. (a) (1) The State Department of Health Care Services may impose a plan of correction or assess civil money penalties pursuant to paragraph (2), or both, against a specified entity licensed or certified by the State Department of Health Care Services that fails to submit data accurately, timely, or as required pursuant to Section 131425 of the Health and Safety Code.

(2) The State Department of Health Care Services may determine a reasonable length of time for the facility to complete a plan of correction. The State Department of Health Care Services may issue a notice of imposition of civil money penalties if the facility fails to complete a plan of correction by the time specified. The State Department of Health Care Services may assess penalties against a facility in the amount of one hundred dollars ($100) per day from the date of notice of imposition of penalties.

(3) A facility may submit a written grievance to the State Department of Health Care Services within 15 working days of the issuance of the notice specified in paragraph (2). The facility shall include any supporting documentation and explain any mitigating circumstances. The State Department of Health Care Services shall make a determination on the grievance within 90 calendar days of receipt of a complete grievance.

(4) A facility may request a formal hearing within 30 calendar days of the State Department of Health Care Services' determination on the grievance pursuant to paragraph (3). Hearings to review the imposition of civil money penalties shall be conducted pursuant to the requirements set forth in Section 100171 of the Health and Safety Code. Civil money penalties against a facility shall continue to accrue until the effective date of the final decision of the State Department of Health Care Services.

(5) The State Department of Health Care Services may obtain a court order to recover unpaid civil money penalties against a specified entity licensed or certified by the State Department of Health Care Services.

(b) Notwithstanding Section 13340 of the Government Code, civil money penalties collected pursuant to this section shall be deposited into the General Fund for use, upon appropriation by the Legislature, for costs for behavioral health care services furnished to persons eligible for the Medi-Cal program, including persons dually eligible for the Medi-Cal program and the Medicare Program.

(c) The State Department of Health Care Services shall seek any federal approvals it deems necessary to implement this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(d) 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, interpret, or make specific this section, in whole or in part, by means of information notices, provider bulletins, or other similar instructions, without further regulatory action.

(e) For purposes of this section, “specified entity” has the same meaning as defined in Section 131400 of the Health and Safety Code.

SEC. 6. Section 7295 of the Welfare and Institutions Code is amended to read:

7295. (a) To ensure its safety and security, a state hospital that is under the jurisdiction of the State Department of State Hospitals, as listed in Section 4100, may develop a list of items that are deemed contraband and prohibited on hospital grounds and control and eliminate contraband on hospital grounds.

(b) The State Department of State Hospitals shall develop a list of items that shall be deemed contraband at every state hospital.

(c) A state hospital shall form a contraband committee, comprised of hospital management and employees designated by the hospital’s director, to develop the list of contraband items. The committee shall develop the list with the participation of patient representatives, or the patient government of the hospital, if one is available, and the Office of Patients’ Rights.

(d) Each hospital’s list of contraband items developed pursuant to subdivision (a), and the statewide list of contraband items developed pursuant to subdivision (b), are subject to review and approval by the Director of State Hospitals or his or her designee.

(e) A list of contraband items developed pursuant to subdivision (a) shall be updated and subject to review and approval by the director of the department, or the director’s designee, no less often than every six months.

(f) If an item presents an emergent danger to the safety and security of a facility, the item may be placed immediately on a contraband list by the Director of State Hospitals or the executive director of the state hospital, but this placement shall be reviewed by the contraband committee, if applicable, and approved by the Director of State Hospitals or the director’s designee within six weeks.

(g) The lists of contraband items developed pursuant to this section shall be posted prominently in every unit of the hospital and throughout the hospital, and provided to a patient upon request.

(h) The lists of contraband items developed pursuant to this section shall be posted on the hospital’s Internet Web site.

(i) For the purposes of this section, “contraband” means materials, articles, or goods that a patient is prohibited from having in his or her possession because the materials, articles, or goods present a risk to the safety and security of the facility.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the hospital and the department may implement, interpret, or make specific this section without taking regulatory action.

(k) The State Department 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) related to the management, inspection, and disposition of contraband items that have been identified by the department pursuant to this section. The adoption of emergency regulations under this subdivision 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. This subdivision shall become inoperative on June 30, 2026, unless a later enacted statute deletes or extends that date.

SEC. 7. Section 14165.50 of the Welfare and Institutions Code is amended to read:

14165.50. (a) To facilitate the financial viability of the Martin Luther King, Jr. Community Hospital, a private nonprofit hospital that serves the population of South Los Angeles that was formerly served by the Los Angeles County Martin Luther King, Jr.-Harbor

Hospital, Medi-Cal funding shall, at a minimum, be made available, as specified in this section, or pursuant to mechanisms that provide equivalent funding under successor or modified Medi-Cal payment systems.

