Assembly Bill No. 80

CHAPTER 12

An act to amend Section 100500 of the Government Code, to amend Sections 1367.0085, 1386, 105250.1, 120962, 120972, 127671, and 127672 of, to amend the heading of Chapter 8.5 (commencing with Section 127671) of Part 2 of Division 107 of, to add Sections 127671.1, 127672.8, 127672.9, 127673.1, 127673.2, 127673.3, 127673.4, 127673.5, 127673.6, 127673.7, 127673.8, 127673.81, 127673.82, 127673.83, 127673.84, and 127674.1 to, to repeal Sections 120512, 120780.6, 122441, and 127671.5 of, and to repeal and add Sections 127673 and 127674 of, the Health and Safety Code, to amend Section 10112.296 of, and to add Chapter 4.1 (commencing with Section 10403) to Part 2 of Division 2 of, the Insurance Code, to amend Section 19548.2 of the Revenue and Taxation Code, and to amend Sections 4107, 4300, 4301, 4305, 4306, 4307, 4308, 4309, 4314, 14007.8, 14011.10, 14021.51, 14042.1, 14046, 14046.1, 14079, 14105.31, 14124.24, 14134, 14188, and 14188.1 of, to amend and repeal Section 14133.22 of, to add Sections 14105.334, 14105.467, 14124.12, and 14301.11 to, to repeal Section 4315 of, and to repeal and add Sections 14046.8 and 14188.4 of, the Welfare and Institutions Code, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.

[Approved by Governor June 29, 2020. Filed with Secretary of State June 29, 2020.]

LEGISLATIVE COUNSEL'S DIGEST

AB 80, Committee on Budget. Public health omnibus.

(1) Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that took effect January 1, 2014. Among other things, PPACA requires each state to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers. Existing state law establishes the California Health Benefit Exchange (the Exchange) within state government, known as Covered California, specifies the powers and duties of the board governing the Exchange, and requires the board to facilitate the purchase of qualified health plans by qualified individuals and qualified small employers. Existing law prohibits a member of the board from being employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of, a carrier or other insurer, an agent or broker, a health care provider, or a health care facility or health clinic while serving on the board or on the staff of the Exchange and from receiving compensation for service on the board, except as specified.

This bill would create an exception to that prohibition by authorizing a member of the board or of the staff of the Exchange to perform volunteer services under specified conditions, including that the member or staff does not receive compensation, as described, for rendering services and does not have an ownership interest in the entity, facility, clinic, or provider group.

(2) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of that act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law, the Information Practices Act of 1977, regulates the collection and disclosure of personal information regarding individuals by state agencies, except as specified. Under existing law, a person who willfully requests or obtains a record containing personal information from an agency under false pretenses or a person who intentionally discloses medical, psychiatric, or psychological information held by an agency is guilty of a misdemeanor.

Existing law states the intent of the Legislature to establish the Health Care Cost Transparency Database to collect information on the cost of health care, and requires the Office of Statewide Health Planning and Development to convene a review committee to advise the office on the establishment and implementation of the database. Existing law requires, subject to appropriation, the office to establish, implement, and administer the database by July 1, 2023. Existing law requires certain health care entities, including a health care service plan, to provide specified information to the office for collection in the database.

This bill would delete those provisions relative to the Health Care Cost Transparency Database and would instead require the office to establish the Health Care Payments Data Program to implement and administer the Health Care Payments Data System, which would include health care data submitted by health care service plans, health insurers, a city or county that offers self-insured or multiemployer-insured plans, and other specified mandatory and voluntary submitters. The bill would require the Department of Managed Health Care and the Department of Insurance to take appropriate action to bring a plan or insurer into compliance if the office notifies the appropriate department of a plan or insurer's failure to submit required data. Because a willful violation of these provisions by a health care service plan would be a crime, and because a city or county that offers self-insured or multiemployer-insured plans would be required to submit health care data to the office, the bill would impose a state-mandated local program. The bill would exempt multiple employer welfare arrangements, as defined, that are regulated pursuant to specified provisions of the Insurance Code from these requirements. The bill would also make a health insurer that fails to comply with the data submission requirements subject to certain civil penalties, as specified.

This bill would require the office to use the above-described data to produce publicly available information, including data products, summaries, analyses, studies, and other reports, to support goals that include improving

public health, reducing disparities, and reducing health care costs. The bill would also require the office to submit a report to the Legislature, on or before March 1, 2024, that includes, among other things, claims data reported by mandatory and voluntary submitters. The bill would protect the confidentiality of personally identifiable data submitted to the system and would exempt it from disclosure, but would authorize controlled access to that nonpublic data by outside data analysts, researchers, and other qualified applicants if the data and requesters meet specified criteria. The bill would require a person accessing nonpublic data to sign a data use agreement subject to the penalties of the Information Practices Act of 1977. Because a willful violation of a data use agreement would be a crime, the bill would impose a state-mandated local program.

This bill would authorize the office to establish pricing mechanisms for data products, custom reports, and the use of nonpublic data, and would require revenues from those activities to be deposited into the Health Care Payments Data Fund, for use by the office upon appropriation by the Legislature. The bill would require the office to establish a Health Care Payments Data Program advisory committee with specified membership to assist and advise the director of the office in formulating program policies regarding data collection, management, use, and access, and development of public information to meet the goals of the program. The bill would also require the office to establish a data release committee with specified membership to make recommendations about applications seeking either program data with direct personal identifiers or the transmission of standardized datasets, except for data requests from other state agencies.

(3) Existing law establishes the State Department of Public Health within the California Health and Human Services Agency.

Existing law authorizes the Director of Public Health to establish and administer a program within the department's Office of AIDS to subsidize certain costs of medications for the prevention of human immunodeficiency virus (HIV) infection and other related medical services to residents of California who are at least 18 years of age, who are HIV negative, and who meet specified other requirements. Existing law also authorizes the program to subsidize, without regard to eligibility and for the prevention of HIV infection, up to 14 days of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) medications and up to 28 days of PEP medications for a victim of sexual assault.

This bill instead would authorize the program to subsidize up to 30 days of PrEP and PEP medications for the prevention of HIV infection, without regard to whether the person was a victim of sexual assault.

Existing law requires, to the extent that funds are appropriated for these purposes, the State Public Health Officer to establish a program to provide drug treatments to persons infected with HIV. Existing law requires the department to establish uniform standards of financial eligibility for the drugs under the program. Existing law requires the department to disclose to the Franchise Tax Board identifying information regarding an applicant for, or recipient of, services under the program for the purpose of verifying

the accuracy of the applicant's or recipient's adjusted gross income reported on the application for the program, and requires the Franchise Tax Board to inform the department of the applicant's federal and state adjusted gross income and other specified income. Existing law also makes this information a confidential public record, as defined. Existing law makes a person who willfully, maliciously, or negligently discloses the content of a confidential public health record to a third party, except pursuant to a written authorization, or as otherwise authorized by law, that results in economic, bodily, or psychological harm to the person whose confidential public health record was disclosed, guilty of a misdemeanor, punishable by imprisonment in a county jail for a period not to exceed one year, or a fine not to exceed $25,000, or both.

This bill would require the department to verify, and the Franchise Tax Board to report to the department, the modified adjusted gross income, rather than the adjusted gross income, of the applicant or recipient. The bill would also require the Franchise Tax Board to inform the department of income received by the taxpayer household and the family size of the taxpayer household. By expanding the scope of the information contained in a confidential public record, the bill would expand the scope of a crime, thereby imposing a state-mandated local program.

Existing law requires the department to develop and review plans and participate in a program for the prevention and control of sexually transmitted diseases. Existing law requires the department, contingent upon appropriation in the annual Budget Act, to allocate grants to local health jurisdictions for sexually transmitted disease, HIV, and hepatitis C virus control and prevention activities. Existing law suspends those programs as of December 31, 2021, unless projected General Fund revenues exceed the projected annual General Fund expenditures in the 2021–22 and 2022–23 fiscal years by a specified amount.

This bill would repeal the contingent suspension of those programs.

(4) Existing law requires the department to implement and administer a residential lead-based paint hazard reduction program. Existing law requires specified persons engaged in lead construction work to have a certificate issued by the department. Existing law authorizes the department to establish fees for accreditation, certification, and licensing in connection with the program for deposit in the Lead-Related Construction Fund. Moneys in the fund are available upon appropriation. Existing law requires the department to prepare a report, as specified, by February 1 of any year in which the department raises or establishes new or additional fees, including the fees described above, to make that report and the list of fees available to the Budget Committees of the Legislature, and to post the report and the list of fees on the department's internet website. Existing law, the Administrative Procedure Act, sets forth the requirements for the adoption, publication, review, and implementation of regulations by state agencies, and for review of those regulatory actions by the Office of Administrative Law.

This bill would make those adjustments and modifications of fees and the publication of the final fee list exempt from the Administrative Procedure

Act, and would instead only require that the revised list of fees be filed with the Secretary of State and printed in the California Code of Regulations.

(5) Existing federal law, the Patient Protection and Affordable Care Act (PPACA), establishes annual limits on health care deductibles and defines bronze, silver, gold, and platinum levels of coverage for the nongrandfathered individual and small group markets. Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and the regulation of health insurers by the Department of Insurance. Existing law authorizes the actuarial value for a nongrandfathered bronze level high deductible health plan or health insurance policy to range from plus 4% to minus 2%.

This bill would instead authorize the actuarial value for a nongrandfathered bronze level health plan or health insurance policy that either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible health plan to range from plus 5% to minus 2%.

(6) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

For purposes of administering the Medi-Cal program, existing law vests the Director of Health Care Services with those powers and duties necessary to conform to requirements for securing federal approval of a state plan. Existing federal law authorizes the Secretary of California Health and Human Services to waive provisions of federal Medicaid law under specified circumstances, including when the secretary finds that the waiver would be cost effective and efficient. Existing state law requires the department to seek a variety of waivers of federal law, such as the Medi-Cal 2020 Demonstration Project, which is scheduled to expire on December 31, 2020. Pursuant to existing law, the President, under the National Emergencies Act, and the Governor, under the California Emergency Services Act, declared a national emergency and a state of emergency, respectively, in response to the novel coronavirus, known as COVID-19.

For the duration of the COVID-19 emergency period, this bill would require the department to implement any federal Medicaid program waiver or flexibility approved by the federal Centers for Medicare and Medicaid Services related to that emergency and to exercise its option under prescribed law to extend medical assistance to uninsured individuals, as specified, for the duration of that emergency period. The bill would authorize the department to extend medical assistance afforded to uninsured individuals to include COVID-19-related treatment services that are otherwise covered for full-scope Medi-Cal beneficiaries, and, if federal financial participation is unavailable, would authorize the department to elect to implement that provision on a state-only funding basis, subject to an appropriation by the Legislature. The bill would require the department to maximize federal financial participation for Medi-Cal expenditures for the COVID-19 public

health emergency, to comply with any federal requirements and conditions for receipt of that federal financial participation, and, subject to Department of Finance approval, to seek any federal approvals to implement those provisions or to maintain sufficient access to covered Medi-Cal benefits during this emergency period. Due to the impact of the COVID-19 public health emergency on the Medi-Cal program, this bill would authorize the department to seek federal approvals for temporary extensions of the Medi-Cal 2020 Demonstration Project, and would require the department to consult with affected stakeholder entities before seeking any extension.

Existing law provides for the suspension of Medi-Cal benefits to an inmate of a public institution, and requires county welfare departments to notify the department within 10 days of receiving information that an individual who is receiving Medi-Cal is or will be an inmate of a public institution. Existing law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their eligibility for Medi-Cal benefits. Existing federal law, the SUPPORT for Patients and Communities Act, prohibits a state from terminating Medi-Cal eligibility for an eligible juvenile if they are an inmate of a public institution, authorizes the suspension of Medicaid benefits to that eligible juvenile, and requires a state to conduct a redetermination of Medicaid eligibility or process an application for medical assistance under the Medicaid program for an eligible juvenile who is an inmate of a public institution.

This bill would conform the suspension of benefits for juveniles, as defined, under state law with those federal provisions. The bill would require the department, in consultation with stakeholders, including the County Welfare Directors Association of California, to develop and implement a redetermination of eligibility, to the extent required by federal law, for juveniles, as defined, whose eligibility is suspended. Because counties are required to make Medi-Cal eligibility determinations, and the bill would expand Medi-Cal determinations of eligibility for eligible juveniles of public institutions, the bill would impose a state-mandated local program.

Existing law requires the Director of Health Care Services to annually review the reimbursement levels for physician and dental services under the Medi-Cal program, and to periodically revise the rates of reimbursement to physicians and dentists to ensure the reasonable access of Medi-Cal beneficiaries to physician and dental services. Existing law requires that the annual review, as it relates to rates for physician services, take into account specified factors, including physician reimbursement levels set forth by Blue Shield of California and other third-party payers, and procedures reflected by the current Relative Value Studies (RVS).

This bill would instead require the director to periodically review those reimbursement levels under the Medi-Cal fee-for-service delivery system, and to periodically revise those rates to the extent they deem necessary to comply with federal Medicaid program requirements on reasonable access to those services for Medi-Cal beneficiaries. The bill would limit the periodic

review, as it relates to physician services, to requirements specified in the department's federally approved access monitoring plan, or any successor methodology for monitoring reasonable access to Medi-Cal services, and to take into account specified factors. The bill would delete the above-specified factors regarding Blue Shield, third-party payers, and RVS.

