AB-144 Health. (2025-2026)

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Assembly Bill No. 144

CHAPTER 105

An act to amend Sections 1246, 1300, 1300.1, 1625.6, 2473, 3041, and 3041.5 of, and to add Sections 901 and 4052.05 to, the Business and Professions Code, to amend Section 48980.4 of the Education Code, to amend Section 100520.5 of, and add Section 100503.6 to, the Government Code, to amend Sections 1206, 1261.3, 1342.2, 1342.3, 1347.8, 1367.002, 1367.3, 1367.35, 100425, 100450, 104151, 120372, 120372.05, 120392.2, 120392.3, 120392.6, 120392.9, 120393, 124981, and 124982 of, to amend, repeal, and add Sections 120336, 120390.6, and 120455 of, to add Sections 1797.11 and 120164 to, to add and repeal Chapter 6.1 (commencing with Section 127640) of Part 2 of Division 107 of, and to repeal Section 11756.8 of, the Health and Safety Code, to amend Sections 10110.7, 10110.75, 10112.2, 10123.5, and 10123.55 of the Insurance Code, to amend Section 30461.6 of the Revenue and Taxation Code, to amend Sections 5961.4, 11265.8, 14005.27, 14005.62, 14007.5, 14007.8, 14012.5, 14105.47, 14105.475, 14124.11, 14146, 14146.5, and 14501 of, to add Section 14132.995 to, and to repeal Sections 14007.95 and 14100.95 of, the Welfare and Institutions Code, to amend Section 118 of Chapter 21 of the Statutes of 2025, and to repeal Section 34 of Chapter 80 of the Statutes of 2005, and Section 67 of Chapter 758 of the Statutes of 2008, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.

[Approved by Governor September 17, 2025. Filed with Secretary of State September 17, 2025.]

LEGISLATIVE COUNSEL'S DIGEST

AB 144, Committee on Budget. Health.

(1) Existing law provides for the licensure and regulation of various healing arts practitioners by boards within the Department of Consumer Affairs. Existing law provides an exemption from these requirements for a health care practitioner licensed in another state who offers or provides health care for which the practitioner is licensed during a state of emergency, as defined, and upon request of the Director of the Emergency Medical Services Authority, as specified.

This bill would exempt health care practitioners licensed in another state, territory, or country from certain healing arts licensure, certification, or registration requirements, as described above, while providing professional services at Olympic and Paralympic activities, as defined, if the health care practitioner has been invited by the Los Angeles Organizing Committee for the 2028 Olympic and Paralympic Games to provide those services and the committee provides specified information to the Director of Consumer Affairs. The bill would specify that the exemption applies while the health care practitioner is providing professional services at the invitation of the committee and only during the time sanctioned by the committee.

This bill would authorize the official team representative who is responsible for any member participating in Olympic and Paralympic activities to give consent to the furnishing of professional services to a team member who, due to age, disability, or injury, is not able to personally consent in the event the consent of a parent, guardian, or legal representative of a team member

cannot be obtained. The bill would specify that in the case of emergency, the consent of the parent, guardian, or legal representative of the team member would not be necessary in order to authorize the performance of professional services.

(2) Existing law sets forth various powers and responsibilities for the State Department of Public Health concerning communicable disease prevention and control, in relation to persons, animals, and places, as necessary to protect or preserve the public health.

This bill would require that the list of immunizations, items, and services that were recommended by the United States Preventive Services Task Force (USPSTF), the federal Advisory Committee on Immunization Practices (ACIP), and the federal Health Resources and Services Administration (HRSA) that were in effect on January 1, 2025, serve as a baseline of recommendations and would authorize the State Department of Public Health, notwithstanding the rulemaking provisions of the Administrative Procedure Act, to modify or supplement those baseline recommendations, as specified. The bill would require the department to publish recommendations and any updates, modifications, or supplements.

(3) Existing law authorizes various healing arts licensees, including dentists, doctors of podiatric medicine, optometrists, and pharmacists, to independently prescribe, initiate, or administer specified immunizations approved or authorized by the United States Food and Drug Administration in compliance with specified recommendations, including those by the ACIP.

This bill would instead authorize those licensees to prescribe, initiate, or administer specified immunizations in a manner consistent with a recommendation made by the State Department of Public Health, as specified.

(4) Existing law provides for the licensure, registration, and regulation of clinical laboratories and various clinical laboratory personnel by the State Department of Public Health. Existing law requires the fees or charges accompanying an application for the issuance or renewal of these licenses, among others, to be adjusted annually by the percentage change printed in the Budget Act and determined by dividing the General Fund appropriation to Laboratory Field Services in the current state fiscal year by the General Fund appropriation to Laboratory Field Services in the preceding state fiscal year. Commencing January 1, 1995, upon establishment of the Clinical Laboratory Improvement Fund, existing law requires this annual adjustment to be determined by dividing the current fiscal year appropriation to the Clinical Laboratory Improvement Fund by the General Fund appropriation to Laboratory Field Services of the department in the preceding fiscal year. Existing law also requires these fees and charges to be adjusted annually by a percentage determined by dividing the total amount of federal funds available for all programs in Laboratory Field Services of the department during the federal fiscal year ending on September 30 of the year immediately preceding the effective date of the change in fees, as specified.

This bill would delete the above provisions pertaining to the annual adjustment of fees or charges and replace them with a requirement that the annual adjustment be done by the department to cover the estimated licensing program costs.

Existing law requires a tissue bank, as defined, to have a current and valid tissue bank license. Under existing law, the application and annual renewal fee for a tissue bank license is $950, adjusted annually by a percentage listed in the Budget Act.

This bill would adjust the fees or charges for a tissue bank license annually pursuant to the provision above requiring the annual adjustment be done by the department to cover the estimated licensing program costs.

This bill would additionally revise the application, registration, and license fees for clinical laboratories and clinical laboratory personnel.

(5) 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. PPACA defines a “qualified health plan” as a plan that, among other requirements, provides an essential health benefits package. 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. Existing law establishes the Health Care Affordability Reserve Fund to be used, upon appropriation by the Legislature, for health care affordability programs operated by the Exchange.

If a qualified health plan is required to cover state-mandated gender-affirming care benefits determined to be in addition to essential health benefits, this bill would require the Exchange to provide payments to issuers of qualified health plans to defray the costs of offering those benefits for plan years beginning on or after January 1, 2026, subject to an appropriation by the Legislature. The bill would authorize the Health Care Affordability Reserve Fund to be used, upon appropriation by the Legislature, for these payments.

(6) Existing law establishes the State Department of Public Health and sets forth its powers and duties, including, but not limited to, duties relating to the licensing and regulation of various entities, including clinics. Existing law exempts specified clinics from these licensure requirements, including, among others, certain federal clinics, clinics maintained as outpatient departments of hospitals, and student health centers operated by public institutions of higher education.

This bill would exempt from the above-described licensure requirements a clinic approved by, and that provides health care services at locations designated or sanctioned by, the Los Angeles Organizing Committee for the 2028 Olympic and Paralympic Games from May 15, 2028, to September 15, 2028, inclusive.

(7) Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, establishes the Emergency Medical Services Authority, which is responsible for the coordination of various state activities concerning emergency medical services (EMS), including, among others, establishing minimum standards and promulgating regulations for the training and scope of practice for an Emergency Medical Technician I and II (EMT-I and EMT-II) and Emergency Medical Technician-Paramedic (EMT-P). Existing law requires the authority to have a chief medical officer who is required to provide clinical leadership and oversight concerning treatment, education, and other matters involving medical decisionmaking and delivery of patient care.

This bill, notwithstanding any other law, would exempt from the EMS licensure, certification, or accreditation requirements of this state an EMT-I, EMT-II, EMT-P, or similar EMS provider, as defined, licensed or certified in another state or territory of the United States, who provides EMS for which they are licensed, if they are authorized by the chief medical officer of the authority to provide EMS at sites in this state sanctioned by the Los Angeles Organizing Committee for the 2028 Olympic and Paralympic Games and associated with the 2028 Olympic and Paralympic Games. The bill would require the chief medical officer to authorize those EMS personnel based on system needs and informed by committee needs, qualifications of the emergency medical services personnel, and public safety considerations. The bill would prohibit EMS providers authorized by the chief medical officer from being liable for any act or omission taken in good faith while providing authorized services. The bill would require authorization pursuant to these provisions to be valid from May 15, 2028, to September 15, 2028, inclusive, or until authorization is otherwise withdrawn by the chief medical officer.

(8) Existing law requires the State Department of Health Care Services (DHCS) to annually report to certain legislative committees, and publicly post, a summary of outcome and expenditure data with regard to outcome measures for alcohol and drug program services, as specified.

This bill would repeal the above-described reporting and publication provisions.

(9) Existing law requires DHCS to provide certain legislative committees with biannual updates on caseload, estimated expenditures, and related program monitoring data for the Every Woman Counts (EWC) Program, as specified. Existing law requires that expenditures for the EWC Program included in the department's budget for services provided on or after July 1, 2017, be charged against the appropriation for the fiscal year in which the billing is paid.

This bill would delete the above-described requirements relating to the EWC Program.

(10) Existing law establishes the public policy of the state that pupils are advised to adhere to current immunization guidelines, as recommended by, among other entities, the ACIP. Existing law prohibits the governing authority of a school or other institution from unconditionally admitting any person as a pupil unless, before the person's admission to that institution, the person has been fully immunized against various diseases, including any disease deemed appropriate by the State Department of Public Health, taking into consideration recommendations of various entities, including the ACIP. Existing law requires a medical exemption form and the appeal process for revocation of a medical exemption to be consistent with specified guidelines, including those by the ACIP.

This bill would delete certain references to the ACIP and replace other references to the ACIP with the State Department of Public Health. Some of these provisions would be operative beginning July 1, 2026. To the extent that this bill imposes new duties on a local education agency, the bill would impose a state-mandated local program.

(11) Existing law, from October 1 to the following April 1, inclusive, of each year, requires specified health facilities to offer immunizations for influenza and pneumococcal disease to residents or inpatients 65 years of age or older who are receiving services at the facility, based upon the latest recommendations of specified entities, including the ACIP.

This bill would replace those references to ACIP with the State Department of Public Health.

Existing law requires the State Department of Public Health to post on its internet website educational information regarding influenza in accordance with the latest recommendations of the ACIP.

This bill would replace the reference to ACIP with the State Department of Public Health.

(12) Existing law, the Hereditary Disorders Act, requires the State Department of Public Health to license genetic counselors and temporary genetic counselors who meet specified requirements. Existing law prohibits the license fee from exceeding $200 for an original license, license renewal, or temporary license. Existing law requires all moneys collected by the department under the act

to be deposited in the Genetic Disease Testing Fund, which is continuously appropriated to the department to carry out the purposes of the act.

This bill would instead set the fee for an original license, license renewal, and temporary license at $300. The bill would authorize the department to adjust those fees to an amount not to exceed $500. The bill would require the department to solicit input from affected stakeholders before raising these fees. By authorizing additional moneys to be deposited into a continuously appropriated fund, the bill would make an appropriation.

(13) 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. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires specified health care service plan contracts, or specified disability or health insurance policies, to cover an evidence-based item, service, or immunization that has in effect a specified rating in the recommendations of the USPSTF or an immunization that has in effect a recommendation from specified entities, including the ACIP. Existing law also requires specified health care service plans or disability insurers to offer benefits for the comprehensive prevention care of children consistent with the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by various entities, including the ACIP.

This bill would require those health care service plan contracts or disability or health insurance policies to cover an evidence-based item, service, or immunization that had in effect on January 1, 2025, a specified rating in the recommendations of USPSTF. The bill would replace references to the ACIP with the State Department of Public Health. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

(14) 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 (Exchange), also known as Covered California, for this purpose. PPACA generally prohibits the use of federal funds for abortion services, but if a qualified health plan provides abortion coverage, PPACA requires the issuer of the plan to collect specified amounts from each enrollee and deposit those funds into a segregated account to be used to pay for abortion services. Under state law, the Exchange makes those payments to qualified health plans on behalf of enrollees. Existing state law requires a health care service plan that provides a qualified health plan through the Exchange to report to the Director of the Department of Managed Health Care the total amount of funds maintained in a segregated account.

This bill would establish the Abortion Access Fund, a continuously appropriated fund, to provide funding for abortion services, including for abortion services funded through grants to provide abortion access. The bill would authorize the Department of Health Care Access and Information to distribute moneys in the fund through grants and contracts. Under the bill, contracts, grants, and related information would be exempt from public disclosure. From the 2025–26 fiscal year to the 2028–29 fiscal year, inclusive, the bill would require the Director of the Department of Managed Health Care to order a health care service plan that provides a qualified health plan through the Exchange to transfer to the Abortion Access Fund up to the total amount previously funded by the Exchange, not to exceed a specified percentage of the ending balance in its segregated account, and would require a plan to complete the transfer. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

(15) Under existing law, the Breast Cancer Fund consists of the Breast Cancer Research Account and the Breast Cancer Control Account. Under existing law, revenues from a specified cigarette tax are deposited into the fund and divided equally between the 2 accounts, to be allocated upon appropriation.

Existing law requires any entity funded by the Breast Cancer Control Program to collect data and maintain records that are determined by the State Department of Public Health to be necessary to facilitate the department's ability to monitor and evaluate the effectiveness of the entities and the program. Existing law requires the department to submit an annual report to the Legislature and any other appropriate entity.

This bill would switch the jurisdiction from the State Department of Public Health to DHCS for purposes of the above-described and other related provisions. The bill would make certain changes to the required contents of the report.

Existing law requires the State Department of Public Health to provide for breast cancer screening services at the level of funding budgeted from state and other resources during the fiscal year in which the Legislature has appropriated funds to the department for this purpose, with administrative or indirect costs not exceeding certain limits.

This bill would delete those provisions.

(16) Existing law establishes the Children and Youth Behavioral Health Initiative, administered by the California Health and Human Services Agency and its departments, as applicable. Under existing law, the purpose of the initiative is 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.

Existing law requires DHCS, or a contracted vendor, to provide competitive grants to qualified entities to build partnerships, capacity, and infrastructure supporting ongoing school-linked behavioral health services, among other purposes, for children and youth 25 years of age and younger. For these purposes, existing law requires the department to develop and maintain a school-linked statewide fee schedule for outpatient mental health or substance use disorder treatment provided to a student who is 25 years of age or younger at a schoolsite. Existing law requires the department to develop and maintain a school-linked statewide provider network of schoolsite behavioral health counselors. Existing law authorizes the department to contract with an entity to administer the school-linked statewide behavioral health provider network. Existing law requires that administrator to, among other things, create and administer a process for the submission and reimbursement of eligible claims.

This bill would require the department to convene a working group twice each year of specified stakeholders, including, among others, behavioral health providers and local educational agencies, to discuss the status of, and receive feedback regarding, the implementation of the fee schedule. The bill would require a contracted administrator to automate the matching of student records with health plan enrollment information and to reimburse claims pursuant to claim payment deadlines, as specified. The bill would require the California Health and Human Service Agency to publish a manual to assist a local educational agency with navigating certain federal laws.

(17) Existing law, the California Work Opportunity and Responsibility to Kids (CalWORKs) program, requires all applicants for or recipients of CalWORKs to ensure and provide documentation that each child in the assistance unit who is not required to be enrolled in school has received all age-appropriate immunizations. Existing law requires all applicants and recipients to be given notice of that obligation and for the notice to include specified recommended childhood immunization schedules, as approved by various entities, including the ACIP.

This bill would remove the reference to the ACIP and replace it with the State Department of Public Health, as specified.

(18) Existing law establishes the Medi-Cal program, which is administered by DHCS and 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 sets a schedule of benefits that are covered by the Medi-Cal program.

This bill would require that vaccines and immunizations are covered in accordance with a recommendation from ACIP, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, and any modification or supplement to a recommendation adopted by the State Department of Public Health. The bill would make the implementation of this provision contingent to the extent that federal financial participation is available and any necessary federal approvals are obtained.

(19) Existing law prohibits the use of an assets or resources test for individuals whose income eligibility for Medi-Cal is determined based on the application of a modified adjusted gross income (MAGI). Existing law prohibits, until January 1, 2026, the use of resources to determine Medi-Cal eligibility for applicants or beneficiaries whose eligibility is not determined using the MAGI-based financial methods, subject to receipt of any necessary federal approvals.

Under existing law, operative on January 1, 2026, for those applicants or beneficiaries whose eligibility is not determined using the MAGI-based financial methods, DHCS is required to seek federal approval to implement a disregard of $130,000 in nonexempt property for a case with one member and $65,000 for each additional household member, up to a maximum of 10 members. Existing law requires that provision to be implemented only after the Director of Health Care Services determines that systems have been programmed for the disregards and they communicate that determination in writing to the Department of Finance.

This bill would additionally specify that the above-described implementation condition occur no sooner than January 1, 2026.

(20) Existing law sets forth provisions for the transition of certain children from the former Healthy Families Program to the Medi-Cal program. Existing law requires DHCS to provide monthly status reports to certain legislative committees on the transition, with a final comprehensive report provided within 90 days after completion of the last phase of transition.

This bill would delete the above-described reporting requirement.

(21) Existing law establishes a program, known as the 250% Working Disabled Program (250% WDP), under which certain working persons with disabilities are eligible for Medi-Cal benefits based on a net countable income of less than 250% of the federal poverty level and other specified criteria. Existing law requires DHCS to report to the Governor and the Legislature any information that DHCS gathers that may explain the low participation rates in 250% WDP and any recommendations on increasing participation, as specified.

This bill would repeal the above-described reporting provision.

(22) The federal Medicaid program prohibits 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 state law extends Medi-Cal eligibility for the full scope of Medi-Cal benefits to individuals who do not have satisfactory immigration status if they are otherwise eligible for those benefits, with the exception of specified dental benefits for individuals who are 19 years of age or older. Existing law makes an individual who is 19 years of age or older, who does not have satisfactory immigration status, and who applies for Medi-Cal on or after January 1, 2026, eligible only for pregnancy-related services and emergency medical treatment. Existing law, beginning no sooner than July 1, 2026, or July 1, 2027, as specified, requires individuals who do not have satisfactory immigration status, who are not pregnant, and who are 19 to 59 years of age, inclusive, to pay a monthly premium of $30, subject to certain exceptions.

This bill would make certain nonminor dependents and foster youths exempt from the service limitations and monthly premium provisions described above. The bill would require the monthly premium payments described above to begin no sooner than July 1, 2027, and make other technical and conforming changes.

(23) Existing law requires DHCS to implement a process that allows applicants and beneficiaries of certain Medi-Cal programs to self-certify the amount and nature of assets and income without the need to submit income or asset documentation. Existing law requires DHCS to implement the process in 2 phases, with the first phase in 2 counties and the 2nd phase statewide, with each county agreeing to meet all federal requirements for income, resource, and other verifications and to perform determinations and verifications in a timely manner. Existing law requires DHCS to promptly provide certain legislative committees with an evaluation of the process and its impact on the Medi-Cal program.

This bill would delete certain provisions relating to the 2 phases, including the evaluation requirement.

(24) Existing law, under Medi-Cal provisions, requires DHCS to enter into demonstration contracts with manufacturers of medical supplies for 4 items of its own selection of medical supplies existing on the pharmacy claims processing system, for the purpose of establishing rebates or other cost-saving mechanisms and demonstrating cost savings in the purchase of these medical supplies.

This bill would repeal those and related provisions. The bill would make conforming changes to other provisions.

(25) Existing law requires DHCS to establish a 2-year pilot program to utilize the federal Public Assistance Reporting Information System (PARIS) to identify veterans and their dependents or survivors who are enrolled in the Medi-Cal program and assist them in obtaining federal veteran health care benefits. Existing law requires DHCS to monitor the pilot program, evaluate the outcomes and savings, and provide the fiscal committees of the Legislature with a report on the findings and recommendations.

This bill would delete the above-described monitoring, evaluation, and reporting requirements.

(26) Existing law, operative until July 1, 2025, requires DHCS to work with stakeholders to conduct a study to identify current requirements for medical interpretation services and make recommendations on strategies that may be employed regarding the provision of medical interpretation services for Medi-Cal beneficiaries who are limited English proficient (LEP). Existing law requires the department to establish a pilot project to evaluate certain factors, including whether disparities in care are reduced, with respect to LEP Medi-Cal beneficiaries compared with Medi-Cal beneficiaries who are proficient in English. Existing law requires the department to expend up to $5,000,000 for the pilot project pursuant to an appropriation made in the Budget Act of 2019, and makes those funds available for that purpose until June 30, 2025.

This bill would extend the operation of these provisions until July 1, 2026, and make those funds available for expenditure, encumbrance, and liquidation until June 30, 2026. By extending the period of time in which previously appropriated funds are available for expenditure, encumbrance, and liquidation, the bill would make an appropriation.

(27) Existing law requires the Office of Family Planning within DHCS to submit a biennial report to the Legislature on specified subjects relating to family planning services.

This bill would instead require the office to post annual reports on its internet website.

(28) Existing law requires the former State Department of Health Services, whose functions were transferred to other departments, to provide certain legislative committees with quarterly updates regarding core activities to improve the Medi-Cal managed care program and county expansion, as specified.

This bill would repeal those reporting provisions.

(29) Existing law requires the former State Department of Mental Health, whose functions were transferred to other departments, to provide certain legislative committees with semiannual updates regarding key results and funding for the capital costs

associated with development, acquisition, construction, and rehabilitation of permanent supportive housing for individuals with mental illness, as specified.

This bill would repeal those reporting provisions.

(30) Existing law authorizes the State Public Health Officer, to the extent allowable under federal law, and upon the availability of funds, to expend moneys from the continuously appropriated AIDS Drug Assistance Program (ADAP) Rebate Fund for a program to cover the costs of prescribed ADAP formulary medications for the prevention of HIV infection and other specified costs. Existing law authorizes the State Department of Public Health to spend up to $75,000,000 from the ADAP Rebate Fund to support current or eligible HIV services and programs, as specified. Existing law prescribes the allocation of those funds, including by authorizing up to $65,000,000 of that $75,000,000 to be spent to supplement or fund services, programs, or initiatives for which federal funding has been reduced or eliminated and making $9,000,000 available to fund state and local disease intervention specialists.

This bill would make up to $18,000,000 of the above-described $65,000,000 available for state operations and would make up to $1,640,000 of the above-described $9,000,000 available for state operations. By adding to the purposes for which the ADAP Rebate Fund may be spent, the bill would make an appropriation.

(31) 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.

(32) 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.

(33) 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: yes

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

SECTION 1. Section 901 is added to the Business and Professions Code, to read:

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

(1) “Committee” means the Los Angeles Organizing Committee for the 2028 Olympic and Paralympic Games.

(2) “Health care practitioner” means any person who engages in acts that are the subject of licensure or regulation under this division or under any initiative act referred to in this division and who maintains an active license in good standing to provide the same or substantially similar services in another state, territory, or country.

(3) “Olympic and Paralympic activities” means any competition, non competition, athlete village, training, or support sites in this state sanctioned by the committee.

(b) Notwithstanding any other law, any licensure, certification, or registration requirements of this division shall not apply to a health care practitioner licensed in another state, territory, or country while providing professional services for which a license would otherwise be required in this state if both of the following conditions are met:

(1) The health care practitioner has been invited by the committee to provide professional services at Olympic and Paralympic activities.

(2) The committee provides to the Director of Consumer Affairs, to forward to the applicable licensing entity within the department that corresponds to the licensing entity in the state, territory, or country where the health care practitioner is licensed before the provision of professional services by a health care practitioner, all of the following information:

(A) The name of the health care practitioner.

(B) The state, territory, or country of the health care practitioner's licensure and the licensing entity from which the health care practitioner holds a license.

(C) The dates for which the health care practitioner has been invited to provide professional services.

(D) The scope of practice the committee requires for that practitioner at Olympic and Paralympic activities.

(c) The exemption granted under this section shall be limited to only those professional services required by or on behalf of the committee. Those professional services shall be within the scope of the health care practitioner's existing licensure, certification, or registration and shall only be provided at Olympic and Paralympic activities.

(d) A health care practitioner shall cease to be exempted under this section upon a request made by the department to the committee on behalf of an applicable licensing entity.

(e) The exemption provided in this section shall remain in force while the health care practitioner is providing professional services at the invitation of the committee and only during the time sanctioned by the committee.

(f) (1) Notwithstanding any other law, in the event the consent of the parent, guardian, or legal representative of a team member cannot be obtained, the official team representative who is responsible for any member participating in Olympic and Paralympic activities may give consent to the furnishing of professional services to a team member who, due to age, disability, or injury, is not able to personally consent.

(2) Consent given pursuant to paragraph (1) shall not be subject to disaffirmance or invalidation due to the individual's age, disability, or injury.

(3) In the case of an emergency, the consent of the parent, guardian, or legal representative of the team member shall not be necessary in order to authorize the performance of professional services.

(g) This section does not apply to persons who engage in acts that are subject to licensure or regulation pursuant to Chapter 9 (commencing with Section 4000) or Chapter 9.5 (commencing with Section 4430).

SEC. 2. Section 1246 of the Business and Professions Code is amended to read:

1246. (a) (1) On and after the effective date of the regulations specified in paragraph (2), any unlicensed person employed by a clinical laboratory performing the duties described in this section shall possess a valid and current certification as a certified phlebotomy technician issued by the department.