(b) Medi-Cal payment for hospital services provided by the hospital, exclusive of any payments pursuant to the Medi-Cal Hospital Reimbursement Improvement Act of 2013 (Article 5.230 (commencing with Section 14169.50)) or funded by another statewide hospital fee program, and exclusive of the supplemental payments specified in subdivision (d), shall include consideration of the hospital's projected Medi-Cal costs for providing the services as set forth in this section.

(1) (A) Subject to paragraph (2) of subdivision (c), and notwithstanding any other law, Medi-Cal payments made to the hospital on a fee-for-service basis, including payments made pursuant to the methodology authorized under Section 14105.28 or successor or modified methodologies, shall provide compensation that is, at a minimum, equal to 100 percent of the hospital's projected Medi-Cal costs for each fiscal year.

(B) To the extent Medi-Cal supplemental payments are necessary for any fiscal year to meet the applicable minimum reimbursement level, as described in subparagraph (A), the department shall seek federal approval, as necessary, to make the Medi-Cal supplemental payments.

(2) (A) To the extent permitted under federal law, except as specified in paragraph (3) of subdivision (b) of Section 14165.51, the department shall require Medi-Cal managed care plans serving Medi-Cal beneficiaries in the County of Los Angeles to pay the hospital amounts determined necessary to meet compensation levels for services provided to Medi-Cal managed care enrollees that are no less than the amount that the hospital would have received on a fee-for-service basis pursuant to paragraph (1). The amounts shall be determined in consultation with the hospital, the County of Los Angeles, and the Medi-Cal managed care plan, and shall be subject to paragraph (2) of subdivision (c).

(B) Consistent with federal law, the capitation rates paid to Medi-Cal managed care plans serving Medi-Cal beneficiaries in the County of Los Angeles shall be determined to reflect the obligations described in subparagraph (A). The increased payments to Medi-Cal managed care plans that would be paid consistent with actuarial certification and enrollment in the absence of this paragraph shall not be reduced as a consequence of this paragraph.

(C) A Medi-Cal managed care plan receiving the increased payments described in subparagraph (B) shall not impose a fee or retention amount, or reduce other payments to the hospital that would result in a direct or indirect reduction to the amounts required to be paid under subparagraph (A).

(3) This subdivision shall not be construed to result in payments that are less than the rates of compensation that would be payable to the hospital for Medi-Cal services without regard to the requirements of paragraphs (1) and (2).

(c) If the applicable minimum reimbursement levels required in subdivision (b) result in payments to the hospital that are above the levels of compensation that would have been payable absent that requirement, and to the extent a nonfederal share is necessary with respect to the additional compensation, the following provisions shall apply:

(1) (A) For each fiscal year through the 2016–17 fiscal year, General Fund amounts appropriated in the annual Budget Act for the Medi-Cal program shall fund the nonfederal share of the additional payments to the extent that the rates of compensation for inpatient hospital services provided by the hospital that would have been payable in the absence of the requirements of subdivision (b) are less than 77 percent of the hospital's projected Medi-Cal costs. With respect to the nonfederal share of the additional payments described in paragraph (2) of subdivision (b), however, this subparagraph shall be applicable only for inpatient services provided in conjunction with the implementation of Section 14182, and other mandatory managed care enrollment provisions implemented subsequent to January 1, 2011.

(B) For the 2017–18 fiscal year and each fiscal year thereafter, General Fund amounts appropriated in the annual Budget Act for the Medi-Cal program shall fund the nonfederal share of the additional payments to the extent that the rates of compensation for inpatient hospital services provided by the hospital that would have been payable in the absence of the requirements of subdivision (b) are less than 72 percent of the hospital's projected Medi-Cal costs. With respect to the nonfederal share of the additional payments described in paragraph (2) of subdivision (b), however, this subparagraph shall be applicable only for inpatient services provided in conjunction with the implementation of Section 14182, and other mandatory managed care enrollment provisions implemented subsequent to January 1, 2011.

(2) (A) The remaining necessary nonfederal share of the additional payments, after taking into account the General Fund amounts described in paragraph (1), may be funded with public funds that are transferred to the state from the County of Los Angeles, at the county's election, pursuant to Section 14164. To the extent the county elects not to fund any portion of the remaining necessary nonfederal share, the applicable minimum reimbursement levels required in subdivision (b) shall be reduced accordingly.

(B) Public funds transferred to the state for payments to the hospital, as described in this paragraph with respect to a fiscal period, shall be expended solely for the nonfederal share of the payments. Notwithstanding any other law, and except as provided in subdivision (m), the department shall not impose any fee or assessment in connection with the transferred funds or the payments provided for under this section, including, but not limited to, reimbursement for state staffing or administrative costs.

