CONCURRENCE IN SENATE AMENDMENTS
AB 184 (Committee on Budget)
As Amended June 26, 2022
Majority vote. Budget Bill Appropriations Takes Effect Immediately

SUMMARY

This is the omnibus health trailer bill which is necessary to implement various provisions of the Budget Act of 2022.

Senate Amendments

Make changes necessary to implement the Budget Act of 2022, affecting the budgets of the California Health and Human Services Agency (Agency), the Health Benefits Exchange (HBEX), the Mental Health Services Oversight and Accountability Commission (OAC), and the following state departments: Health Care Access and Information (HCAI), Health Care Services (DHCS), Public Health (CDPH), and State Hospitals (DSH).

Specifically, this bill:

Extension of Time Limitation Restrictions for Working Capital Financing

1. Extends the amount of interest on any loan, from one year's worth to two years' worth, which may be defined as "working capital," as otherwise defined in statute as moneys to be used by or on behalf of a participating health institution for specified expenses in connection with the ownership or operation of a health facility.
2. Extends the time for a participating health institution that is a private nonprofit corporation or association to repay and discharge a loan for working capital from within 15 months to within 24 months of the loan date.

Office of Health Care Affordability

3. Establishes the Office of Health Care Affordability (OHCA) within the Department of Health Care Access and Information (HCAI), and requires it to:
   a. Increase cost transparency through public reporting of per capita total health care spending and factors contributing to health care cost growth;
   b. Support the board through data collection and analysis and recommendation to establish a statewide health care cost target for per capita total health care spending;
   c. Support the board through data collection and analysis and recommendation to establish health care cost targets by health care sector;
   d. Collect and analyze data from existing and emerging public and private data sources to track spending, set cost targets, approve performance improvement plans, and monitor impacts on workforce stability;
   e. Analyze cost and quality trends for drugs covered by pharmaceutical and medical benefits;

f. Oversee the state's progress towards meeting the health care cost target;

g. Promote, measure, and publicly report performance on quality and health equity through the adoption of a priority set of standard quality and equity measures for health care entities;

h. Advance standards for promoting the adoption of alternative payment models, and for health care workforce stability and training (related to costs);

i. Measure and promote sustained system-wide investments in primary care and behavioral health;

j. Disseminate best practices;

k. Review and evaluate consolidation, market power, and other market failures through cost and market impact reviews of mergers, acquisitions, or corporate affiliations;

l. Analyze trends in the price of health care technologies, and in the cost of labor;

m. Conduct ongoing research and evaluation on payers, fully integrated delivery systems and providers;

n. Collect data and other information it determines necessary from health care entities to carry out its functions, including using the Health Care Payments Data Program, to the greatest extent possible, to minimize reporting burdens for payers and providers;

o. Establish requirements for payers and fully integrated delivery systems to submit data and information;

p. Require health care service plans, health insurers, hospitals, and physician organizations to report data and other information necessary for standard quality measures;

q. Require payers, fully integrated delivery systems, restricted health care service plans, and limited health care service plans to submit data and other information to measure the adoption of alternative payment models and the percentage of total health care expenditures allocated to primary care and behavioral health care;

r. Require providers and any physician organization that are part of a fully integrated delivery system to submit audited financial reports, except for providers that do not routinely prepare audited financial reports, who will be required to submit a comprehensive financial statement instead;

s. Adopt and promulgate regulations for implementing this chapter; and

t. Establish advisory or technical committees, as necessary.

4) Requires payers and fully integrated delivery systems to submit data on total health care expenditures for the 2022 and 2023 calendar years on or before September 1, 2024 (baseline reporting).

5) Requires payers and fully integrated delivery systems to submit data on total health care expenditures for the 2024 and 2025 calendar years based on a reporting schedule established by the OHCA.

6) Requires the OHCA to prepare a report on baseline health care spending on or before June 1, 2025 and requires the OHCA to prepare and publish, by June 1, 2027, its first annual report on health care spending trends, including policy recommendations to control costs and improve quality performance and equity.