(2) The department shall adopt regulations for certification by January 1, 2001, as a certified phlebotomy technician that shall include all of the following:

(A) The applicant shall hold a valid, current certification as a phlebotomist issued by a national accreditation agency approved by the department, and shall submit proof of that certification when applying for certification pursuant to this section.

(B) An applicant with fewer than 1,040 hours of work experience shall complete education, training, and experience requirements as specified by regulations that shall include, but not be limited to, the following:

(i) At least 40 hours of didactic instruction.

(ii) At least 40 hours of practical instruction.

(iii) At least 50 successful venipunctures.

(C) An applicant who has at least 1,040 hours of work experience that includes at least 50 successful venipunctures shall complete at least 20 hours of didactic instruction, as specified in regulations adopted by the department.

(D) Each certified phlebotomy technician shall complete at least three hours per year or six hours every two years of continuing education or training. The department shall consider a variety of programs in determining the programs that meet the continuing education or training requirement.

(E) The applicant has been found to be competent in phlebotomy by a licensed physician and surgeon or person licensed pursuant to this chapter.

(F) The applicant works under the supervision of a licensed physician and surgeon, licensed registered nurse, or person licensed under this chapter, or the designee of a licensed physician and surgeon or the designee of a person licensed under this chapter.

(3) A certified phlebotomy technician may collect blood through a peripheral venous catheter if all of the following are met:

(A) The blood collection procedure is performed in a facility licensed under Division 2 (commencing with Section 1200) of the Health and Safety Code.

(B) The blood collection procedures or protocols are developed and approved by the facility's supervising physician and surgeon or licensed clinical laboratory director and approved by the licensed facility.

(C) The certified phlebotomy technician has received a minimum of three hours of training by the supervising physician and surgeon or their delegate in the proper procedures to be employed when collecting blood through a peripheral venous catheter.

(i) Training in the blood collection procedure through a peripheral venous catheter shall be conducted according to standardized training procedures developed and approved by the facility's supervising physician and surgeon or licensed clinical laboratory director. The facility shall make these standardized procedures available to the department upon request.

(ii) The instructor shall document the certified phlebotomy technician's successful completion of training. The facility shall maintain and make available to the department, upon request, documentation of training completed by a certified phlebotomy technician pursuant to this paragraph.

(D) The certified phlebotomy technician performs the blood collection procedure under the supervision of a physician and surgeon licensed under Chapter 5 (commencing with Section 2000). Notwithstanding subdivision (b), the physician and surgeon may only delegate the supervision duties in this subparagraph to a registered nurse. A physician and surgeon or a registered nurse may restrict or limit a certified phlebotomy technician's ability to collect blood from a patient's peripheral venous catheter.

(E) The certified phlebotomy technician performs the blood collection procedure using a device or devices approved by the licensed facility and the United States Food and Drug Administration.

(F) This paragraph does not authorize the certified phlebotomy technician to manage, stop, or restart a patient's active intravenous infusion or insert or remove a peripheral intravenous catheter.

(4) Paragraph (3) does not authorize a certified phlebotomy technician to withdraw blood through a peripherally inserted central catheter or central venous catheter.

(5) The department shall adopt regulations establishing standards for approving training programs designed to prepare applicants for certification pursuant to this section. The standards shall ensure that these programs meet the state's minimum education and training requirements for comparable programs.

(6) The department shall adopt regulations establishing standards for approving national accreditation agencies to administer certification examinations and tests pursuant to this section.

(7) The department shall charge fees for application for and renewal of the certificate authorized by this section pursuant to subdivision (f) of Section 1300.

(b) (1) (A) A certified phlebotomy technician may perform venipuncture or skin puncture to obtain a specimen for nondiagnostic tests assessing the health of an individual, for insurance purposes, provided that the technician works under the general supervision of a physician and surgeon licensed under Chapter 5 (commencing with Section 2000). The physician and surgeon may delegate the general supervision duties to a registered nurse or a person licensed under this chapter, but shall remain responsible for ensuring that all those duties and responsibilities are properly performed. The physician and surgeon shall make available to the department, upon request, records maintained documenting when a certified phlebotomy technician has performed venipuncture or skin puncture pursuant to this paragraph.

(B) As used in this paragraph, general supervision requires the supervisor of the technician to determine that the technician is competent to perform venipuncture or skin puncture, or to collect blood, before the technician's first blood withdrawal, and on an annual basis thereafter. The supervisor is also required to determine, on a monthly basis, that the technician complies with appropriate venipuncture, skin puncture, and blood collection policies and procedures approved by the medical director and required by state regulations. The supervisor, or another designated licensed physician and surgeon, registered nurse, or person licensed under this chapter, shall be available for consultation with the technician, either in person or through telephonic or electronic means, at the time of blood withdrawal.

(2) (A) Notwithstanding any other law, a person who has been issued a certified phlebotomy technician certificate pursuant to this section may draw blood following policies and procedures approved by a physician and surgeon licensed under Chapter 5

(commencing with Section 2000), appropriate to the location where the blood is being drawn and in accordance with state regulations. The blood collection shall be done at the request and in the presence of a peace officer for forensic purposes in a jail, law enforcement facility, or medical facility, with general supervision.

(B) As used in this paragraph, "general supervision" means that the supervisor of the technician is licensed under this code as a physician and surgeon, physician assistant, clinical laboratory bioanalyst, registered nurse, or clinical laboratory scientist, and reviews the competency of the technician before the technician may perform blood withdrawals without direct supervision, and on an annual basis thereafter. The supervisor is also required to review the work of the technician at least once a month to ensure compliance with venipuncture policies, procedures, and regulations. The supervisor, or another person licensed under this code as a physician and surgeon, physician assistant, clinical laboratory bioanalyst, registered nurse, or clinical laboratory scientist, shall be accessible to the location where the technician is working to provide onsite, telephone, or electronic consultation, within 30 minutes when needed.

(c) The department may adopt regulations providing for the issuance of a certificate to an unlicensed person employed by a clinical laboratory authorizing only the performance of skin punctures for test purposes.

SEC. 3. Section 1300 of the Business and Professions Code is amended to read:

1300. The amount of application, registration, certification, and license fees under this chapter shall be as follows:

(a) The application fee for a histocompatibility laboratory director's, clinical laboratory bioanalyst's, clinical chemist's, clinical microbiologist's, clinical laboratory toxicologist's, clinical genetic molecular biologist's, clinical cytogeneticist's, clinical laboratory geneticist's, or clinical reproductive biologist's license, or license for another specialty or subspecialty specified by regulation adopted by the department, is five hundred seventy dollars ($570).

(b) The annual renewal fee for a license listed in subdivision (a) is five hundred seventy dollars ($570).

(c) The application fee for a clinical laboratory scientist's or limited clinical laboratory scientist's license is three hundred dollars ($300).

(d) The application and annual renewal fee for a cytotechnologist's license is two hundred sixty dollars ($260).

(e) The annual renewal fee for a clinical laboratory scientist's or limited clinical laboratory scientist's license is three hundred dollars ($300).

(f) The application and annual renewal fee for a phlebotomist's certification is one hundred fifty dollars ($150).

(g) A clinical laboratory applying for a license to perform tests or examinations classified as of moderate or of high complexity under CLIA and a clinical laboratory applying for certification under subdivision (c) of Section 1223 shall pay an application fee for that license or certification based on the number of tests it performs or expects to perform in a year, as follows:

(1) Less than 2,001 tests: three hundred thirty-five dollars ($335).

(2) Between 2,001 and 10,000, inclusive, tests: one thousand one hundred dollars ($1,100).

(3) Between 10,001 and 25,000, inclusive, tests: one thousand eight hundred dollars ($1,800).

(4) Between 25,001 and 50,000, inclusive, tests: two thousand two hundred dollars ($2,200).

(5) Between 50,001 and 75,000, inclusive, tests: two thousand seven hundred dollars ($2,700).

(6) Between 75,001 and 100,000, inclusive, tests: three thousand three hundred dollars ($3,300).

(7) Between 100,001 and 500,000, inclusive, tests: four thousand dollars ($4,000).

(8) Between 500,001 and 1,000,000, inclusive, tests: seven thousand two hundred dollars ($7,200).

(9) More than 1,000,000 tests: eight thousand six hundred thirty dollars ($8,630) plus four hundred twenty dollars ($420) for every 500,000 tests over 1,000,000, up to a maximum of 15,000,000 tests.

(h) A clinical laboratory performing tests or examinations classified as of moderate or of high complexity under CLIA and a clinical laboratory with a certificate issued under subdivision (c) of Section 1223 shall pay an annual renewal fee based on the number of tests it performed in the preceding calendar year, as follows:

(1) Less than 2,001 tests: three hundred thirty-five dollars ($335).

(2) Between 2,001 and 10,000, inclusive, tests: one thousand one hundred dollars ($1,100).

(3) Between 10,001 and 25,000, inclusive, tests: one thousand eight hundred dollars ($1,800).

(4) Between 25,001 and 50,000, inclusive, tests: two thousand two hundred dollars ($2,200).

(5) Between 50,001 and 75,000, inclusive, tests: two thousand seven hundred dollars ($2,700).

(6) Between 75,001 and 100,000, inclusive, tests: three hundred three hundred dollars ($3,300).

(7) Between 100,001 and 500,000, inclusive, tests: four thousand dollars ($4,000).

(8) Between 500,001 and 1,000,000, inclusive, tests: seven thousand two hundred dollars ($7,200).

(9) More than 1,000,000 tests per year: eight thousand six hundred thirty dollars ($8,630) plus four hundred twenty dollars ($420) for every 500,000 tests over 1,000,000, up to a maximum of 15,000,000 tests.

(i) The application fee for a trainee's license is forty-five dollars ($45).

(j) The annual renewal fee for a trainee's license is forty-five dollars ($45).

(k) The application fee for a duplicate license is five dollars ($5).

(l) The personnel licensing delinquency fee is equal to the annual renewal fee.

(m) The director may establish a fee for examinations required under this chapter. The fee shall not exceed the total cost to the department in conducting the examination.

(n) A clinical laboratory subject to registration under paragraph (2) of subdivision (a) of Section 1265 and performing only those clinical laboratory tests or examinations considered waived under CLIA shall pay an annual fee of one hundred fifty-five dollars ($155). A clinical laboratory subject to registration under paragraph (2) of subdivision (a) of Section 1265 and performing only provider-performed microscopy, as defined under CLIA, shall pay an annual fee of two hundred thirty-five dollars ($235). A clinical laboratory performing both waived and provider-performed microscopy shall pay an annual registration fee of two hundred thirty-five dollars ($235).

(o) The costs of the department in conducting a complaint investigation, imposing sanctions, or conducting a hearing under this chapter shall be paid by the clinical laboratory. The fee shall be no greater than the fee the laboratory would pay under CLIA for the same type of activities and shall not be payable if the clinical laboratory would not be required to pay those fees under CLIA.

(p) The state, a district, city, county, city and county, or other political subdivision, or any public officer or body shall be subject to the payment of fees established pursuant to this chapter or regulations adopted thereunder.

(q) In addition to the payment of registration or licensure fees, a clinical laboratory located outside the State of California shall reimburse the department for travel and per diem to perform any necessary onsite inspections at the clinical laboratory in order to ensure compliance with this chapter.

(r) The department shall establish an application fee and a renewal fee for a medical laboratory technician license, the total fees collected not to exceed the costs of the department for the implementation and operation of the program licensing and regulating medical laboratory technicians pursuant to Section 1260.3.

(s) The costs of the department to conduct any reinspections to ensure compliance of a laboratory applying for initial licensure shall be paid by the laboratory. This additional cost for each visit shall be equal to the initial application fee and shall be paid by the laboratory prior to issuance of a license. The department shall not charge a reinspection fee if the reinspection is due to error or omission on the part of the department.

(t) A fee of twenty-eight dollars ($28) shall be assessed for approval of each additional location authorized by paragraph (2) of subdivision (d) of Section 1265.

(u) On or before July 1, 2013, the department shall report to the Legislature during the annual legislative budget hearing process the extent to which the state oversight program meets or exceeds federal oversight standards and the extent to which the federal Department of Health and Human Services is accepting exemption applications and the potential cost to the state for an exemption.

SEC. 4. Section 1300.1 of the Business and Professions Code is amended to read:

1300.1. (a) The application, registration, certification, and license fees specified in Section 1300 shall be adjusted annually in the manner specified in Section 100450 of the Health and Safety Code. The adjustments shall be rounded off to the nearest whole dollar amount.

(b) This section shall become operative on January 1, 2020.

SEC. 5. Section 1625.6 of the Business and Professions Code is amended to read:

1625.6. (a) In addition to the actions authorized under Section 1625, a dentist may independently prescribe and administer influenza and COVID-19 vaccines, consistent with recommendations adopted pursuant to Section 120164 of the Health and Safety Code, to persons 3 years of age or older.

(b) In order to prescribe and administer a vaccine described in subdivision (a), a dentist shall do all of the following:

(1) Complete an immunization training program biennially that is either offered by the CDC or taken through a registered provider approved by the board that, at a minimum, includes vaccine administration, prevention and management of adverse reactions, and maintenance of vaccine records.

(2) Comply with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient's primary care provider, if applicable, and entering in the information in the appropriate immunization registry designated by the Immunization Branch of the State Department of Public Health.

(c) The board may adopt regulations to implement this section. The adoption, amendment, repeal, or readoption of a regulation authorized by this section is deemed to address an emergency, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted for this purpose from the requirements of subdivision (b) of Section 11346.1 of the Government Code. For purposes of subdivision (e) of Section 11346.1 of the Government Code, the 180-day period, as applicable to the effective period of an emergency regulatory action and submission of specified materials to the Office of Administrative Law, is hereby extended to 240 days.

SEC. 6. Section 2473 of the Business and Professions Code is amended to read:

2473. (a) A doctor of podiatric medicine may independently prescribe and administer influenza and COVID-19 vaccines, consistent with recommendations adopted pursuant to Section 120164 of the Health and Safety Code, to persons three years of age or older.

(b) In order to prescribe and administer a vaccine described in subdivision (a), a doctor of podiatric medicine shall do all of the following:

(1) Complete an immunization training program biennially that is either offered by the CDC or taken through a registered provider approved by the board that, at a minimum, includes vaccine administration, prevention and management of adverse reactions, and maintenance of vaccine records.

(2) Comply with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient's primary care provider, if applicable, and entering in the information in the appropriate immunization registry designated by the Immunization Branch of the State Department of Public Health.

(c) The board may adopt regulations to implement this section. The adoption, amendment, repeal, or readoption of a regulation authorized by this section is deemed to address an emergency, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted for this purpose from the requirements of subdivision (b) of Section 11346.1 of the Government Code. For purposes of subdivision (e) of Section 11346.1 of the Government Code, the 180-day period, as applicable to the effective period of an emergency regulatory action and submission of specified materials to the Office of Administrative Law, is hereby extended to 240 days.

SEC. 7. Section 3041 of the Business and Professions Code is amended to read:

3041. (a) The practice of optometry includes the diagnosis, prevention, treatment, and management of disorders and dysfunctions of the visual system, as authorized by this chapter, as well as the provision of habilitative or rehabilitative optometric services, and is the doing of any or all of the following:

(1) The examination of the human eyes and their adnexa, including through the use of all topical and oral diagnostic pharmaceutical agents that are not controlled substances, and the analysis of the human vision system, either subjectively or objectively.

(2) The determination of the powers or range of human vision and the accommodative and refractive states of the human eyes, including the scope of their functions and general condition.

(3) The prescribing, using, or directing the use of any optical device in connection with ocular exercises, visual training, vision training, or orthoptics.

(4) The prescribing, fitting, or adaptation of contact and spectacle lenses to, the human eyes, including lenses that may be classified as drugs or devices by any law of the United States or of this state, and diagnostic or therapeutic contact lenses that incorporate a medication or therapy the optometrist is certified to prescribe or provide.

(5) For an optometrist certified pursuant to Section 3041.3, diagnosing and preventing conditions and diseases of the human eyes and their adnexa, and treating nonmalignant conditions and diseases of the anterior segment of the human eyes and their adnexa, including ametropia and presbyopia:

(A) Using or prescribing, including for rational off-label purposes, topical and oral prescription and nonprescription therapeutic pharmaceutical agents that are not controlled substances and are not antiglaucoma agents or limited or excluded by subdivision (b). For purposes of this section, “controlled substance” has the same meaning as used in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and the United States Uniform Controlled Substances Act (21 U.S.C. Sec. 801 et seq.).

(B) Prescribing the oral analgesic controlled substance codeine with compounds, hydrocodone with compounds, and tramadol as listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and the United States Uniform Controlled Substances Act (21 U.S.C. Sec. 801 et seq.), limited to three days, with referral to an ophthalmologist if the pain persists.

(C) If also certified under subdivision (c), using or prescribing topical and oral antiglaucoma agents for the medical treatment of all primary open-angle, exfoliation, pigmentary, and steroid-induced glaucomas in persons 18 years of age or over. In the case of steroid-induced glaucoma, the prescriber of the steroid medication shall be promptly notified if the prescriber did not refer the patient to the optometrist for treatment.

(D) If also certified under subdivision (d), independent initiation and administration of immunizations for influenza, herpes zoster virus, pneumococcus, and SARS-CoV-2 in compliance with recommendations adopted pursuant to Section 120164 of the Health and Safety Code in persons 18 years of age or older.

(E) Utilizing the following techniques and instrumentation necessary for the diagnosis of conditions and diseases of the eye and adnexa:

(i) Laboratory tests or examinations ordered from an outside facility.

(ii) Laboratory tests or examinations performed in a laboratory with a certificate of waiver under the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) (42 U.S.C. Sec. 263a; Public Law 100-578), which shall also be allowed for:

(I) Detecting indicators of possible systemic disease that manifests in the eye for the purpose of facilitating appropriate referral to or consultation with a physician and surgeon.

(II) Detecting the presence of SARS-CoV-2 virus.

(iii) Skin testing performed in an office to diagnose ocular allergies, limited to the superficial layer of the skin.

(iv) X-rays ordered from an outside facility.

(v) Other imaging studies ordered from an outside facility subject to prior consultation with an appropriate physician and surgeon.

(vi) Other imaging studies performed in an office, including those that utilize laser or ultrasound technology, but excluding those that utilize radiation.

(F) Performing the following procedures, which are excluded from restrictions imposed on the performance of surgery by paragraph (6) of subdivision (b), unless explicitly indicated:

(i) Corneal scraping with cultures.

(ii) Debridement of corneal epithelium not associated with band keratopathy.

(iii) Mechanical epilation.

(iv) Collection of blood by skin puncture or venipuncture for laboratory testing authorized by this subdivision.

(v) Suture removal subject to comanagement requirements in paragraph (7) of subdivision (b).

(vi) Treatment or removal of sebaceous cysts by expression.

(vii) Lacrimal punctal occlusion using plugs, or placement of a stent or similar device in a lacrimal canaliculus intended to deliver a medication the optometrist is certified to prescribe or provide.

(viii) Foreign body and staining removal from the cornea, eyelid, and conjunctiva with any appropriate instrument. Removal of corneal foreign bodies and any related stain shall, as relevant, be limited to that which is nonperforating, no deeper than the midstroma, and not reasonably anticipated to require surgical repair.

(ix) Lacrimal irrigation and dilation in patients 12 years of age or over, excluding probing of the nasolacrimal tract. The board shall certify any optometrist who graduated from an accredited school of optometry before May 1, 2000, to perform this procedure after submitting proof of satisfactory completion of 10 procedures under the supervision of an ophthalmologist as confirmed by the ophthalmologist. Any optometrist who graduated from an accredited school of optometry on or after May 1, 2000, shall be exempt from the certification requirement contained in this paragraph.

(x) Administration of oral fluorescein for the purpose of ocular angiography.

(xi) Intravenous injection for the purpose of performing ocular angiography at the direction of an ophthalmologist as part of an active treatment plan in a setting where a physician and surgeon is immediately available.

(xii) Use of noninvasive devices delivering intense pulsed light therapy or low-level light therapy that do not rely on laser technology, limited to treatment of conditions and diseases of the adnexa.

(xiii) Use of an intranasal stimulator in conjunction with treatment of dry eye syndrome.

(G) Using additional noninvasive medical devices or technology that:

(i) Have received a United States Food and Drug Administration approved indication for the diagnosis or treatment of a condition or disease authorized by this chapter. A licensee shall successfully complete any clinical training imposed by a related manufacturer prior to using any of those noninvasive medical devices or technologies.

(ii) Have been approved by the board through regulation for the rational treatment of a condition or disease authorized by this chapter. Any regulation under this paragraph shall require a licensee to successfully complete an appropriate amount of clinical training to qualify to use each noninvasive medical device or technology approved by the board pursuant to this paragraph.

(b) Exceptions or limitations to the provisions of subdivision (a) are as follows:

(1) Treatment of the following is excluded from the practice of optometry in a patient under 18 years of age, unless explicitly allowed otherwise:

(A) Anterior segment inflammation, which shall not exclude treatment of:

(i) The conjunctiva.

(ii) Nonmalignant ocular surface disease, including dry eye syndrome.

(iii) Contact lens-related inflammation of the cornea.

(iv) An infection of the cornea.

(B) Conditions or diseases of the sclera.

(2) Use of any oral prescription steroid anti-inflammatory medication for a patient under 18 years of age shall be done pursuant to a documented, timely consultation with an appropriate physician and surgeon.

(3) Use of any nonantibiotic oral prescription medication for a patient under five years of age shall be done pursuant to a documented, prior consultation with an appropriate physician and surgeon.

(4) The following classes of agents are excluded from the practice of optometry unless they have an explicit United States Food and Drug Administration-approved indication for treatment of a condition or disease authorized under this section:

(A) Antiamoebics.

(B) Antineoplastics.

(C) Coagulation modulators.

(D) Hormone modulators.

(E) Immunomodulators.

(5) The following are excluded from authorization under subparagraph (G) of paragraph (5) of subdivision (a):

(A) A laboratory test or imaging study.

(B) Any noninvasive device or technology that constitutes surgery under paragraph (6).

(6) Performing surgery is excluded from the practice of optometry. “Surgery” means any act in which human tissue is cut, altered, or otherwise infiltrated by any means. It does not mean an act that solely involves the administration or prescribing of a topical or oral therapeutic pharmaceutical.

(7) (A) Treatment with topical and oral medications authorized in subdivision (a) related to an ocular surgery shall be comanaged with the ophthalmologist that performed the surgery, or another ophthalmologist designated by that surgeon, during the customary preoperative and postoperative period for the procedure. For purposes of this subparagraph, this may involve treatment of ocular inflammation in a patient under 18 years of age.

(B) Where published, the postoperative period shall be the “global” period established by the federal Centers for Medicare and Medicaid Services, or, if not published, a reasonable period not to exceed 90 days.

(C) Such comanaged treatment may include addressing agreed-upon complications of the surgical procedure occurring in any ocular or adnexal structure with topical and oral medications authorized in subdivision (a). For patients under 18 years of age, this subparagraph shall not apply unless the patient’s primary care provider agrees to allowing comanagement of complications.

(c) An optometrist certified pursuant to Section 3041.3 shall be certified to medically treat authorized glaucomas under this chapter after meeting the following requirements:

(1) For licensees who graduated from an accredited school of optometry on or after May 1, 2008, submission of proof of graduation from that institution.

(2) For licensees who were certified to treat glaucoma under this section before January 1, 2009, submission of proof of completion of that certification program.

(3) For licensees who completed a didactic course of not less than 24 hours in the diagnosis, pharmacological, and other treatment and management of glaucoma, submission of proof of satisfactory completion of the case management requirements for certification established by the board.

(4) For licensees who graduated from an accredited school of optometry on or before May 1, 2008, and who are not described in paragraph (2) or (3), submission of proof of satisfactory completion of the requirements for certification established by the board under Chapter 352 of the Statutes of 2008.

(d) An optometrist certified pursuant to Section 3041.3 shall be certified to administer authorized immunizations, as described in subparagraph (D) of paragraph (5) of subdivision (a), after the optometrist meets all of the following requirements:

(1) Completes an immunization training program endorsed by the federal Centers for Disease Control and Prevention (CDC) or the Accreditation Council for Pharmacy Education that, at a minimum, includes hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines, and maintains that training.

(2) Is certified in basic life support.

(3) Complies with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient’s primary care provider and entering information in the appropriate immunization registry designated by the immunization branch of the State Department of Public Health.

(4) Applies for an immunization certificate in accordance with Section 3041.5.

(e) Other than for prescription ophthalmic devices described in subdivision (b) of Section 2541, any dispensing of a therapeutic pharmaceutical agent by an optometrist shall be without charge.

(f) An optometrist licensed under this chapter is subject to the provisions of Section 2290.5 for purposes of practicing telehealth.

(g) For the purposes of this chapter, all of the following definitions shall apply:

(1) “Adnexa” means the eyelids and muscles within the eyelids, the lacrimal system, and the skin extending from the eyebrows inferiorly, bounded by the medial, lateral, and inferior orbital rims, excluding the intraorbital extraocular muscles and orbital contents.

(2) “Anterior segment” means the portion of the eye anterior to the vitreous humor, including its overlying soft tissue coats.

(3) “Ophthalmologist” means a physician and surgeon, licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, specializing in treating eye disease.

(4) “Physician and surgeon” means a physician and surgeon licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

(5) “Prevention” means use or prescription of an agent or noninvasive device or technology for the purpose of inhibiting the development of an authorized condition or disease.

(6) “Treatment” means use of or prescription of an agent or noninvasive device or technology to alter the course of an authorized condition or disease once it is present.