Existing law establishes the Drug Medi-Cal Treatment Program (Drug Medi-Cal), under which the department is authorized to enter into contracts with each county, or enter into contracts directly with certified providers, for the provision of alcohol and drug use treatment services, including substance use disorder services, narcotic treatment program services, and naltrexone services, to Medi-Cal beneficiaries. Existing federal law requires, from October 1, 2020, to September 30, 2025, inclusive, medication-assisted treatment, as defined, to be a covered health care service under a state Medicaid program.

This bill would, subject to federal approval and the availability of federal financial participation, expand narcotic treatment program services to include medication-assisted treatment under Drug Medi-Cal, and would make conforming changes. The bill would authorize the department to implement provisions on services, reimbursement, and audits related to Drug Medi-Cal by various means, including bulletins, and would require the department, by July 1, 2023, to subsequently adopt regulations.

Existing law requires the department to establish a 3-year pilot program in specified counties to provide medically tailored meals, as defined, to Medi-Cal participants with specified health conditions, such as cancer and renal disease. Existing law requires the department to evaluate, at the conclusion of the program, the impact of the pilot program on specified matters related to participants, including hospital readmission and emergency room utilization rates, and to send, on or before January 1, 2021, or within 12 months after the end of the program, a report on the evaluation to the Legislature. Existing law makes these provisions inoperative on the earlier of January 1, 2021, or 6 months following the end of the program.

This bill would extend the duration of the pilot program to 4 years, delete the January 1, 2021, due date for the report, and make related, conforming, and technical changes. The bill would also make these provisions inoperative on the earlier of the date the department submits its report to the Legislature or 12 months after the end of the program.

Existing law, until July 1, 2021, and only to the extent that federal participation is available, requires the department to establish and administer the Medi-Cal Electronic Health Records Incentive Program to provide federal incentive payments to Medi-Cal providers for the implementation and use of electronic health records systems.

This bill would recast that program as the Medi-Cal Promoting Interoperability Program and would extend its operation until January 1, 2024.

(7) Existing law establishes the State Department of State Hospitals within the California Health and Human Services Agency and provides the department with jurisdiction over specified facilities for the care and

treatment of persons with mental health disorders. Existing law requires the Director of State Hospitals to appoint and define the duties of specified officers, including the clinical director and hospital administrator of each state hospital. Existing law requires a hospital administrator to be a college graduate, as specified. Existing law authorizes, until September 2020, the State Department of State Hospitals to house up to 1,530 patients at Patton State Hospital.

This bill would, among other things, eliminate the clinical director position and instead require the Governor, upon the recommendation of the Director of State Hospitals, to appoint one medical director for the department and one medical director for each state hospital. The bill would include any other hospital employee appointed and deemed by the Director of State Hospitals to be an officer, and would require a hospital administrator to be selected based on their overall knowledge of the hospital and the operation of its administrative, business, and life-support functions. This bill would extend the date the State Department of State Hospitals may house up to 1,530 patients at Patton State Hospital to September 2030.

(8) Existing law authorizes the Department of Health Care Services to enter into contracts with drug manufacturers, based on the manufacturer's best price for purposes of the Medi-Cal program, under which qualified low-income individuals receive health care services. Under existing law, "best price" is defined to mean the negotiated price, or the manufacturer's lowest available price, to any specified entity within the United States.

This bill instead defines "best price" to mean the negotiated price for any specified entity, including entities both within and outside of the United States.

Existing law authorizes the department, among other things, to enter into contracts with certain drug manufacturers that provide for state rebates for drugs covered under the Medi-Cal program. Under existing law, the department is entitled to various drug rebates, including federal rebates in accordance with certain conditions.

This bill authorizes the department, upon approval by the Department of Finance, to seek the necessary federal approvals to establish and administer a drug rebate program to collect rebate payments from drug manufacturers for drugs furnished to selected populations of California residents who are ineligible for full-scope Medi-Cal.

(9) Existing law limits prescribed drugs under the Medi-Cal program to not more than 6 drugs per month, unless prior authorization is obtained, and except under specified circumstances.

This bill repeals that provision.

(10) Existing law requires Medi-Cal beneficiaries to make set copayments for specified services, including a $1 copayment for a drug prescription or refill, and prohibits the department from reducing the provider reimbursement as a result of the copayment.

This bill would repeal the copayment requirement for a drug prescription or refill.

(11) Existing law governs the licensing of clinics, excluding, among others, a clinic operated by a city or county or conducted, operated, or maintained as an outpatient department of a hospital. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, 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 federal law requires the United States Secretary of Health and Human Services to enter into an agreement with each manufacturer of covered drugs that are not subject to a rebate under an agreement between the state Medicaid program and the manufacturer under which the amount required to be paid to the manufacturer for covered drugs purchased by a covered entity does not exceed an amount equal to the average manufacturer price for the drug under the federal Medicaid program in the preceding calendar quarter, reduced by the rebate received pursuant to the Medicaid agreement. This program is commonly referred to as the 340B Drug Pricing program or 340B program.

This bill would require the State Department of Health Care Services, subject to an appropriation by the Legislature, to establish, implement, and maintain a supplemental payment pool for nonhospital 340B community clinics, which include licensed clinics and clinics operated by a city, county, city and county, or hospital authority, as specified. The bill would require the department, beginning January 1, 2021, to make available fee-for-service-based supplemental payments from the pool, subject to an appropriation by the Legislature. The bill would require the department, on or before July 15, 2020, to establish a stakeholder process to develop and implement the methodology for distribution of supplemental pool payments to qualifying nonhospital 340B community clinics, which would be finalized no later than October 1, 2020. The bill would require the department to implement these provisions only to the extent that any necessary federal approvals have been obtained, and federal financial participation is available and is not otherwise jeopardized.

(12) The federal Medicaid program prohibits payment to a state for medical assistance furnished to a person who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Existing law extends eligibility for full-scope Medi-Cal benefits to individuals under 25 years of age who are otherwise eligible for those benefits but for their immigration status. Existing law requires the department to claim federal financial participation to the extent that the department determines it is available, and requires the department to use state funds to the extent that federal financial participation is not available, to implement full-scope Medi-Cal for those who are otherwise eligible but for their immigration status.

This bill would provide that Medi-Cal benefits for invidivuals who are 65 years of age or older, and who do not have satisfactory immigration statuses or are unable to establish satisfactory immigration statuses, as specified, will be prioritized in the Budget Act for the upcoming fiscal year

if the Department of Finance projects a positive ending balance in the Special Fund for Economic Uncertainties for the upcoming fiscal year and each of the ensuing three fiscal years that exceeds the cost of providing those individuals full scope Medi-Cal benefits.

(13) Under existing law, health care services are provided under the Medi-Cal program pursuant to a schedule of benefits, and those benefits are provided to beneficiaries through various health care delivery systems, including fee-for-service and managed care.

Existing law authorizes the department to enter into various types of contracts for the provision of services to beneficiaries, including contracts with Medi-Cal managed care plans. Existing law requires the department to pay capitations rates to health plans participating in the Medi-Cal managed care program using actuarial methods, and authorizes the department to establish health-plan and county-specific rates, as specified.

Pursuant to existing law, the President, under the National Emergencies Act, and the Governor, under the California Emergency Services Act, declared a national emergency and a state of emergency, respectively, in response to the novel coronavirus, known as COVID-19.

To account for the impacts of the COVID-19 public health emergency on Medi-Cal managed care capitation rates, this bill would require the department to develop and pay capitation rates and capitation rate increments for Medi-Cal managed care plan contracts, including developing and implementing a risk corridor. The bill would require the department to reduce applicable capitation rate increments by up to 1.5% for capitation rates associated with the period of July 1, 2019, to December 31, 2020, inclusive, and to apply this reduction to rating periods starting on or after January 1, 2021, as prescribed. The bill would require the department to evaluate the impact of the COVID-19 public health emergency on capitation rates, and to make any adjustments to ensure capitation rates are actuarially appropriate.

This bill would authorize the department, in consultation with the Department of Finance, to modify the prescribed payment methodologies and related requirements or modify any application of those provisions to Medi-Cal managed care plans, certain capitation rate increments, certain Medi-Cal managed care enrollee categories and subcategories of aid, or certain categories or subcategories of medical assistance provided under those contracts, if the department determines the modification is necessary to meet federal requirements, to obtain or maintain federal approval, or to maximize federal financial participation.

(14) Existing law, the California Healthcare, Research, and Prevention Tobacco Tax Act of 2016, or Proposition 56, which was approved by voters at the November 8, 2016, statewide general election, increases taxes imposed on distributors of cigarettes and tobacco products and allocates a specified percentage of those revenues to the department to increase funding for the Medi-Cal program, in a manner that, among other things, ensures timely access, limits specific geographic shortages of services, or ensures quality

care. Existing law establishes the Healthcare Treatment Fund for this purpose.

Existing law requires the Department of Health Care Services to develop, using moneys appropriated in the Budget Act for this purpose from the Healthcare Treatment Fund, value-based payment (VBP) programs that require designated Medi-Cal managed care plans to make incentive payments to qualified network providers in behavioral health integration, prenatal and postpartum care, and chronic disease management for specified purposes and to implement the VBP programs for a period no shorter than 3 fiscal years, as specified. Existing law requires these payments to be suspended on December 31, 2021.

This bill would suspend the authority for the State Department of Health Care Services to make value-based payments pursuant on or after July 1, 2021, unless one of two specified conditions applies.

(15) This bill would reappropriate $1,430,000 to support the Medically Tailored Meals Pilot Program, as specified.

(16) The bill would provide that its provisions are severable.

(17) 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.

(18) 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.

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

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. The Legislature hereby finds and declares that the amendments made by this act to Article 5.8 of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code are all of the following:

(a) Made in accordance with the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (commencing with Section 30130.50) of Chapter 2 of Part 13 of Division 2 of the Revenue and Taxation Code.

(b) Based on criteria developed and periodically updated as part of the annual state budget process, in accordance with subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

(c) Consistent with the purposes and conditions of expenditures described in subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

SEC. 2. Section 100500 of the Government Code is amended to read:

100500. (a) There is in state government the California Health Benefit Exchange, an independent public entity not affiliated with an agency or department, which shall also be known as Covered California. Covered California shall be governed by an executive board consisting of five members who are residents of California. Of the members of the board, two shall be appointed by the Governor, one shall be appointed by the Senate Committee on Rules, and one shall be appointed by the Speaker of the Assembly. The Secretary of California Health and Human Services or the secretary's designee shall serve as a voting, ex officio member of the board.

(b) Members of the board, other than an ex officio member, shall be appointed for a term of four years, except that the initial appointment by the Senate Committee on Rules shall be for a term of five years, and the initial appointment by the Speaker of the Assembly shall be for a term of two years. Appointments by the Governor shall be subject to confirmation by the Senate. A member of the board may continue to serve until the appointment and qualification of the member's successor. A vacancy shall be filled by appointment for the unexpired term. The board shall elect a chairperson on an annual basis.

(c) (1) A person appointed to the board shall have demonstrated and acknowledged expertise in at least two of the following areas:

(A) Individual health care coverage.

(B) Small employer health care coverage.

(C) Health benefits plan administration.

(D) Health care finance.

(E) Administering a public or private health care delivery system.

(F) Purchasing health plan coverage.

(G) Marketing of health insurance products.

(H) Information technology system management.

(I) Management information systems.

(J) Enrollment counseling assistance, with priority to cultural and linguistic competency.

(2) Appointing authorities shall consider the expertise of the other members of the board and attempt to make appointments so that the board's composition reflects a diversity of expertise.

(d) A member of the board shall have the responsibility and duty to meet the requirements of this title, the federal act, and all applicable state and federal laws and regulations, to serve the public interest of the individuals and small businesses seeking health care coverage through the Exchange, and to ensure the operational well-being and fiscal solvency of the Exchange.

(e) In making appointments to the board, the appointing authorities shall take into consideration the cultural, ethnic, and geographical diversity of the state so that the board's composition reflects the communities of California.

(f) (1) A member of the board or of the staff of the Exchange shall not be employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of, a carrier or other insurer, an agent or broker, a health care professional, or a health care facility or health clinic while serving on the board or on the staff of the Exchange. A member of the board or of the staff of the Exchange shall not be a member, a board member, or an employee of a trade association of carriers, health facilities, health clinics, or health care professionals while serving on the board or on the staff of the Exchange. A member of the board or of the staff of the Exchange shall not be a health care professional unless the member or staff does not receive compensation for rendering services as a health care professional and does not have an ownership interest in a professional health care practice.

(2) A board member shall not receive compensation for service on the board, but may receive a per diem and reimbursement for travel and other necessary expenses, as provided in Section 103 of the Business and Professions Code, while engaged in the performance of official duties of the board.

(3) For purposes of this subdivision, "health care professional" means a person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Act or the Chiropractic Act.

(4) (A) It is the intent of the Legislature that clinical volunteer services be performed in settings that predominantly serve populations that are high need, underserved, or otherwise vulnerable, including the homeless and those who receive health care coverage through the Medi-Cal program. Notwithstanding paragraph (1), a member of the board or of the staff of the Exchange may perform volunteer services if all of the following conditions are met:

(i) The member of the board or staff is a health care professional who was actively participating in that profession prior to appointment to the Exchange.