(C) If any portion of the funds transferred pursuant to this paragraph is not expended, or not expected to be expended, for the specified rate amounts required in subdivision (b), the unexpended funds shall be returned promptly to the transferring county.

(3) This subdivision shall not be construed to reduce the nonfederal share of payments funded by General Fund amounts below the amounts that would be funded without regard to the minimum payment levels required under this section.

(d) (1) In addition to payments meeting the applicable minimum reimbursement levels described in subdivision (b), except as specified in paragraph (3) of subdivision (b) of Section 14165.51, the hospital shall be eligible to receive supplemental payments. The supplemental payments shall be provided annually in amounts determined in consultation with the hospital and the County of Los Angeles, and subject to paragraph (3).

(2) The department shall seek federal approval, as necessary, to enable the hospital to receive supplemental payments that are in addition to the applicable minimum reimbursement levels required in subdivision (b). The supplemental payments may be provided for under the mechanisms described in Sections 14166.12 and 14301.4 or successor or modified mechanisms, or any other federally permissible payment mechanism. Supplemental payments that are payable through a Medi-Cal managed care plan shall be subject to the same requirements described in subparagraph (C) of paragraph (2) of subdivision (b).

(3) If a nonfederal share is necessary to fund the supplemental payments, the County of Los Angeles may voluntarily provide public funds that are transferred to the state pursuant to Section 14164. The county may specify the type of supplemental payment for which it is transferring funds, and any other category relevant to the payment, including, but not limited to, fee-for-service supplemental payment, managed care rate range payment, and payment for services rendered to newly eligible beneficiaries as defined in subdivision (s) of Section 17612.2.

(4) Public funds transferred to the state for supplemental payments to the hospital, as described in this subdivision with respect to a fiscal period, shall be expended solely for the nonfederal share of the supplemental payments as specified pursuant to paragraph (3). Notwithstanding any other law, subdivision (o) of Section 14166.12 shall not apply, and the department shall not assess the fee described in subdivision (d) of Section 14301.4, or any other similar fee, except as provided in subdivision (m). If any portion of the funds transferred pursuant to this subdivision is not expended, or not expected to be expended, for the specified supplemental payments, the unexpended funds shall be returned promptly to the transferring county.

(e) Notwithstanding any other law, all payments provided for under this section shall be treated as having been paid for purposes of any determination of available room under the federal upper payment limit, as specified in Part 447 of Title 42 of the Code of Federal Regulations, with respect to the applicable class of services and class of health care provider.

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

(1) “Hospital” means a health facility that is certified under Title XVIII and Title XIX of the federal Social Security Act, and is licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code to provide acute inpatient hospital services, and includes all components of the facility, with an inpatient hospital service location on the campus of the Martin Luther King, Jr. Community Hospital.

(2) “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).

(g) For purposes of this article, the hospital’s projected Medi-Cal costs shall be based on the cost finding principles applied under subdivision (b) of Section 14166.4, except that the projected costs shall not be multiplied by the federal medical assistance percentage and are not subject to the reimbursement limitations set forth in Article 7.5 (commencing with Section 51536) of Chapter 3 of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations. The projected Medi-Cal costs shall be determined prior to the start of each fiscal year in consultation with the hospital, using the best available and reasonable current estimates or projections made with respect to the hospital for an annual period, and shall be considered final as of the start of the fiscal year for purposes of the minimum payment levels described in subdivision (b).

(h) Notwithstanding any other law, the hospital shall not be eligible to receive payments pursuant to Section 14166.11. This subdivision, however, shall not be construed to preclude the hospital from eligibility for disproportionate share status, or from

receipt of any federal Medicaid disproportionate share hospital payments to which it would be entitled, pursuant to the Medi-Cal State Plan.

(i) Except as specified in subdivision (h) and paragraph (3) of subdivision (b) of Section 14165.51, this section shall not be construed to preclude the hospital from receiving any other payment for which it is eligible in addition to the payments provided for by this section.

(j) Notwithstanding any other law, for purposes of Article 12 (commencing with Section 17612.1) of Chapter 6 of Part 5, the intergovernmental transfers described in this section as reflected in the actual net expenditures for all operating budget units of the County of Los Angeles Department of Health Services shall not be reduced in any manner in the determination of total costs under paragraph (6) of subdivision (b) of Section 17612.5, by application of the imputed other entity intergovernmental transfer amounts or otherwise.

(k) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of all-facility letters, all-county letters, or similar instructions, without taking further regulatory action. This section shall not be construed to preclude the department from adopting regulations.

(l) (1) The department shall obtain federal approvals or waivers as necessary to implement this section and to obtain federal matching funds to the maximum extent permitted by federal law. This section shall be implemented only if, and to the extent that, federal financial participation is available and this section does not jeopardize the federal financial participation available for any other state program.