(h) In an emergency, an optometrist shall stabilize, if possible, and immediately refer any patient who has an acute attack of angle closure to an ophthalmologist.

SEC. 8. Section 3041.5 of the Business and Professions Code is amended to read:

3041.5. (a) A person requesting to be certified to administer immunizations pursuant to Section 3041 shall apply for a certificate from the board pursuant to an application that shall be in substantially the following form:

“Application for Optometrists to Administer Immunizations

Per California Business and Professions Code §3041(g), you must have a current California Optometrist License and have a Therapeutic Pharmaceutical Agents (TPA) license type to be eligible for a certificate to administer immunizations. “Immunization” means the administration of immunizations for influenza, herpes zoster virus, pneumococcus, and SARS-CoV-2, consistent with recommendations adopted pursuant to Section 120164 of the Health and Safety Code, for persons 18 years of age or older.

If eligible, you must also meet and maintain the following requirements for an immunization certificate:

1. Complete an immunization training program endorsed by the CDC or the Accreditation Council for Pharmacy Education that, at a minimum, includes hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines, and maintain that training.

2. Be certified in basic life support.

3. Comply with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient’s primary care provider and entering information in the appropriate immunization registry designated by the immunization branch of the California State Department of Public Health.

To apply for an immunization certificate, provide documentation for items #1 and #2 above with your application. All documentation must be provided, or the application will be rejected.

First, Middle, and Last Name:_____

Email address:_____

License No.:_____

1. I declare under penalty of perjury under the laws of the State of California that the information provided on this form and the attached documents or other requested proof of completion is true and accurate. I understand and agree that any misstatements of material facts may be cause for denial of the Application for Optometrists to Administer Immunizations and disciplinary action by the California State Board of Optometry.

AND

2. I declare under penalty of perjury under the laws of the State of California that I will comply with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient’s primary care provider and entering information in the appropriate immunization registry designated by the immunization branch of the California State Department of Public Health.

Optometrist Signature: _____

Date:_____”

(b) The application for an immunization certificate set forth in subdivision (a) shall be accompanied by an application fee of fifty dollars ($50), or a fee in an amount as determined by the board, not to exceed the reasonable cost of administering this section.

(c) After the effective date of this section, the board may modify the Application for Optometrists to Administer Immunizations set forth in subdivision (a) by regulation in accordance with Section 3025.

SEC. 9. Section 4052.05 is added to the Business and Professions Code, to read:

4052.05. A pharmacist may independently initiate and administer an immunization that, on January 1, 2025, had in effect a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention, regardless of whether the immunization is recommended for routine use, or as modified or supplemented by the State Department of Public Health pursuant to Section 120164 of the Health and Safety Code, to individuals three years of age or older.

SEC. 10. Section 48980.4 of the Education Code is amended to read:

48980.4. (a) (1) Until June 30, 2026, the notification required pursuant to Section 48980 for pupils admitted to, or advancing to, grade 6 shall include a notification to the pupil’s parent or guardian containing a statement about the state’s public policy described in subdivision (a) of Section 120336 of the Health and Safety Code, advising that the pupil adhere to current immunization guidelines, as recommended by the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention as of January 1, 2025, the American Academy of Pediatrics, and the American Academy of Family Physicians, regarding full human papillomavirus (HPV) immunization before admission or advancement to the grade 8.

(2) Beginning July 1, 2026, the notification required pursuant to Section 48980 for pupils admitted to, or advancing to, grade 6 shall include a notification to the pupil’s parent or guardian containing a statement about the state’s public policy described in subdivision (a) of Section 120336 of the Health and Safety Code, advising that the pupil adhere to current immunization guidelines, as recommended by the State Department of Public Health, in accordance with Section 120164 of the Health and Safety Code, regarding full human papillomavirus (HPV) immunization before admission or advancement to the grade 8.

(b) The notification sent pursuant to subdivision (a) shall conform to the notification requirements outlined in this article.

(c) The notification sent pursuant to subdivision (a) shall also include the statement specified in subdivision (c) of Section 120336 of the Health and Safety Code.

SEC. 11. Section 100503.6 is added to the Government Code, to read:

100503.6. (a) If a qualified health plan is required to cover state-mandated gender-affirming care benefits determined to be in addition to essential health benefits pursuant to Section 18031(d)(3)(B) of Title 42 of the United States Code, the Exchange shall provide payments to issuers of qualified health plans offered through the Exchange to defray the costs of offering those benefits to qualified health plan enrollees.

(b) In accordance with Section 155.170 of Title 45 of the Code of Federal Regulations, the payments required by subdivision (a) shall equal the cost of the additional required benefits reported to the Exchange.

(c) The payments required under subdivision (a) shall only 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 an appropriation by the Legislature, the payments shall be made for plan years beginning on or after January 1, 2026.

(e) 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.

(f) The Director of the Department of Managed Health Care may issue guidance regarding gender-affirming care benefits subject to 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).

SEC. 12. Section 100520.5 of the Government Code is amended 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, and benefit programs pursuant to Section 100503.6, 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.

(f) Upon order of the Department of Finance, a loan of six hundred million dollars ($600,000,000) is authorized from the Health Care Affordability Reserve Fund to the General Fund in the 2023–24 fiscal year. The loan shall be repaid in annual installments of two hundred million dollars ($200,000,000) over the 2026–27, 2027–28, and 2028–29 fiscal years.

SEC. 13. Section 1206 of the Health and Safety Code is amended to read:

1206. This chapter does not apply to the following:

(a) Except with respect to the option provided with regard to surgical clinics in paragraph (1) of subdivision (b) of Section 1204 and, further, with respect to specialty clinics specified in paragraph (2) of subdivision (b) of Section 1204, any place or establishment owned or leased and operated as a clinic or office by one or more licensed health care practitioners and used as an office for the practice of their profession, within the scope of their license, regardless of the name used publicly to identify the place or establishment.

(b) Any clinic directly conducted, maintained, or operated by the United States or by any of its departments, officers, or agencies, and any primary care clinic specified in subdivision (a) of Section 1204 that is directly conducted, maintained, or operated by this state or by any of its political subdivisions or districts, or by any city. This subdivision does not preclude the department from adopting regulations that utilize clinic licensing standards as eligibility criteria for participation in programs funded wholly or partially under Title XVIII or XIX of the federal Social Security Act.

(c) (1) Any clinic conducted, maintained, or operated by a federally recognized Indian tribe or tribal organization, as defined in Section 1603 or 5304 of Title 25 of the United States Code, that is located on land recognized as tribal land by the federal government.

(2) Any clinic conducted, maintained, or operated by a federally recognized Indian tribe or tribal organization, as defined in Section 1603 or 5304 of Title 25 of the United States Code, under a contract with the United States pursuant to the Indian Self-Determination and Education Assistance Act (Public Law 93-638), regardless of the location of the clinic, except that if the clinic chooses to apply to the State Department of Public Health for a state facility license, then the State Department of Public Health will retain authority to regulate that clinic as a primary care clinic as defined by subdivision (a) of Section 1204.

(d) A clinic conducted, operated, or maintained as outpatient departments of hospitals.

(e) Any facility licensed as a health facility under Chapter 2 (commencing with Section 1250).

(f) Any freestanding clinical or pathological laboratory licensed under Chapter 3 (commencing with Section 1200) of Division 2 of the Business and Professions Code.

(g) A clinic operated by, or affiliated with, any institution of learning that teaches a recognized healing art and is approved by the state board or commission vested with responsibility for regulation of the practice of that healing art.

(h) A clinic that is operated by a primary care community or free clinic and that is operated on separate premises from the licensed clinic and is only open for limited services of no more than 40 hours a week. An intermittent clinic as described in this subdivision shall, however, meet all other requirements of law, including administrative regulations and requirements, pertaining to fire and life safety.

(i) The offices of physicians in group practice who provide a preponderance of their services to members of a comprehensive group practice prepayment health care service plan subject to Chapter 2.2 (commencing with Section 1340).

(j) Student health centers operated by public institutions of higher education.

(k) Nonprofit speech and hearing centers, as defined in Section 1201.5. Any nonprofit speech and hearing clinic desiring an exemption under this subdivision shall make application therefor to the director, who shall grant the exemption to any facility meeting the criteria of Section 1201.5. Notwithstanding the licensure exemption contained in this subdivision, a nonprofit speech and hearing center shall be an organized outpatient clinic for purposes of qualifying for reimbursement as a rehabilitation center under the Medi-Cal Act (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(l) A clinic operated by a nonprofit corporation exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954, as amended, or a statutory successor thereof, that conducts medical research and health education and provides health care to its patients through a group of 40 or more physicians and surgeons, who are independent contractors representing not less than 10 board-certified specialties, and not less than two-thirds of whom practice on a full-time basis at the clinic.

(m) Any clinic, limited to in vivo diagnostic services by magnetic resonance imaging functions or radiological services under the direct and immediate supervision of a physician and surgeon who is licensed to practice in California. This shall not be construed to permit cardiac catheterization or any treatment modality in these clinics.

(n) A clinic operated by an employer or jointly by two or more employers for their employees only, or by a group of employees, or jointly by employees and employers, without profit to the operators thereof or to any other person, for the prevention and treatment of accidental injuries to, and the care of the health of, the employees comprising the group.

(o) A community mental health center, as defined in Section 5667 of the Welfare and Institutions Code.

(p) (1) A clinic operated by a nonprofit corporation exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954, as amended, or a statutory successor thereof, as an entity organized and operated exclusively for scientific and charitable purposes and that satisfied all of the following requirements on or before January 1, 2005:

(A) Commenced conducting medical research on or before January 1, 1982, and continues to conduct medical research.

(B) Conducted research in, among other areas, prostatic cancer, cardiovascular disease, electronic neural prosthetic devices, biological effects and medical uses of lasers, and human magnetic resonance imaging and spectroscopy.

(C) Sponsored publication of at least 200 medical research articles in peer-reviewed publications.

(D) Received grants and contracts from the National Institutes of Health.

(E) Held and licensed patents on medical technology.

(F) Received charitable contributions and bequests totaling at least five million dollars ($5,000,000).

(G) Provides health care services to patients only:

(i) In conjunction with research being conducted on procedures or applications not approved or only partially approved for payment (I) under the Medicare program pursuant to Section 1359y(a)(1)(A) of Title 42 of the United States Code, or (II) by a health care service plan registered under Chapter 2.2 (commencing with Section 1340), or a disability insurer regulated under Chapter 1 (commencing with Section 10110) of Part 2 of Division 2 of the Insurance Code; provided that

services may be provided by the clinic for an additional period of up to three years following the approvals, but only to the extent necessary to maintain clinical expertise in the procedure or application for purposes of actively providing training in the procedure or application for physicians and surgeons unrelated to the clinic.

(ii) Through physicians and surgeons who, in the aggregate, devote no more than 30 percent of their professional time for the entity operating the clinic, on an annual basis, to direct patient care activities for which charges for professional services are paid.

(H) Makes available to the public the general results of its research activities on at least an annual basis, subject to good faith protection of proprietary rights in its intellectual property.

(I) Is a freestanding clinic, whose operations under this subdivision are not conducted in conjunction with any affiliated or associated health clinic or facility defined under this division, except a clinic exempt from licensure under subdivision (m). For purposes of this subparagraph, a freestanding clinic is defined as "affiliated" only if it directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, a clinic or health facility defined under this division, except a clinic exempt from licensure under subdivision (m). For purposes of this subparagraph, a freestanding clinic is defined as "associated" only if more than 20 percent of the directors or trustees of the clinic are also the directors or trustees of any individual clinic or health facility defined under this division, except a clinic exempt from licensure under subdivision (m). Any activity by a clinic under this subdivision in connection with an affiliated or associated entity shall fully comply with the requirements of this subdivision. This subparagraph does not apply to agreements between a clinic and any entity for purposes of coordinating medical research.

(2) By January 1, 2007, and every five years thereafter, the Legislature shall receive a report from each clinic meeting the criteria of this subdivision and any other interested party concerning the operation of the clinic's activities. The report shall include, but not be limited to, an evaluation of how the clinic impacted competition in the relevant health care market, and a detailed description of the clinic's research results and the level of acceptance by the payer community of the procedures performed at the clinic. The report shall also include a description of procedures performed both in clinics governed by this subdivision and those performed in other settings. The cost of preparing the reports shall be borne by the clinics that are required to submit them to the Legislature pursuant to this paragraph.

(q) A primary care clinic operated as part of a Program of All-Inclusive Care for the Elderly (PACE) organization, as defined in Section 460.6 of Title 42 of the Code of Federal Regulations and approved by the State Department of Health Care Services pursuant to Section 14592 of the Welfare and Institutions Code, that exclusively serves PACE participants, as defined in Section 460.6 of Title 42 of the Code of Federal Regulations.

(1) A primary care clinic approved by the State Department of Health Care Services pursuant to Section 14592 of the Welfare and Institutions Code to operate exclusively as part of a PACE organization may provide services to individuals who are being assessed for eligibility to enroll in the PACE program for not more than 60 calendar days after an individual submits an application for enrollment.

(2) If the State Department of Health Care Services determines that a primary care clinic approved to operate exclusively as part of a PACE organization has provided services to individuals other than those enrolled in the PACE program, or who are being assessed for eligibility pursuant to paragraph (1), the clinic shall apply for licensure with the State Department of Public Health. A clinic required to obtain licensure from the State Department of Public Health pursuant to this paragraph shall apply for the license not later than 60 calendar days following the determination by the State Department of Health Care Services described in this paragraph. The clinic shall not accept any new participants in the PACE program until licensure is obtained.

(3) This subdivision shall become operative only if the Director of Health Care Services determines, and communicates that determination in writing to the State Department of Public Health, that operating standards compliance programs consistent with subdivisions (d) and (e) of Section 14592 of the Welfare and Institutions Code have been established. A primary care clinic described in subdivision (c) of Section 14592 of the Welfare and Institutions Code shall remain under the oversight and regulatory authority of the State Department of Public Health until the Director of Health Care Services communicates their written determination to the State Department of Public Health.

(r) (1) A clinic, including any location thereof, operated by a nonprofit corporation exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954, as amended, or a statutory successor thereof, as an entity organized and operated exclusively to provide health care services and health education services within the Los Angeles County Service Planning Area 6, is located in a Clinic Service Area, as defined in paragraph (3), and satisfies all of the following requirements:

(A) Provides health care services and health education services solely within a Clinic Service Area, as defined in paragraph (3).

(B) Provides health care services to patients through an independent agreement with a multispecialty medical group of 26 or more physicians and surgeons who represent not less than 10 board-certified specialties, and not less than two-thirds of whom practice on a full-time basis at the clinic by July 1, 2021.

(C) Serves substantial beneficiaries of a "federal health care program," as that term is defined in subsection (f) of Section 1320a-7b of Title 42 of the United States Code and indigent and uninsured individuals pursuant to an authorized and adopted charity care policy.

(D) Participates in a graduate medical education program that is administered by the Martin Luther King, Jr. Community Hospital, as described in Section 14165.50 of the Welfare and Institutions Code, in furtherance of its charitable mission to reduce health care disparities in a Clinic Service Area, as defined in paragraph (3), through the training and retention of physicians and surgeons by 2022.

(2) (A) By July 1, 2022, and every five years thereafter, a clinic that is exempt from licensing provisions pursuant to this subdivision shall provide the Legislature with a report that includes all of the following:

(i) A copy of the current Community Health Needs Assessment, developed by the Martin Luther King, Jr. Community Hospital.

(ii) A community needs assessment for physicians and surgeons, including an analysis of the clinic's role in physician and surgeon recruitment and retention, and meeting the community needs for a physician and surgeon workforce.

(iii) A copy of the Martin Luther King, Jr. Community Hospital's most recent Internal Revenue Service Form 990, Schedule H, including a description of the federally-funded payer mix, and identification of the clinic as a component of the Martin Luther King, Jr. Community Hospital's community benefit activities.

(iv) The clinic's role in the hospital-sponsored graduate medical education program.

(v) An analysis of how the clinic impacted physicians and surgeons practicing or providing services in the Clinic Service Area prior to January 1, 2020.

(B) A report to be submitted pursuant to subparagraph (A) of paragraph (2) shall be submitted in compliance with Section 9795 of the Government Code.

(3) For purposes of this subdivision, "Clinic Service Area" means the geographic area within any ZIP Code that is located within six miles of the physical location of the Martin Luther King, Jr. Community Hospital, as described in Section 14165.50 of the Welfare and Institutions Code.

(s) (1) From May 15, 2028, to September 15, 2028, inclusive, a clinic that meets all of the following requirements:

(A) Approved by the Los Angeles Organizing Committee for the 2028 Olympic and Paralympic Games.

(B) Is either of the following:

(i) Conducted, operated, or maintained by a California licensed health care practitioner acting within the scope of their license.

(ii) Operated by or affiliated with a health facility, as defined in subdivision (a) or (b) of Section 1250.

(C) Provides health care services at either of the following:

(i) A competition, noncompetition, athlete village, training, or support site designated by the committee.

(ii) An event in this state sanctioned by the committee.

(2) This subdivision exempts a clinic from this chapter only for health care services provided at the locations described in subparagraph (C) of paragraph (1).

(3) For purposes of this subdivision, "committee" means the Los Angeles Organizing Committee for the 2028 Olympic and Paralympic Games.

SEC. 14. Section 1261.3 of the Health and Safety Code is amended to read:

1261.3. (a) Notwithstanding any other provision of law, for a patient aged 50 years or older, a registered nurse or licensed pharmacist may administer in a skilled nursing facility, as defined in subdivision (c) of Section 1250, influenza and pneumococcal immunizations pursuant to standing orders and without patient-specific orders if all of the following criteria are met:

(1) The skilled nursing facility medical director, as defined in Section 72305 of Title 22 of the California Code of Regulations, has approved the immunization standing orders established by the facility.

(2) The standing orders meet the recommendations adopted by the State Department of Public Health pursuant to Section 120164.

(b) Nothing in this section amends, alters, or restricts the scope of registered nurse practice including, but not limited to, the scope of practice set forth in Article 2 (commencing with Section 2725) of Chapter 6 of Division 2 of the Business and Professions Code, the implementing regulations, and interpretative bulletins or practice advisories issued by the Board of Registered Nursing.

SEC. 15. Section 1342.2 of the Health and Safety Code is amended to read:

1342.2. (a) Notwithstanding any other law, a health care service plan contract that covers medical, surgical, and hospital benefits, excluding a specialized health care service plan contract, shall cover the costs for COVID-19 diagnostic and screening testing and health care services related to diagnostic and screening testing approved or granted emergency use authorization by the federal Food and Drug Administration for COVID-19, regardless of whether the services are provided by an in-network or out-of-network provider. Coverage required by this section shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing. Services related to COVID-19 diagnostic and screening testing include, but are not limited to, hospital or health care provider office visits for the purposes of receiving testing, products related to testing, the administration of testing, and items and services furnished to an enrollee as part of testing. Services related to COVID-19 diagnostic and screening testing do not include bonus payments for the use of specialized equipment or expedited processing.

(1) To the extent a health care provider would have been entitled to receive cost sharing but for this section, the health care service plan shall reimburse the health care provider the amount of that lost cost sharing.

(2) A health care service plan contract shall not impose prior authorization or any other utilization management requirements on COVID-19 diagnostic and screening testing.

(3) With respect to an enrollee, a health care service plan shall reimburse the provider of the testing according to either of the following:

(A) If the health plan has a specifically negotiated rate for COVID-19 diagnostic and screening testing with such provider in effect before the public health emergency declared under Section 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such negotiated rate shall apply throughout the period of such declaration.

(B) If the health plan does not have a specifically negotiated rate for COVID-19 diagnostic and screening testing with such provider, the plan may negotiate a rate with such provider.

(4) For an out-of-network provider with whom a health care service plan does not have a specifically negotiated rate for COVID-19 diagnostic and screening testing and health care services related to testing, a plan shall reimburse the provider for all testing items or services in an amount that is reasonable, as determined in comparison to prevailing market rates for testing items or services in the geographic region where the item or service is rendered. An out-of-network provider shall accept this payment as payment in full, shall not seek additional remuneration from an enrollee for services related to testing, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee.

(5) Beginning six months after the federal public health emergency expires, a health care service plan shall no longer be required to cover the cost sharing for COVID-19 diagnostic and screening testing and health care services related to testing when delivered by an out-of-network provider, except as otherwise required by law. All other requirements of this subdivision shall remain in effect after the federal public health emergency expires.

(6) Changes to a contract between a health care service plan and a provider delegating financial risk for diagnostic and screening testing related to a declared public health emergency shall be considered a material change to the parties' contract. A health care service plan shall not delegate the financial risk to a contracted provider for the cost of enrollee services provided under this section unless the parties have negotiated and agreed upon a new provision of the parties' contract pursuant to Section 1375.7.

(b) (1) A health care service plan contract that covers medical, surgical, and hospital benefits shall cover without cost sharing any item, service, or immunization that is intended to prevent or mitigate COVID-19 and that is either of the following with respect to the individual enrollee:

(A) An evidence-based item or service that had in effect on January 1, 2025, a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force or any modification or supplement to that recommendation adopted pursuant to Section 120164.

(B) An immunization that had in effect on January 1, 2025 a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention or any modification or supplement to that recommendation adopted pursuant to Section 120164, regardless of whether the immunization is recommended for routine use.

(2) The item, service, or immunization covered pursuant to paragraph (1) shall be covered upon operation of the act that amended this subdivision.

(3) Any modification or supplement to the recommendations described in paragraph (1) shall be covered or removed from coverage no later than 15 business days after the date on which the State Department of Public Health publishes the updated recommendations pursuant to Section 120164.

(4) (A) A health care service plan subject to this subdivision shall not impose any cost-sharing requirements, including a copayment, coinsurance, or deductible, for any item, service, or immunization described in paragraph (1), regardless of whether such service is delivered by an in-network or out-of-network provider.

(B) To the extent a health care provider would have been entitled to receive cost sharing but for this section, the health care service plan shall reimburse the health care provider the amount of that lost cost sharing.

(C) With respect to an enrollee, a health care service plan shall reimburse the provider of the immunization according to either of the following:

(i) If the health plan has a negotiated rate with such provider in effect before the public health emergency declared under Section 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such negotiated rate shall apply throughout the period of such declaration.

(ii) If the health plan does not have a negotiated rate with such provider, the plan may negotiate a rate with such provider.

(D) A health care service plan shall not impose cost sharing for any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1), including, but not limited to, provider office visits and vaccine administration, regardless of whether the service is delivered by an in-network or out-of-network provider.

(E) (i) For an out-of-network provider with whom a health care service plan does not have a negotiated rate for an item, service, or immunization described in paragraph (1), a health care service plan shall reimburse the provider for all related items or services, including any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1), in an amount that is reasonable, as determined in comparison to prevailing market rates for such items or services in the geographic region in which the item or service is rendered. An out-of-network provider shall accept this payment as payment in full, shall not seek additional remuneration from an enrollee, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee for items, services, and immunizations described in subdivision (b), including any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1).

(ii) Beginning six months after the federal public health emergency expires, a health care service plan shall no longer be required to cover the cost sharing for any item, service, or immunization described in paragraph (1) and to cover items or services that are necessary for the furnishing of the items, services, or immunizations described in paragraph (1) when delivered by an out-of-network provider, except as otherwise required by law. All other requirements of this section shall remain in effect after the federal public health emergency expires.

(5) A health care service plan subject to this subdivision shall not impose prior authorization or any other utilization management requirements on any item, service, or immunization described in paragraph (1) or to items or services that are necessary for the furnishing of the items, services, or immunizations described in subparagraph (D) of paragraph (3).

(6) Changes to a contract between a health care service plan and a provider delegating financial risk for immunization related to a declared public health emergency, shall be considered a material change to the parties' contract. A health plan shall not delegate the financial risk to a contracted provider for the cost of enrollee services provided under this section unless the parties have negotiated and agreed upon a new provision of the parties' contract pursuant to Section 1375.7.

(c) The director may 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). The department shall consult with the Department of Insurance in issuing the guidance specified in this subdivision.

(d) This section, excluding subdivision (h), shall apply retroactively beginning from the Governor's declared State of Emergency related to the SARS-CoV-2 (COVID-19) pandemic on March 4, 2020. Notwithstanding Section 1390, this subdivision does not create criminal liability for transactions that occurred before January 1, 2022.

(e) For purposes of this section:

(1) "Diagnostic testing" means all of the following:

(A) Testing intended to identify current or past infection and performed when a person has signs or symptoms consistent with COVID-19, or when a person is asymptomatic but has recent known or suspected exposure to SARS-CoV-2.

(B) Testing a person with symptoms consistent with COVID-19.

(C) Testing a person as a result of contact tracing efforts.

(D) Testing a person who indicates that they were exposed to someone with a confirmed or suspected case of COVID-19.

(E) Testing a person after an individualized clinical assessment by a licensed health care provider.

(2) "Screening testing" means tests that are intended to identify people with COVID-19 who are asymptomatic and do not have known, suspected, or reported exposure to SARS-CoV-2. Screening testing helps to identify unknown cases so that measures can be taken to prevent further transmission. Screening testing includes all of the following:

(A) Workers in a workplace setting.

(B) Pupils, faculty, and staff in a school setting.

(C) A person before or after travel.

(D) At home for someone who does not have symptoms associated with COVID-19 and does not have a known exposure to someone with COVID-19.

(f) This section does not relieve a health care service plan from continuing to cover testing as required by federal law and guidance.