(ii) The member of the board or staff does not receive compensation for performing volunteer services and does not have an ownership interest or other financial interest in the entity, facility, clinic, or provider group.

(iii) The volunteer services are performed at the University of California or a nonprofit educational institution; a facility, clinic, or provider group operated by, or affiliated with, an academic medical center of either the University of California or a nonprofit educational institution; or a facility, clinic, or provider group operated by a state agency or county health system that does not directly contract with the Exchange.

(B) For purposes of this paragraph, compensation and financial interest for a health care professional who performs volunteer services does not include either of the following:

(i) A contribution to a professional liability insurance program made by the entity, facility, clinic, or provider group for the member or staff.

(ii) The provision of physical space, equipment, support staff, or other supports made by the entity, facility, clinic, or provider group for the member or staff necessary for the performance of volunteer services described in subparagraph (A).

(g) A member of the board shall not make, participate in making, or in any way attempt to use the member's official position to influence the making of a decision that the member knows or has reason to know will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on the board member or a member of the board member's immediate family, or on either of the following:

(1) A source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms available to the public without regard to official status aggregating two hundred fifty dollars ($250) or more in value provided to, received by, or promised to the member within 12 months prior to the time when the decision is made.

(2) A business entity in which the member is a director, officer, partner, trustee, employee, or holds any position of management.

(h) The board or a member of the board, or an officer or employee of the board, is not liable in a private capacity for or on account of an act performed or obligation entered into in an official capacity, when done in good faith, without intent to defraud, and in connection with the administration, management, or conduct of this title or affairs related to this title.

(i) The board shall hire an executive director to organize, administer, and manage the operations of the Exchange. The executive director shall be exempt from civil service and shall serve at the pleasure of the board.

(j) The board is subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2), except that the board may hold closed sessions when considering matters related to litigation, personnel, contracting, and rates.

(k) (1) The board shall apply for planning and establishment grants made available to the Exchange pursuant to Section 1311 of the federal act. If an executive director has not been hired under subdivision (i) when the United States Secretary of Health and Human Services makes the planning and establishment grants available, the California Health and Human Services Agency shall, upon request of the board, submit the initial application for planning and establishment grants to the United States Secretary of Health and Human Services.

(2) If a majority of the board has not been appointed when the United States Secretary of Health and Human Services makes the planning and establishment grants available, the California Health and Human Services Agency shall submit the initial application for planning and establishment grants to the United States Secretary of Health and Human Services. Any subsequent applications shall be made as described in paragraph (1) once a majority of the members have been appointed to the board.

(3) The board is responsible for using the funds awarded by the United States Secretary of Health and Human Services for the planning and

establishment of the Exchange, consistent with subdivision (b) of Section 1311 of the federal act.

(*l*) A reference to the California Health Benefit Exchange or the Exchange is deemed to refer to Covered California.

SEC. 3. Section 1367.0085 of the Health and Safety Code is amended to read:

1367.0085. Notwithstanding paragraph (1) of subdivision (b) of Section 1367.008 and paragraph (1) of subdivision (b) of Section 1367.009, the actuarial value for a nongrandfathered bronze level health plan that either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible health plan, as defined in Section 223(c)(2) of Title 26 of the United States Code, may range from plus 5 percent to minus 2 percent.

SEC. 4. Section 1386 of the Health and Safety Code is amended to read:

1386. (a) The director may, after appropriate notice and opportunity for a hearing, by order suspend or revoke any license issued under this chapter to a health care service plan or assess administrative penalties if the director determines that the licensee has committed any of the acts or omissions constituting grounds for disciplinary action.

(b) The following acts or omissions constitute grounds for disciplinary action by the director:

(1) The plan is operating at variance with the basic organizational documents as filed pursuant to Section 1351 or 1352, or with its published plan, or in any manner contrary to that described in, and reasonably inferred from, the plan as contained in its application for licensure and annual report, or any modification thereof, unless amendments allowing the variation have been submitted to, and approved by, the director.

(2) The plan has issued, or permits others to use, evidence of coverage or uses a schedule of charges for health care services that do not comply with those published in the latest evidence of coverage found unobjectionable by the director.

(3) The plan does not provide basic health care services to its enrollees and subscribers as set forth in the evidence of coverage. This subdivision shall not apply to specialized health care service plan contracts.

(4) The plan is no longer able to meet the standards set forth in Article 5 (commencing with Section 1367).

(5) The continued operation of the plan will constitute a substantial risk to its subscribers and enrollees.

(6) The plan has violated or attempted to violate, or conspired to violate, directly or indirectly, or assisted in or abetted a violation or conspiracy to violate any provision of this chapter, any rule or regulation adopted by the director pursuant to this chapter, or any order issued by the director pursuant to this chapter.

(7) The plan has engaged in any conduct that constitutes fraud or dishonest dealing or unfair competition, as defined by Section 17200 of the Business and Professions Code.

(8) The plan has permitted, or aided or abetted any violation by an employee or contractor who is a holder of any certificate, license, permit, registration, or exemption issued pursuant to the Business and Professions Code or this code that would constitute grounds for discipline against the certificate, license, permit, registration, or exemption.

(9) The plan has aided or abetted or permitted the commission of any illegal act.

(10) The engagement of a person as an officer, director, employee, associate, or provider of the plan contrary to the provisions of an order issued by the director pursuant to subdivision (c) of this section or subdivision (d) of Section 1388.

(11) The engagement of a person as a solicitor or supervisor of solicitation contrary to the provisions of an order issued by the director pursuant to Section 1388.

(12) The plan, its management company, or any other affiliate of the plan, or any controlling person, officer, director, or other person occupying a principal management or supervisory position in the plan, management company, or affiliate, has been convicted of or pleaded nolo contendere to a crime, or committed any act involving dishonesty, fraud, or deceit, which crime or act is substantially related to the qualifications, functions, or duties of a person engaged in business in accordance with this chapter. The director may revoke or deny a license hereunder irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code.

(13) The plan violates Section 510, 2056, or 2056.1 of the Business and Professions Code or Section 1375.7.

(14) The plan has been subject to a final disciplinary action taken by this state, another state, an agency of the federal government, or another country for any act or omission that would constitute a violation of this chapter.

(15) The plan violates the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code).

(16) The plan violates Section 806 of the Military and Veterans Code.

(17) The plan violates Section 1262.8.

(18) The plan violates Chapter 8.5 (commencing with Section 127671) of Part 2 of Division 107, including the data submission requirements of that chapter.

(c) (1) The director may prohibit any person from serving as an officer, director, employee, associate, or provider of any plan or solicitor firm, or of any management company of any plan, or as a solicitor, if either of the following applies:

(A) The prohibition is in the public interest and the person has committed, caused, participated in, or had knowledge of a violation of this chapter by a plan, management company, or solicitor firm.

(B) The person was an officer, director, employee, associate, or provider of a plan or of a management company or solicitor firm of any plan whose license has been suspended or revoked pursuant to this section and the person had knowledge of, or participated in, any of the prohibited acts for which the license was suspended or revoked.

(2) A proceeding for the issuance of an order under this subdivision may be included with a proceeding against a plan under this section or may constitute a separate proceeding, subject in either case to subdivision (d).

(d) A proceeding under this section shall be subject to appropriate notice to, and the opportunity for a hearing with regard to, the person affected in accordance with subdivision (a) of Section 1397.

SEC. 5. Section 105250.1 of the Health and Safety Code is amended to read:

105250.1. (a) Notwithstanding Section 105250, and beginning on July 1, 2018, the Lead-Related Construction Program fee for an application submitted for lead certification shall be eighty-seven dollars ($87), but shall not exceed the department's reasonable administrative costs in connection with the application. The application fees provided in this section, and any application fee increase pursuant to subdivision (b) or Section 105250, shall be sufficient to ensure that processing times for completed applications do not exceed an average of 60 days.

(b) Notwithstanding subdivision (a) and Section 105250, in any year the department raises or establishes new or additional fees, the department shall, by February 1 of the year the increase or establishment takes effect, prepare a report that describes the need for a fee increase or establishment of a fee, and shall make the report and the list of fees available to the budget committees of the Legislature, and shall post the report and list of fees on the department's internet website. The proposed increased fee shall take effect on July 1 of the year for which it is proposed. The adjustment of fees and the publication of the final fee list shall not be subject to the rulemaking requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Modification of the fees shall be exempt from the administrative regulation and rulemaking requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code and shall be implemented without being adopted as a regulation, except that the revised list of fees shall be filed with the Secretary of State and printed in the California Code of Regulations.

SEC. 6. Section 120512 of the Health and Safety Code is repealed.

SEC. 7. Section 120780.6 of the Health and Safety Code is repealed.

SEC. 8. Section 120962 of the Health and Safety Code is amended to read:

120962. (a) (1) For the purpose of verifying financial eligibility pursuant to Section 120960 and the federal Ryan White HIV/AIDS Treatment Extension Act of 2009 (42 U.S.C. Sec. 201 et seq.), the department shall verify the accuracy of the modified adjusted gross income reported on an AIDS Drug Assistance Program application submitted by an applicant or recipient with data, if available, from the Franchise Tax Board.

(2) Notwithstanding any other law, the department shall disclose the name and individual taxpayer identification number (ITIN) or social security number of an applicant for, or recipient of, services under this chapter to the Franchise Tax Board for the purpose of verifying the modified adjusted gross income of, any tax-exempt interest received by, any tax-exempt social

security benefits received by, and any foreign earned income of an applicant or recipient pursuant to subdivision (b) of Section 120960.

(b) (1) The Franchise Tax Board, upon receipt of this information, shall inform the department of all of the following:

(A) The amount of the federal adjusted gross income received by the taxpayer household as reported by the taxpayer to the Franchise Tax Board.

(B) The amount of the California adjusted gross income received by the taxpayer household as reported by the taxpayer to the Franchise Tax Board or as adjusted by the Franchise Tax Board.

(C) The amount of any tax-exempt interest received by the taxpayer household, as reported to the Franchise Tax Board.

(D) The amount of any tax-exempt social security benefits received by the taxpayer household, as reported to the Franchise Tax Board.

(E) The amount of any foreign earned income of the taxpayer household, as reported to the Franchise Tax Board.

(F) The family size of the taxpayer household, as reported to the Franchise Tax Board.

(2) The Franchise Tax Board shall provide the information to the department for the most recent taxable year that the Franchise Tax Board has information available, and shall include the first and last name, date of birth, and the ITIN or social security number of the taxpayer.

(c) (1) Information provided by the department pursuant to this section shall constitute confidential public health records as defined in Section 121035, and shall remain subject to the confidentiality protections and restrictions on further disclosure by the recipient under subdivisions (d) and (e) of Section 121025.

(2) To the extent possible, verification of financial eligibility shall be done in a way to eliminate or minimize, by use of computer programs or other electronic means, Franchise Tax Board staff and contractors' access to confidential public health records.

(3) Prior to accessing confidential HIV-related public health records, Franchise Tax Board staff and contractors shall be required to annually sign a confidentiality agreement developed by the department that includes information related to the penalties under Section 121025 for a breach of confidentiality and the procedures for reporting a breach of confidentiality under subdivision (h) of Section 121022. Those agreements shall be reviewed annually by the department.

(4) The Franchise Tax Board shall return or destroy all information received from the department after completing the exchange of information.

(d) For purposes of this section, "foreign earned income" also includes any deduction taken for the housing expenses of an individual while living abroad pursuant to Section 911 of Title 26 of the Internal Revenue Code.

(e) For purposes of this section, "household" means the applicant or recipient, and, in addition, the applicant's or recipient's spouse or registered domestic partner, and all other individuals for whom the applicant or recipient, or the applicant's or recipient's spouse or registered domestic partner, is allowed a federal income tax deduction for the taxable year.

(f) For purposes of this section, "family size" has the meaning given to that term in Section 36B(d)(1) of Title 26 of the Internal Revenue Code, and includes same or opposite sex married couples, registered domestic partners, and any dependent, as defined by Section 152 of Title 26 of the Internal Revenue Code, of either spouse or registered domestic partner.

SEC. 9. Section 120972 of the Health and Safety Code is amended to read:

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

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

(2) Are HIV negative.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The program.

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

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

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

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

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

(2) If disclosure is otherwise authorized by law.

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

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

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

SEC. 10. Section 122441 of the Health and Safety Code is repealed.

SEC. 11. The heading of Chapter 8.5 (commencing with Section 127671) of Part 2 of Division 107 of the Health and Safety Code is amended to read:

CHAPTER 8.5. HEALTH CARE PAYMENTS DATA PROGRAM

SEC. 12. Section 127671 of the Health and Safety Code is amended to read:

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

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

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

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

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

(f) For purposes of this chapter:

(1) "Director" means the Director of the Office of Statewide Health Planning and Development.

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

(3) "Office" means the Office of Statewide Health Planning and Development.

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

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

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

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

SEC. 13. Section 127671.1 is added to the Health and Safety Code, to read:

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

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

SEC. 14. Section 127671.5 of the Health and Safety Code is repealed.

SEC. 15. Section 127672 of the Health and Safety Code is amended to read:

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

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

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

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

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

(E) Self-insured employers.

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

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

(H) Organized labor.

(I) Organizations representing consumers.