7) Establishes the Health Care Affordability Board with eight members, as follows:

   a. Four members appointed by the Governor and confirmed by the Senate;

   b. One member appointed by the Senate Committee on Rules;

   c. One member appointed by the Speaker of the Assembly

   d. The Secretary of Health and Human Services, or their designee; and

   e. The CalPERS Chief Health Director or their deputy (non-voting member).

8) Requires the board to establish a statewide health care cost target and specific targets by health care sector

9) Authorizes the board to adjust cost targets by health care sector when warranted to account for the baseline costs in comparison to other cost targets.

10) Requires the board to approve the:

    a. Methodology for setting cost targets;

    b. Scope and range for administrative penalties and the justification for assessing penalties;

    c. Benchmarks for primary care and behavioral health spending;

    d. Statewide goals for the adoption of alternative payment models; and

    e. Standards to advance the stability of the health workforce.

11) Requires the board to establish a statewide health care cost target for the 2025 calendar year and for each calendar year thereafter.

12) Requires the board to establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities by June 1, 2028.

13) Requires that no appointee of the board shall receive financial compensation from or be employed by health care entities subject to the cost targets or entities subject to cost and market impact reviews or exempted providers.

14) Requires the HCAI director to enforce the cost targets in a manner that: ensures compliance with targets; allows each health care entity opportunities for remediation; and ensures health care entities do not implement performance improvement plans in ways that are likely to erode access, quality, equity, or workforce stability.

15) Authorizes the HCAI director to take the following progressive enforcement actions: 1) provide technical assistance; 2) require or compel public testimony by the health care entity regarding its failure to comply with the target; 3) require submission and implementation of performance improvement plans, including input from the board; and 4) assess administrative penalties.

16) Requires the OHCA to adopt a single set of standard measures for assessing health care quality and equity for health care service plans, health insurers, hospitals, and physician organizations. Requires performance on quality and equity measures be included in the required annual report.

17) Requires the OHCA to promote the shift from payments based on fee-for-service to alternative payment models that provide financial incentives for equitable high-quality and cost-efficient care.

18) Requires the OHCA to measure and promote a sustained system-wide investment in primary care and behavioral health.

19) Requires the OHCA to monitor cost trends, including conducting research and studies, on the health care market, including, but not limited to, the impact of consolidation, market power, venture capital activity, profit margins, and other market failures on competition, prices, access, quality, and equity.

20) Requires the board to establish a Health Care Affordability Advisory Committee to provide input, including recommendations, to the board and the office on a range of issues, including: statewide and sector targets, methodology for setting the targets, definitions of health care sectors, quality and equity metrics, and benchmarks for primary care and behavioral health.

21) Makes findings and declarations related to the value of accessible, affordable, equitable high-quality, and universal health care for all Californians.

22) Establishes legislative intent that the OHCA results in the reduction in the rate of growth in health care costs.

23) Defines various terms, including: exempted provider, physician organization, high-cost outlier, provider, administrative costs and profits, affordability for consumers, affordability for purchasers, fully integrated delivery system, health care cost target, expenditures for covered benefits, and per capita total health care expenditures.

24) States that the provisions of this measure are severable.

CalRx Contract Exemption

25) Permits, until December 31, 2027, the California Health and Human Services Agency (CHHSA) and its departments to enter into exclusive or nonexclusive contracts on a bid or

negotiated basis, and exempts these contracts from review or approval by the Department of General Services for purposes of implementing the California Affordable Drug Manufacturing Act of 2020.

26) Exempts all nonpublic information and documents prepared under the California Affordable Drug Manufacture Act of 2020 from disclosure under the California Public Records Act, and makes findings demonstrating the interest protected by the limitation which is in order to protect proprietary, confidential information regarding manufacturer or distribution costs and drug pricing, utilization, and rebates.

27) Extends the deadlines for CHHSA to submit two reports to the legislature: 1) a report assessing the feasibility of directly manufacturing generic prescription drugs from July 1, 2023 to December 31, 2023; and 2) a report describing the status of the drugs targeted for manufacture and the related impacts from July 1, 2022 to December 31, 2022.