(g) The department shall hold health care service plans accountable for timely access to services required under this section and coverage requirements established under federal law, regulations, or guidelines.

(h) (1) This subdivision applies to a health care service plan contract issued, amended, or renewed on or after the operative date of this subdivision that covers medical, surgical, and hospital benefits, excluding a specialized health care service plan contract, with respect to therapeutics for COVID-19 covered under the contract, which shall include therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration for treatment of COVID-19 when prescribed or furnished by a licensed health care provider acting within their scope of practice and the standard of care.

(2) A health care service plan shall reimburse a provider for the therapeutics described in paragraph (1) at the specifically negotiated rate for those therapeutics, if the plan and provider have negotiated a rate. If the plan does not have a negotiated rate with a provider, the plan may negotiate a rate with the provider.

(3) For an out-of-network provider with whom a health care service plan does not have a negotiated rate for the therapeutics described in paragraph (1), a health care service plan shall reimburse the provider for the therapeutics in an amount that is reasonable, as determined in comparison to prevailing market rates for the therapeutics in the geographic region in which the therapeutic was delivered. An out-of-network provider shall accept this payment as payment in full, shall not seek additional remuneration from an enrollee, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee for therapeutics described in this subdivision.

(4) A health care service plan shall cover COVID-19 therapeutics without cost sharing, regardless of whether the therapeutics are provided by an in-network or out-of-network provider, and without utilization management. If a provider would have been entitled to receive cost sharing but for this section, the health care service plan shall reimburse the provider for the amount of that lost cost sharing. A provider shall accept this payment as payment in full, shall not seek additional remuneration from an enrollee, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee for therapeutics pursuant to this subdivision.

(5) Beginning six months after the federal public health emergency expires, a health care service plan shall no longer be required to cover the cost sharing for COVID-19 therapeutics delivered by an out-of-network provider, unless otherwise

required by law. All other requirements of this subdivision shall remain in effect after the federal public health emergency expires.

(6) This section does not apply to a Medi-Cal managed care plan that contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 16. Section 1342.3 of the Health and Safety Code is amended to read:

1342.3. (a) A health care service plan contract that covers medical, surgical, and hospital benefits, excluding a specialized health care service plan contract, shall cover, without cost sharing and without prior authorization or other utilization management, the costs of the following health care services to prevent or mitigate a disease when the Governor of the State of California has declared a public health emergency due to that disease:

(1) An evidence-based item, service, or immunization that is intended to prevent or mitigate a disease and that is either of the following:

(A) An item or service that, as of January 1, 2025, had in effect a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force, or any modification or supplement to that recommendation adopted pursuant to Section 120164.

(B) An immunization that, as of January 1, 2025, had in effect a recommendation of the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention, or any modification or supplement to that recommendation adopted pursuant to Section 120164.

(2) A health care service or product related to diagnostic and screening testing for the disease that is approved or granted emergency use authorization by the federal Food and Drug Administration, or is recommended by the State Department of Public Health or the federal Centers for Disease Control and Prevention.

(3) Therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration for the disease.

(b) (1) The item, service, or immunization covered pursuant to paragraph (1) of subdivision (a) shall be covered upon operation of the act that added this paragraph.

(2) Any modification or supplement to the recommendations described in subparagraphs (A) or (B) of paragraph (1) of subdivision (a) shall be covered or removed from coverage no later than 15 business days after the date on which the State Department of Public Health publishes the updated recommendations pursuant to Section 120164.

(c) For purposes of this section, "health care service plan" includes a Medi-Cal managed care plan that contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code. The State Department of Health Care Services shall seek any federal approvals it deems necessary to implement this section. This section applies to a Medi-Cal managed care plan contract only to the extent that the State Department of Health Care Services obtains any necessary federal approvals, and federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.

SEC. 17. Section 1347.8 of the Health and Safety Code is amended to read:

1347.8. (a) (1) Beginning on July 1, 2023, and annually thereafter, a health care service plan providing a qualified health plan through the Exchange shall report to the director the total amount of funds maintained in a segregated account pursuant to subsection (b) of Section 1303 of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(2) This annual report shall contain the ending balance of the account and the total dollar amount of claims paid during the reporting year. This report shall also include any related documentation required by the director.

(b) For purposes of this section:

(1) "Exchange" means the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code.

(2) "Qualified health plan" has the same meaning as defined in Section 1301 of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(c) Annually from the 2025–26 fiscal year to the 2028–29 fiscal year, inclusive, and upon receipt of the required annual report, the director shall order the transfer of funds from each qualified health plan's segregated account with a positive balance, and each

qualified health plan shall complete the transfer, to the Abortion Access Fund established in Section 127641, as follows:

(1) On or before October 30, 2025, up to the total amount provided by the California Health Benefit Exchange to qualified health plans pursuant to Section 100503.5 of the Government Code as of July 1, 2025, not to exceed 75 percent of the amount of the ending balance of the qualified health plan's segregated account as of July 1, 2025.

(2) On or before September 1, 2026, and each year thereafter through the 2028–29 fiscal year, up to the total amount provided by the California Health Benefit Exchange to qualified health plans pursuant to Section 100503.5 of the Government Code as of July 1 of that year, not to exceed 50 percent of the amount of the ending balance of a qualified health plan's segregated account that exceeds claims paid in the prior plan year.

SEC. 18. Section 1367.002 of the Health and Safety Code is amended to read:

1367.002. (a) A group or individual nongrandfathered health care service plan contract shall, at a minimum, provide coverage for and shall not impose any cost-sharing requirements for any of the following:

(1) Evidence-based items or services that had in effect on January 1, 2025, a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force or any modification or supplement to that recommendation adopted pursuant to Section 120164.

(2) Immunizations that had in effect on January 1, 2025, a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention or any modification or supplement to that recommendation adopted pursuant to Section 120164 with respect to the individual involved.

(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided in the comprehensive guidelines, as periodically updated, supported by the United States Health Resources and Services Administration, as of January 1, 2025, or any modification or supplement to that recommendation adopted pursuant to Section 120164.

(4) With respect to women, those additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the United States Health Resources and Services Administration as of January 1, 2025, or any modification or supplement to that recommendation adopted pursuant to Section 120164.

(5) For the purposes of this section:

(A) The recommendations of the United States Preventive Services Task Force as of January 1, 2025, or any modification or supplement to that recommendation adopted pursuant to Section 120164, regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

(B) A health care service plan contract issued, amended, or renewed on or after January 1, 2025, shall not impose any cost-sharing requirements for any items or services that are integral to the provision of an item or service that is required by this section, regardless of whether or not the integral item or service is billed separately from an item or service that is required by this section.

(6) For the purposes of this section, a health care service plan contract shall not impose cost sharing for office visits associated with the preventive care services described in this section if the preventive care service is not billed separately, or is not tracked as an individual encounter separately, from the office visit and the primary purpose of the office visit is the delivery of the preventive care service.

(b) This section does not prohibit a health care service plan contract from providing coverage for preventive items or services in addition to those required by subdivision (a).

(c) A health care service plan shall provide coverage pursuant to subdivision (a) for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(1) A health care service plan that is required to provide coverage for any items and services specified in a recommendation or guideline described in subdivision (a) on the first day of a plan year shall provide coverage through the last day of the plan year, even if the recommendation or guideline changes or is no longer described in subdivision (a) during the plan year.

(2) Notwithstanding paragraph (1) and consistent with the authority granted to the State Department of Public Health pursuant to Section 120164, if any item or service associated with any recommendation or guideline specified in subdivision (a) is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service during a plan year, a health care service plan is not required to cover the item or service through the last day of the plan year.

(d) A health care service plan contract issued, amended, or renewed on or after January 1, 2025, shall cover items and services pursuant to this section in accordance with any applicable requirement of this chapter, including, but not limited to, Section 1342.74 on prophylaxis of HIV infection, Section 1367.34 as added by Section 3 of Chapter 486 of the Statutes of 2021 on home test kits for sexually transmitted diseases, Section 1367.66 on cervical cancer screening, and Section 1367.668 on colorectal cancer screening.

(e) This section does not apply to a specialized health care service plan that does not cover an essential health benefit, as defined in Section 1367.005. This section shall only apply to a health savings account-eligible health care service plan to the extent it does not fail to be treated as a high deductible health plan under Section 223 of Title 26 of the United States Code.

(f) The department shall coordinate with the Department of Insurance if it adopts regulations to implement this section.

SEC. 19. Section 1367.3 of the Health and Safety Code is amended to read:

1367.3. (a) Every health care service plan that covers hospital, medical, or surgical expenses on a group basis shall offer benefits for the comprehensive preventive care of children. This section shall apply to children 17 and 18 years of age, except as provided in subparagraph (D) of paragraph (2) of subdivision (b). Every plan shall communicate the availability of these benefits to all group contractholders and to all prospective group contractholders with whom they are negotiating. This section shall apply to a plan that, by rule or order of the director, has been exempted from subdivision (i) of Section 1367, insofar as that section and the rules thereunder relate to the provision of the preventive health care services described herein.

(b) For purposes of this section, benefits for the comprehensive preventive care of children shall comply with both of the following:

(1) Be consistent with both of the following:

(A) The most recent Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics.

(B) The Recommended Childhood Immunization Schedule/United States, jointly adopted as of January 1, 2025, by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians. Immunizations subject to this subparagraph may be modified or supplemented by the State Department of Public Health pursuant to Section 120164.

(2) Provide for the following:

(A) Periodic health evaluations.

(B) Immunizations.

(C) Laboratory services in connection with periodic health evaluations.

(D) Screening for blood lead levels in children of any age who are at risk for lead poisoning, as determined by a physician and surgeon affiliated with the plan, if the screening is prescribed by a health care provider affiliated with the plan.

(c) For purposes of this section, a health care provider is any of the following:

(1) A person licensed to practice medicine pursuant to Article 3 (commencing with Section 2050) of Chapter 5 of Division 2 of the Business and Professions Code.

(2) A nurse practitioner licensed to practice pursuant to Article 8 (commencing with Section 2834) of Chapter 6 of Division 2 of the Business and Professions Code.

(3) A physician assistant licensed to practice pursuant to Article 3 (commencing with Section 3513) of Chapter 7.7 of Division 2 of the Business and Professions Code.

SEC. 20. Section 1367.35 of the Health and Safety Code is amended to read:

1367.35. (a) On and after January 1, 1993, every health care service plan that covers hospital, medical, or surgical expenses on a group basis shall provide benefits for the comprehensive preventive care of children 16 years of age or younger under terms and conditions agreed upon between the group subscriber and the plan. Every plan shall communicate the availability of these benefits to all group contractholders and to all prospective group contractholders with whom they are negotiating. This section shall apply to each plan that, by rule or order of the director, has been exempted from subdivision (i) of Section 1367, insofar as that section and the rules thereunder relate to the provision of the preventive health care services described in this section.

(b) For purposes of this section, benefits for the comprehensive preventive care of children shall comply with both of the following:

(1) Be consistent with both of the following:

(A) The Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics in September of 1987.

(B) The Recommended Childhood Immunization Schedule/United States, jointly adopted as of January 1, 2025, by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians. Immunizations subject to this subparagraph may be modified or supplemented by the State Department of Public Health pursuant to Section 120164.

(2) Provide for all of the following:

(A) Periodic health evaluations.

(B) Immunizations.

(C) Laboratory services in connection with periodic health evaluations.

SEC. 21. Section 1797.11 is added to the Health and Safety Code, to read:

1797.11. (a) (1) Notwithstanding any other law, the licensure, certification, or accreditation requirements of this division shall not apply to any Emergency Medical Technician (EMT-I), Advanced Emergency Medical Technician (EMT-II), or Emergency Medical Technician-Paramedic (EMT-P), or similar emergency medical services (EMS) provider licensed or certified as an EMT-I, EMT-II, EMT-P, or similar EMS provider in another state or territory of the United States, who provides EMS for which they are licensed, if they are authorized by the chief medical officer pursuant to subdivision (b) to provide EMS at sites in this state sanctioned by the Los Angeles Organizing Committee for the 2028 Olympic and Paralympic Games and associated with the 2028 Olympic and Paralympic Games.

(2) For purposes of this subdivision, “similar EMS provider” means an EMS provider that meets both of the following requirements:

(A) Licensed or certified in a state or territory of the United States that uses a license categorization that differs from this state.

(B) Licensed or certified to provide services similar to those provided by an EMT-I, EMT-II, or EMT-P licensed or certified in this state.

(b) The chief medical officer (CMO) shall do both of the following:

(1) Authorize EMS personnel under this section, based on system needs and informed by committee needs, qualifications of the emergency medical services personnel, and public safety considerations.

(2) Be medical control for any EMS personnel who are authorized under paragraph (1) of this subdivision.

(c) To be authorized by the CMO under this section, and before being deployed by the CMO, EMS personnel shall provide the CMO a valid copy of a professional license or certification and photograph identification issued by the state or territory in which the EMS personnel holds a license or certification.

(d) Emergency medical services providers authorized by the CMO to provide health care pursuant to this section shall not be liable on account of any act or omission taken in good faith while engaged in the provision of services authorized pursuant to this section. As used in this subdivision, “good faith” shall not include willful misconduct, gross negligence, or recklessness.

(e) Emergency medical services providers authorized by the CMO to provide health care pursuant to this section shall be authorized to perform the California basic scope of practice for an EMT-I, EMT-II, and EMT-P, as defined in Title 22 of Division 9 of the California Code of Regulations, if the provider has successfully completed the training to perform these skills and they are within the scope of practice for the state in which they are licensed or certified.

(f) Sites that may be sanctioned by the committee include competition, noncompetition, athlete village, training, or support sites in this state.

(g) Authorization under this section shall be valid from May 15, 2028, to September 15, 2028, inclusive, or until authorization is otherwise withdrawn by the CMO.

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

(1) “Chief medical officer” or “CMO” means the chief medical officer of the Emergency Medical Services Authority.

(2) “Committee” means the Los Angeles Organizing Committee for the 2028 Olympic and Paralympic Games.

SEC. 22. Section 11756.8 of the Health and Safety Code is repealed.

SEC. 23. Section 100425 of the Health and Safety Code is amended to read:

100425. (a) The fees or charges for the issuance or renewal of any permit, license, registration, or document pursuant to Sections 1676, 1677, 2805, 11839.25, 103625, 106700, 106890, 106925, 107080, 107090, 107095, 107160, 110210, 110470, 110471, 111130, 111140, 111630, 111923.5, 111923.6, 112405, 112510, 112750, 112755, 113060, 113065, 114065, 115035, 115065, 115080, 117923, 117995, 118045, 118210, and 118245 shall be adjusted annually by the percentage change printed in the Budget Act for those items appropriating funds to the state department. After the first annual adjustment of fees or charges pursuant to this section, the fees or charges subject to subsequent adjustment shall be the fees or charges for the prior calendar year. The percentage change shall be determined by the Department of Finance, and shall include at least the total percentage change in salaries and operating expenses of the state department. However, the total increase in amounts collected under this section shall not exceed the total increased cost of the program or service provided.

(b) The state department shall publish annually a list of the actual numerical fee charges for each permit, license, certification, or registration governed by this section.

(c) This adjustment of fees and publication of the fee list shall not be subject to the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) With respect to the fees or charges pursuant to Section 103625, the actual dollar fee or charge shall be rounded to the nearest whole dollar.

SEC. 24. Section 100450 of the Health and Safety Code is amended to read:

100450. (a) The fees or charges required to accompany an application for the issuance or renewal of any license pursuant to Section 1300 of the Business and Professions Code or pursuant to Sections 1616 or 1639.5 shall be adjusted annually pursuant to Section 1300.2 of the Business and Professions Code. The fees or charges subject to adjustment pursuant to this subdivision shall be the fees or charges that would have been payable in the prior calendar year without regard to the provisions of subdivision (b).

(b) The annual adjustment for fees or charges assessed under subdivision (a) shall be determined by the department so that license fee revenues cover the estimated licensing program costs pursuant to Section 1300.2 of the Business and Professions Code.

(c) The department shall by January 1 of each year publish a list of actual numerical fee charges as adjusted pursuant to this section. This adjustment of fees and the publication of the fee list shall not be subject to the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 25. Section 104151 of the Health and Safety Code is amended to read:

104151. Notwithstanding Section 10231.5 of the Government Code, each year, by no later than January 10 and concurrently with the release of the May Revision, the State Department of Health Care Services shall provide the fiscal committees of the Legislature with an estimate package for the Every Woman Counts Program. This estimate package shall include all significant assumptions underlying the estimate for the Every Woman Counts Program’s current-year and budget-year proposals, and shall contain concise information identifying applicable estimate components, such as caseload; a breakout of costs, including, but not limited to, clinical service activities, including office visits and consults, screening mammograms, diagnostic mammograms, diagnostic breast procedures, case management, and other clinical services; policy changes; contractor information; General Fund, special fund, and federal fund information; and other assumptions necessary to support the estimate.

SEC. 26. Section 120164 is added to the Health and Safety Code, to read:

120164. (a) Consistent with subdivision (b), the list of immunizations, items, and services that were recommended by the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), and the Health Resources and Services Administration (HRSA), and that were in effect on January 1, 2025, shall serve as the baseline recommendations for purposes of this section.

(b) The State Department of Public Health may modify or supplement the baseline recommendations described in subdivision (a). In making modifications or supplements, the department shall take into consideration guidance and recommendations from

additional medical and scientific organizations, including, but not limited to, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

(c) In modifying or supplementing the baseline recommendations, the department may also incorporate subsequent evidence-based recommendations issued by the USPSTF, ACIP, or HRSA, to the extent the department determines those recommendations are consistent with the purposes of this section and promote public health.

(d) Publishing the baseline recommendations or any modification or supplement adopted pursuant to this section 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.

(e) The department shall publish the recommendations of immunizations, items, and services, and publish any updates, modifications, or supplements adopted pursuant to this section. Any modification or supplement shall be deemed effective on the date of publication. The recommendations and schedules shall be filed with the Secretary of State and published in the California Code of Regulations.

SEC. 27. Section 120336 of the Health and Safety Code is amended to read:

120336. (a) Pupils in the state are advised, as described in subdivision (b), to adhere to current immunization guidelines, as recommended by the Advisory Committee on Immunization Practices (ACIP) of the federal Centers for Disease Control and Prevention (CDC) as of January 1, 2025, the American Academy of Pediatrics, and the American Academy of Family Physicians, regarding full human papillomavirus (HPV) immunization before admission or advancement to grade 8 of any private or public elementary or secondary school.

(b) Upon a pupil's admission or advancement to grade 6, the governing authority of any private or public elementary or secondary school shall submit to the pupil and their parent or guardian a notification containing a statement about the state's public policy described in subdivision (a) and advising that the pupil adhere to current HPV immunization guidelines, as described in subdivision (a), before admission or advancement to grade 8, in compliance with the notification requirements of Article 4 (commencing with Section 48980) of Chapter 6 of Part 27 of Division 4 of Title 2 of the Education Code.

(c) The notification sent pursuant to subdivision (b) shall also include a statement, as determined by the department, summarizing the recommended ages for the HPV vaccine and scientific rationale for vaccination at those ages, based on guidance issued by ACIP of the CDC as of January 1, 2025, the American Academy of Pediatrics, and the American Academy of Family Physicians. The notification shall further state the following:

"HPV vaccination can prevent over 90 percent of cancers caused by HPV. HPV vaccines are very safe, and scientific research shows that the benefits of HPV vaccination far outweigh the potential risks."

(d) This section does not apply to a pupil in a home-based private school.

(e) This section shall become inoperative on July 1, 2026, and, as of January 1, 2027, is repealed.

SEC. 28. Section 120336 is added to the Health and Safety Code, to read:

120336. (a) Pupils in the state are advised, as described in subdivision (b), to adhere to current immunization guidelines, as recommended by the State Department of Public Health, in accordance with Section 120164, regarding full human papillomavirus (HPV) immunization before admission or advancement to grade 8 of any private or public elementary or secondary school.

(b) Upon a pupil's admission or advancement to grade 6, the governing authority of any private or public elementary or secondary school shall submit to the pupil and their parent or guardian a notification containing a statement about the state's public policy described in subdivision (a) and advising that the pupil adhere to current HPV immunization guidelines, as described in subdivision (a), before admission or advancement to grade 8, in compliance with the notification requirements of Article 4 (commencing with Section 48980) of Chapter 6 of Part 27 of Division 4 of Title 2 of the Education Code.

(c) The notification sent pursuant to subdivision (b) shall also include a statement, as determined by the department, summarizing the recommended ages for the HPV vaccine and scientific rationale for vaccination at those ages, based on guidance issued by State Department of Public Health, in accordance with Section 120164. The notification shall further state the following:

"HPV vaccination can prevent over 90 percent of cancers caused by HPV. HPV vaccines are very safe, and scientific research shows that the benefits of HPV vaccination far outweigh the potential risks."

(d) This section does not apply to a pupil in a home-based private school.

(e) This section shall be operative on July 1, 2026.

SEC. 29. Section 120372 of the Health and Safety Code is amended to read:

120372. (a) (1) By January 1, 2021, the department shall develop and make available for use by licensed physicians and surgeons an electronic, standardized, statewide medical exemption certification form that shall be transmitted directly to the department's California Immunization Registry (CAIR) established pursuant to Section 120440. Pursuant to Section 120375, the form shall be printed, signed, and submitted directly to the school or institution at which the child will attend, submitted directly to the governing authority of the school or institution, or submitted to that governing authority through the CAIR where applicable. Notwithstanding Section 120370, commencing January 1, 2021, the standardized form shall be the only documentation of a medical exemption that the governing authority may accept.

(2) At a minimum, the form shall require all of the following information:

(A) The name, California medical license number, business address, and telephone number of the physician and surgeon who issued the medical exemption, and of the primary care physician of the child, if different from the physician and surgeon who issued the medical exemption.

(B) The name of the child for whom the exemption is sought, the name and address of the child's parent or guardian, and the name and address of the child's school or other institution.

(C) A statement certifying that the physician and surgeon has conducted a physical examination and evaluation of the child consistent with the relevant standard of care and complied with all applicable requirements of this section.

(D) Whether the physician and surgeon who issued the medical exemption is the child's primary care physician. If the issuing physician and surgeon is not the child's primary care physician, the issuing physician and surgeon shall also provide an explanation as to why the issuing physician and not the primary care physician is filling out the medical exemption form.

(E) How long the physician and surgeon has been treating the child.

(F) A description of the medical basis for which the exemption for each individual immunization is sought. Each specific immunization shall be listed separately and space on the form shall be provided to allow for the inclusion of descriptive information for each immunization for which the exemption is sought.

(G) Whether the medical exemption is permanent or temporary, including the date upon which a temporary medical exemption will expire. A temporary exemption shall not exceed one year. All medical exemptions shall not extend beyond the grade span, as defined in Section 120370.

(H) An authorization for the department to contact the issuing physician and surgeon for purposes of this section and for the release of records related to the medical exemption to the department, the Medical Board of California, and the Osteopathic Medical Board of California.

(I) A certification by the issuing physician and surgeon that the statements and information contained in the form are true, accurate, and complete.

(3) An issuing physician and surgeon shall not charge for either of the following:

(A) Filling out a medical exemption form pursuant to this section.

(B) A physical examination related to the renewal of a temporary medical exemption.

(b) Commencing January 1, 2021, if a parent or guardian requests a licensed physician and surgeon to submit a medical exemption for the parent's or guardian's child, the physician and surgeon shall inform the parent or guardian of the requirements of this section. If the parent or guardian consents, the physician and surgeon shall examine the child and submit a completed medical exemption certification form to the department. A medical exemption certification form may be submitted to the department at any time.

(c) By January 1, 2021, the department shall create a standardized system to monitor immunization levels in schools and institutions as specified in Sections 120375 and 120440, and to monitor patterns of unusually high exemption form submissions by a particular physician and surgeon.

(d) (1) The department, at a minimum, shall annually review immunization reports from all schools and institutions in order to identify medical exemption forms submitted to the department and under this section that will be subject to paragraph (2).

(2) A clinically trained immunization department staff member, who is either a physician and surgeon or a registered nurse, shall review all medical exemptions from any of the following:

(A) Schools or institutions subject to Section 120375 with an overall immunization rate of less than 95 percent.

(B) Physicians and surgeons who have submitted five or more medical exemptions in a calendar year beginning January 1, 2020.

(C) Schools or institutions subject to Section 120375 that do not provide reports of vaccination rates to the department.

(3) (A) The department shall identify those medical exemption forms that do not meet applicable AAP criteria for appropriate medical exemptions. The department may contact the primary care physician and surgeon or issuing physician and surgeon to request additional information to support the medical exemption.

(B) Notwithstanding subparagraph (A), the department, based on the medical discretion of the clinically trained immunization staff member, may accept a medical exemption that is based on other contraindications or precautions, including consideration of family medical history, if the issuing physician and surgeon provides written documentation to support the medical exemption that is consistent with the relevant standard of care.

(C) A medical exemption that the reviewing immunization department staff member determines to be inappropriate or otherwise invalid under subparagraphs (A) and (B) shall also be reviewed by the State Public Health Officer or a physician and surgeon from the department's immunization program designated by the State Public Health Officer. Pursuant to this review, the State Public Health Officer or physician and surgeon designee may revoke the medical exemption.

(4) Medical exemptions issued prior to January 1, 2020, shall not be revoked unless the exemption was issued by a physician or surgeon that has been subject to disciplinary action by the Medical Board of California or the Osteopathic Medical Board of California.