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

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

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

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

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

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

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

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

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

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

SEC. 16. Section 127672.8 is added to the Health and Safety Code, to read:

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

SEC. 17. Section 127672.9 is added to the Health and Safety Code, to read:

127672.9. Until January 1, 2026, for purposes of implementing this chapter, including, but not limited to, hiring staff and consultants, facilitating and conducting meetings, conducting research and analysis, and developing the required reports, the office may enter into exclusive or nonexclusive contracts on a bid or negotiated basis. Contracts entered into or amended pursuant to this section are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and are exempt from the review or approval of any division of the Department of General Services.

SEC. 18. Section 127673 of the Health and Safety Code is repealed.

SEC. 19. Section 127673 is added to the Health and Safety Code, to read:

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

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

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

(2) Pricing information for health care items, services, and medical and surgical episodes of care gathered from payments for covered health care

items and services, including contracted rates, allowed amounts, fee schedules, and other information regarding the cost of care necessary to determine the amounts paid by health plans, health insurers, and public programs to health care providers, suppliers, and other entities. This shall include nonclaims-based payment information such as deductibles, copayments, and coinsurance and other information as needed to determine the total cost of care.

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) On or before December 31, 2021, the office shall adopt emergency regulations pursuant to Chapter 3.5 (commencing with Section 11340) of

Part 1 of Division 3 of Title 2 to implement this chapter, including on all of the following:

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

(2) Required and exempted lines of business.

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

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

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

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

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

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

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

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

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

(i) To the extent possible, the office shall incorporate into the system any data collected by the office from providers and suppliers, including hospital discharge abstract data records and emergency care data records

provided to the office by health facilities and ambulatory surgery data records provided to the office by ambulatory surgical centers.

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

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

(A) Claims data reported by mandatory submitters.

(B) Claims data reported by voluntary submitters.

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

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

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

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

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

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

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

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

SEC. 20. Section 127673.1 is added to the Health and Safety Code, to read:

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

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

(b) All entities submitting health care data are responsible for submitting complete and accurate data directly to the system and facilitating data submissions from data owners, including, but not limited to, data feeds from

pharmacy benefit managers, behavioral health organizations, and any subsidiaries, affiliates, or subcontractors that a submitter has contracted with for services covered by this chapter.

SEC. 21. Section 127673.2 is added to the Health and Safety Code, to read:

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

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

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

SEC. 22. Section 127673.3 is added to the Health and Safety Code, to read:

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

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

(1) Other data maintained by the office.

(2) Vital statistics.

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

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

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

SEC. 23. Section 127673.4 is added to the Health and Safety Code, to read:

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

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

(1) Source data intake.

(2) Data conversion and processing.

(3) Data analysis, reporting, and release.

(4) Other data processes necessary for the system.

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

(1) Descriptions of processes and methodologies.

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

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

SEC. 24. Section 127673.5 is added to the Health and Safety Code, to read:

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

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

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

SEC. 25. Section 127673.6 is added to the Health and Safety Code, to read:

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

SEC. 26. Section 127673.7 is added to the Health and Safety Code, to read:

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

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

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

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

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

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

SEC. 27. Section 127673.8 is added to the Health and Safety Code, to read:

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

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

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

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

SEC. 28. Section 127673.81 is added to the Health and Safety Code, to read:

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

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

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

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

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

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

SEC. 29. Section 127673.82 is added to the Health and Safety Code, to read:

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

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

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

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

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

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

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

SEC. 30. Section 127673.83 is added to the Health and Safety Code, to read:

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

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

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

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

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

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

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

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

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

(1) The office may develop standardized limited datasets that do not include any of the direct personal identifiers listed in Section 164.514(e) of Title 45 of the Code of Federal Regulations, and have the minimum necessary personal information for types of purposes specified by the office. Standardized datasets may be transmitted to qualified applicants if the

requester has documented expertise with privacy protection and with the analysis of large sets of confidential data, data security will meet the standards that the office shall apply to personal data, and project approval has been recommended by the data release committee.

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

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

SEC. 31. Section 127673.84 is added to the Health and Safety Code, to read:

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

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

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

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

(2) In making recommendations about applications seeking program data, except for data requests from other state agencies, the data release committee shall consider whether the use of the data is consistent with the goals of the system, whether it provides greater transparency regarding health care costs, utilization, quality, or equity, or how the information may be used to inform policy decisions regarding the provision of quality health care, improving public health, reducing health disparities, advancing health coverage, or reducing health care costs.

(e) Upon request of the director, the data release committee shall generally advise the director about privacy and security matters related to the program and provide feedback on the program’s data application review processes and other matters.

(f) The chairperson of the data release committee shall be appointed from among the members by the director.

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

SEC. 32. Section 127674 of the Health and Safety Code is repealed.

SEC. 33. Section 127674 is added to the Health and Safety Code, to read:

127674. (a) The office shall expend the General Fund moneys appropriated in the 2018–19 Budget Act (Chapter 23 of the Statutes of 2019) for the purposes of this chapter and the former Health Care Transparency Database to fund the implementation and operation of the program.

(b) The Health Care Payments Data Program shall not be funded with General Fund moneys beyond moneys appropriated in the 2018–19 Budget Act.

(c) The Health Care Payments Data Fund is hereby established within the office for the purpose of receiving and expending revenues collected pursuant to this chapter.

(d) All revenues collected pursuant to this chapter shall be deposited in the fund. Any amounts raised by the collection of the revenues shall remain in the fund and shall be available in succeeding years upon appropriation by the Legislature.

(e) The office shall seek to maximize federal financial participation from the Medicaid program for the system, working through the sole state agency for Medicaid, the State Department of Health Care Services, and shall do so while relying on moneys appropriated from the General Fund in the 2018–19 Budget Act, and on an ongoing basis using any federally allowed fund source for the state match.

(f) (1) The office may impose a data user fee for an eligible user that is in compliance with this chapter, including, but not limited to, provisions related to consumer privacy and data security.

(2) In establishing the user fee schedule and fee waivers, the office shall work with the advisory committee to make considerations for state agencies, data submitters, and consumer organizations that have been awarded reasonable advocacy and witness fees in a proceeding or proceedings of the Department of Managed Health Care pursuant to Section 1348.9.

(3) The office shall adopt regulations on the fee waiver consistent with subdivisions (e) and (f) of Section 127673.

(g) On or before March 1, 2023, the office shall submit a report to the Legislature on recommendations for funding options for the program pursuant to Section 9795 of the Government Code.

(h) The office may accept foundation funding from foundations not affiliated or controlled by a health care entity.

SEC. 34. Section 127674.1 is added to the Health and Safety Code, to read:

127674.1. The office shall notify the Department of Managed Health Care or the Department of Insurance, as appropriate, if a health care service plan or health insurer fails to comply with this chapter. The Department of Managed Health Care and the Department of Insurance shall take appropriate action necessary to bring the plan or insurer into compliance.

SEC. 35. Chapter 4.1 (commencing with Section 10403) is added to Part 2 of Division 2 of the Insurance Code, to read:

CHAPTER 4.1. GENERAL REGULATION OF HEALTH INSURERS

10403. A health insurer that is subject to the requirements of Chapter 8.5 (commencing with Section 127671) of Part 2 of Division 107 of the Health and Safety Code and that fails to comply with the data submission requirements of that chapter is subject to a civil penalty not to exceed five thousand dollars ($5,000) for each 30-day period in which the insurer fails to comply. If the failure to comply is willful, the insurer is subject to a civil penalty not to exceed ten thousand dollars ($10,000) for each 30-day period in which the person fails to comply. The aggregate penalty for each instance of noncompliance shall not exceed one hundred thousand dollars ($100,000). In determining the penalty, the commissioner shall consider the good faith of the insurer and any similar prior violations by the insurer.

SEC. 36. Section 10112.296 of the Insurance Code is amended to read:

10112.296. Notwithstanding paragraph (1) of subdivision (b) of Section 10112.295 and paragraph (1) of subdivision (b) of Section 10112.297, the actuarial value for a nongrandfathered bronze level health insurance policy that either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible health plan, as defined in Section 223(c)(2) of Title 26 of the United States Code, may range from plus 5 percent to minus 2 percent.

SEC. 37. Section 19548.2 of the Revenue and Taxation Code is amended to read:

19548.2. (a) Notwithstanding any other law and in accordance with Section 120962 of the Health and Safety Code, the State Department of Public Health shall disclose the name and individual taxpayer identification number (ITIN) or social security number of an applicant for, or recipient of services pursuant to Chapter 6 (commencing with Section 120950) of Part 4 of Division 105 of the Health and Safety Code to the Franchise Tax Board for the purpose of verifying the modified adjusted gross income of, any tax-exempt interest received by, any tax-exempt social security benefits received by, and any foreign earned income of an applicant or recipient.

(b) (1) The Franchise Tax Board, upon receipt of this information, shall inform the State Department of Public Health of all of the following:

(A) The amounts of the federal adjusted gross income received by the taxpayer household as reported by the taxpayer to the Franchise Tax Board.

(B) The amounts of the California adjusted gross income received by the taxpayer household as reported by the taxpayer to the Franchise Tax Board or as adjusted by the Franchise Tax Board.

(C) The amount of any tax-exempt interest received by the taxpayer household, as reported to the Franchise Tax Board.

(D) The amount of any tax-exempt social security benefits received by the taxpayer household, as reported to the Franchise Tax Board.

(E) The amount of any foreign earned income of the taxpayer household, as reported to the Franchise Tax Board.

(F) The family size of the taxpayer household, as reported to the Franchise Tax Board.

(2) The Franchise Tax Board shall provide the information to the State Department of Public Health for the most recent taxable year that the Franchise Tax Board has information available, and shall include the first and last name, date of birth, and the ITIN or social security number of the taxpayer.

(c) (1) Information provided by the State Department of Public Health pursuant to this section shall constitute confidential public health records as defined in Section 121035 of the Health and Safety Code, and shall remain subject to the confidentiality protections and restrictions on further disclosure by the recipient under subdivisions (d) and (e) of Section 121025.

(2) Prior to accessing confidential HIV-related public health records, Franchise Tax Board staff and contractors shall be required to annually sign a confidentiality agreement developed by the State Department of Public Health that includes information related to the penalties under Section 121025 of the Health and Safety Code for a breach of confidentiality and the procedures for reporting a breach of confidentiality under subdivision (h) of Section 121022 of the Health and Safety Code. Those agreements shall be reviewed annually by the State Department of Public Health.

(3) The Franchise Tax Board shall return or destroy all information received from the State Department of Public Health after completing the exchange of information.

(d) For purposes of this section, “foreign earned income” also includes any deduction taken for the housing expenses of an individual while living abroad pursuant to Section 911 of Title 26 of the Internal Revenue Code.

(e) For purposes of this section, “household” means the applicant or recipient, and, in addition, the applicant’s or recipient’s spouse or registered domestic partner, and all other individuals for whom the applicant or recipient, or the applicant’s or recipient’s spouse or registered domestic partner, is allowed a federal income tax deduction for the taxable year.

(f) For purposes of this section, “family size” has the meaning given to that term in Section 36B(d)(1) of Title 26 of the Internal Revenue Code, and includes same or opposite sex married couples, registered domestic partners, and any dependent, as defined by Section 152 of Title 26 of the Internal Revenue Code, of either spouse or registered domestic partner.

SEC. 38. Section 4107 of the Welfare and Institutions Code is amended to read:

4107. (a) The security of patients committed pursuant to Section 1026 of, and Chapter 6 (commencing with Section 1367) of Title 10 of Part 2 of, the Penal Code, and former Sections 6316 and 6321, at Patton State Hospital shall be the responsibility of the Secretary of the Department of Corrections and Rehabilitation.

(b) The Department of Corrections and Rehabilitation and the State Department of Mental Health shall jointly develop a plan to transfer all patients committed to Patton State Hospital pursuant to the provisions in subdivision (a) from Patton State Hospital no later than January 1, 1986, and shall transmit this plan to the Senate Committee on Judiciary and to the Assembly Committee on Criminal Justice, and to the Senate Health and Welfare Committee and Assembly Health Committee by June 30, 1983. The plan shall address whether the transferred patients shall be moved to other state hospitals or to correctional facilities, or both, for commitment and treatment.

(c) Notwithstanding any other law, the State Department of State Hospitals shall house no more than 1,336 patients at Patton State Hospital. However, until September 2030, up to 1,530 patients may be housed at the hospital.

(d) This section shall remain in effect only until all patients committed, pursuant to the provisions enumerated in subdivision (a), have been removed from Patton State Hospital and shall have no force or effect on or after that date.

SEC. 39. Section 4300 of the Welfare and Institutions Code is amended to read:

4300. As used in this chapter, "officers" of a state hospital means:

(a) Medical director.

(b) Hospital administrator.

(c) Hospital director.

(d) Chief of police services at the hospital.

(e) Any other hospital employee appointed and deemed by the Director of State Hospitals to be an officer.

SEC. 40. Section 4301 of the Welfare and Institutions Code is amended to read:

4301. (a) The Director of State Hospitals shall appoint and define the duties, subject to the laws governing civil service, of all of the following officers:

(1) A hospital administrator.

(2) A hospital director.

(3) A chief of police services.

(4) Any other hospital employee appointed and deemed by the Director of State Hospitals to be an officer.

(b) The Director of State Hospitals shall appoint a program director for each program at a state hospital.