Community Health Workers

28) Requires HCAI, by July 1, 2023, to:

   a. Develop statewide requirements for the community health worker certificate programs, in consultation with stakeholders, including community health workers;

   b. Seek stakeholder input on implementing this article and on the development of certificate requirements; and

   c. Review, approve, or renew evidence-based curricula for core competencies, specialized programs or training.

29) Authorizes an organization to seek approval of a community health worker certificate program in accordance with this article and any standards approved by the department, and requires such an organization to oversee and enforce the requirements developed pursuant to this article.

30) Requires an organization seeking approval or renewal of the community health worker certificate program to:

   a. Submit a community health worker certificate program plan that describes how the program meets state requirements;

   b. Submit to periodic reviews conducted to ensure adherence to state requirements; and

   c. Submit annual community health worker certificate program reports on participant training and employment.

31) Authorizes HCAI to request program participants to submit data consistent with section 502 of the Business and Professions Code, and exempts, until June 30, 2024, this data from the requirements of the Administrative Procedures Act, requires HCAI to determine the frequency and manner of data submission, and to maintain the privacy of data submitted consistent with all relevant federal and state laws.

32) Authorizes HCAI to implement this contract utilizing contracts with vendors, and exempts HCAI from developing regulations for the implementation of this article.

33) Defines the following terms: community health worker, core competencies, cultural competence, lived experience, and specialty certificate.

California Health Workforce Education and Training Council

34) Revises and recasts various provisions related to the establishment of the California Health Workforce Education and Training Council, including adding the Secretary of Labor and Workforce Development onto the council.

35) Revises the requirement of the Director of HCAI to develop Song-Brown Program application and contract criteria based on health care workforce needs and the priorities of the council, to just be based on health care workforce needs and priorities.

Midwife Training in Song-Brown

36) Establishes that programs that train midwives qualify for participation in the Song-Brown Program.

37) Defines "programs that train midwives" to mean programs that train certified nurse-midwives and programs that train licensed midwives, each as defined pursuant to Section 128297.

Abortion Practical Support Fund

38) Establishes the Abortion Practical Support Fund as a continuously appropriated fund, and requires HCAI to administer the Fund for the purpose of providing grants to assist pregnant people who are low income or face other financial barriers with access to abortions in California, and for research to support equitable access to abortion.

39) Authorizes HCAI to receive and deposit moneys in the fund from: a) nonstate entities, such as private sector or philanthropic entities; and b) local and federal government agencies.

40) Defines "grantee" as a qualifying nonprofit organization in California that assists pregnant people with direct practical support for the purposes of obtaining an abortion.

41) Defines "practical support" as direct assistance, in-state travel, dependent childcare, doula support, and translation services to help a person access and obtain an abortion in California.

42) Defines in-state travel as airfare, lodging, ground transportation, gas money, and meals.

43) Requires HCAI, or its contracted vendor, to use moneys in the fund to maintain a system of financial reporting on all aspects of the fund.

44) Finds and declares that this section imposes a limitation on the public's right of access to the meetings of public bodies because the public interest to protect the privacy of patients of abortion services outweighs the public's right of access to that information.

Record Retention Requirements

45) Extends the length of time, from 3 to 10 years, for which every primary supplier of pharmaceuticals, medical equipment, or supplies is required to maintain accounting records subject to audit by the Department of Health Care Services (DHCS).

Premiums in the Medi-Cal Program

46) Authorizes DHCS, effective July 1, 2022, to the extent allowable under federal law, to elect not to impose Medi-Cal premiums, or subscriber contributions, on select beneficiaries, with household incomes between 160 and 261 percent of the federal poverty level, within specified programs within the Medi-Cal program, including: optional targeted low-income children, Medi-Cal Access program, and employed individuals with disabilities.

47) Requires DHCS to publish its choice to not impose premiums, or to reinstate premiums, in the Medi-Cal Local Assistance Estimate for the impacted fiscal year, subject to appropriation in the annual Budget Act.