(5) The department shall notify the parent or guardian, issuing physician and surgeon, the school or institution, and the local public health officer with jurisdiction over the school or institution of a denial or revocation under this subdivision.

(6) If a medical exemption is revoked pursuant to this subdivision, the child shall continue in attendance. However, within 30 calendar days of the revocation, the child shall commence the immunization schedule required for conditional admittance under Chapter 4 (commencing with Section 6000) of Division 1 of Title 17 of the California Code of Regulations in order to remain in attendance, unless an appeal is filed pursuant to Section 120372.05 within that 30-day time period, in which case the child shall continue in attendance and shall not be required to otherwise comply with immunization requirements unless and until the revocation is upheld on appeal.

(7) (A) If the department determines that a physician's and surgeon's practice is contributing to a public health risk in one or more communities, the department shall report the physician and surgeon to the Medical Board of California or the Osteopathic Medical Board of California, as appropriate. The department shall not accept a medical exemption form from the physician and surgeon until the physician and surgeon demonstrates to the department that the public health risk no longer exists, but in no event shall the physician and surgeon be barred from submitting these forms for less than two years.

(B) If there is a pending accusation against a physician and surgeon with the Medical Board of California or the Osteopathic Medical Board of California relating to immunization standards of care, the department shall not accept a medical exemption form from the physician and surgeon unless and until the accusation is resolved in favor of the physician and surgeon.

(C) If a physician and surgeon licensed with the Medical Board of California or the Osteopathic Medical Board of California is on probation for action relating to immunization standards of care, the department and governing authority shall not accept a medical exemption form from the physician and surgeon unless and until the probation has been terminated.

(8) The department shall notify the Medical Board of California or the Osteopathic Medical Board of California, as appropriate, of any physician and surgeon who has five or more medical exemption forms in a calendar year that are revoked pursuant to this subdivision.

(9) Notwithstanding any other provision of this section, a clinically trained immunization program staff member who is a physician and surgeon or a registered nurse may review any exemption in the CAIR or other state database as necessary to protect public health.

(e) The department, the Medical Board of California, and the Osteopathic Medical Board of California shall enter into a memorandum of understanding or similar agreement to ensure compliance with the requirements of this section.

(f) In administering this section, the department and the independent expert review panel created pursuant to Section 120372.05 shall comply with all applicable state and federal privacy and confidentiality laws. The department may disclose information submitted in the medical exemption form in accordance with Section 120440, and may disclose information submitted pursuant to this chapter to the independent expert review panel for the purpose of evaluating appeals.

(g) The department shall establish the process and guidelines for review of medical exemptions pursuant to this section. The department shall communicate the process to providers and post this information on the department's website.

(h) If the department or the California Health and Human Services Agency determines that contracts are required to implement or administer this section, the department may award these contracts on a single-source or sole-source basis. The contracts are not subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, or Sections 4800 to 5180, inclusive, of the State Administrative Manual as they relate to approval of information technology projects or approval of increases in the duration or costs of information technology projects.

(i) Notwithstanding 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), the department may implement and administer this section through provider bulletins, or similar instructions, without taking regulatory action.

(j) For purposes of administering this section, the department and the California Health and Human Services Agency appeals process shall be exempt from the rulemaking and administrative adjudication provisions in the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), Chapter 4.5 (commencing with 11400), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).

SEC. 30. Section 120372.05 of the Health and Safety Code is amended to read:

120372.05. (a) A medical exemption revoked pursuant to Section 120372 may be appealed by a parent or guardian to the Secretary of California Health and Human Services. Parents, guardians, or the physician who issued the medical exemption may provide necessary information for purposes of the appeal.

(b) The secretary shall establish an independent expert review panel, consisting of three licensed physicians and surgeons who have relevant knowledge, training, and experience relating to primary care or immunization to review appeals. The agency shall establish the process and guidelines for the appeals process pursuant to this section, including the process for the panel to contact the issuing physician and surgeon, parent, or guardian. The agency shall post this information on the agency's internet website. The agency shall also establish requirements, including conflict-of-interest standards, consistent with the purposes of this chapter, that a physician and surgeon shall meet in order to qualify to serve on the panel.

(c) The independent expert review panel shall evaluate appeals consistent with the American Academy of Pediatrics guidelines or the relevant standard of care, as applicable.

(d) The independent expert review panel shall submit its determination to the secretary. The secretary shall adopt the determination of the independent expert review panel and shall promptly issue a written decision to the child's parent or guardian. The decision shall not be subject to further administrative review.

(e) A child whose medical exemption revocation pursuant to subdivision (d) of Section 120372 is appealed under this section shall continue in attendance and shall not be required to commence the immunization required for conditional admittance under Chapter 4 (commencing with Section 6000) of Division 1 of Title 17 of the California Code of Regulations, provided that the appeal is filed within 30 calendar days of revocation of the medical exemption.

(f) For purposes for administering this section, the department and the California Health and Human Services Agency appeals process shall be exempt from the rulemaking and administrative adjudication provisions in the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), Chapter 4.5 (commencing with 11400), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).

SEC. 31. Section 120390.6 of the Health and Safety Code is amended to read:

120390.6. (a) It is the public policy of the state that pupils who are 26 years of age or younger are advised to adhere to current immunization guidelines, as recommended by the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention as of January 1, 2025, the American Academy of Pediatrics, and the American Academy of Family Physicians, regarding full human papillomavirus (HPV) immunization before first-time enrollment at an institution of the California State University, the University of California, or the California Community Colleges.

(b) This section shall become inoperative on July 1, 2026, and, as of January 1, 2027, is repealed.

SEC. 32. Section 120390.6 is added to the Health and Safety Code, to read:

120390.6. (a) It is the public policy of the state that pupils who are 26 years of age or younger are advised to adhere to current immunization guidelines, as recommended by the department, in accordance with Section 120164, regarding full human

papillomavirus (HPV) immunization before first-time enrollment at an institution of the California State University, the University of California, or the California Community Colleges.

(b) This section shall become operative on July 1, 2026.

SEC. 33. Section 120392.2 of the Health and Safety Code is amended to read:

120392.2. (a) Each year, commencing October 1 to the following April 1, inclusive, every health care facility, as defined in subdivision (a) of Section 120392, shall offer, pursuant to Section 120392.4, immunizations for influenza and pneumococcal disease to residents, 65 years of age or older, receiving services at the facility consistent with recommendations adopted pursuant to Section 120164 and the latest recommendations of appropriate entities for the prevention, detection, and control of influenza outbreaks in California long-term care facilities.

(b) Each health care facility, as defined in subdivision (a) of Section 120392, shall offer, pursuant to Section 120392.4, pneumococcal vaccine to all new admittees to the health care facility, consistent with the immunization recommendations adopted pursuant to Section 120164.

(c) The facility shall be reimbursed the standard Medi-Cal rate for an immunization provided to a Medi-Cal recipient, unless the Medi-Cal recipient is also a Medicare recipient whose coverage includes reimbursement for the immunization.

SEC. 34. Section 120392.3 of the Health and Safety Code is amended to read:

120392.3. (a) The department shall provide appropriate flu vaccine to local governmental or private, nonprofit agencies at no charge in order that the agencies may provide the vaccine, at a minimal cost, at accessible locations. The department and the California Department of Aging shall prepare, publish, and disseminate information regarding the immunization recommendations adopted pursuant to Section 120164 or other criteria in order to ensure that the vaccination program is efficient and effective in meeting public health goals. Any guidance issued pursuant to this subdivision shall be 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 of the Government Code). In the absence of guidance from the department, local agencies shall be guided by the influenza recommendations of the federal Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices as of January 1, 2025, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, or the American Academy of Family Physicians.

(b) The department may provide appropriate vaccine that prevents other respiratory infections to local governmental or private, nonprofit agencies at no charge in order that the agencies may provide the vaccine, at a minimal cost, at accessible locations for groups identified as high risk by the department.

(c) The program shall be designed to use voluntary assistance from public or private sectors in administering the vaccines. However, local governmental or private, nonprofit agencies may charge and retain a fee not exceeding two dollars ($2) per person to offset administrative operating costs.

(d) Except when the department determines that it is not feasible to use federal funds due to excessive administrative costs, the department shall seek and use available federal funds to the maximum extent possible for the cost of the vaccine, the cost of administering the vaccine, and the minimal fee charged under this section, including reimbursement under the Medi-Cal program for persons eligible therefor to the extent permitted by federal law.

(e) A private, nonprofit volunteer agency whose involvement with an immunization program governed by this section is limited to the provision of a clinic site or promotional and logistical support pursuant to subdivision (c), or any employee or member thereof, shall not be liable for any injury caused by an act or omission in the administration of the vaccine or other immunizing agent, if the immunization is performed pursuant to this section in conformity with applicable federal, state, or local governmental standards and the act or omission does not constitute willful misconduct or gross negligence. As used in this subdivision, "injury" includes the residual effects of the vaccine or other immunizing agent. It is the intent of the Legislature in adding this subdivision to affect only the liability of private, nonprofit volunteer agencies and their members that are not health facilities, as defined in Section 1250.

(f) This section shall not be construed to require the physical presence of a directing or supervising physician, or the examination by a physician of persons to be tested or immunized.

SEC. 35. Section 120392.6 of the Health and Safety Code is amended to read:

120392.6. No person who has been offered the vaccine as required under this chapter may receive either an influenza vaccine or pneumococcal vaccine pursuant to this chapter if any of the following conditions exists:

(a) The vaccine is medically contraindicated, as described in the product labeling approved by the federal Food and Drug Administration.

(b) Receipt of the vaccine is against the resident's personal beliefs.

(c) Receipt of the vaccine is against the resident's wishes, or, if the person lacks the capacity to make medical decisions, is against the wishes of the person legally authorized to make medical decisions on the resident's behalf.

SEC. 36. Section 120392.9 of the Health and Safety Code is amended to read:

120392.9. Pursuant to its standardized procedures and if it has the vaccine in its possession, each year, commencing October 1 to the following April 1, inclusive, a general acute care hospital, as defined in subdivision (a) of Section 1250, shall offer, prior to discharge, immunizations for influenza and pneumococcal disease to inpatients, 65 years of age or older, consistent with recommendations adopted pursuant to Section 120164 or the recommendations of appropriate entities for the prevention, detection, and control of influenza outbreaks in California general acute care hospitals.

SEC. 37. Section 120393 of the Health and Safety Code is amended to read:

120393. (a) The State Department of Public Health shall post educational information, in accordance with the latest recommendations adopted pursuant to Section 120164, regarding influenza disease and the availability of influenza vaccinations on the department's internet website. It is the intent of the Legislature to increase the average number of Californians who receive an influenza vaccination.

(b) The educational information posted on the department's internet website pursuant to subdivision (a) shall include, but not be limited to, all of the following:

(1) The health benefits of an influenza vaccination.

(2) That the influenza vaccination may be a covered benefit for those with health insurance coverage.

(3) That influenza vaccinations may be available for a minimal fee to those individuals who do not have health insurance coverage.

(4) The locations where free or low-cost vaccinations are available.

(c) The department may use additional available resources to educate the public about the information described in subdivision (b), including public service announcements, media events, public outreach to individuals and groups who are susceptible to influenza, and any other preventive and wellness education efforts recommended by public health officials.

SEC. 38. Section 120455 of the Health and Safety Code is amended to read:

120455. (a) Notwithstanding any other law, a person shall not be liable for any injury caused by an act or omission in prescribing, dispensing, ordering, furnishing, or in the administration of a vaccine or other immunizing agent, including the residual effects of the vaccine or immunizing agent, if the immunization is required by state law, administered in accordance with guidance from the State Department of Public Health pursuant to Section 120164, or given as part of an outreach program pursuant to Sections 120400 through 120415, inclusive, and the act or omission does not constitute willful misconduct or gross negligence.

(b) This section shall remain in effect only until January 1, 2030, and as of that date is repealed.

SEC. 39. Section 120455 is added to the Health and Safety Code, to read:

120455. (a) A person shall not be liable for any injury caused by an act or omission in the administration of a vaccine or other immunizing agent to a minor, including the residual effects of the vaccine or immunizing agent, if the immunization is either required by state law, or given as part of an outreach program pursuant to Sections 120400 through 120415, inclusive, and the act or omission does not constitute willful misconduct or gross negligence.

(b) This section shall become operative on January 1, 2030.

SEC. 40. Section 124981 of the Health and Safety Code is amended to read:

124981. (a) A person shall not use the title of genetic counselor unless the person has applied for and obtained a license from the department.

(b) The applicant for a genetic counselor license shall meet minimum qualifications that include, but are not limited to, both of the following:

(1) Has earned a master's degree or above from a program specializing in or having substantial course content in genetics.

(2) Has demonstrated competence by an examination administered or approved by the department.

(c) The license shall be valid for three years unless at any time during that period it is revoked or suspended. The license may be renewed prior to the expiration of the three-year period.

(d) To qualify to renew the license, a licenseholder shall have completed 45 hours of continuing education units during the three-year license renewal period. At least 30 hours of the continuing education units shall be in genetics.

(e) (1) The fee for an original license and license renewal shall be three hundred dollars ($300).

(2) (A) The department may adjust these fees to an amount not to exceed five hundred dollars ($500).

(B) The department shall solicit input from affected stakeholders before raising fees under this subdivision.

SEC. 41. Section 124982 of the Health and Safety Code is amended to read:

124982. (a) The department shall issue a temporary genetic counselor license to a person to practice as a licensed genetic counselor who meets all of the following:

(1) The requirements for licensure set forth in subdivision (b) of Section 124981, except passing the certification examination as required by paragraph (2) of subdivision (b) of Section 124981.

(2) Either of the following requirements:

(A) The person meets the requirements to apply for and has applied for the first available certification examination offered. The department may require an applicant for a temporary genetic counselor license to provide documentation of acceptance for the examination.

(B) The person meets the requirements to apply for the certification examination and plans to apply to sit for the examination in the year following the year of the first available examination. The department shall require the applicant to provide documentation showing registration for the examination, when the documentation is received by the applicant. After the applicant takes the examination, the department shall require the applicant to provide documentation showing that the applicant took the examination.

(3) (A) The fee for a temporary license shall be three hundred dollars ($300).

(B) (i) The department may adjust this fee to an amount not to exceed five hundred dollars ($500).

(ii) The department shall solicit input from affected stakeholders before raising fees under this paragraph.

(b) A temporary genetic counselor license shall be valid for 24 months and shall not be extended or renewed.

(c) Notwithstanding subdivision (a), a temporary license issued pursuant to this section shall expire upon any of the following events, whichever occurs earlier:

(1) The issuance of a license pursuant to Section 124981.

(2) Thirty days after notification of the department that an applicant has failed the certification examination.

(3) The expiration date on the temporary license.

(d) A person holding a temporary genetic counselor license issued pursuant to this section, shall be required to work under the supervision of a licensed genetic counselor or a licensed physician and surgeon.

(e) The department may revoke the temporary license of a genetic counselor licensed pursuant to this section if the person has been convicted of a felony charge that is substantially related to the qualifications, functions, or duties of a genetic counselor. A plea of guilty or nolo contendere to a felony charge shall be deemed a conviction for the purposes of this subdivision.

SEC. 42. Chapter 6.1 (commencing with Section 127640) is added to Part 2 of Division 107 of the Health and Safety Code, to read:

CHAPTER 6.1. Reproductive Health Protection

127640. For purposes of this chapter:

(a) “Abortion” has the same meaning as defined in Section 123464.

(b) “Department” means the Department of Health Care Access and Information, or any other entity within, and as designated by, the California Health and Human Services Agency.

(c) “Fund” means the Abortion Access Fund established pursuant to Section 127641.

127641. (a) The Abortion Access Fund is hereby established in the State Treasury.

(b) Notwithstanding any other law, all of the following apply:

(1) The fund is a special fund, permanently separate and apart from the General Fund or any other state fund or account.

(2) Notwithstanding Section 16305.7 of the Government Code, any interest or dividends earned on moneys in the fund shall be retained in the fund and used solely as set forth in this chapter.

(3) The purpose of the fund is to provide funding for abortion services, including for abortion services funded through grants to provide abortion access.

(4) The moneys in the fund are continuously appropriated to the department without regard to fiscal year for the purposes of this chapter.

127642. (a) The department shall distribute moneys in the fund for the purpose of funding abortion services.

(b) The department may carry out the program described in this chapter through grants and contracts, including exclusive or nonexclusive contracts, or amending existing contracts, on a bid or negotiated basis. Contracts and grants 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.

(c) Contracts, grants, and related information created pursuant to this chapter shall not be made public and are exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

(d) 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.

127643. This chapter shall become inoperative on July 1, 2029, and, as of January 1, 2030, is repealed.

SEC. 43. Section 10110.7 of the Insurance Code is amended to read:

10110.7. (a) This section, except for subdivision (i), applies to a disability insurance policy that provides coverage for hospital, medical, or surgical benefits, excluding a specialized health insurance policy and a policy that provides excepted benefits as described in Sections 2722 (42 U.S.C. Sec. 300gg-21) and 2791 (42 U.S.C. Sec. 300gg-91) of the federal Public Health Service Act, subject to Section 10198.61.

(b) Notwithstanding any other law, a disability insurance policy shall cover the costs for COVID-19 diagnostic and screening testing and health care services related to the diagnostic and screening testing approved or granted emergency use authorization by the federal Food and Drug Administration for COVID-19, regardless of whether the services are provided by an in-network or out-of-network provider. Coverage required by this section shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing. Services related to COVID-19 diagnostic and screening testing include, but are not limited to, hospital or health care provider office visits for the purposes of receiving testing, products related to testing, the administration of testing, and items and services furnished to an insured as part of testing. Services related to COVID-19 diagnostic and screening testing do not include bonus payments for the use of specialized equipment or expedited processing.

(1) To the extent a health care provider would have been entitled to receive cost sharing but for this section, the insurer shall reimburse the health care provider the amount of that lost cost sharing.

(2) A disability insurance policy shall not impose prior authorization or any other utilization management requirements on COVID-19 diagnostic and screening testing.

(3) With respect to an insured, a health insurer shall reimburse the provider of the testing according to either of the following:

(A) If the health insurer has a specifically negotiated rate for COVID-19 diagnostic and screening testing with such provider in effect before the public health emergency declared under Section 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such negotiated rate shall apply throughout the period of such declaration.

(B) If the health insurer does not have a specifically negotiated rate for COVID-19 diagnostic and screening testing with such provider, the insurer may negotiate a rate with such provider.

(4) For an out-of-network provider with whom an insurer does not have a specifically negotiated rate for COVID-19 diagnostic and screening testing and health care services related to testing, an insurer shall reimburse the provider for all testing items or services in an amount that is reasonable, as determined in comparison to prevailing market rates for testing items or services in the geographic region where the item or service is rendered. An out-of-network provider shall accept this payment as payment in full, shall not seek additional remuneration from an insured for services related to testing, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the insured.

(5) Beginning six months after the federal public health emergency expires, an insurer shall no longer be required to cover the cost sharing for COVID-19 diagnostic and screening testing and health care services related to testing when delivered by an out-of-network provider, except as otherwise required by law. All other requirements of this subdivision shall remain in effect after the federal public health emergency expires.

(c) (1) A disability insurance policy shall cover without cost sharing any item, service, or immunization that is intended to prevent or mitigate COVID-19 and that is either of the following with respect to the individual insured:

(A) An evidence-based item or service that had in effect on January 1, 2025, a rating of “A” or “B” in the recommendations of the United States Preventive Services Task Force or any modification or supplement to that recommendation adopted pursuant to Section 120164 of the Health and Safety Code.

(B) An immunization that as of January 1, 2025, had in effect a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention or any modification or supplement to that recommendation adopted pursuant to Section 120164 of the Health and Safety Code, regardless of whether the immunization is recommended for routine use.

(2) The items, services, and immunizations described in paragraph (1) that were in effect as of January 1, 2025, shall be covered upon the enactment of the act that added this paragraph.

(3) Any modification or supplement to the recommendations described in paragraph (1) shall be covered no later than 15 business days after the date on which the State Department of Public Health publishes the updated recommendations pursuant to Section 120164 of the Health and Safety Code.

(4) To the extent a health care provider would have been entitled to receive cost sharing but for this section, the insurer shall reimburse the health care provider the amount of that lost cost sharing.

(5) (A) A disability insurance policy subject to this subdivision shall not impose any cost-sharing requirements, including a copayment, coinsurance, or deductible, for any item, service, or immunization described in paragraph (1), regardless of whether such service is delivered by an in-network or out-of-network provider.

(B) A disability insurance policy shall not impose cost sharing for any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1), including, but not limited to, provider office visits and vaccine administration, regardless of whether the service is delivered by an in-network or out-of-network provider.

(C) With respect to an insured, a health insurer shall reimburse the provider of the immunization according to either of the following:

(i) If the health insurer has a negotiated rate with such provider in effect before the public health emergency declared under Section 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such negotiated rate shall apply throughout the period of such declaration.

(ii) If the health insurer does not have a negotiated rate with such provider, the insurer may negotiate a rate with such provider.

(D) For an out-of-network provider with whom a disability insurer does not have a negotiated rate for an item, service, or immunization described in paragraph (1), an insurer shall reimburse the provider for all such items or services, including any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1), in an amount that is reasonable, as determined in comparison to prevailing market rates for such items or services in the geographic region in which the item or service is rendered. An out-of-network provider shall accept this payment as

payment in full, shall not seek additional remuneration from an insured, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the insured for items, services, and immunizations described in paragraph (1), including any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1).

(E) Beginning six months after the federal public health emergency expires, an insurer shall no longer be required to cover the cost sharing for any item, service, or immunization described in paragraph (1) and to cover any items or services that are necessary for the furnishing of the items, services, or immunizations described in paragraph (1) when delivered by an out-of-network provider, except as otherwise required by law. All other requirements of this section shall remain in effect after the federal public health emergency expires.

(6) A disability insurer subject to this subdivision shall not impose prior authorization or any other utilization management requirements on any item, service, or immunization described in paragraph (1) or to items or services that are necessary for the furnishing of the items, services, or immunizations described in subparagraph (B) of paragraph (5).

(d) The commissioner may issue guidance to 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). The department shall consult with the Department of Managed Health Care in issuing the guidance specified in this subdivision.

(e) This section, excluding subdivision (i), shall apply retroactively beginning from the Governor's declared State of Emergency related to the SARS-CoV-2 (COVID-19) pandemic on March 4, 2020.

(f) For purposes of this section:

(1) "Diagnostic testing" means all of the following:

(A) Testing intended to identify current or past infection and performed when a person has signs or symptoms consistent with COVID-19, or when a person is asymptomatic but has recent known or suspected exposure to SARS-CoV-2.

(B) Testing a person with symptoms consistent with COVID-19.

(C) Testing a person as a result of contact tracing efforts.

(D) Testing a person who indicates that they were exposed to someone with a confirmed or suspected case of COVID-19.

(E) Testing a person after an individualized clinical assessment by a licensed health care provider.

(2) "Screening testing" means tests that are intended to identify people with COVID-19 who are asymptomatic and do not have known, suspected, or reported exposure to SARS-CoV-2. Screening testing helps to identify unknown cases so that measures can be taken to prevent further transmission. Screening testing includes all of the following:

(A) Workers in a workplace setting.

(B) Pupils, faculty, and staff in a school setting.

(C) A person before or after travel.

(D) At home for someone who does not have symptoms associated with COVID-19 and does not have a known exposure to someone with COVID-19.

(g) This section does not relieve an insurer from continuing to cover testing as required by federal law and guidance.

(h) The department shall hold insurers accountable for timely access to services required under this section and coverage requirements established under federal law, regulations, or guidelines.

(i) (1) This subdivision applies to a disability insurance policy issued, amended, or renewed on or after the operative date of this subdivision that covers hospital, medical, surgical, or prescription drug benefits, excluding a specialized health insurance policy that provides coverage only for dental or vision benefits, with respect to therapeutics for COVID-19 covered under the policy, which shall include therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration for treatment of COVID-19 when prescribed or furnished by a licensed health care provider acting within their scope of practice and the standard of care.

(2) A disability insurer shall reimburse a provider for the therapeutics described in paragraph (1) at the specifically negotiated rate for those therapeutics, if the insurer and provider have negotiated a rate. If the insurer does not have a negotiated rate with a provider, the insurer may negotiate a rate with the provider.

(3) For an out-of-network provider with whom a disability insurer does not have a negotiated rate for the therapeutics described in paragraph (1), a disability insurer shall reimburse the provider for the therapeutics in an amount that is reasonable, as determined in comparison to prevailing market rates for the therapeutics in the geographic region in which the therapeutic was delivered. An out-of-network provider shall accept this payment as payment in full, shall not seek additional remuneration from an insured, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the insured for therapeutics described in this subdivision.

(4) A disability insurer shall cover COVID-19 therapeutics without cost sharing, regardless of whether the therapeutics are provided by an in-network or out-of-network provider, and without utilization management. If a provider would have been entitled to receive cost sharing but for this section, the disability insurer shall reimburse the provider for the amount of that lost cost sharing. A provider shall accept this payment as payment in full, shall not seek additional remuneration from an insured, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the insured for therapeutics pursuant to this subdivision.

(5) Beginning six months after the federal public health emergency expires, a disability insurer shall no longer be required to cover the cost sharing for COVID-19 therapeutics delivered by an out-of-network provider, unless otherwise required by law. All other requirements of this subdivision shall remain in effect after the federal public health emergency expires.