(c) The Governor, upon the recommendation of the Director of State Hospitals, shall appoint one medical director for the department and one medical director for each state hospital. The medical director of the

department shall be a physician licensed to practice medicine in California and shall be responsible for standards, research, coordination, surveillance, and planning for the improvement of medical care for the department.

SEC. 41. Section 4305 of the Welfare and Institutions Code is amended to read:

4305. (a) Subject to the rules and regulations established by the department, and under the supervision of the hospital director, the medical director of a state hospital shall be responsible for the planning, development, direction, management, supervision, and evaluation of medical care provided.

(b) A medical director of a state hospital shall be a physician who has passed, or shall pass, an examination for a license to practice medicine in California and shall be a qualified specialist in a branch of medicine that includes diseases affecting the brain and nervous system. The medical director of a state hospital shall be well qualified by training or experience to have proven skills in mental hospital program administration.

SEC. 42. Section 4306 of the Welfare and Institutions Code is amended to read:

4306. (a) Subject to the rules and regulations established by the department, under the supervision of the hospital director, the hospital administrator shall be responsible for the planning, development, direction, management and supervision of all administrative and supportive services in the hospital facility. These services include, but are not limited to, all of the following:

(1) All administrative functions, such as personnel, accounting, budgeting, and patients' accounts.

(2) All life-support functions, such as food services, facility maintenance and patient supplies.

(3) All other business functions.

(b) It shall be the responsibility of the hospital administrator to provide support services, as specified in this section, within available resources, to all hospital treatment programs.

SEC. 43. Section 4307 of the Welfare and Institutions Code is amended to read:

4307. The hospital director is the chief executive officer of the hospital and is responsible for all hospital operations.

SEC. 44. Section 4308 of the Welfare and Institutions Code is amended to read:

4308. (a) If a vacancy occurs in a hospital under the jurisdiction of the Director of State Hospitals, the Director of State Hospitals shall appoint, as provided in Section 4301, a hospital administrator, a hospital director, and program directors.

(b) A hospital administrator shall be selected based on their overall knowledge of the hospital and the operation of its administrative, business, and life-support functions and shall have had experience in this area.

(c) The hospital director shall be selected based on their overall knowledge of the hospital, its programs, and its relationship to its community, and on their demonstrated abilities to administer a large facility.

(d) The standards for the professional qualifications of a program director shall be established by the Director of State Hospitals for each patient program. The Director of State Hospitals shall not adopt regulations that prohibit a licensed psychiatrist, psychologist, psychiatric technician, or clinical social worker from employment in a patient program in any professional, administrative, or technical position. However, the program director of a medical-surgical unit shall be a licensed physician.

(e) If the program director is not a physician, a physician shall be available to assume responsibility for all those acts of diagnosis, treatment, or prescribing or ordering of drugs that may only be performed by a licensed physician.

SEC. 45. Section 4309 of the Welfare and Institutions Code is amended to read:

4309. The hospital director is responsible for the overall management of the hospital. In the hospital director's absence, one of the other hospital officers, or in the absence of the other hospital officers, a program director, or other hospital representative shall be designated to perform the hospital director's duties and assume the hospital director's responsibilities.

SEC. 46. Section 4314 of the Welfare and Institutions Code is amended to read:

4314. (a) The Director of State Hospitals may set aside and designate any space on the grounds of any of the institutions under the jurisdiction of the department that is not needed for other authorized purposes, to enable the institution to establish and maintain therein a store or canteen for the sale to or for the benefit of patients of the institution of candies, sundries, and other articles. The stores shall be conducted subject to the rules and regulations of the department and the rental, utility, and service charges shall be fixed as will reimburse the institutions for the cost thereof. The stores when conducted under the direction of a hospital administrator shall be operated on a nonprofit basis but any profits derived shall be deposited in the benefit fund of each institution as set forth in Section 4125.

(b) Before any store is authorized or established, the Director of State Hospitals shall first determine that the facilities are not being furnished adequately by private enterprise in the community where it is proposed to locate the store, and may hold public hearings or cause surveys to be made, to determine the same.

(c) The Director of State Hospitals may rent space to private individuals, for the maintenance of a store or canteen at any of these institutions upon any terms and subject to any regulations that are approved by the Department of General Services, in accordance with the provisions of Section 13109 of the Government Code. The terms imposed shall provide that the rental, utility, and service charges to be paid shall be fixed so as to reimburse the institution for the cost thereof and any additional charges required to be paid shall be deposited in the benefit fund of the institution as set forth in Section 4125.

SEC. 47. Section 4315 of the Welfare and Institutions Code is repealed.

SEC. 48. Section 14007.8 of the Welfare and Institutions Code is amended to read:

14007.8. (a) (1) After the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of this section, but no sooner than May 1, 2016, an individual who is under 19 years of age and who does not have satisfactory immigration status or is unable to establish satisfactory immigration status as required by Section 14011.2 shall be eligible for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(2) (A) An individual under 19 years of age enrolled in Medi-Cal pursuant to subdivision (d) of Section 14007.5 at the time the director makes the determination described in paragraph (1) shall be enrolled in the full scope of Medi-Cal benefits, if otherwise eligible, pursuant to an eligibility and enrollment plan. This plan shall include outreach strategies developed by the department in consultation with interested stakeholders, including, but not limited to, counties, health care service plans, consumer advocates, and the Legislature. An individual subject to this subparagraph shall not be required to file a new application for Medi-Cal.

(B) The effective date of enrollment into Medi-Cal for an individual described in subparagraph (A) shall be on the same day on which the systems are operational to begin processing new applications pursuant to the director's determination described in paragraph (1).

(C) Beginning January 31, 2016, and until the director makes the determination described in paragraph (1), the department shall provide monthly updates to the appropriate policy and fiscal committees of the Legislature on the status of the implementation of this section.

(b) After the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of this subdivision, but no sooner than July 1, 2019, an individual who is 19 to 25 years of age, inclusive, and who does not have satisfactory immigration status or is unable to establish satisfactory immigration status as required by Section 14011.2 shall be eligible for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(c) If in determining the projected budget condition for the upcoming fiscal year, the Department of Finance projects a positive ending balance in the Special Fund for Economic Uncertainties for the upcoming fiscal year and each of the ensuing three fiscal years that exceeds the cost of providing individuals who are 65 years of age or older, and who do not have satisfactory immigration statuses or are unable to establish satisfactory immigration statuses as required by Section 14011.2 for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter, such benefits to such individuals shall be prioritized for inclusion in the budget for the upcoming fiscal year.

(d) To the extent permitted by state and federal law, an individual eligible under this section shall be required to enroll in a Medi-Cal managed care

health plan. Enrollment in a Medi-Cal managed care health plan shall not preclude a beneficiary from being enrolled in any other children's Medi-Cal specialty program that they would otherwise be eligible for.

(e) (1) The department shall maximize federal financial participation in implementing this section to the extent allowable, and, 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 not available, the department shall implement this section using state funds appropriated for this purpose.

(f) 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.

(g) (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) Commencing six months after the effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(h) 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 the following:

(1) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part.

(2) Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code.

(3) Review or approval of contracts by the Department of General Services.

SEC. 49. Section 14011.10 of the Welfare and Institutions Code is amended to read:

14011.10. (a) Except as provided in Sections 14053.7 and 14053.8, benefits provided under this chapter to an individual who is an inmate of a public institution shall be suspended in accordance with Section 1396d(a)(29)(A) of Title 42 of the United States Code as provided in subdivisions (c) and (d).

(b) A county welfare department shall notify the department within 10 days of receiving information that an individual on Medi-Cal in the county is or will be an inmate of a public institution.

(c) Until October 1, 2020, if an individual is a Medi-Cal beneficiary on the date they become an inmate of a public institution, their benefits under this chapter and under Chapter 8 (commencing with Section 14200) shall be suspended effective the date they become an inmate of a public institution. The suspension shall end on the date they are no longer an inmate of a public institution or one year from the date they become an inmate of a public institution, whichever is sooner.

(d) Commencing October 1, 2020, if an individual is a Medi-Cal beneficiary on the date they become an inmate of a public institution, their benefits under this chapter and under Chapter 8 (commencing with Section 14200) shall be suspended effective the date they become an inmate of a public institution. The suspension shall end according to the following:

(1) For an individual who is not defined as a juvenile under Section 1396a(nn)(1)(A) or 1396a(nn)(1)(B) of Title 42 of the United States Code, the suspension shall end on the date the individual is no longer an inmate of a public institution or one year from the date the individual becomes an inmate of a public institution, whichever is sooner.

(2) For an individual who is defined as a juvenile under Section 1396a(nn)(1)(A) or 1396a(nn)(1)(B) of Title 42 of the United States Code, the suspension shall end in accordance with Section 1396a(a)(84) of Title 42 of the United States Code, or one year from the date the individual becomes an inmate of a public institution, whichever is later.

(e) The department, in consultation with stakeholders, including the County Welfare Directors Association of California and advocates, shall develop and implement a redetermination of eligibility, to the extent required by federal law, pursuant to Section 14005.37, for individuals referenced in paragraph (2) of subdivision (d) whose eligibility is suspended pursuant to this section.

(f) This section does not create a state-funded benefit or program. Health care services under this chapter and Chapter 8 (commencing with Section 14200) shall not be available to inmates of public institutions whose Medi-Cal benefits have been suspended under this section.

(g) This section shall be implemented only if and to the extent allowed by federal law. This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approval of state plan amendments or other federal approvals have been obtained.

(h) This section shall be implemented on January 1, 2010, or the date when all necessary federal approvals are obtained, whichever is later.

(i) By January 1, 2010, or the date when all necessary federal approvals are obtained, whichever is later, the department, in consultation with the Chief Probation Officers of California and the County Welfare Directors Association of California, shall establish the protocols and procedures necessary to implement this section, including any needed changes to the

protocols and procedures previously established to implement Section 14029.5.

(j) The department shall determine whether federal financial participation will be jeopardized by implementing this section and shall implement this section only if and to the extent that federal financial participation is not jeopardized.

(k) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of all-county letters or similar instructions without taking regulatory action. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 50. Section 14021.51 of the Welfare and Institutions Code is amended to read:

14021.51. (a) For purposes of this section, "narcotic treatment program services" includes, but is not limited to, all of the following:

(1) Admission, physical evaluation, and diagnosis.

(2) Drug screening.

(3) Pregnancy tests.

(4) Narcotic replacement therapy dosing.

(5) Any medication approved under Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), and all biological products licensed under Section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders.

(6) (A) Intake assessment, treatment planning, and counseling services.

(B) The frequency of counseling, behavioral therapy, or medical psychotherapy, outcomes, and rates shall be addressed through guidance issued by the department pursuant to subdivision (k). For purposes of this paragraph, these services include substance use services to pregnant and postpartum Medi-Cal beneficiaries.

(b) (1) The department shall establish a narcotic replacement therapy dosing fee for methadone.

(2) In addition to the narcotic replacement therapy dosing fee specified in paragraph (1), a narcotic treatment program shall be reimbursed for the ingredient costs of methadone dispensed to a Medi-Cal beneficiary. These costs may be determined on an average daily dose of methadone, as set forth by the department.

(c) Reimbursement for narcotic treatment program services shall be based on a per capita uniform statewide daily reimbursement rate for each individual patient, as established by the department. The uniform statewide daily reimbursement rate for narcotic treatment program services shall be based upon, if available and appropriate, all of the following:

(1) The outpatient rates for the same or similar services under the fee-for-service Medi-Cal program.

(2) Cost report data.

(3) Other data deemed reliable and relevant by the department.

(4) The rate studies completed pursuant to Section 54 of Chapter 197 of the Statutes of 1996.

(d) The uniform statewide daily reimbursement rate for ancillary services shall not exceed, for individual services or in the aggregate, the outpatient rates for the same or similar services under the fee-for-service Medi-Cal program.

(e) The uniform statewide daily reimbursement rate shall be established after consultation with narcotic treatment program providers and county alcohol and drug program administrators.

(f) Reimbursement for narcotic treatment program services shall be limited to those services specified in state law and any authorized federally approved Medicaid state plan amendments or waivers related to the Drug Medi-Cal program, and shall be provided in accordance with federal and state law governing the licensing and administration of narcotic treatment programs.

(g) Reimbursement under this section shall be limited to claims for narcotic treatment program services at the uniform statewide daily reimbursement rate for these services. These rates shall be exempt from the requirements of Section 14021.6.

(h) (1) Reimbursement to a narcotic treatment program provider shall be limited to the lower of the uniform statewide daily reimbursement rate, pursuant to subdivision (c), or the provider's usual and customary charge to the general public for the same or similar service.

(2) (A) Reimbursement paid by a county to a narcotic treatment program provider for services provided to any person subject to Section 1210.1 or 3063.1 of the Penal Code, and for which the individual client is not liable to pay, is not a usual and customary charge to the general public for the purposes of this section.

(B) Subparagraph (A) is not a change in, but is declaratory of, existing law.

(i) A program shall not be reimbursed for services or medications not rendered to or received by a patient of a narcotic treatment program.

(j) Reimbursement for narcotic treatment program services shall be administered by the department and any county electing to participate in the program. Utilization and payment for these services shall be subject to federal Medicaid and state utilization and audit requirements.

(k) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, may implement, interpret, or make specific this section, in whole or in part, by means of bulletins or similar instructions, until the time that any necessary regulations are adopted.