Align Medi-Cal Redeterminations with Federal Guidelines

48) Deletes certain requirements related to re-determining eligibility of Medi-Cal beneficiaries to align with federal guidelines, including the requirement on counties to prepopulate the form, and the requirement on beneficiaries to sign or return the form.

49) Requires DHCS to develop future revisions to the form.

50) Requires that eligibility re-determinations be performed in a timely manner, without requiring new applications, and without rescinding preceding terminations, when beneficiaries submit to counties a signed and completed form, within 90 days of termination, and are found eligible for Medi-Cal.

Medi-Cal Dental Managed Care Extension

51) Requires DHCS to conduct a competitive bid and procurement process to award new dental managed care contracts, commencing on an effective date no sooner than January 1, 2024.

52) Extends the existing dental managed care contracts through December 31, 2023, or through the calendar day immediately preceding the effective date of the new contracts, whichever is later.

53) Requires DHCS, if the new dental managed care contracts have not taken effect on or before July 1, 2024, to provide an update to the Legislature detailing the specific circumstances that contributed to the delay and an expected commencement date for the new contracts.

54) Conditions implementation of these provisions on receipt of any necessary federal approvals.

Expansion of Medi-Cal to 26-49, Regardless of Immigration Status

55) Expands eligibility for full scope Medi-Cal benefits to individuals who are 26 to 49 years of age, inclusive, and who do not have satisfactory immigration status or are unable to establish satisfactory immigration status, if they are otherwise eligible for full scope Medi-Cal benefits.

56) Implements this expansion after the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation, but no later than January 1, 2024.

Update to Medi-Cal Dental Policy With Evidence-Based Practices

57) Provides Medi-Cal dental coverage of laboratory-processed crowns on posterior teeth for persons 21 years of age or older when medically necessary to restore a posterior tooth back to normal function.

58) Deletes obsolete requirements on DHCS related to oral health.

59) Requires that covered dental benefits and accompanying criteria for receipt of those dental benefits under the Medi-Cal program be identified in the Medi-Cal Dental Manual of Criteria.

60) Requires DHCS to consider evidence-based practices consistent with the American Academy of Pediatric Dentistry and the American Dental Association guidelines for all covered dental benefits.

61) Makes these provisions contingent on receiving federal approvals and federal financial participation.

Suspension of Medi-Cal Benefits for Incarcerated Adults

62) Suspends an adult's Medi-Cal benefits on the date the adult becomes an inmate of a public institution, consistent with current law, and ends the suspension of those benefits on the date that the individual is no longer an inmate of a public institution, if otherwise eligible, effective January 1, 2023, as compared to current law which terminates enrollment in Medi-Cal either on the date the individual is no longer an inmate or one year after becoming an inmate, whichever is sooner.

Medication Assisted Treatment Project Expansion

63) Requires, no sooner than July 1, 2022, certified alcohol and drug programs to either offer medications for addiction treatment (MAT) directly to clients, or have an effective referral process in place with narcotic treatment programs, community health centers, or other MAT providers.

64) Requires an "effective referral process" to include an established relationship with a MAT provider and transportation to appointments for MAT.

65) Requires certified alcohol and other drug programs to implement and maintain a MAT policy approved by the department and requires the MAT policy to:

   a. Explain how a client receives information about the benefits and risks of MAT.

   b. Describe the availability of MAT at the program, if applicable, or the referral process for MAT.

   c. Identify an evidence-based assessment for determining a client's MAT needs.

d. Address administration, storage, and disposal of MAT, if applicable.

e. Outline training for staff about the benefits and risks of MAT and on the MAT policy.

66) Requires DHCS, no sooner than July 1, 2022, to establish a program for the operation and regulation of mobile narcotic treatment programs, and specifies that a narcotic treatment program shall:

a. Operate under the license of a primary narcotic treatment program with which it is affiliated and associated.

b. Provide opioid addiction treatment in a motor vehicle.

c. Comply with any applicable federal requirements.

d. Receive approval from the department prior to operating a mobile narcotic treatment program.

e. Establish the requirements for approval of a mobile narcotic treatment program and oversee and enforce the requirements.