SEC. 44. Section 10110.75 of the Insurance Code is amended to read:

10110.75. (a) This section applies to a disability insurance policy that provides coverage for hospital, medical, surgical, or prescription drug benefits, excluding a specialized health insurance policy that provides coverage only for dental or vision benefits.

(b) (1) A disability insurance policy shall cover, without cost sharing and without prior authorization or other utilization management requirements, the costs of the following health care services to prevent or mitigate a disease when the Governor of the State of California has declared a public health emergency due to that disease:

(A) An item or service that, as of January 1, 2025, had in effect a rating of “A” or “B” in the recommendations of the United States Preventive Services Task Force, or any modification or supplement to that recommendation adopted pursuant to Section 120164 of the Health and Safety Code.

(B) An immunization that, as of January 1, 2025, had in effect a recommendation of the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention, or any modification or supplement to that recommendation adopted pursuant to Section 120164 of the Health and Safety Code.

(C) A health care service or product related to diagnostic and screening testing for the disease that is approved or granted emergency use authorization by the federal Food and Drug Administration, or is recommended by the State Department of Public Health or the federal Centers for Disease Control and Prevention.

(D) Therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration for the disease.

(2) The items, services, and immunizations described in subparagraphs (A) and (B) of paragraph (1) that were in effect as of January 1, 2025, shall be covered upon enactment of the act that amended this section.

(3) Any modification or supplement to the recommendations described in subparagraphs (A) or (B) of paragraph (1) that is adopted pursuant to Section 120164 of the Health and Safety Code shall be covered no later than 15 business days after the date on which the State Department of Public Health publishes the updated schedule pursuant to Section 120164 of the Health and Safety Code.

(4) The item, service, or immunization covered pursuant to paragraph (1) shall be covered no later than 15 business days after the date on which the United States Preventive Services Task Force, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians or the State Department of Public Health makes a recommendation relating to the item, service, or immunization.

SEC. 45. Section 10112.2 of the Insurance Code is amended to read:

10112.2. (a) A group or individual nongrandfathered health insurance policy shall, at a minimum, provide coverage for and shall not impose any cost-sharing requirements for any of the following:

(1) Evidence-based items or services that had in effect on January 1, 2025, a rating of “A” or “B” in the recommendations of the United States Preventive Services Task Force or any modification or supplement to that recommendation adopted pursuant to Section 120164 of the Health and Safety Code.

(2) Immunizations that had in effect on January 1, 2025, a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention or any modification or supplement to that recommendation adopted pursuant to Section 120164 of the Health and Safety Code with respect to the individual involved.

(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided in the comprehensive guidelines, as periodically updated, supported by the United States Health Resources and Services Administration as of January 1, 2025, or any modification or supplement to that recommendation adopted pursuant to Section 120164 of the Health and Safety Code.

(4) With respect to women, those additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the United States Health Resources and Services Administration as of January 1, 2025, or any modification or supplement to that recommendation adopted pursuant to Section 120164 of the Health and Safety Code.

(5) For the purposes of this section:

(A) The recommendations of the United States Preventive Services Task Force as of January 1, 2025, or any modification or supplement to that recommendation adopted pursuant to Section 120164 of the Health and Safety Code regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

(B) A health insurance policy issued, amended, or renewed on or after January 1, 2025, shall not impose any cost-sharing requirements for any items or services that are integral to the provision of an item or service that is required by this section, regardless of whether or not the integral item or service is billed separately from an item or service that is required by this section.

(6) For the purposes of this section, a health insurance policy shall not impose cost sharing for office visits associated with the preventive care services described in this section if the preventive care service is not billed separately, or is not tracked as an individual encounter separately, from the office visit and the primary purpose of the office visit is the delivery of the preventive care service.

(b) This section does not prohibit a health insurance policy from providing coverage for preventive items or services in addition to those required by subdivision (a).

(c) A health insurer shall provide coverage pursuant to subdivision (a) for policy years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(1) A health insurer that is required to provide coverage for any items and services specified in a recommendation or guideline described in subdivision (a) on the first day of a policy year shall provide coverage through the last day of the policy year, even if the recommendation or guideline changes or is no longer described in subdivision (a) during the policy year.

(2) Notwithstanding paragraph (1) and consistent with the authority granted to the State Department of Public Health pursuant to Section 120164 of the Health and Safety Code, if any item or service associated with any recommendation or guideline specified in subdivision (a) is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service during a policy year, a health insurer is not required to cover the item or service through the last day of the policy year.

(d) A health insurance policy issued, amended, or renewed on or after January 1, 2025, shall cover items and services pursuant to this section in accordance with any applicable requirement of this part, including, but not limited to, Section 10123.18 on cervical cancer screening, Section 10123.1933 on prophylaxis of HIV infection, Section 10123.207 on colorectal cancer screening, and Section 10123.208 on home test kits for sexually transmitted diseases.

(e) This section does not apply to a specialized health insurance policy that does not cover an essential health benefit, as defined in Section 10112.27. This section shall only apply to a health savings account-eligible health insurance policy to the extent it does not fail to be treated as a high deductible health insurance policy under Section 223 of Title 26 of the United States Code.

(f) The department shall coordinate with the Department of Managed Health Care if it adopts regulations to implement this section.

(g) The commissioner may exercise the authority provided by this code and the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4.5 (commencing with Section 11400), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code) to implement and enforce this section and all sections related to preventive services, including those referenced herein. If the commissioner assesses a civil penalty for a violation, any hearing that is requested by the insurer may be conducted by an administrative law judge of the Administrative Hearing Bureau of the

department under the formal procedure of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. A civil penalty shall not exceed five thousand dollars ($5,000) for each violation, or, if a violation was willful, shall not exceed ten thousand dollars ($10,000) for each violation. This subdivision does not impair or restrict the commissioner's authority pursuant to another provision of this code or the Administrative Procedure Act.

SEC. 46. Section 10123.5 of the Insurance Code is amended to read:

10123.5. (a) On or after January 1, 1993, every insurer issuing group disability insurance that covers hospital, medical, or surgical expenses shall provide benefits for the comprehensive preventive care of children 16 years of age or younger under those terms and conditions as may be agreed upon between the group policyholder and the insurer. Every insurer shall communicate the availability of these benefits to all group policyholders and to all prospective group policyholders with whom they are negotiating.

(b) For purposes of this section, benefits for the comprehensive preventive care of children shall comply with both of the following:

(1) Be consistent with both of the following:

(A) The most recent Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics.

(B) The Recommended Childhood Immunization Schedule/United States, jointly adopted as of January 1, 2025, by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians. Immunizations subject to this subparagraph may be modified or supplemented by the State Department of Public Health pursuant to Section 120164.

(2) Provide for the following:

(A) Periodic health evaluations.

(B) Immunizations.

(C) Laboratory services in connection with periodic health evaluations.

(D) Screening for blood lead levels in children who are at risk for lead poisoning, as determined by a health care provider in accordance with the applicable California regulations.

(c) For purposes of this section, a health care provider is any of the following:

(1) A person licensed to practice medicine pursuant to Article 3 (commencing with Section 2050) of Chapter 5 of Division 2 of the Business and Professions Code.

(2) A nurse practitioner licensed to practice pursuant to Article 8 (commencing with Section 2834) of Chapter 6 of Division 2 of the Business and Professions Code.

(3) A physician assistant licensed to practice pursuant to Article 3 (commencing with Section 3513) of Chapter 7.7 of Division 2 of the Business and Professions Code.

SEC. 47. Section 10123.55 of the Insurance Code is amended to read:

10123.55. (a) On or after January 1, 1993, every insurer issuing group disability insurance that covers hospital, medical, or surgical expenses shall offer benefits for the comprehensive preventive care of children 17 and 18 years of age under those terms and conditions as may be agreed upon between the group policyholder and the insurer. Every insurer shall communicate the availability of these benefits to all group policyholders and to all prospective group policyholders with whom they are negotiating.

(b) For purposes of this section, benefits for the comprehensive preventive care of children shall comply with both of the following:

(1) Be consistent with both of the following:

(A) The most recent Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics.

(B) The Recommended Childhood Immunization Schedule/United States, jointly adopted as of January 1, 2025, by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians. Immunizations subject to this subparagraph may be modified or supplemented by the State Department of Public Health pursuant to Section 120164.

(2) Provide for the following:

(A) Periodic health evaluations.

(B) Immunizations.

(C) Laboratory services in connection with periodic health evaluations.

(D) Screening for blood lead levels in children who are at risk for lead poisoning, as determined by a health care provider in accordance with the applicable California regulations.

(c) For purposes of this section, a health care provider is any of the following:

(1) A person licensed to practice medicine pursuant to Article 3 (commencing with Section 2050) of Chapter 5 of Division 2 of the Business and Professions Code.

(2) A nurse practitioner licensed to practice pursuant to Article 8 (commencing with Section 2834) of Chapter 6 of Division 2 of the Business and Professions Code.

(3) A physician assistant licensed to practice pursuant to Article 3 (commencing with Section 3513) of Chapter 7.7 of Division 2 of the Business and Professions Code.

SEC. 48. Section 30461.6 of the Revenue and Taxation Code is amended to read:

30461.6. (a) Notwithstanding Section 30461, the board shall transmit the revenue derived from the increase in the cigarette tax rate of one mill ($0.001) per cigarette imposed by Section 30101 on and after January 1, 1994, to the Treasurer to be deposited in the State Treasury to the credit of the Breast Cancer Fund, which fund is hereby created. The Breast Cancer Fund shall consist of two accounts: the Breast Cancer Research Account and the Breast Cancer Control Account. The revenues deposited in the fund shall be divided equally between the two accounts.

(b) The moneys in the accounts within the Breast Cancer Fund shall, upon appropriation by the Legislature, be allocated as follows:

(1) The moneys in the Breast Cancer Research Account shall be allocated for research with respect to the cause, cure, treatment, earlier detection, and prevention of breast cancer as follows:

(A) Ten percent to the Cancer Surveillance Section of the State Department of Health Care Services for the collection of breast cancer-related data and the conduct of breast cancer-related epidemiological research by the state cancer registry established pursuant to Section 103885 of the Health and Safety Code.

(B) Ninety percent to the Breast Cancer Research Program, that is hereby created at the University of California, for the awarding of grants and contracts to researchers for research with respect to the cause, cure, treatment, prevention, and earlier detection of breast cancer and with respect to the cultural barriers to accessing the health care system for early detection and treatment of breast cancer.

(2) The moneys in the Breast Cancer Control Account shall be allocated to the Breast Cancer Control Program, that is hereby created for the provision of early breast cancer detection services for uninsured and underinsured women. The Breast Cancer Control Program shall be established in the State Department of Health Care Services and shall be administered in coordination with the breast and cervical cancer control program established pursuant to Public Law 101-354.

(c) The early breast cancer detection services provided by the Breast Cancer Control Program shall include all of the following:

(1) Screening, including mammography, of women for breast cancer as an early detection health care measure.

(2) After screening, medical referral of screened women and services necessary for definitive diagnosis, including nonradiological techniques or biopsy.

(3) If a positive diagnosis is made, then assistance and advocacy shall be provided to help the person obtain necessary treatment.

(4) Outreach and health education activities to ensure that uninsured and underinsured women are aware of and appropriately utilize the services provided by the Breast Cancer Control Program.

(d) (1) Any entity funded by the Breast Cancer Control Program shall coordinate with other local providers of breast cancer screening, diagnostic, followup, education, and advocacy services to avoid duplication of effort. Any entity funded by the program shall comply with any applicable state and federal standards regarding mammography quality assurance.

(2) To the extent required or permitted by federal law, a provider of breast cancer screening or diagnostic services may employ digital mammography technology for the purposes of mammography screening and diagnostic procedures that are conducted prior to January 1, 2014, when film, otherwise known as analog, mammography technology is unavailable. To the extent required or permitted by federal law and notwithstanding paragraph (3) of subdivision (a) of Section 14105.18 of the Welfare and Institutions Code, the payment rate for all mammography screening that is conducted prior to January 1, 2014, shall be limited to the Medi-Cal payment rate for film mammography screening.

(e) Notwithstanding Section 10231.5 of the Government Code, each year, the State Department of Health Care Services shall submit an annual report about the Breast Cancer Control Program, including information described in subdivision (f), to the fiscal and appropriate policy committees of the Legislature and to other appropriate entities. The department shall submit the report, in accordance with Section 9795 of the Government Code, no later than February 28 each fiscal year.

(f) Any entity funded by the Breast Cancer Control Program shall collect data and maintain records that are determined by the State Department of Health Care Services to be necessary to facilitate the department's ability to monitor and evaluate the effectiveness of the program entities and the program. The costs associated with the report described in subdivision (e) shall be paid from the allocation made pursuant to paragraph (2) of subdivision (b). The report shall describe the activities and effectiveness of the program and shall include, but not be limited to, the following types of information:

(1) The number of recipients served.

(2) The ethnic, geographic, and age breakdown.

(3) The breast and cervical cancer stages of presentation.

(4) The breast and cervical cancer diagnostic and treatment status.

(5) Program caseload.

(6) Estimated clinical claims and expenditures.

(7) Program activities and monitoring data.

(8) A breakdown of expenditures for clinical service activities, including, but not limited to, office visits and consults, screening mammograms, diagnostic mammograms, diagnostic breast procedures, case management, and other clinical services.

(g) The Breast Cancer Control Program shall be conducted in consultation with the Breast Cancer Research Program created pursuant to subparagraph (B) of paragraph (1) of subdivision (b).

(h) In implementing the Breast Cancer Control Program, the State Department of Health Care Services may appoint and consult with an advisory panel appointed by the Director of Health Care Services and consisting of one ex officio, nonvoting member from the Breast Cancer Research Program, breast cancer researchers, and representatives from voluntary, nonprofit health organizations, health care professional organizations, breast cancer survivor groups, and breast cancer and health care-related advocacy groups. It is the intent of the Legislature that breast cancer-related survivors and advocates and health advocates for low-income women compose at least one-third of the advisory panel. It is also the intent of the Legislature that the State Department of Health Care Services collaborate closely with the panel.

(i) It is the intent of the Legislature in enacting the Breast Cancer Control Program to decrease cancer mortality rates attributable to breast cancer among uninsured and underinsured women, with special emphasis on low-income, Native American, and minority women. It is also the intent of the Legislature that the communities served by the Breast Cancer Control Program reflect the ethnic, racial, cultural, and geographic diversity of the state and that the Breast Cancer Control Program fund entities where uninsured and underinsured women are most likely to seek their health care.

(j) The State Department of Health Care Services or any entity funded by the Breast Cancer Control Program shall collect personal and medical information necessary to administer this program from any individual applying for services under the program. The information shall be confidential and shall not be disclosed other than for purposes directly connected with the administration of this program or except as otherwise provided by law or pursuant to prior written consent of the subject of the information.

The State Department of Health Care Services or any entity funded by the Breast Cancer Control Program may disclose the confidential information to medical personnel and fiscal intermediaries of the state to the extent necessary to administer this program, and to other state public health agencies or medical researchers when the confidential information is necessary to carry out the duties of those agencies or researchers in the investigation, control, or surveillance of breast cancer.

(k) The State Department of Health Care Services shall adopt regulations to implement this act 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). The initial adoption of implementing regulations shall be deemed an emergency and shall be considered as necessary for the immediate preservation of the public peace, health and safety, or general welfare, within the meaning of Section 11346.1 of the Government Code. Emergency regulations adopted pursuant to this section shall remain in effect for no more than 180 days.

(l) It is the intent of the Legislature in enacting this section that this section supersede and be operative in place of Section 30461.6 of the Revenue and Taxation Code as added by Chapter 660 of the Statutes of 1993.

(m) To implement the Breast Cancer Control Program, the State Department of Health Care Services may contract, to the extent permitted by Section 19130 of the Government Code, with public and private entities, or utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary. However, the Medi-Cal program's fiscal intermediary shall only be utilized if services provided under the program are specifically identified and reimbursed in a manner that does not claim federal financial reimbursement. Any contracts with, and the utilization of, the Medi-Cal program's fiscal intermediary shall not be subject to Chapter 3 (commencing with Section 12100) of Part 2 of Division 2 of the Public Contract Code. Contracts to implement the Breast Cancer Control Program entered into by the State Department of Health Care Services with entities other than the Medi-Cal program's fiscal intermediary shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

SEC. 49. Section 5961.4 of the Welfare and Institutions Code is amended to read:

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 (h), 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) (1) The department may contract with an entity to administer the school-linked statewide behavioral health provider network in accordance with this subdivision.

(2) The entity that administers the school-linked statewide behavioral health provider network shall do all of the following:

(A) Create and administer a process for enrolling and credentialing all eligible practitioners and providers seeking to provide medically necessary schoolsite services described in this section.

(B) Create and administer a process for the submission and reimbursement of claims eligible to be reimbursed pursuant to this section, which may include resolving disputes related to the school-linked statewide all-payer fee schedule and administering fee collection pursuant to subdivision (g).

(C) (i) Create and administer a mechanism for the sharing of data between the entity contracted pursuant to this subdivision and a health care service plan, insurer, or Medi-Cal managed care plan that covers medically necessary schoolsite services subject to the school-linked statewide all-payer fee schedule that is necessary to facilitate timely claims processing, payment, and reporting, avoid duplication of claims, allow for tracking of grievance remediation, and to facilitate coordination of care and continuity of care for enrollees.

(ii) Clause (i) includes requiring the entity that administers the school-linked statewide behavioral health provider network to automate, to the maximum extent possible, matching student records with health plan enrollment information, in order to reduce or eliminate the administrative burden of collecting health plan enrollment data from individual students and families on local educational agencies and institutions of higher education.

(iii) The department shall require any entity administering the school-linked statewide behavioral health provider network to ensure both of the following:

(I) Claims submitted pursuant to Section 1374.722 of the Health and Safety Code, Section 10144.53 of the Insurance Code, and subdivisions (c) and (f) are properly reimbursed according to applicable claim payment deadlines.

(II) The deadline for a local educational agency or institutions of higher education to submit a retroactive claim for payment is the longer of the time permitted under either federal or state law.

(e) A provider or practitioner of medically necessary schoolsite services participating in the school-linked statewide behavioral health provider network described in this section shall do all of the following:

(1) Comply with all administrative requirements necessary to be enrolled and credentialed, as applicable, by the entity that administers the school-linked statewide behavioral health provider network.

(2) Submit all claims for reimbursement for services billed under the school-linked statewide all-payer fee schedule through the entity that administers the school-linked statewide behavioral health provider network.

(3) If a provider or practitioner of medically necessary schoolsite services has, or enters into, a direct agreement established with a health care service plan, insurer, or Medi-Cal managed care plan that covers medically necessary schoolsite services outside of the school-linked statewide all-payer fee schedule, they shall be allowed to bill for services provided directly under the terms of the established agreement.

(f) (1) A health care service plan, insurer, or Medi-Cal managed care plan that covers medically necessary schoolsite services subject to the school-linked statewide all-payer fee schedule, pursuant to Section 1374.722 of the Health and Safety Code, Section 10144.53 of the Insurance Code, and this section, shall comply with all administrative requirements necessary to cover and reimburse those services set forth by the entity that administers the school-linked statewide behavioral health provider network.

(2) If an agreement exists between a health care service plan, insurer, or Medi-Cal managed care plan and a provider or practitioner of medically necessary schoolsite services outside of the school-linked statewide all-payer fee schedule, the health care service plan, insurer, or Medi-Cal managed care plan shall do all of the following:

(A) At minimum, reimburse the contracted provider or practitioner at the school-linked statewide all-payer fee schedule rates.

(B) Provide to the department data deemed necessary and appropriate for program reporting and compliance purposes.

(C) Comply with all administrative requirements necessary to cover and reimburse medically necessary schoolsite services subject to the school-linked statewide all-payer fee schedule, as determined by the department.

(g) (1) The department shall establish and charge a fee to participating health care service plans, insurers, or Medi-Cal managed care plans to cover the reasonable cost of administering the school-linked statewide behavioral health provider network.

(2) The department shall set the fees in an amount that it projects is sufficient to cover all administrative costs incurred by the state associated with implementing this section and consider the assessed volume of claims and providers or practitioners of medically necessary schoolsite services that are credentialed and enrolled by the entity contracted pursuant to subdivision (d).

(3) The department shall not assess the fee authorized by this subdivision until the time that the contract between the department and the entity contracted pursuant to subdivision (d) commences.

(4) (A) The department may periodically update the amount and structure of the fees, as necessary, to provide sufficient funding for the purpose specified in this subdivision.

(B) The fees authorized in this paragraph shall be evaluated annually and based on the state's projected costs for the forthcoming fiscal year.

(C) If the department proposes to increase the fees, it shall notify the Legislature of the proposed increase through the submission of the semiannual Medi-Cal estimate provided to the Legislature.

(5) (A) (i) The Behavioral Health Schoolsite Fee Schedule Administration Fund is hereby established in the State Treasury.

(ii) The department shall administer the Behavioral Health Schoolsite Fee Schedule Administration Fund consistent with this subdivision.

(B) All revenues, less refunds, derived from the fees authorized in this subdivision shall be deposited in the Behavioral Health Schoolsite Fee Schedule Administration Fund.

(C) The moneys in the Behavioral Health Schoolsite Fee Schedule Administration Fund shall be available upon appropriation by the Legislature and shall be used only for purposes of this subdivision.

(D) Notwithstanding Section 16305.7 of the Government Code, interest and dividends earned on moneys in the Behavioral Health Schoolsite Fee Schedule Administration Fund shall be retained in the fund and used solely for the purposes specified in this section.

(E) Notwithstanding any other provision of law, the Controller may use moneys in the Behavioral Health Schoolsite Fee Schedule Administration Fund for cashflow loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code.

(F) Funds remaining in the Behavioral Health Schoolsite Fee Schedule Administration Fund at the end of a fiscal year shall be available for use in the following fiscal year and taken into consideration in establishment of fees for the subsequent fiscal year.

(h) 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.

(i) 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.

(j) The California Health and Human Service Agency shall publish a policy manual to assist a local education agency with navigating the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and the federal Family Educational Rights and Privacy Act (20 U.S.C. Sec. 1232g) for purposes of participating in the school-linked statewide behavioral health provider network.

(k) (1) The State Department of Health Care Services shall, not less than twice a year, convene a working group of stakeholders to discuss the status of, and receive feedback regarding, implementation of the fee schedule. The working group shall include, but is not limited to, representatives of all of the following:

(A) Medi-Cal managed care plans.

(B) Medi-Cal behavioral health plans.

(C) Health care service plans.

(D) Insurers.

(E) Behavioral health providers.

(F) Local educational agencies.

(G) Labor representatives of school employees.

(H) Members of the educational community.

(2) The department shall provide notice, and relevant updates and information on the status of the implementation of the fee schedule, to all of the following:

(A) The Assembly Committee on Budget.

(B) The Assembly Committee on Education.

(C) The Assembly Committee on Health.

(D) The Senate Committee on Budget and Fiscal Review.

(E) The Senate Committee on Education.

(F) The Senate Committee on Health.

(3) This subdivision shall become inoperative on July 1, 2030.

(l) 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.

SEC. 50. Section 11265.8 of the Welfare and Institutions Code is amended to read:

11265.8. (a) All applicants for aid under this chapter, within 30 days of the determination of eligibility for Medi-Cal benefits under Chapter 7 (commencing with Section 14000), and 45 days for applicants already eligible for benefits under Chapter 7 (commencing with Section 14000), and all recipients of aid under this chapter within 45 days of a full or financial redetermination of eligibility for aid under this chapter, shall provide documentation that all children in the assistance unit not required to be enrolled in school have received all age appropriate immunizations, unless it has been medically determined that an immunization for a child is not appropriate or the applicant or recipient has filed with the county welfare department an affidavit that the immunizations are contrary to the applicant’s or recipient’s beliefs. If the county determines that good cause exists for not providing the required documentation due to lack of reasonable access to immunization services, the period shall be extended by an additional 30 days. A circumstance that shall constitute good cause includes, but is not limited to, the applicant or recipient does not have reasonable access to immunization services due to a situation of domestic violence. If the documentation is not provided within the required time period, the needs of all parents or caretaker relatives in the assistance unit shall not be considered in determining the grant to the assistance unit under Section 11450 until the required documentation is provided. The department shall track and maintain information concerning the number of sanctions imposed under this section.

(b) At the time of application and at the next redetermination of eligibility for aid under this chapter, all applicants and recipients shall be given notice advising them of their obligation to secure the immunizations required in subdivision (a). The notice shall also contain all of the following:

(1) The Recommended Childhood Immunization Schedule, United States, and the Recommended Immunization Schedule for Children Not Immunized on Schedule in the First Year of Life, as appropriate, approved as of January 1, 2025, by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, and any modification or supplement thereto by the State Department of Public Health, including the recommended immunization schedule, in accordance with Section 120164 of Health and Safety Code. Notwithstanding 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), the department may implement any policy changes required pursuant to this paragraph by means of all-county letters or similar instructions from the department until regulations are adopted. These all-county letters or similar written instructions shall have the same force and effect as regulations until the adoption of regulations, which shall occur no later than June 30, 2027.

(2) A description of how to obtain the immunizations through a fee-for-service provider that accepts Medi-Cal, a Medi-Cal managed care plan, a county public health clinic, or any other source that may be available in the county as appropriate.

(3) A statement that the applicant or recipient may file an affidavit claiming that the immunizations are contrary to the applicant’s or recipient’s beliefs.