(*l*) The department shall adopt regulations necessary to implement this section by July 1, 2023.

(m) This section shall be implemented to the extent that any necessary federal approval of state plan amendments or other federal approvals, including waivers, are obtained, and federal financial participation is available and not otherwise jeopardized.

SEC. 51. Section 14042.1 of the Welfare and Institutions Code is amended to read:

14042.1. (a) No earlier than January 1, 2018, the State Department of Health Care Services shall establish a Medically Tailored Meals Pilot Program to operate for a period of four years from the date the program is established, or until funding is no longer available for the program, whichever date is earlier.

(1) The department shall determine the number of eligible participants and providers in the program and shall use data from the Medi-Cal program to identify eligible beneficiaries for participation in the program.

(2) The program shall provide medically tailored meal intervention services to Medi-Cal participants with one or more of the following health conditions: congestive heart failure, cancer, diabetes, chronic obstructive pulmonary disease, or renal disease.

(3) The department may establish additional eligibility requirements based on acuity and other selection criteria. Each participant in the program shall receive a standard intervention, as determined by the department, of up to 21 meals per week for 12 to 24 weeks. The provided meals shall be medically tailored and designed to meet the specific nutritional needs of the participant's specific illness.

(4) The program shall be conducted in the Counties of Alameda, Los Angeles, Marin, San Diego, San Francisco, San Mateo, Santa Clara, and Sonoma.

(5) (A) At the conclusion of the program, the department shall use the data from the Medi-Cal program on the program participants to evaluate what impact, to the extent it can be determined, the program had on hospital readmissions, decreased admissions to long-term care facilities, and emergency room utilization.

(B) The department shall send a report containing its evaluation to the Legislature within 12 months after the end of the four-year program.

(C) The legislative report submitted pursuant to subparagraph (B) shall be submitted in compliance with Section 9795 of the Government Code.

(b) For the purposes of this section, "medically tailored meals" means a specifically tailored diet to address the participant's specific medical condition and associated symptoms.

(c) The department shall develop a methodology for reimbursing contractors, or other entities, as applicable, for services or activities provided pursuant to this section based on, and not to exceed, the aggregate amount of funds allocated per year for purposes of the program. The department may use up to 20 percent of the funds allocated per year for the program to support its administration and evaluation.

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

(e) For purposes of implementing this section, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this section shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(f) The department shall seek any federal approvals necessary to implement this section, including any waivers it deems necessary to obtain federal financial participation for the program, and shall claim federal financial participation to the full extent permitted by law. If federal financial participation is unavailable, the department shall implement the program using available state-only funds, subject to annual appropriation by the Legislature.

(g) This section shall remain in effect until the earlier of the date the department submits its report containing its evaluation of the program to the Legislature pursuant to subparagraph (B) of paragraph (5) of subdivision (a), or 12 months after the end of the program, and as of that date is repealed.

SEC. 52. Section 14046 of the Welfare and Institutions Code is amended to read:

14046. The department shall establish and administer the Medi-Cal Promoting Interoperability Program for the purposes of providing federal incentive payments to Medi-Cal providers for the implementation and use of electronic health records systems.

SEC. 53. Section 14046.1 of the Welfare and Institutions Code is amended to read:

14046.1. (a) The program shall be administered in accordance with the State Medicaid Health Information Technology Plan, as developed by the department and approved by the federal Centers for Medicare and Medicaid Services. Upon federal approval, the department shall provide copies of the plan to the appropriate fiscal and policy committees of the Legislature.

(b) The State Medicaid Health Information Technology Plan shall address all of the following:

(1) Identify and establish the planning, policies, and procedures required to operationalize the Medi-Cal Promoting Interoperability Program.

(2) Specify the criteria for enrollment, eligibility, and data collection.

(3) Specify timeframes for technology modifications.

(4) Specify the process for provider outreach and department coordination with established regional extension centers in the state, established to provide technical support to providers.

(5) Establish the audit and appeals processes.

(6) Participate in the National Level Registry.

SEC. 54. Section 14046.8 of the Welfare and Institutions Code is repealed.

SEC. 55. Section 14046.8 is added to the Welfare and Institutions Code, to read:

14046.8. This article shall remain in effect only until January 1, 2024, and as of that date is repealed.

SEC. 56. Section 14079 of the Welfare and Institutions Code is amended to read:

14079. (a) The director shall periodically review the reimbursement levels for physician and dental services in the Medi-Cal fee-for-service delivery system, and shall periodically revise the rates of reimbursement to physicians and dentists to the extent the director deems necessary to comply with applicable federal Medicaid program requirements, including provisions on reasonable access to physician and dental services for Medi-Cal beneficiaries.

(b) To the extent consistent with the department's federally approved access monitoring plan, or any successor methodology for monitoring reasonable access to Medi-Cal covered services, as described in Section 1396a(a)(30)(A) of Title 42 of the United States Code, this periodic review, as it relates to rates for physician services, shall take into account at least the following factors:

(1) Annual cost increases for physicians as reflected by the Consumer Price Index.

(2) Physician reimbursement levels under the Medicare Program.

(3) Prevailing customary physician charges within the state and in various geographical areas.

(4) Characteristics of the current population of Medi-Cal beneficiaries and the medical services needed.

SEC. 57. Section 14105.31 of the Welfare and Institutions Code is amended to read:

14105.31. For purposes of the Medi-Cal contract drug list, the following definitions shall apply:

(a) "Single-source drug" means a drug that is produced and distributed under an original New Drug Application approved by the federal Food and Drug Administration. This shall include a drug marketed by the innovator manufacturer and any cross-licensed producers or distributors operating under the New Drug Application, and shall also include a biological product, except for vaccines, marketed by the innovator manufacturer and any cross-licensed producers or distributors licensed by the federal Food and Drug Administration pursuant to Section 262 of Title 42 of the United States Code. A drug ceases to be a single-source drug when the same drug in the same dosage form and strength manufactured by another manufacturer is approved by the federal Food and Drug Administration under the provisions for an Abbreviated New Drug Application.

(b) "Best price" means the negotiated price, or the manufacturer's lowest price available to any foreign or domestic class of trade organization or entity, including, but not limited to, wholesalers, retailers, hospitals, repackagers, providers, or governmental entities, that contracts with a manufacturer for a specified price for drugs, inclusive of cash discounts, free goods, volume discounts, rebates, and on- or off-invoice discounts or

credits, shall be based upon the manufacturer's commonly used retail package sizes for the drug sold by wholesalers to retail pharmacies.

(c) "Manufacturer" means any person, partnership, corporation, or other institution or entity that is engaged in the production, preparation, propagation, compounding, conversion, or processing of drugs, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, or in the packaging, repackaging, labeling, relabeling, and distribution of drugs.

(d) "Price escalator" means a mutually agreed-upon price specified in the contract, to cover anticipated cost increases over the life of the contract.

(e) "Medi-Cal pharmacy costs" or "Medi-Cal drug costs" means all reimbursements to pharmacy providers for services or merchandise, including single-source or multiple-source prescription drugs, over-the-counter medications, and medical supplies, or any other costs billed by pharmacy providers under the Medi-Cal program.

(f) "Medicaid rebate" means the rebate payment made by drug manufacturers pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8).

(g) "State rebate" means the amount negotiated between the manufacturer and the department for reimbursement by the manufacturer, as specified in the contract, in addition to the Medicaid rebate.

(h) "Date of mailing" means the date that is evidenced by the postmark date by the United States Postal Service or other common mail carrier on the envelope.

(i) The amendments made to this section by the act that added this subdivision shall be effective no sooner than January 1, 2021.

(j) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available.

SEC. 58. Section 14105.334 is added to the Welfare and Institutions Code, to read:

14105.334. (a) Notwithstanding any other law, upon approval of the Department of Finance, the department shall seek the necessary federal approvals to establish and administer a drug rebate program to collect rebate payments from drug manufacturers with respect to drugs furnished to selected populations of California residents that are ineligible for full-scope Medi-Cal benefits under this chapter.

(b) The department shall administer the drug rebate program for qualified non-Medi-Cal populations consistent with the applicable requirements and procedures of the federal Medicaid Drug Rebate Program implemented pursuant to Section 14105.33 and Section 1396r-8 of Title 42 of the United States Code.

(c) The department, in consultation with the Department of Finance, shall determine the non-Medi-Cal populations to be included in the drug rebate program administered pursuant to this section based on the level to which the department can demonstrate that their inclusion furthers the goals and objectives of the Medi-Cal program, increases the efficiency and economy

of the Medi-Cal program, and sufficiently benefits the Medi-Cal population as a whole.

(d) The department shall seek any federal approvals from the federal Centers for Medicare and Medicaid Services, via submission of State Plan Amendments or other applicable mechanism, it deems necessary to implement this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

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

(f) For purposes of implementing this section, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis with manufacturers of single-source and multiple-source drugs. Contracts entered into or amended pursuant to this section shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services. Contracts entered into or amended pursuant to this section shall be confidential and shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(g) Any rebate payments collected from manufacturers pursuant to this section shall be deposited in the Medi-Cal Drug Rebate Fund, created pursuant to Section 14105.36.

SEC. 59. Section 14105.467 is added to the Welfare and Institutions Code, to read:

14105.467. (a) The department shall establish, implement, and maintain a supplemental payment pool for nonhospital 340B community clinics, subject to an appropriation by the Legislature.

(b) Beginning January 1, 2021, and any subsequent fiscal year to the extent funds are appropriated by the Legislature for the purpose described in this section, the department shall make available fee-for-service-based supplemental payments from a fixed-amount payment pool to qualifying nonhospital 340B community clinics in accordance with this section and any terms of federal approval obtained pursuant to subdivision (f).

(c) (1) On or before July 15, 2020, the department shall establish a stakeholder process, which shall include representatives of qualifying nonhospital 340B community clinics. Representatives shall be geographically diverse and consist of qualifying nonhospital 340B community clinics with differing pharmacy arrangements, including those that operate in-house pharmacies and those with contract pharmacy arrangements. The stakeholder process shall be utilized to develop and implement the methodology for

distribution of supplemental pool payments to qualifying nonhospital 340B community clinics. This shall include the eligibility criteria for receipt of supplemental payments, the aggregate amount of pool funding available in a respective fiscal year, the criteria for apportioning the pool funding among qualifying nonhospital 340B community clinics, and the timing, frequency, and amount of the resultant supplemental payments.

(2) The department shall conduct at least three meetings with stakeholders and shall finalize the methodology for distribution no later than October 1, 2020.

(d) (1) For any fiscal year that the department implements this section, the aggregate amount of supplemental payments available shall not exceed the pool amount established by the department for the respective fiscal year pursuant to subdivision (b).

(2) For any fiscal year that the department implements this section, the supplemental payment amounts received by a qualifying nonhospital 340B community clinic shall not exceed the apportioned amounts of the pool funding attributable to that individual clinic under the methodology developed pursuant to subdivision (c).

(e) To the extent permissible under federal law, supplemental payments received by qualifying nonhospital 340B community clinics pursuant to this section shall be considered separate and apart from the prospective payment system (PPS) reimbursement the clinic receives pursuant to Section 1396a(bb) of Title 42 of the United States Code and shall not be considered during annual reconciliation of the PPS rate.

(f) (1) The department may modify any methodology or other requirement specified in this section to the extent it deems necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure federal financial participation is available or not otherwise jeopardized.

(2) If the department determines that a modification is necessary pursuant to paragraph (1), the department shall consult with participants of the stakeholder process established pursuant to subdivision (c) to the extent practicable.

(3) If a modification is made, the department shall notify qualifying nonhospital 340B community clinics, the Joint Legislative Budget Committee, and the relevant policy and fiscal committees of the Legislature within 10 business days of that modification.

(g) The department shall implement this section only to the extent that any necessary federal approvals have been obtained, and federal financial participation is available and is not otherwise jeopardized.

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

(i) For purposes of this section:

(1) "340B" means the discount drug purchasing program described in Section 256b of Title 42 of the United States Code.

(2) "Qualifying nonhospital 340B community clinic" means a center or clinic that is licensed under subdivision (a) of Section 1204 of the Health and Safety Code, or a clinic operated by a city, county, city and county, or hospital authority that is exempt from licensure under subdivision (b) of Section 1206 of the Health and Safety Code, and that is a 340B covered entity pursuant to Section 256b of Title 42 of the United States Code for the duration of each applicable fiscal year for which the department implements this section.

SEC. 60. Section 14124.12 is added to the Welfare and Institutions Code, immediately following Section 14124.11, to read:

14124.12. (a) (1) Notwithstanding any other law, for the duration of the COVID-19 emergency period, the department shall implement any federal Medicaid program waiver or flexibility approved by the federal Centers for Medicare and Medicaid Services related to the COVID-19 public health emergency. This includes, but is not limited to, any waiver or flexibility approved pursuant to Sections 1315, 1320b-5, or 1396n of Title 42 of the United States Code, or the Medi-Cal state plan. Any request for a federal Medicaid program waiver or flexibility shall be subject to Department of Finance approval before the department submits that request to the federal Centers for Medicare and Medicaid Services.

(2) During the COVID-19 emergency period, if there is a conflict between this chapter, Chapter 8 (commencing with Section 14200), Chapter 8.8 (commencing with Section 14600), or Chapter 8.9 (commencing with Section 14700), and any approved federal waiver or flexibility, as described in paragraph (1), the approved federal waiver or flexibility shall control over any conflict in the specified state law.