67) Subjects the primary narcotic treatment program to action under Section 11839.9 for any violation by its mobile narcotic treatment program of any requirements imposed under this section.

68) Authorizes DHCS to terminate the operation of a mobile narcotic treatment program for failing to comply with this section.

Opioid Settlement Fund

69) Establishes the Opioid Settlements Fund in the State Treasury to receive funds from the Litigation Deposits Fund from the settlement of People v. McKinsey & Company, Inc.

70) Requires that funds received from this settlement that are not deposited in the Litigation Deposits fund be deposited into the Opioid Settlements Fund.

71) Requires the Controller to transfer funds received in the Litigation Deposits Fund allocated to the state for state opioid remediation from the 2022 opioid settlements with Johnson & Johnson, Janssen Pharmaceuticals, McKesson, Cardinal Health, and AmerisourceBergen to the Opioid Settlements Fund.

72) Requires that funds received from this settlement that are not deposited in the Litigation Deposits fund be deposited into the Opioid Settlements Fund.

73) Requires, upon appropriation by the Legislature, moneys in the Opioid Settlements Fund be used for opioid remediation in accordance with the terms of the judgment or settlement from which the funds were received.

74) Requires DHCS to administer the Opioid Settlements Fund and oversee those activities funded by the Opioid Settlements, including designating high-impact abatement activities,

conducting related stakeholder engagement, monitoring participating subdivisions for compliance, and preparing periodic written reports.

75) Requires that any settlement funds received by a participating subdivision, that are not expended or encumbered within the time period specified in the California State-Subdivision Agreement Regarding Distribution and Use of Settlement Funds, be transferred to the state and be deposited into the Opioid Settlements Fund.

76) Authorizes DHCS to implement this section without taking regulatory action.

77) Authorizes DHCS to enter into contracts for implementing this section, and provides an exemption from the Public Contracts Code for this purpose.

Shift of Suicide Prevention Voluntary Contribution Fund Administration

78) Shifts revenue collected through the Suicide Prevention Voluntary Tax Contribution Fund from the Mental Health Services Oversight and Accountability Commission to DHCS.

79) Eliminates the requirement that 50% of these funds be awarded as grants to provide suicide prevention services to rural and desert communities and that 50% of the funds be disbursed on a proportional basis to crisis centers based on the number of calls answered by the crisis centers.

80) Requires these funds to be disbursed to crisis centers located in the state that are active members of the National Suicide Prevention Lifeline, with priority given to those crisis centers located in rural and desert communities.

81) Prohibits the use of these funds to supplant state administrative funding.

82) Authorizes DHCS to implement this section by way of contracts, and provides an exemption from the Public Contracts Code for this purpose.

California Advancing and Innovating Medi-Cal (CalAIM)

83) Deletes the requirement that grants for Medi-Cal behavioral health delivery systems to support the implementation of evidence-based interventions and community-defined promising practices as part of the Children and Youth Behavioral Health Initiative Act be administered through the Behavioral Health Quality Improvement Program (BHQIP) established in existing law through AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, the health budget trailer bill from last year.

84) Expands the purposes of the BHQIP, which provides grants to Medi-Cal behavioral health delivery systems for the purpose of preparing those entities and their contracting providers for implementation of the CalAIM changes, by deleting the additional purpose of the BHQIP implementing changes to the behavioral health delivery system in the Children and Youth Behavioral Health Initiative, and by instead broadening the purpose to being "other purposes related to Medi-Cal behavioral health delivery systems as specified in an annual Budget Act or enacted legislation providing appropriations related to those acts."

85) Expands the scope of Medi-Cal benefits to pregnant individuals to full-scope benefits (instead of "pregnancy only" benefits) for individuals with an effective income between

138% and 213% of the federal poverty level (FPL), effective January 1, 2024, and makes conforming changes.

86) Delays the requirement in existing law, from January 1, 2023 to July 1, 2023, that DHCS include institutional long-term care services (other than skilled nursing facility services) as a capitated benefit in each contract with a Medi-Cal managed care plan, and makes conforming changes to the dates in existing provisions of law on Medi-Cal payment rates.