SEC. 51. Section 14005.27 of the Welfare and Institutions Code is amended to read:

14005.27. (a) Individuals enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code on June 27, 2012, and who are determined eligible to receive benefits pursuant to subdivision (a) of Section 14005.26, or, effective January 1, 2014, subdivision (b) of Section 14005.26, shall be transitioned into Medi-Cal, pursuant to this section.

(b) To the extent necessary and for the purposes of carrying out the provisions of this section, in performing initial eligibility determinations for children enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code, the department shall adopt the option pursuant to Section 1902(e)(13) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(13)) to allow the department or county human services departments to rely upon findings made by the Managed Risk Medical Insurance Board (MRMIB) regarding one or more components of eligibility. The department shall seek federal approval of a state plan amendment to implement this subdivision.

(c) To the extent necessary, the department shall seek federal approval of a state plan amendment or a waiver to provide presumptive eligibility for the optional targeted low-income category of eligibility pursuant to Section 14005.26 for individuals presumptively eligible for or enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code. The presumptive eligibility shall be based upon the most recent information contained in the individual's Healthy Families Program file. The timeframe for the presumptive eligibility shall begin no sooner than January 1, 2013, and shall continue until a determination of Medi-Cal eligibility is made, which determination shall be performed within one year of the individual's Healthy Families Program annual review date.

(d) (1) The California Health and Human Services Agency, in consultation with the Managed Risk Medical Insurance Board, the State Department of Health Care Services, the Department of Managed Health Care, and diverse stakeholders groups, shall provide the fiscal and policy committees of the Legislature with a strategic plan for the transition of the Healthy Families Program pursuant to this section by no later than October 1, 2012. This strategic plan shall, at a minimum, address all of the following:

(A) State, county, and local administrative components that facilitate a successful subscriber transition such as communication and outreach to subscribers and applicants, eligibility processing, enrollment, communication, and linkage with health plan providers, payments of applicable premiums, and overall systems operation functions.

(B) Methods and processes for diverse stakeholder engagement throughout the entire transition, including all phases of the transition.

(C) State monitoring of managed care health plans' performance and accountability for provision of services, and initial quality indicators for children and adolescents transitioning to Medi-Cal.

(D) Health care and dental delivery system components such as standards for informing and enrollment materials, network adequacy, performance measures and metrics, fiscal solvency, and related factors that ensure timely access to quality health and dental care for children and adolescents transitioning to Medi-Cal.

(E) Inclusion of applicable operational steps, timelines, and key milestones.

(F) A time certain for the transfer of the Healthy Families Advisory Board, as described in Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code, to the State Department of Health Care Services.

(2) The intent of this strategic plan is to serve as an overall guide for the development of each plan for each phase of this transition, pursuant to paragraphs (1) to (8), inclusive, of subdivision (e), to ensure clarity and consistency in approach and subscriber continuity of care. This strategic plan may also be updated by the California Health and Human Services Agency as applicable and provided to the Legislature upon completion.

(e) (1) The department shall transition individuals from the Healthy Families Program to the Medi-Cal program in four phases, as follows:

(A) Phase 1. Individuals enrolled in a Healthy Families Program health plan that is a Medi-Cal managed care health plan shall be enrolled in the same plan no earlier than January 1, 2013, pursuant to the requirements of this section and Section 14011.6, and to the extent the individual is otherwise eligible under this chapter and Chapter 8 (commencing with Section 14200).

(B) Phase 2. Individuals enrolled in a Healthy Families Program managed care health plan that is a subcontractor of a Medi-Cal managed health care plan, to the extent possible, shall be enrolled into a Medi-Cal managed health care plan that includes the individuals' current plan pursuant to the requirements of this section and Section 14011.6, and to the extent the individuals are otherwise eligible under this chapter and Chapter 8 (commencing with Section 14200). The transition of individuals described in this subparagraph shall begin no earlier than April 1, 2013.

(C) Phase 3. Individuals enrolled in a Healthy Families Program plan that is not a Medi-Cal managed care plan and does not contract or subcontract with a Medi-Cal managed care plan shall be enrolled in a Medi-Cal managed care plan in that county. Enrollment shall include consideration of the individuals' primary care providers pursuant to the requirements of this section and Section 14011.6, and to the extent the individuals are otherwise eligible under this chapter and Chapter 8

(commencing with Section 14200). The transition of individuals described in this subparagraph shall begin no earlier than August 1, 2013.

(D) Phase 4.

(i) Individuals residing in a county that is not a Medi-Cal managed care county shall be provided services under the Medi-Cal fee-for-service delivery system, subject to clause (ii). The transition of individuals described in this subparagraph shall begin no earlier than September 1, 2013.

(ii) In the event the department creates a managed health care system in the counties described in clause (i), individuals residing in those counties shall be enrolled in managed health care plans pursuant to this chapter and Chapter 8 (commencing with Section 14200).

(2) For the transition of individuals pursuant to subparagraphs (A), (B), (C), and (D) of paragraph (1), implementation plans shall be developed to ensure state and county systems readiness, health plan network adequacy, and continuity of care with the goal of ensuring there is no disruption of service and there is continued access to coverage for all transitioning individuals. If an individual is not retained with the individual's primary care provider, the implementation plan shall require the managed care plan to report to the department as to how continuity of care is being provided. Transition of individuals described in subparagraphs (A), (B), (C), and (D) of paragraph (1) shall not occur until 90 days after the department has submitted an implementation plan to the fiscal and policy committees of the Legislature. The implementation plans shall include, but not be limited to, information on health and dental plan network adequacy, continuity of care, eligibility and enrollment requirements, consumer protections, and family notifications.

(3) The following requirements shall be in place prior to implementation of Phase 1, and shall be required for all phases of the transition:

(A) Managed care plan performance measures shall be integrated and coordinated with the Healthy Families Program performance standards including, but not limited to, child-only Healthcare Effectiveness Data and Information Set (HEDIS) measures, and measures indicative of performance in serving children and adolescents. These performance measures shall also be in compliance with all performance 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) and existing Medi-Cal managed care performance measurements and standards as set forth in this chapter and Chapter 8 (commencing with Section 14200), and all-plan letters, including, but not limited to, network adequacy and linguistic services, and shall be met prior to the transition of individuals pursuant to Phase 1.

(B) Medi-Cal managed care health plans shall allow enrollees to remain with their current primary care provider. If an individual does not remain with the current primary care provider, the plan shall report to the department as to how continuity of care is being provided.

(4) (A) As individuals are transitioned pursuant to subparagraphs (A), (B), (C), and (D) of paragraph (1), for individuals residing in all counties except the Counties of Sacramento and Los Angeles, their dental coverage shall transition to fee-for-service dental coverage and may be provided by their current provider if the provider is a Medi-Cal fee-for-service dental provider.

(B) For individuals residing in the County of Sacramento, their dental coverage shall continue to be provided by their current dental managed care plan if their plan is a Medi-Cal dental managed care plan. If their plan is not a Medi-Cal dental managed care plan, they shall select a Medi-Cal dental managed care plan. If they do not choose a Medi-Cal dental managed care plan, they shall be assigned to a plan with preference to a plan with which their current provider is a contracted provider. Any children in the Healthy Families Program transitioned into Medi-Cal dental managed care plans shall also have access to the beneficiary dental exception process, pursuant to Section 14089.09. Further, the Sacramento advisory committee, established pursuant to Section 14089.08, shall be consulted regarding the transition of children in the Healthy Families Program into Medi-Cal dental managed care plans.

(C) (i) For individuals residing in the County of Los Angeles, for purposes of continuity of care, their dental coverage shall continue to be provided by their current dental managed care plan if that plan is a Medi-Cal dental managed care plan. If their plan is not a Medi-Cal dental managed care plan, they may select a Medi-Cal dental managed care plan or choose to move into Medi-Cal fee-for-service dental coverage.

(ii) It is the intent of the Legislature that children transitioning to Medi-Cal under this section have a choice in dental coverage, as provided under existing law.

(5) Dental health plan performance measures and benchmarks shall be in accordance with Section 14459.6.

(6) Medi-Cal managed care health and dental plans shall report to the department, as frequently as specified by the department, specified information pertaining to transition implementation, enrollees, and providers, including, but not limited to, grievances related to access to care, continuity of care requests and outcomes, and changes to provider networks, including provider enrollment and disenrollment changes. The plans shall report this information by county, and in the format requested by the department.

(7) The department may develop supplemental implementation plans to separately account for the transition of individuals from the Healthy Families Program to specific Medi-Cal delivery systems.

(8) The department shall consult with the Legislature and stakeholders, including, but not limited to, consumers, families, consumer advocates, counties, providers, and health and dental plans, in the development of implementation plans described in paragraph (3) for individuals who are transitioned to Medi-Cal in Phase 2, Phase 3, and Phase 4, as described in subparagraphs (B), (C), and (D) of paragraph (1).

(9) (A) The department shall consult and collaborate with the Department of Managed Health Care in assessing Medi-Cal managed care health plan network adequacy in accordance with 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) for purposes of the developed transition plans pursuant to paragraph (2) for each of the phases.

(B) For purposes of individuals transitioning in Phase 1, as described in subparagraph (A) of paragraph (1), network adequacy shall be assessed as described in this paragraph and findings from this assessment shall be provided to the fiscal and appropriate policy committees of the Legislature 60 days prior to the effective date of implementing this transition.

(f) (1) The department and MRMIB shall work collaboratively in the development of notices for individuals transitioned pursuant to paragraph (1) of subdivision (e).

(2) The state shall provide written notice to individuals enrolled in the Healthy Families Program of their transition to the Medi-Cal program at least 60 days prior to the transition of individuals in Phase 1, as described in subparagraph (A) of paragraph (1) of subdivision (e), and at least 90 days prior to transition of individuals in Phases 2, 3, and 4, as described in subparagraphs (B), (C), and (D) of paragraph (1) of subdivision (e).

(3) Notices developed pursuant to this subdivision shall ensure individuals are informed regarding the transition, including, but not limited to, how individuals' systems of care may change, when the changes will occur, and whom they can contact for assistance when choosing a Medi-Cal managed care plan, if applicable, including a toll-free telephone number, and with problems they may encounter. The department shall consult with stakeholders regarding notices developed pursuant to this subdivision. These notices shall be developed using plain language, and written translation of the notices shall be available for those who are limited English proficient or non-English speaking in all Medi-Cal threshold languages.

(4) The department shall designate department liaisons responsible for the coordination of the Healthy Families Program and may establish a children's-focused section for this purpose and to facilitate the provision of health care services for children enrolled in Medi-Cal.

(5) The department shall provide a process for ongoing stakeholder consultation and make information publicly available, including the achievement of benchmarks, enrollment data, utilization data, and quality measures.

(g) (1) In order to aid the transition of Healthy Families Program enrollees, MRMIB, on the effective date of the act that added this section and continuing through the completion of the transition of Healthy Families Program enrollees to the Medi-Cal program, shall begin requesting and collecting from health plans contracting with MRMIB pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code, information about each health plan's provider network, including, but not limited to, the primary care and all specialty care providers assigned to individuals enrolled in the health plan. MRMIB shall obtain this information in a manner that coincides with the transition activities described in subdivision (d), and shall provide all of the collected information to the department within 60 days of the department's request for this information to ensure timely transitions of Healthy Families Program enrollees.

(2) The department shall analyze the existing Healthy Families Program delivery system network and the Medi-Cal fee-for-service provider networks, including, but not limited to, Medi-Cal dental providers, to determine overlaps of the provider networks in each county for which there are no Medi-Cal managed care plans or dental managed care plans. To the extent there is a lack of existing Medi-Cal fee-for-service providers available to serve the Healthy Families Program enrollees, the department shall work with the Healthy Families Program provider community to encourage participation of those providers in the Medi-Cal program, and develop a streamlined process to enroll them as Medi-Cal providers.

(3) (A) MRMIB, within 60 days of a request by the department, shall provide the department any data, information, or record concerning the Healthy Families Program as is necessary to implement the transition of enrollment required pursuant to this

section.

(B) Notwithstanding any other law, all of the following shall apply:

(i) The term “data, information, or record” shall include, but is not limited to, personal information as defined in Section 1798.3 of the Civil Code.

(ii) Any data, information, or record shall be exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code) and any other law, to the same extent that it was exempt from disclosure or privileged prior to the provision of the data, information, or record to the department.

(iii) The provision of this data, information, or record to the department shall not constitute a waiver of any evidentiary privilege or exemption from disclosure.

(iv) The department shall keep all data, information, or records provided by MRMIB confidential to the full extent permitted by law, including, but not limited to, the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code), and consistent with MRMIB’s contractual obligations to keep the data, information, or records confidential.

(h) This section shall be implemented only to the extent that all necessary federal approvals and waivers have been obtained and the enhanced rate of federal financial participation under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.) is available for targeted low-income children pursuant to that act.

(i) (1) (A) Except as provided in subparagraph (B), the department shall exercise the option pursuant to Section 1916A of the federal Social Security Act (42 U.S.C. Sec. 1396o-1) to impose premiums for individuals described in subdivision (a) of Section 14005.26 whose family income has been determined to be above 150 percent and up to and including 200 percent of the federal poverty level, after application of the income disregard pursuant to paragraph (2) of subdivision (a) of Section 14005.26. The department shall not impose premiums under this subdivision for individuals described in subdivision (a) of Section 14005.26 whose family income has been determined to be at or below 150 percent of the federal poverty level, after application of the income disregard pursuant to paragraph (2) of subdivision (a) of Section 14005.26. The department shall obtain federal approval for the implementation of this subdivision.

(B) Effective January 1, 2014, the family income range for the imposition of premiums pursuant to subparagraph (A) for individuals described in subdivision (a) or (b) of Section 14005.26 shall be above 160 percent and shall go up to and include 261 percent of the federal poverty level as determined, counted, and valued in accordance with the requirements of Section 14005.64. The department shall not impose premiums for eligible individuals whose family income has been determined to be at or below 160 percent of the federal poverty level.

(2) All premiums imposed under this section shall equal the family contributions described in paragraph (2) of subdivision (d) of Section 12693.43 of the Insurance Code and shall be reduced in conformity with subdivisions (e) and (f) of Section 12693.43 of the Insurance Code.

(j) The department shall not enroll targeted low-income children described in this section in the Medi-Cal program until all necessary federal approvals and waivers have been obtained, or no sooner than January 1, 2013.

(k) (1) (A) Except as provided in subparagraph (B), to the extent the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is not fully operational, for the purposes of implementing this section, for individuals described in subdivision (a) whose family income has been determined to be at or below 150 percent of the federal poverty level, after application of the disregard pursuant to paragraph (2) of subdivision (a) of Section 14005.26, the department shall utilize the budgeting methodology for this population as contained in the November 2011 Medi-Cal Local Assistance Estimate for Medi-Cal county administration costs for eligibility operations.

(B) Effective January 1, 2014, the federal poverty level percentage used under subparagraph (A) for individuals described in subdivision (a) shall equal 160 percent of the federal poverty level as determined, counted, and valued in accordance with the requirements of Section 14005.64.

(2) (A) Except as provided in subparagraph (B), for purposes of implementing this section, the department shall include in the Medi-Cal Local Assistance Estimate an amount for Medi-Cal eligibility operations associated with the transfer of Healthy Families Program enrollees eligible pursuant to subdivision (a) of Section 14005.26 and whose family income is determined to be above 150 percent and up to and including 200 percent of the federal poverty level, after application of the income disregard pursuant to paragraph (2) of subdivision (a) of Section 14005.26. In developing an estimate for this activity, the department shall consider the projected number of final eligibility determinations each county will process and projected county costs.

Within 60 days of the passage of the annual Budget Act, the department shall notify each county of their allocation for this activity based upon the amount allotted in the annual Budget Act for this purpose.

(B) Effective January 1, 2014, for purposes of implementing this section, the department shall include in the Medi-Cal Local Assistance Estimate an amount for Medi-Cal eligibility operations associated with the transfer of Healthy Families Program enrollees eligible pursuant to subdivision (a) or (b) of Section 14005.26 and whose family income is determined to be above 160 percent and up to and including 261 percent of the federal poverty level.

(l) When the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is fully operational, the new budget methodology shall be utilized to reimburse counties for eligibility determinations made for individuals pursuant to this section.

(m) Except as provided in subdivision (b), eligibility determinations and annual redeterminations made pursuant to this section shall be performed by county eligibility workers.

(n) In conducting the eligibility determinations for individuals pursuant to this section and Section 14005.26, the following reporting and performance standards shall apply to all counties:

(1) Counties shall report to the department, in a manner and for a time period determined by the department, in consultation with the County Welfare Directors Association, the number of applications processed on a monthly basis, a breakout of the applications based on income using the federal percentage of poverty levels, the final disposition of each application, including information on the approved Medi-Cal program, if applicable, and the average number of days it took to make the final eligibility determination for applications submitted directly to the county and from the single point of entry (SPE).

(2) Notwithstanding any other law, the following performance standards shall be applied to counties for eligibility determinations for individuals eligible pursuant to this section:

(A) For children whose applications are received by the county human services department from the SPE, the following standards shall apply:

(i) Applications for children who are granted accelerated enrollment by the SPE shall be processed according to the timeframes specified in subdivision (d) of Section 14154.

(ii) Applications for children who are not granted accelerated enrollment by the SPE due to the existence of an already active Medi-Cal case shall be processed according to the timeframes specified in subdivision (d) of Section 14154.

(iii) For applications for children who are not described in clause (i) or (ii), 90 percent shall be processed within 10 working days of being received, complete and without client errors.

(iv) If an application described in this section also contains adults, and the adult applicants are required to submit additional information beyond the information provided for the children, the county shall process the eligibility for the child or children without delay, consistent with this section while gathering the necessary information to process eligibility for the adults.

(B) The department, in consultation with the County Welfare Directors Association, shall develop reporting requirements for the counties to provide regular data to the state regarding the timeliness and outcomes of applications processed by the counties that are received from the SPE.

(C) Performance thresholds and corrective action standards as set forth in Section 14154 shall apply.

(D) For applications received directly by the county, these applications shall be processed by the counties in accordance with the performance standards established under subdivision (d) of Section 14154.

(3) This subdivision shall be implemented no sooner than January 1, 2013.

(4) Twelve months after implementation of this section pursuant to subdivision (e), the department shall provide enrollment information regarding individuals determined eligible pursuant to subdivision (a) to the fiscal and appropriate policy committees of the Legislature.

(o) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, for purposes of this transition, 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 regulations are adopted. It is the intent of the Legislature that the department be allowed temporary authority as necessary to implement program changes until completion of the regulatory process.

(2) To the extent otherwise required by Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall adopt emergency regulations implementing this section no later than July 1, 2014. The department may thereafter readopt the emergency regulations pursuant to that chapter. The adoption and readoption, by the department, of regulations implementing this section 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, and the department is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

(p) To implement this section, the department may enter into and continue contracts with the Healthy Families Program administrative vendor, for the purposes of implementing and maintaining the necessary systems and activities for providing health care coverage to optional targeted low-income children in the Medi-Cal program for purposes of accelerated enrollment application processing by single point of entry, noneligibility-related case maintenance and premium collection, maintenance of the Health-E-App web portal, call center staffing and operations, certified application assistant services, and reporting capabilities. To further implement this section, the department may also enter into a contract with the Health Care Options Broker of the department for purposes of managed care enrollment activities. The contracts entered into or amended under this section may initially be completed on a noncompetitive bid basis and are exempt from the Public Contract Code. Contracts thereafter shall be entered into or amended on a competitive bid basis and shall be subject to the Public Contract Code.

(q) (1) If at any time the director determines that this section or any part of this section may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), or any amendment or extension of that act, or any additional federal funds that the director, in consultation with the Department of Finance, determines would be advantageous to the state, the director shall give notice to the fiscal and policy committees of the Legislature and to the Department of Finance. After giving notice, this section or any part of this section shall become inoperative on the date that the director executes a declaration stating that the department has determined, in consultation with the Department of Finance, that it is necessary to cease to implement this section or a part or parts thereof in order to receive federal financial participation, any increase in the federal medical assistance percentage available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, has determined would be advantageous to the state.

(2) The director shall retain the declaration described in paragraph (1), shall provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel, and shall post the declaration on the department's internet website.

(3) In the event that the director makes a determination under paragraph (1) and this section ceases to be implemented, the children shall be enrolled back into the Healthy Families Program.

SEC. 52. Section 14005.62 of the Welfare and Institutions Code, as added by Section 59 of Chapter 21 of the Statutes of 2025, is amended 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 10 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 January 1, 2026.

(b) (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. Such instructions shall include a list of all exempt property for use until such time that regulations are adopted.

(2) Within two years of implementing the requirements set forth in this subdivision, 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 reflect the consideration of assets and resources as described in subdivision (a).

(c) Upon operation of subdivision (a), the department shall make available, on a quarterly basis data, the number of Medi-Cal enrollees who lost eligibility due to the asset limit. The department shall consult with stakeholders to determine the appropriate data elements and level of detail, including, but not limited to, the reasons for termination.

(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.

(e) This section shall become operative on January 1, 2026.

SEC. 53. Section 14007.5 of the Welfare and Institutions Code is amended to read:

14007.5. (a) Persons who are not citizens or nationals of the United States shall be eligible for Medi-Cal, whether federally funded or state-funded, only to the same extent as permitted under federal law and regulations for receipt of federal financial participation under Title XIX of the federal Social Security Act, except as otherwise provided in this section and elsewhere in this chapter.

(b) In accordance with Section 1903(v)(1) of the federal Social Security Act (42 U.S.C. Sec. 1396b(v)(1)), a person who is not a citizen or a national of the United States shall only be eligible for the full scope of Medi-Cal benefits if the person has an immigration status described in Section 1641(b) of Title 8 of the United States Code. For purposes of this section, persons who are not citizens or nationals of the United States and who are “permanently residing in the United States under color of law” shall be interpreted to include all persons who are not citizens or nationals of the United States residing in the United States with the knowledge and permission of the United States Department of Homeland Security and whose departure the United States Department of Homeland Security does not contemplate enforcing and with respect to whom federal financial participation is not available under Title XIX of the federal Social Security Act.

(c) A person who has an immigration status described in Section 1641(b) of Title 8 of the United States Code, but who is subject to the limitation described in Section 1613(a) of Title 8 of the United States Code, or a person who is otherwise permanently residing in the United States under color of law, shall be eligible for the full scope of Medi-Cal benefits, subject to the service limitations described in subdivision (l).

(d) Any person who is not a citizen or national of the United States who is otherwise eligible for Medi-Cal services, but who does not meet the requirements under subdivision (b) or (c), shall only be eligible for care and services that are necessary for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law, except as described in Sections 14007.65, 14007.7, and 14007.8. For purposes of this section, the term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(1) Placing the patient’s health in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction to any bodily organ or part. It is the intent of this section to entitle eligible individuals to inpatient and outpatient services that are necessary for the treatment of the emergency medical condition in the same manner as administered by the department through regulations and provisions of federal law.

(e) (1) (A) No sooner than July 1, 2027, all individuals described in subdivisions (c) and (d), except for those individuals described in subparagraph (B), shall be required to pay a monthly premium as a condition of eligibility for the full scope of Medi-Cal benefits, subject to the service limitations described in subdivision (l), if they are otherwise eligible for benefits under this chapter.

(B) The following individuals are not subject to the monthly premium requirements described in subparagraph (A):

(i) Individuals under 19 years of age.

(ii) Individuals over 59 years of age.

(iii) Individuals who are pregnant.

(2) Monthly premiums imposed under this subdivision shall be thirty dollars ($30) per beneficiary.

(3) An individual required to pay premiums pursuant to this subdivision, after no more than 90 days of nonpayment of the monthly premium, is only eligible for medically necessary pregnancy-related services, and care and services necessary for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law. All outstanding premium balances shall be paid in full as a condition of continued eligibility for the full scope of Medi-Cal benefits.

(4) The monthly premium requirements and service limitations described in paragraphs (1), (2), and (3) shall not apply to nonminor dependents, as defined in Section 11400, and individuals who but for their immigration status are eligible for Medi-Cal pursuant to Section 14005.28. These individuals shall remain eligible for the full scope of Medi-Cal benefits until their 26th birthday.

(f) Pursuant to Section 14001.2, each county department shall require that each applicant for, or beneficiary of, Medi-Cal, including a child, shall provide their social security number account number, or numbers, if they have more than one social security number.

(g) (1) In order to be eligible for benefits under subdivision (b) or (c), an applicant or beneficiary shall present United States Citizenship and Immigration Services registration documentation or other proof of satisfactory immigration status from the United States Citizenship and Immigration Services.

(2) Any person who meets all other program requirements but who lacks documentation of United States Citizenship and Immigration Services registration or other proof of satisfactory immigration status shall be provided a reasonable opportunity to submit the evidence. For purposes of this paragraph, “reasonable opportunity” means 30 days or the time it actually takes the county to process the Medi-Cal application, whichever is longer.

(3) During the reasonable opportunity period under paragraph (2), the county department shall process the applicant’s application for medical assistance in a manner that conforms to its normal processing procedures and timeframes.

(h) (1) The county department shall grant only the Medi-Cal benefits set forth in subdivision (d) of this section or in Section 14007.65, 14007.7, or 14007.8 to any individual who, after 30 calendar days or the time it actually takes the county to process the Medi-Cal application, whichever is longer, has failed to submit documents constituting reasonable evidence indicating a satisfactory immigration status for Medi-Cal purposes, or who is reported by the United States Citizenship and Immigration Services to lack a satisfactory immigration status for Medi-Cal purposes.