(b) (1) To the extent that federal financial participation is available, the department, subject to Department of Finance approval, shall exercise its option under Section 1396a(a)(10)(A)(ii)(XXIII) of Title 42 of the United States Code to extend the medical assistance, as described in Section 1396a(a)(10)(A)(ii)(XVIII) of Title 42 of the United States Code, to uninsured individuals, as defined in Section 1396a(ss) of Title 42 of the United States Code, for the duration of the COVID-19 emergency period.

(2) The department, subject to Department of Finance approval, may seek federal approval pursuant to Section 1315 of Title 42 of the United States Code to extend the medical assistance afforded to uninsured individuals pursuant to paragraph (1) to include COVID-19-related treatment services that are otherwise covered for full-scope Medi-Cal beneficiaries, as defined by the department. If federal financial participation is unavailable, the department, subject to Department of Finance approval, may elect to implement this paragraph on a state-only funding basis, and subject to an appropriation by the Legislature.

(c) Notwithstanding any other law, the department shall seek to maximize federal financial participation for Medi-Cal expenditures that it determines to be available for the COVID-19 public health emergency, and shall comply

with any federal requirements and conditions for receipt of that federal financial participation. This includes, but is not limited to, the temporary increase in the federal medical assistance percentage made available pursuant to Section 6008 of the federal Families First Coronavirus Response Act (Public Law 116-127).

(d) Due to the impact of the COVID-19 public health emergency on the department's ongoing administration of the Medi-Cal program, the department may seek any federal approvals it deems necessary for any number of temporary extensions of all or select components of the California Medi-Cal 2020 Demonstration (No. 11-W-00193/9) pursuant to Article 5.5 (commencing with Section 14184), which is scheduled to expire on December 31, 2020. If the department elects to seek any extension, the department shall determine the length of time for the extension sought and whether to seek an extension for the entirety of the demonstration or select components of the demonstration. In implementing this subdivision, the department, to the extent practicable, shall consult with affected stakeholder entities before seeking a temporary extension.

(e) The department, subject to Department of Finance approval, shall seek any federal approvals it deems necessary to implement this section or to maintain sufficient access to covered benefits under the Medi-Cal program during the COVID-19 emergency period. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

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

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

(1) "COVID-19 emergency period" has the same meaning as "emergency period" as defined in Section 1320b-5(g)(1)(B) of Title 42 of the United States Code, unless otherwise defined in federal law or any federal approval obtained pursuant to this section.

(2) "COVID-19 public health emergency" means the Public Health Emergency declared by the Secretary of the United States Department of Health and Human Services on January 31, 2020, pursuant to Section 247d of Title 42 of the United States Code, and entitled "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus," including any subsequent renewal of that declaration.

SEC. 61. Section 14124.24 of the Welfare and Institutions Code is amended to read:

14124.24. (a) For purposes of this chapter, "Drug Medi-Cal reimbursable services" means the substance use disorder services described in the California Medicaid State Plan and includes, but is not limited to, all of the following services, administered by the department, and to the extent consistent with state and federal law:

(1) Narcotic treatment program services, as described in subdivision (a) of Section 14021.51.

(2) Intensive outpatient treatment services.

(3) Perinatal residential services for pregnant women and women in the postpartum period.

(4) Naltrexone services.

(5) Outpatient drug-free services.

(6) Other services upon approval of a federal Medicaid state plan amendment or waiver authorizing federal financial participation.

(b) (1) While seeking federal approval for any federal Medicaid state plan amendment or waiver associated with Drug Medi-Cal services, the department shall consult with the counties and stakeholders in the development of the state plan amendment or waiver.

(2) Upon federal approval of a federal Medicaid state plan amendment authorizing federal financial participation for the following services, and subject to appropriation of funds, "Drug Medi-Cal reimbursable services" shall also include the following services, administered by the department, and to the extent consistent with state and federal law:

(A) Medication-assisted treatment services, including both of the following:

(i) Any medication approved under Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), and all biological products licensed under Section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders.

(ii) Counseling services and behavioral therapy.

(B) Case management services, including supportive services to assist a person with substance use disorder diagnoses in gaining access to medical, social, educational, and other needed services.

(C) Aftercare services.

(c) (1) The nonfederal share for Drug Medi-Cal services shall be funded through a county's Behavioral Health Subaccount of the Support Services Account of the Local Revenue Fund 2011, and any available county funds eligible under federal law for federal Medicaid reimbursement. The funds contained in each county's Behavioral Health Subaccount of the Support Services Account of the Local Revenue Fund 2011 shall be considered state funds distributed by the principal state agency for the receipt of the federal block grant funds for prevention and treatment of substance abuse found at Subchapter XVII of Chapter 6A of Title 42 of the United States Code. Pursuant to applicable federal Medicaid law and regulations, including Section 433.51 of Title 42 of the Code of Federal Regulations, a county may claim allowable Medicaid federal financial participation for Drug Medi-Cal services based on the county's certification of their actual total funds expenditures for eligible Drug Medi-Cal services to the department.

(2) (A) If the director determines that a county's provision of Drug Medi-Cal treatment services are disallowed by the federal government or by state or federal audit or review, the impacted county shall be responsible for repayment of all disallowed federal funds. In addition to any other

recovery methods available, including, but not limited to, offset of Medicaid federal financial participation funds owed to the impacted county, the director may offset these amounts in accordance with Section 12419.5 of the Government Code.

(B) A county subject to an action by the director pursuant to subparagraph (A) may challenge that action by requesting a hearing in writing no later than 30 days from receipt of notice of the department's action. The proceeding shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the director shall have the powers granted therein. Upon a county's timely request for hearing, the county's obligation to make payment as determined by the director shall be stayed pending the county's exhaustion of administrative remedies provided but no longer than necessary to ensure the department's compliance with Section 1903(d)(2)(C) of the federal Social Security Act (42 U.S.C. Sec. 1396b).

(d) Drug Medi-Cal services are only reimbursable to a Drug Medi-Cal provider with an approved Drug Medi-Cal contract.

(e) A county shall negotiate contracts only with providers certified to provide Drug Medi-Cal services.

(f) The department shall develop methods to ensure timely payment of Drug Medi-Cal claims.

(g) (1) A county or a contracted provider, except for a provider subject to the requirements of subdivision (h), shall submit accurate and complete cost reports for the previous fiscal year by November 1, following the end of the fiscal year. The department may settle Drug Medi-Cal reimbursable services, based on the cost report as the final amendment to the approved county Drug Medi-Cal contract.

(2) Any amount paid for any service provided to a Drug Medi-Cal beneficiary shall be audited by the department in the manner and form described in Section 14170.

(3) Administrative appeals to review grievances or complaints arising from the findings of an audit or examination made pursuant to this section shall be subject to Section 14171.

(h) A certified narcotic treatment program provider that is exclusively billing the state or the county for services rendered to persons subject to Section 1210.1 or 3063.1 of the Penal Code or Section 14021.52 shall submit accurate and complete performance reports for the previous state fiscal year by November 1 following the end of that fiscal year. That provider shall estimate its budgets using the uniform state daily reimbursement rate. The format and content of the performance reports shall be mutually agreed to by the department, the County Behavioral Health Directors Association of California, and representatives of the treatment provider.

(i) Any contract entered into pursuant to this section shall be exempt from the requirements of Chapter 1 (commencing with Section 10100) and Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(j) Annually, the department shall publish procedures for contracting for Drug Medi-Cal services with certified providers and for claiming payments, including procedures and specifications for electronic data submission for services rendered.

(k) If the department commences or concludes a preliminary criminal investigation of a certified provider, the department shall promptly notify each county that currently contracts with the provider for Drug Medi-Cal services that a preliminary criminal investigation has commenced or concluded.

(1) Notice of the commencement and conclusion of a preliminary criminal investigation shall be made to the county behavioral health director or their equivalent.

(2) Communication between the department and a county specific to the commencement or conclusion of a preliminary criminal investigation shall be confidential and shall not be subject to any disclosure request, including, but not limited to, the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code), the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), requests pursuant to a subpoena, or for any other public purpose, including, but not limited to, court testimony.

(3) Information shared by the department with a county on a preliminary criminal investigation shall be maintained in a manner to ensure protection of the confidentiality of the criminal investigation.

(4) The information provided to a county pursuant to this section shall only include the provider name, national provider identifier number, address, and the notice that an investigation has commenced or concluded.

(5) A county shall not take any adverse action against a provider based solely upon the preliminary criminal investigation information disclosed to the county.

(6) In the event of a preliminary criminal investigation of a county owned or operated program, the department has the option, but is not required, to notify the county when the department commences or concludes a preliminary criminal investigation.

(7) This section does not limit the voluntary or otherwise legally mandated or contractually mandated sharing of information between the department and a county of information on an audit or investigation of a Drug Medi-Cal provider.

(8) "Commenced" means the time at which a complaint or allegation is assigned to an investigator for a field investigation.

(9) "Preliminary criminal investigation" means an investigation to gather information to determine if criminal law or statutes have been violated.

(*l*) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, may implement, interpret, or make specific this section, in whole or in part, by means of bulletins or similar instructions, until the time that any necessary regulations are adopted.

(m) The department shall adopt regulations necessary to implement this section by July 1, 2023.

(n) This section shall be implemented to the extent that any necessary federal approval of state plan amendments or other federal approvals, including waivers, are obtained, and federal financial participation is available and not otherwise jeopardized.

SEC. 62. Section 14133.22 of the Welfare and Institutions Code is amended to read:

14133.22. (a) Prescribed drugs shall be limited to no more than six per month, unless prior authorization is obtained.

(b) The limit in subdivision (a) shall not apply to patients receiving care in a nursing facility.

(c) The limit in subdivision (a) shall not apply to drugs for family planning.

(d) The department may issue Medi-Cal cards that contain labels for prescribed drugs to implement this section.

(e) In carrying out this section, the department may contract either directly, or through the fiscal intermediary, for pharmacy consultant staff necessary to accomplish the treatment authorization request reviews.

(f) This section shall become inoperative on January 1, 2021, and shall be repealed on July 1, 2021, unless a later enacted statute, enacted before that date, deletes or extends that date.

SEC. 63. Section 14134 of the Welfare and Institutions Code is amended to read:

14134. (a) Except for any visit, service, device, or item for which the program's payment is ten dollars ($10) or less, in which case no copayment shall be required, a recipient of services under this chapter shall be required to make copayments not to exceed the maximum permitted under federal regulations or federal waivers, as follows:

(1) Copayment of five dollars ($5) shall be made for nonemergency services received in an emergency department or emergency room when the services do not result in the treatment of an emergency medical condition or inpatient admittance. For the purposes of this section, "nonemergency services" means services not required to, as appropriate, medically screen, examine, evaluate, or stabilize an emergency medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, so that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(A) Placing the individual's health, or, with respect to a pregnant individual, the health of the pregnant individual or pregnant individual's unborn child, in serious jeopardy.

(B) Serious impairment to bodily functions.

(C) Serious dysfunction of any bodily organ or part.

(2) Copayment of one dollar ($1) shall be made for each visit for services under subdivisions (a) and (h) of Section 14132.

(3) The copayment amounts set forth in paragraphs(1) and(2) may be collected and retained, or waived by the provider.

(4) The department shall not reduce the reimbursement otherwise due to providers as a result of the copayment. The copayment amounts shall be in addition to any reimbursement otherwise due to the provider for services rendered under this program.

(5) This section does not apply to emergency services, family planning services, or to any services received by any of the following:

(A) A child in AFDC-Foster Care, as defined in Section 11400.

(B) A person who is an inpatient in a health facility, as defined in Section 1250 of the Health and Safety Code.

(C) A person 18 years of age or under.

(D) A woman receiving perinatal care.

(6) A provider of service shall not deny care or services to an individual solely because of that person's inability to copay under this section. However, an individual shall remain liable to the provider for any copayment amount owed.

(7) This section shall not apply to preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force provided by a physician or other licensed practitioner of the healing arts, or any approved adult vaccines and their administration recommended by the Advisory Committee on Immunization Practices. Pursuant to Section 1905(b) of the federal Social Security Act (42 U.S.C. Sec. 1396d(b)), these services shall be provided without any cost sharing by the beneficiary in order for the state to receive an increased federal medical assistance percentage for these services.

(b) The department shall seek any federal waivers necessary to implement this section. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented, but provisions for which waivers are either obtained or found to be unnecessary shall be unaffected by the inability to obtain federal waivers for the other provisions.

(c) The director shall adopt regulations necessary to implement this section as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The director shall transmit these emergency regulations directly to the Secretary of State for filing and the regulations shall become effective immediately upon filing. Upon completion of the formal regulation adoption process and prior to the expiration of the 120 day duration period of emergency regulations, the director shall transmit directly to the Secretary of State for filing the adopted regulations, the rulemaking file, and the certification of compliance as required by subdivision (e) of Section 11346.1 of the Government Code.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code and subdivision (c), the department may implement, interpret, or make specific the amendments made to this section by the act that added this subdivision, in whole or in

part, by means of policy letter, provider bulletin, or other similar instruction, without taking regulatory action.

(e) The amendments made to this section by the act that added this subdivision shall be effective no sooner than January 1, 2021.