(2) This section shall be implemented only if, and to the extent that, any necessary federal approvals are obtained.

(m) As part of its voluntary participation to provide the nonfederal share of payments under this section, the County of Los Angeles shall agree to reimburse the state for the nonfederal share of state staffing and administrative costs directly attributable to the cost of administrating the payments and associated intergovernmental transfers pursuant to this section. The costs shall be documented and subject to review by the county.

SEC. 8. Section 14165.51 is added to the Welfare and Institutions Code, to read:

14165.51. (a) (1) For dates of service commencing no later than January 1, 2026, the department shall establish a Medi-Cal managed care directed payment reimbursement methodology in accordance with Section 438.6(c) of Title 42 of the Code of Federal Regulations applicable to the hospital.

(2) The directed payment reimbursement methodology shall, at minimum:

(A) Provide reimbursement for contracted hospital inpatient services such that aggregate managed care reimbursement to the hospital for hospital inpatient services, exclusive of any payments pursuant to Article 5.230 (commencing with Section 14169.50), is projected by the department to be at least equal to 72 percent of the hospital's projected Medi-Cal costs for hospital inpatient services associated with the implementation of Section 14182, and other mandatory managed care enrollment provisions implemented subsequent to January 1, 2011.

(B) Provide additional reimbursements to the hospital for contracted hospital inpatient and hospital outpatient services in a form and manner that is projected by the department to total twenty-five million dollars ($25,000,000) annually in addition to the amount described in subparagraph (A).

(C) Align with the goals and objectives of the department's comprehensive quality strategy.

(D) To the extent appropriate, link payments to value and outcomes, consistent with measures selected by the department consistent with subparagraph (C), in addition to access to and utilization of services.

(E) Be developed with consideration of the stability of the hospital's cash flow.

(F) Be developed in consultation with the hospital.

(3) (A) The department shall, annually on a prospective basis, make the projections pursuant to subparagraphs (A) and (B) of paragraph (2), and may develop the projections on either an aggregate or individual service level, or both.

(B) The department may require Medi-Cal managed care plans and the hospital 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.

(C) In the event payments to the hospital at the level set forth in paragraph (2), in combination with any other reimbursement, exceed any federal statutory or regulatory limits on Medicaid reimbursement, the amount of payments that

the Medi-Cal managed care plans make shall be reduced to comply with the applicable federal limitation.

(D) In establishing the reimbursement methodology pursuant to paragraph (1) and the parameters for Medi-Cal managed care plans in the County of Los Angeles to make increased payments to the hospital pursuant to subdivision (b), the department shall consider strategies that are designed to result in the hospital receiving the payments pursuant to this section as quickly as practicable and on an ongoing or periodic basis that supports the stability of the hospital's cash flow.

(4) To the extent necessary to meet the objectives identified in paragraph (2) or to comply with federal requirements, the department may, in consultation with the hospital, adjust or modify the directed payment reimbursement methodology to meet applicable federal requirements and be consistent with actuarial rate development principles and standards.

(b) (1) Medi-Cal managed care plans in the County of Los Angeles shall increase payments to the hospital in accordance with the requirements of the directed payment methodology established by the department pursuant to this section and guidance issued pursuant to subdivision (c).

(2) Except as provided in paragraph (3), this section shall not be construed to preclude the hospital from receiving any other payment for which it is eligible in addition to the payments provided for by this section.

(3) For any dates of service for which this section is implemented, in whole or in part, and notwithstanding any other law, a Medi-Cal managed care plan shall not be required to make any payments pursuant to Section 14165.50.

(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, interpret, or make specific this section, in whole or in part, by means of all-county letters, plan letters, provider bulletins, information notices, or similar instructions, without taking any further regulatory action.

(d) (1) The department shall seek any federal approvals it deems necessary to implement this section.

(2) 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) (1) The nonfederal share of increases to Medi-Cal managed care plan capitation rates made in accordance with this section shall be funded using General Fund moneys or other state funds appropriated to the department as the state share in the annual Budget Act.

(2) Implementation of this section in each applicable fiscal year is subject to an appropriation in the annual Budget Act or another statute for the express purpose of this section.

SEC. 9. The Legislature finds and declares that a special statute is necessary and that a general statute cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because of the fact that the Martin Luther King, Jr. Community Hospital is a critical safety net hospital with a need for more funding.

SEC. 10. Notwithstanding any other provision of law, $45,000,000 of the amount appropriated in Item 4260-101-0001 of the Budget Act of 2021 (Chs. 21, 69, and 240, Stats. 2021) related to Provision 16(c) of that item are reappropriated and shall be available for encumbrance or expenditure until June 30, 2025, for the same programs and purposes.

SEC. 11. 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.