(2) If a person who is not a citizen or national of the United States has been receiving Medi-Cal benefits based on eligibility established prior to the effective date of this section and that individual, upon redetermination of eligibility for benefits, fails to submit documents constituting reasonable evidence indicating a satisfactory immigration status for Medi-Cal purposes, the county department shall discontinue the Medi-Cal benefits, except for the care and services set forth in subdivision (d) of this section or in Section 14007.65, 14007.7, or 14007.8. The county department shall provide adequate notice to the individual of any adverse action and shall accord the individual an opportunity for a fair hearing if the individual requests one.

(i) To the extent permitted by federal law and regulations, a person who is not a citizen or national of the United States applying for services under subdivisions (b) and (c) shall be granted eligibility for the scope of services to which they would otherwise be entitled if, at the time the county department makes the determination about their eligibility, the person meets either of the following requirements:

(1) The person has not had a reasonable opportunity to submit documents constituting reasonable evidence indicating satisfactory immigration status.

(2) The person has provided documents constituting reasonable evidence indicating a satisfactory immigration status, but the county department has not received timely verification of the person’s immigration status from the United States Citizenship and Immigration Services.

(3) The verification process shall protect the privacy of all participants. A person’s immigration status shall be subject to verification by the United States Citizenship and Immigration Services, to the extent required for receipt of federal financial participation in the Medi-Cal program.

(j) If a person does not declare status as a lawful permanent resident or person permanently residing under color of law, or as a person legalized under Section 210, 210A, or 245A of the federal Immigration and Nationality Act (Public Law 82-414), Medi-Cal coverage under subdivision (d) of this section or in Section 14007.65, 14007.7, or 14007.8 shall be provided to the individual if they are otherwise eligible.

(k) If a person subject to this section is not fluent in English, the county department shall provide an understandable explanation of the requirements of this section in a language in which the person is fluent.

(l) (1) No sooner than July 1, 2026, all individuals described in subdivisions (c) and (d) who are 19 years of age or older shall not be eligible for dental services set forth in this chapter, except for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law.

(2) Paragraph (1) shall not apply to nonminor dependents, as defined in Section 11400, and individuals who but for their immigration status are eligible for Medi-Cal pursuant to Section 14005.28. These individuals shall remain eligible for the full

scope of Medi-Cal benefits until their 26th birthday.

(m) 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 plan or county letter, information notices, plan or provider bulletins, or other similar instructions, without taking any further regulatory action.

(n) Subdivisions (e) and (l) shall be implemented only after the director determines, and communicates in writing to the Department of Finance, that systems have been programmed for implementation.

SEC. 54. 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, subject to the service limitations described in subdivisions (b), (c), and (k), 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 subparagraph, but no sooner than May 1, 2022, an individual who is 50 years of age or older, 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, subject to the service limitations described in subdivisions (b), (c), and (k), if they are otherwise eligible for benefits under this chapter.

(B) After the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of this subparagraph, but no later than January 1, 2024, an individual who is 26 to 49 years of age, inclusive, and who does not have satisfactory immigration status as required by Section 14011.2, shall be eligible for the full scope of Medi-Cal benefits, subject to the service limitations described in subdivisions (b), (c), and (k), if they are otherwise eligible for benefits under this chapter.

(b) (1) No sooner than January 1, 2026, an individual who is 19 years of age or older, who does not have satisfactory immigration status as required by Section 14011.2, who is otherwise eligible for Medi-Cal services pursuant to subdivision (d) of Section 14007.5, and who applies for Medi-Cal on or after January 1, 2026, shall only be eligible for medically necessary pregnancy-related services, and care and services necessary for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law.

(2) Notwithstanding paragraph (1), an individual who is 19 years of age or older, who does not have satisfactory immigration status as required by Section 14011.2, who was enrolled in full-scope Medi-Cal and was not pregnant, but loses coverage for full-scope Medi-Cal, shall be eligible to reenroll in full-scope Medi-Cal within three months from the date of disenrollment for full-scope Medi-Cal, pregnancy-only Medi-Cal, or postpartum Medi-Cal. Payment of outstanding premium balances prior to the initiation of the three-month cure period shall be a condition of reenrollment under this subdivision for individuals disenrolled from Medi-Cal due to nonpayment of premiums. For purposes of this paragraph, “full-scope Medi-Cal” means the full scope of Medi-Cal benefits, subject to the service limitations described in subdivision (k).

(3) Paragraphs (1) and (2) shall not apply to nonminor dependents, as defined in Section 11400, and individuals who but for their immigration status are eligible for Medi-Cal pursuant to Section 14005.28. These individuals shall remain eligible for the full scope of Medi-Cal benefits until their 26th birthday.

(c) (1) No sooner than January 1, 2026, if an individual described in subdivision (a) who is 19 years of age or older loses eligibility for full-scope Medi-Cal on or after January 1, 2026, the individual shall only be eligible for medically necessary pregnancy-related services, and care and services necessary for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law.

(2) No sooner than January 1, 2026, notwithstanding paragraph (1), if an individual described in subdivision (a) who is 19 years of age or older loses eligibility for full-scope Medi-Cal while pregnant, the individual shall remain eligible for the full scope of Medi-Cal benefits, subject to the service limitations described in subdivision (k), throughout the pregnancy and for 12 months after the pregnancy ends.

(3) Paragraphs (1) and (2) shall not apply to nonminor dependents, as defined in Section 11400, and individuals who but for their immigration status are eligible for Medi-Cal pursuant to Section 14005.28. These individuals shall remain eligible for the full scope of Medi-Cal benefits until their 26th birthday.

(d) 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.

(e) To the extent permitted by state and federal law, an individual eligible for full-scope Medi-Cal pursuant to subdivision (a) 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.

(f) (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.

(g) 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.

(h) (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.

(i) 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.

(j) (1) (A) No sooner than July 1, 2027, all individuals described in subdivision (a), except for those individuals described in subparagraph (B), shall be required to pay a monthly premium as a condition of eligibility for Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(B) The following individuals are not subject to the monthly premium requirements described in subparagraph (A):

(i) Individuals under 19 years of age.

(ii) Individuals over 59 years of age.

(iii) Individuals who are pregnant.

(2) Monthly premiums imposed under this section shall be thirty dollars ($30) per beneficiary.

(3) An individual described in paragraph (1), after no more than 90 days of nonpayment of the monthly premium, will only be eligible for medically necessary pregnancy-related services, and care and services necessary for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law. All outstanding premium balances shall be paid in full as a condition of continued eligibility for full-scope Medi-Cal coverage, subject to the service limitations described in subdivision (k).

(4) The monthly premium requirements and service limitations described in paragraphs (1), (2), and (3) shall not apply to nonminor dependents, as defined in Section 11400, and individuals who but for their immigration status are eligible for Medi-Cal pursuant to Section 14005.28. These individuals shall remain eligible for the full scope of Medi-Cal benefits until their 26th birthday.

(k) (1) No sooner than July 1, 2026, an individual who is 19 years of age or older, who is eligible for Medi-Cal benefits pursuant to subdivision (a), shall not be eligible for dental services set forth in this chapter, except for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law.

(2) Paragraph (1) shall not apply to nonminor dependents, as defined in Section 11400, and individuals who but for their immigration status are eligible for Medi-Cal pursuant to Section 14005.28. These individuals shall remain eligible for the full scope of Medi-Cal benefits until their 26th birthday.

(l) Subdivisions (b), (c), (j), and (k) shall be implemented only after the director determines, and communicates in writing to the Department of Finance, that systems have been programmed for implementation.

SEC. 55. Section 14007.95 of the Welfare and Institutions Code is repealed.

SEC. 56. Section 14012.5 of the Welfare and Institutions Code is amended to read:

14012.5. (a) By July 1, 2007, the department shall implement a process that allows applicants and beneficiaries to self-certify the amount and nature of assets and income without the need to submit income or asset documentation.

(b) The process shall apply to applicants and beneficiaries in the program described in Section 14005.30, the federal poverty level programs for infants, children and pregnant women, the Medically-Indigent and Medically-Needy Programs for children and families, and other similar programs designated by the department, in order to preserve family unity or simplify administration. The process shall not apply to applicants or beneficiaries whose eligibility is based on their status as aged, blind, or based upon a disability determination unless, to the extent possible, they are members of families in which a child, parent, or spouse of that person is also a Medi-Cal applicant or beneficiary.

(c) The director may modify or terminate the first phase of implementation not sooner than 90 days after providing notification to the Chair of the Joint Legislative Budget Committee. This notification shall articulate the specific reasons for the modification or termination and shall include all relevant data elements that are applicable to document the reasons provided for said modifications or termination. Upon the request of the Chair of the Joint Legislative Budget Committee, the director shall promptly provide any additional clarifying information regarding the first phase of implementation as requested.

(d) Following two years of operation in two counties and submission of the evaluation to the Legislature, the director, in consultation with the Department of Finance, shall determine whether to implement the self-certification process statewide. This determination shall be based on the outcomes of the evaluation, including the ability to increase enrollment of eligible children and families, and to maintain the overall integrity of the Medi-Cal program. Statewide implementation shall be contingent on a specific appropriation being provided for this purpose in the Budget Act or subsequent legislation.

(e) This section shall be implemented only if, and to the extent that, federal financial participation is available.

(f) 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 any further regulatory action. Thereafter, the department shall adopt regulations, as necessary, to implement this section 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.

(g) The department, in consultation with the Department of Finance, counties, and other interested stakeholders, shall determine which types of assets and income are appropriate for self-certification under this section.

(h) Nothing in this section shall be read to preclude a county from requesting documentation from any applicant or beneficiary regarding any income or asset where a question arises about such income or asset during the county's determination or redetermination of eligibility following receipt of the application or annual redetermination form.

(i) Nothing in this section shall change the ability of the department to self-certify income, assets, or other program information to the extent allowed under state or federal law, waiver, or the state plan.

(j) (1) This section shall not be implemented if the voters approve Proposition 86, the tobacco tax initiative, at the statewide general election on November 7, 2006.

(2) Notwithstanding paragraph (1) if Proposition 86 is approved by the voters at the statewide general election on November 7, 2006, this section shall be implemented during the pendency of any legal action concerning the validity of the proposition.

SEC. 57. Section 14100.95 of the Welfare and Institutions Code is repealed.

SEC. 58. Section 14105.47 of the Welfare and Institutions Code is amended to read:

14105.47. (a) (1) The department shall establish a list of medical supplies. The list shall specify utilization controls to be applied to each medical supply product.

(2) The utilization controls specified shall include, but not be limited to, those provided by regulation of the department.

(3) The department shall notify providers at least 30 days prior to the effective date of a change in utilization controls.

(b) (1) The department shall establish a list of maximum allowable product costs (MAPCS) for medical supplies, which shall be published in provider bulletins.

(2) The department shall update existing MAPCS and establish additional MAPCS in accordance with all of the following:

(A) In establishing the MAPCS, the director shall assure that eligible persons shall receive medical supply products that are available to the public generally, without discrimination or segregation based purely on economic disability.

(B) All related medical supply products within each particular medical supply type available for retail distribution shall be reviewed by the department in consultation with representatives from the California Association of Medical Product Suppliers and the California Pharmacists Association.

(C) The department shall base MAPCS on the mean of the wholesale selling price of related medical supply products that are available in California. For purposes of this section, “wholesale selling price” means the price, including discounts and rebates, paid by a provider to a wholesaler, distributor, or manufacturer for a medical supply product.

(D) In establishing the MAPCS, the department shall consider the provider related costs of the product that include, but are not limited to, shipping, handling, storage, and delivery.

(E) The department shall notify Medi-Cal providers at least 30 days prior to the effective date of MAPCS.

(c) (1) In establishing the list of medical supplies, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis with manufacturers, distributors, dispensers, or suppliers of medical supplies pursuant to Section 14105.3.

(2) To ensure that the health needs of Medi-Cal beneficiaries are met, the department shall, when evaluating a decision to execute a contract, and when evaluating medical supplies for retention on, addition to, or deletion from, the list of medical supplies, consider all of the following criteria:

(A) The safety of the product.

(B) The effectiveness of the product.

(C) The essential need for the product.

(D) The potential for misuse of the product.

(E) The immediate or long-term cost effectiveness of the product.

(3) The deficiency of a product when measured by one of the criteria specified in paragraph (2) may be sufficient to support a decision that the product should be deleted from, should not be added to, or should not be retained on, the list of medical supplies. However, the superiority of a product under one criterion may be sufficient to warrant the addition or retention of the product, notwithstanding a deficiency in another criterion.

(4) In the evaluation of the effectiveness of a product, the department may require the manufacturer, distributor, dispenser, or supplier to submit its products to testing by an independent laboratory. For the purposes of this section, “independent laboratory” means an analytical laboratory that is not a subsidiary of, affiliated with, or on retainer for, the manufacturer, distributor, dispenser, or supplier. The department shall only utilize this paragraph involving products where there is a demonstrated experience of a significant variation in performance among the products subject to this particular contracting process.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, actions under this section shall not be subject to the Administrative Procedure Act or to the review and approval of the Office of Administrative Law.

SEC. 59. Section 14105.475 of the Welfare and Institutions Code is amended to read:

14105.475. (a) In maintaining the lists of medical supplies, incontinence medical supplies, and enteral nutrition products, the department may perform a review of, and contract for, various products in a specific product category.

(b) The department shall notify each manufacturer of products in the categories selected pursuant to Sections 14105.47, 14105.8, and Sections 14125 to 14125.9, inclusive.

(c) If, within 30 days of notification, a manufacturer does not enter into negotiations for a contract pursuant to those sections, the department may delete the products from their respective lists, or refuse to consider for addition, products of that manufacturer in the selected product categories.

(d) If, after 270 days from the initial notification, a contract is not executed for a product currently on the list of medical supplies, incontinence medical supplies, or enteral nutrition products, the department may delete the product from its respective list.

(e) If, within 270 days from the initial notification, a contract is executed for a product currently on the list of medical supplies, incontinence medical supplies, or enteral nutrition products, the department shall retain the product on its respective list.

(f) If, within 270 days from the date of the initial notification, a contract is executed for a product not currently on the list of medical supplies, incontinence medical supplies, or enteral nutrition products, the department shall add the product to its respective list.

(g) The department shall terminate all negotiations 270 days after the initial notification.

(h) The department may delete any product from its respective list at the expiration of the contract term or when the contract between the department and the manufacturer of that product is terminated.

(i) In the absence of a contract, the department may deem any product on the list of medical supplies, incontinence medical supplies, or enteral nutrition products, a nonbenefit of the program and delete that product from its respective list.

(j) Deletions made to the lists of medical supplies, incontinence supplies, and enteral nutrition products, shall become effective no sooner than 30 days after publication of the changes in provider bulletins.

(k) (1) A manufacturer of a medical supply, incontinence supply, or enteral nutrition product denied a contract pursuant to this section, or pursuant to Sections 14105.47, 14105.8, and Sections 14125 to 14125.9, inclusive, may file an appeal of that decision with the director within 30 calendar days of the department's written decision.

(2) The director shall issue a final decision on the appeal within 60 calendar days of the postmark date of the appeal.

(l) The department shall provide individual notice to Medi-Cal beneficiaries at least 60 calendar days prior to the effective date of the deletion or suspension of any product pursuant to this subdivision. The notice shall include a description of the beneficiary's right to a fair hearing and shall encourage the beneficiary to consult a physician to determine if an appropriate substitute product is available from Medi-Cal.

SEC. 60. Section 14124.11 of the Welfare and Institutions Code is amended to read:

14124.11. (a) The department shall establish a two-year pilot program to utilize the federal Public Assistance Reporting Information System (PARIS) to identify veterans and their dependents or survivors who are enrolled in the Medi-Cal program and assist them in obtaining federal veteran health care benefits.

(b) The department shall select three consenting counties that have in operation a United States Department of Veterans Affairs (USDVA) medical center to participate in the pilot program.

(c) Under the pilot program, the department shall exchange information with PARIS and identify veterans and their dependents or survivors who are receiving Medi-Cal benefits in the pilot program counties.

(d) The department shall refer identified Medi-Cal beneficiaries who are receiving high-cost services, including long-term care, to county veteran service officers (CVSOs) to obtain information regarding, and assistance in obtaining, USDVA benefits.

(e) Prior to commencement of the pilot program, the department shall do all of the following:

(1) Enter into an agreement with the California Department of Veterans Affairs (CDVA) to perform CVSO outreach services in connection with the pilot program. The CDVA agreement shall contain performance standards that would allow the department to measure the effectiveness of the pilot program.

(2) Enter into any agreements that are required by the federal government to utilize the PARIS system.

(3) Perform any information technology activities that are necessary to utilize the PARIS system.

(f) If the department determines that the pilot program is cost effective, it may implement the program statewide at any time and continue operation of PARIS indefinitely.

(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 written directives without taking further regulatory action.

(h) The department shall implement the pilot program by July 1, 2009.

(i) 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 and from Chapter 3 (commencing with Section 11250) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 61. Section 14132.995 is added to the Welfare and Institutions Code, to read:

14132.995. (a) Notwithstanding any other law, vaccines and immunizations are covered in accordance with a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians or any modification or supplement to that recommendation adopted pursuant to Section 120164 of the Health and Safety Code, with respect to the individual involved.

(b) This section 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.

(c) Notwithstanding any other law, the department, without taking any further regulatory action, may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions.

SEC. 62. Section 14146 of the Welfare and Institutions Code is amended to read:

14146. (a) (1) The department shall work with identified stakeholders to conduct a study to identify current requirements for medical interpretation services as well as education, training, and licensure requirements, analyze other state Medicaid programs, and make recommendations on strategies that may be employed regarding the provision of medical interpretation services for Medi-Cal beneficiaries who are limited English proficient (LEP), in compliance with applicable state and federal requirements.

(2) The study also shall assess and make recommendations based on pilot projects, studies, and available data that would further the objectives of this article, including funding for those activities and the allowable use of federal funding.

(b) (1) The department shall work with identified stakeholders to establish a pilot project concurrent with the study.

(2) A pilot project shall include up to four separate sites to evaluate the provision of medical interpretation services for LEP Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans and in fee-for-service Medi-Cal. In identifying sites, the department shall take into account the need for those services, the availability of a pool of medical interpreters that meet the language needs of the Medi-Cal population for use by providers and managed care plans, and the studies and available data identified under paragraph (2) of subdivision (a).

(c) (1) The department may use or contract with an external vendor, vendors, or other contracted subject matter experts to implement the activities described in this section, including the pilot project. However, the vendor for the study shall not be used for the pilot project. The department shall consult with identified stakeholders regarding the draft initial scope of work that shall be used to seek and evaluate proposals pursuant to this section.

(2) At a minimum, the pilot project shall be designed to evaluate all of the following:

(A) Whether Medi-Cal beneficiary satisfaction is greater than for those beneficiaries without access to in-person medical interpretation.

(B) Whether the satisfaction of physicians and surgeons, nurse practitioners, physician assistants, and other health professionals acting within their scope of practice increases.

(C) Whether noncompliance with treatment regimens or avoidable medical errors are reduced.

(D) Whether disparities in care are reduced, with respect to LEP Medi-Cal beneficiaries compared with Medi-Cal beneficiaries who are proficient in English.

(E) Whether the Medi-Cal managed care plans identify improvements in quality of care.

(F) The utilization of medical interpreters by providers and Medi-Cal managed care plans.

(d) (1) Each year, commencing in 2017, during the annual state budget process, the department shall provide an update to the budget committees of the Legislature on the implementation of this article.

(2) Any report submitted under this subdivision shall be submitted in compliance with Section 9795 of the Government Code.

(e) (1) For activities under this section, the department may expend up to three million dollars ($3,000,000) under Provision 14 of Item 4260-101-0001 of Section 2.00 of the Budget Act of 2016 (Chapter 23 of the Statutes of 2016) for the support of activities related to a medical interpreters pilot project, study, or both. In addition, the department shall expend up to five million dollars ($5,000,000) for the pilot project under Provision 15 of Item 4260-101-0001 of Section 2.00 of the Budget Act of 2019 (Chapter 23 of the Statutes of 2019), which shall be available for expenditure, encumbrance, and liquidation until June 30, 2026.

(2) The department may seek any available federal funding for support of activities relating to medical interpretation services as provided under this section.

(3) Expenditure or encumbrance of the funds described in this subdivision is contingent upon approval by the Department of Finance.

SEC. 63. Section 14146.5 of the Welfare and Institutions Code is amended to read:

14146.5. This article shall become inoperative on July 1, 2026, and, as of January 1, 2027, is repealed.

SEC. 64. Section 14501 of the Welfare and Institutions Code is amended to read:

14501. The Office of Family Planning has all of the following functions, powers, and duties:

(a) To make available to citizens of the state of childbearing age comprehensive medical knowledge, assistance, and services relating to the planning of families.

(b) To consult with state and local agencies that provide or administer family planning services and to participate in the formulation of regulations and other policy decisions governing the provision or administration of family planning services pursuant to state law or regulation.

(c) To establish goals and priorities for all state agencies providing or administering family planning services.

(d) To coordinate all family planning services and related programs conducted or administered by state agencies with the federal government so as to maximize the availability of these services by utilizing all available federal funds.

(e) To conduct a survey of all of the existing facilities within the state having to do with family planning and infertility and the rendering of advice and assistance on birth control techniques and information.

(f) To evaluate all existing programs and to establish in each county a viable program for the dispensation of family planning, infertility, and birth control information and techniques.

(g) To develop and administer scientific investigation into problems of infertility and existing and new family planning and birth control techniques.

(h) To survey, evaluate, and establish programs of professional education and training for physicians, nurses, medical and nursing students, and other health care practitioners in rendering advice on family planning, infertility, and birth control techniques and information.

(i) To enter into agreements with, and award grants to, individuals, colleges, universities, associations, corporations, municipalities, and other units of government as may be deemed necessary and advisable to carry out the general intent and purposes of this chapter, which may provide for payment by the state within the limit of funds available for material, equipment, and services.

(j) To post annual reports on its internet website, including, but not limited to, the subjects specified in subdivisions (a) to (i), inclusive.

(k) To annually update and analyze family planning data. The data shall include, but not be limited to, the following:

(1) Client number.

(2) Ethnicity.

(3) Family size.

(4) Method.

(5) Family income.

(6) Service type.

(7) Birthdate.

(8) Total billing amount.

(9) Pay source.

(10) Date of visit.

(11) Site number.

(12) County of residence.

(13) Updated estimates of women in need of subsidized family planning services from the federal government, when available, for all Office of Family Planning clinical service grantees by county of service, as well as statewide totals.

SEC. 65. Section 34 of Chapter 80 of the Statutes of 2005 is repealed.

SEC. 66. Section 67 of Chapter 758 of the Statutes of 2008 is repealed.

SEC. 67. Section 118 of Chapter 21 of the Statutes of 2025 is amended to read:

SEC. 118. (a) The State Department of Public Health may spend up to seventy-five million dollars ($75,000,000) from the AIDS Drug Assistance Program Rebate Fund to support current or eligible services and programs, consistent with Sections 120955, 120956, 120960, 120972, 120972.1, and 120972.2 of the Health and Safety Code and with the following:

(1) Beginning July 1, 2025, up to sixty-five million dollars ($65,000,000) is available to supplement or fund services, programs, or initiatives funded by the AIDS Drug Assistance Program Rebate Fund for which federal funding has been reduced or eliminated as a result of federal policy actions to cancel, delay, or reduce funding for HIV and AIDS prevention and treatment programs. Of this amount, up to eighteen million dollars ($18,000,000) is available for state operations.

(A) Upon notification to the department of federal action, or the nonreceipt of Notices of Award, that result in reductions to or elimination of federal funding for those services, programs, or initiatives, the department shall notify the Department of Finance. The Department of Finance shall authorize funding allocations that are equivalent to the amount, to the extent these amounts are within the amount of funds appropriated for this purpose, and correspond to services that would have otherwise been funded by the reduced or eliminated federal funds as soon as practicable, but no later than 30 days following notification from the department.

(B) (i) If the federal funding that was reduced or eliminated is restored by the federal government, funding made available under this paragraph shall be repaid to the AIDS Drug Assistance Program Rebate Fund within 180 days. A repayment process shall be established by the department, in consultation with the Department of Finance.

(ii) A local public health agency or community-based organization that has received funding made available under this paragraph shall not be required to repay the funding until it has received the restored federal funding.

(2) Beginning July 1, 2025, nine million dollars ($9,000,000) is available to fund state and local disease intervention specialists. Of this amount, up to one million six hundred forty thousand dollars ($1,640,000) is available for state operations.

(3) Beginning July 1, 2025, one million dollars ($1,000,000) is available for the department to purchase rapid Hepatitis C Virus (HCV) testing equipment for distribution to local health departments and community-based organizations. The department shall establish a process for local health departments and community-based organizations to receive HCV testing equipment based on need in the specific geographic area.

(b) The department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts and grants 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, the State Administrative Manual, and the State Contracting Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(c) The department may, in consultation with the Department of Finance, use an alternative local fiscal agent that is not identified in this section, if necessary, to achieve the intended legislative purpose.

SEC. 68. The Legislature finds and declares that Section 42 of this act, which adds Section 127642 to 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 confidential and personal medical information, as well as the safety of medical providers, it is necessary that grants and contracts entered or amended pursuant to Section 127642 of the Health and Safety Code remain confidential.

SEC. 69. 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. 70. 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.