(f) This section shall be implemented only to the extent any necessary federal approvals are obtained and federal financial participation is available.

SEC. 64. Section 14188 of the Welfare and Institutions Code is amended to read:

14188. (a) The Legislature finds and declares both of the following:

(1) Value-based payment (VBP) strategies offer financial incentives to health care providers that improve their performance on predetermined measures or meet specified targets that focus on quality and efficiency of care.

(2) Funding pursuant to the California Healthcare, Research and Prevention Tobacco Tax Act of 2016, or Proposition 56, which was approved by voters at the November 8, 2016, statewide general election, is intended, in part, to supplement payments to Medi-Cal providers to ensure quality care in the Medi-Cal program.

(b) In accordance with Proposition 56 and subject to an appropriation by the Legislature, Proposition 56 funding may be used, pursuant to Section 14188.2, for directed payment programs or incentive arrangements in Medi-Cal managed care, including VBPs required of Medi-Cal managed care plans as designated by the department and as described in this article. The purpose of the VBPs shall be to help improve care for some of the most vulnerable or at-risk populations in the Medi-Cal managed care delivery system.

(c) Effective no earlier than July 1, 2019, the department shall implement the VBP programs described in Section 14188.1, only to the extent that federal financial participation is available and that any necessary federal approvals have been obtained. The department shall develop the structure and parameters of the VBP programs, including designation of those Medi-Cal managed care plans that are required to participate in VBP programs. The department may modify the VBP programs to the extent it deems necessary to obtain or maintain federal approval, if needed to target spending in a manner that furthers the purpose of the programs, or based on evaluation of the programs.

(d) (1) The department shall require the designated Medi-Cal managed care plans to make VBPs to network providers that meet the requirements of the VBP programs implemented pursuant to Section 14188.1, in the amounts, form, and manner as directed by the department.

(2) The department shall not require a county mental health plan contracted with the department pursuant to Chapter 8.9 (commencing with Section 14700), or a county Drug Medi-Cal organized delivery system authorized in the California Medi-Cal 2020 Demonstration pursuant to Article 5.5 (commencing with Section 14184) or a successor demonstration or waiver as applicable, to participate in any VBP program described in Section 14188.1.

(3) VBPs made pursuant to this article shall be in addition to any other payments made by the designated Medi-Cal managed care plans to applicable network providers for services or other performance-based incentives.

(e) For purposes of this article, "VBP" means value-based payment.

SEC. 65. Section 14188.1 of the Welfare and Institutions Code is amended to read:

14188.1. Subject to Section 14188, the department shall develop all of the following VBP programs:

(a) A VBP program that is aimed at improving behavioral health integration in Medi-Cal managed care.

(1) Designated Medi-Cal managed care plans shall make incentive payments to qualified network providers that adopt a team-based care approach for individuals with serious mental health conditions or other chronic health conditions.

(2) Qualified network providers may be eligible for different levels of incentive payments, depending on the level of integration, using either a coordination or collocation approach. The qualified network providers may be eligible for partial incentive payments for meeting above-minimum standards.

(3) The requirements for receiving an incentive payment and the methodology for determining the value of the payment shall be determined by the department, in accordance with this article.

(b) A VBP program that is aimed at improving prenatal and postpartum care in Medi-Cal managed care.

(1) Designated Medi-Cal managed care plans shall make incentive payments to qualified network primary care or appropriate specialist providers that meet achievement levels on selected prenatal and postpartum care measures, as determined by the department.

(2) Qualified network primary care or appropriate specialist providers may be eligible for maximum incentive payments if they meet the designated high-performance standards, and partial incentive payments for meeting above-minimum standards.

(3) The requirements for receiving an incentive payment and the methodology for determining the value of the payment shall be determined by the department, in accordance with this article.

(c) A VBP program that is aimed at improving chronic disease management in Medi-Cal managed care.

(1) Designated Medi-Cal managed care plans shall make incentive payments to qualified network providers that meet achievement levels on selected chronic disease care measures, as determined by the department. The measures shall be in chronic disease care areas, including, but not limited to, diabetes care and control of hypertension, using measures currently recognized for those areas in the Healthcare Effectiveness Data and Information Set (HEDIS) or other nationally recognized measures that the department deems appropriate.

(2) Qualified network providers may be eligible for maximum incentive payments if they meet the designated high-performance standards, and partial incentive payments for meeting above-minimum standards.

(3) The requirements for receiving an incentive payment and the methodology for determining the value of the payment shall be determined by the department, in accordance with this article.

(d) A VBP program that is aimed at improving quality and outcomes for children in Medi-Cal managed care.

(1) Designated Medi-Cal managed care plans shall make incentive payments to qualified network providers that meet achievement levels on selected childhood health care quality measures, as determined by the department. The measures shall be developed using measures currently recognized for those areas in HEDIS or other nationally recognized measures that the department deems appropriate.

(2) Qualified network providers may be eligible for maximum incentive payments if they meet the designated high-performance standards, and partial incentive payments for meeting above-minimum standards.

(3) The requirements for receiving an incentive payment and the methodology for determining the value of the payment shall be determined by the department, in accordance with this article.

(e) (1) Notwithstanding any other law, this section shall become inoperative on July 1, 2021 pursuant to the suspension described in subdivision (a) of Section 14188.4 unless otherwise provided by Section 14188.4.

(2) To the extent applicable, the department shall withdraw any request for federal approval it submitted to implement this article as it read prior to the changes made to this article by the act that added this subdivision.

SEC. 66. Section 14188.4 of the Welfare and Institutions Code is repealed.

SEC. 67. Section 14188.4 is added to the Welfare and Institutions Code, to read:

14188.4. (a) Notwithstanding any other law, the authority for the State Department of Health Care Services to make value-based payments pursuant to this article shall be suspended for payments associated with service periods on or after July 1, 2021, unless the conditions in either subdivision (b) or (d) apply.

(b) The suspension provided for in subdivision (a) shall not take effect if the estimates of General Fund revenues and expenditures for the 2021–22 and 2022–23 fiscal years, as determined pursuant to Section 12.5 of Article IV of the California Constitution that accompany the May Revision required to be released by May 14, 2021, pursuant to Section 13308 of the Government Code, contain estimated annual General Fund revenues that exceed estimated annual General Fund expenditures for the 2021–22 and 2022–23 fiscal years, by an amount equal to or greater than the sum total of all General Fund appropriations for all programs subject to suspension pursuant to this act and all bills providing for appropriations related to this act.

(c) It is the intent of the Legislature to consider alternative solutions to restore this program if the suspension takes effect.

(d) (1) The suspensions pursuant to subdivision (a) shall be implemented only to the extent that the State Department of Health Care Services obtains any necessary federal approvals, determines that federal financial participation for the Medi-Cal program is not otherwise jeopardized as a result of the suspensions, and the necessary system changes have been completed.

(2) In the event federal approval is not available for any such suspension, or if any such suspensions are held to be invalid or unconstitutional by a decision of a court of competent jurisdiction, the department shall implement the remaining suspensions for which any necessary federal approvals are obtained.

SEC. 68. Section 14301.11 is added to the Welfare and Institutions Code, immediately following Section 14301.1, to read:

14301.11. (a) Notwithstanding any law, and subject to subdivisions (e) and (f), in order to account for the impacts of the COVID-19 public health emergency on Medi-Cal managed care capitation rates, the department shall develop and pay capitation rates and capitation increments under any Medi-Cal managed care plan contract pursuant to this section.

(b) In consultation with affected Medi-Cal managed care plans, the department shall develop and implement a risk corridor that is symmetrical to risk and profit to limit the financial risk of either significant capitation rate overpayments or underpayments, pursuant to both of the following:

(1) The risk corridor shall apply to those capitation increments, services and populations, as determined by the department.

(2) The risk corridor shall apply from July 1, 2019, to December 31, 2020, inclusive. The department may continue to apply the risk corridor for rating periods starting on or after January 1, 2021, if the department determines that the continuation of the risk corridor is actuarially appropriate and necessary to account for the impacts of the COVID-19 public health emergency.

(c) To the extent the department determines appropriate, the department shall reduce applicable capitation rate increments by up to 1.5 percent pursuant to subsection (c)(3) of Section 438.7 of Title 42 of the Code of Federal Regulations for capitation rates associated with the July 1, 2019, to December 31, 2020 rating period. The department may apply this reduction to rating periods starting on or after January 1, 2021, if the department determines that the continued reduction is actuarially appropriate and necessary to account for the impacts of the COVID-19 public health emergency.

(d) The department shall evaluate the impact of the COVID-19 public health emergency on capitation rates it develops and pays under Medi-Cal managed care plan contracts, and shall make any adjustments it determines are necessary to ensure capitation rates are actuarially appropriate.

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

(2) The department shall seek any federal approvals it deems necessary to implement the adjustments described in this section, subject to subdivision (f). If federal approval is unavailable with respect to one or more of the adjustments described in this section, or if one or more of the adjustments is held to be invalid or unconstitutional by a decision of a court of competent jurisdiction, the department shall implement the remaining adjustments for which any necessary federal approvals are obtained.

(f) The department, in consultation with the Department of Finance, may modify the requirements of this section, or modify any application of this section with respect to certain capitation rate increments, certain Medi-Cal managed care enrollee categories and subcategories of aid, or certain categories or subcategories of medical assistance provided under a Medi-Cal managed care plan contract, if the department determines necessary to meet federal requirements, to obtain or maintain federal approval, or to maximize federal financial participation.

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

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

(1) "COVID-19 public health emergency" means the Public Health Emergency declared by the federal Secretary of Health and Human Services on January 31, 2020 pursuant to Section 247d of Title 42 of the United States Code (entitled "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus"), and any subsequent renewal of such declaration.

(2) "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a comprehensive risk contract with the department to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries pursuant to Chapter 7 (commencing with Section 14000) or this chapter.

SEC. 69. (a) Notwithstanding any other law, the authority for the State Department of Health Care Services to make supplemental payments or rate increases pursuant to Section 30130.55 of the Revenue and Taxation Code for the below described service categories shall be suspended for such payments associated with service periods on or after July 1, 2021, unless the conditions in either subdivision (b) or (d) apply:

(1) Physician Services.

(2) Dental Services.

(3) Intermediate Care Facilities for the Developmentally Disabled.

(4) Facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20 of the Welfare and Institutions Code.

(5) HIV/AIDS waiver providers.

(6) Home health providers for children and adults in the Medi-Cal fee-for-service system or through home and community-based service waivers.

(7) Pediatric day health care facilities in the Medi-Cal fee-for-service system.

(8) Trauma screenings for children and adults.

(9) Developmental screenings for children.

(10) Provider training for trauma screenings.

(11) Stand-alone Pediatric Subacute Facilities.

(12) Community-Based Adult Services.

(13) Nonemergency medical transportation.

(b) The suspension provided for in subdivision (a) shall not take effect if the estimates of General Fund revenues and expenditures for the 2021–22 and 2022–23 fiscal years, as determined pursuant to Section 12.5 of Article IV of the California Constitution that accompany the May Revision required to be released by May 14, 2021, pursuant to Section 13308 of the Government Code, contain estimated annual General Fund revenues that exceed estimated annual General Fund expenditures for the 2021–22 and 2022–23 fiscal years, by an amount equal to or greater than the sum total of all General Fund appropriations for all programs subject to suspension pursuant to this act and all bills providing for appropriations related to this act.

(c) It is the intent of the Legislature to consider alternative solutions to restore this program if the suspension takes effect.

(d) (1) The suspensions pursuant to subdivision (a) shall be implemented only to the extent that the State Department of Health Care Services obtains any necessary federal approvals, determines that federal financial participation for the Medi-Cal program is not otherwise jeopardized as a result of the suspensions, and the necessary system changes have been completed.

(2) In the event federal approval is not available for any such suspension, or if any such suspensions are held to be invalid or unconstitutional by a decision of a court of competent jurisdiction, the department shall implement the remaining suspensions for which any necessary federal approvals are obtained.

(e) The Legislature finds and declares that the suspension of payments pursuant to this section is:

(1) Made in accordance with the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Article 2.5 (commencing with Section 30130.50) of Chapter 2 of Part 13 of Division 2 of the Revenue and Taxation Code).

(2) Based on criteria developed and periodically updated as part of the annual state budget process, in accordance with subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

(3) Consistent with the purposes and conditions of expenditures described in subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

SEC. 70. Of the balance of the amounts appropriated in Item 4260-101-0001 of Section 2.00 of the Budget Act of 2017 (Chapter 14 of the Statutes of 2017), the sum of one million, four hundred thirty-thousand dollars ($1,430,000) is hereby reappropriated to support the Medically Tailored Meals Pilot Program, as authorized under Section 14042.1 of the Welfare and Institutions Code, and shall be available for encumbrance or expenditure until June 30, 2023.

SEC. 71. The Legislature finds and declares that Sections 127673, 127673.5, and 127673.81 of the Health and Safety Code, as added by this act, impose 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 proprietary information submitted for inclusion in the Health Care Payments Data System, it is necessary for that information to remain confidential.

SEC. 72. The Legislature finds and declares that Section 14105.334 of the Welfare and Institutions Code, as added by this act, 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 facilitate manufacturer participation and deliver affordable prescription drugs to low-income Californians, it is necessary to protect the confidentiality of trade secrets and pricing information.

SEC. 73. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 74. 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. 75. 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.

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