87) Renames "in lieu of services" as "community supports" and defines "community supports" as those alternative services and settings approved in the California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions that are administered pursuant to federal Medicaid managed care regulation; community supports are services that Medi-Cal managed care plans are authorized to offer as an optional benefit for Medi-Cal beneficiaries in plans that are "in lieu of" a covered Medi-Cal service.

88) Permits DHCS, as a component of the Specialty Mental Health Services Program (the Medi-Cal county mental health plan [MHP] benefit is known as specialty mental health services, and is provided by county MHPs for more severely mentally ill individuals), in consultation with counties and other affected stakeholders, to seek federal approval for a federal Medicaid demonstration project which may include receipt of federal financial participation (FFP) for services furnished to Medi-Cal beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as institutions for mental diseases (IMDs).

89) Permits DHCS to elect to seek approval for the IMD demonstration project to operate on a statewide basis or on a county-by-county basis.

90) Requires DHCS to implement the IMD exclusion demonstration in accordance with the terms of the federal approval and only to the extent that:

   a) FFP is available and is not otherwise jeopardized:

   b) DHCS receives the necessary federal approvals to implement the demonstration project; and,

   c) The IMD demonstration project is approved by the Department of Finance.

91) Defines an IMD, pursuant to the definition of federal law, as a a hospital, nursing facility or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

92) Expands eligibility for a qualifying inmate of a public institution for targeted Medi-Cal services by deleting the existing law reference to the number of days approved in the CalAIM Terms and Conditions if "fewer than" 90 days to instead permit a number "different than" 90 days with respect to an eligible population, effectively allowing a period greater than 90 days for a subset of the inmate population.

93) Applies the 85% medical loss ratio (MLR) requirement, which currently applies to Medi-Cal managed care plans, to subcontracting MCMC plans, effective July 1, 2022 by repealing the exemption for subcontracting MCMC plans in existing law.

94) Extends the requirement that DHCS post the MLR of each MCMC plan to also include posting the MLR of each subcontractor plan or other delegated entity, under contract with the MCMC plan, which is required to report an MLR pursuant to the CalAIM Terms and Conditions.

95) Extends the remittance requirement, which is the amount owed by each MCMC plan for failure to meet the 85% MLR, to each subcontractor plan or other delegated entity to that MCMC care plan pursuant to the CalAIM Terms and Conditions

96) Deletes the exemption from the MLR remittance requirement in existing law for Denti-Cal managed care plans, effective January 1, 2024, thereby applying the remittance requirement to these plans.

97) Permits DHCS to implement, interpret, or make specific the MLR provisions in existing law, in whole or in part, by means of plan letters, plan or provider bulletins, or similar instructions, without taking any further regulatory action.

Conform Clinical Trials With Federal Law

98) Expands, effective July 1, 2022, the routine patient care coverage requirements for qualifying clinical cancer trials for purposes of the Medi-Cal program, to conform to the federal Medicaid definition of a qualifying clinical trial.

99) Requires treatment to be provided in a qualifying clinical trial, which means a clinical trial, in any clinical phase of development, that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition and is described in Section 1396d(gg)(2)(A) of Title 42 of the United States Code.

Continuous Glucose Monitors Reimbursement Methodology

100) Amends the definition of medical supplies under the Medi-Cal pharmacy benefit to be inclusive of diabetic products, allowing for the implementation of a revised reimbursement methodology for continuous glucose monitoring, from the current estimated acquisition cost, plus the pharmacy professional dispensing fee, to a Maximum Acquisition Cost plus 23 percent.

Restoration of Medi-Cal Provider Rate Reductions

101) Eliminates, effective July 1, 2022 (unless indicated otherwise), a ten percent provider rate reduction that was adopted through AB 97 (2011 budget trailer bill) for the following providers: nurses, alternative birth centers, audiologists, hearing aid dispensers, respiratory care providers, durable medical equipment, chronic dialysis clinics, emergency medical air transportation services, nonemergency medical transportation services, doula services, community health worker services, durable medical equipment, health care services delivered via remote patient monitoring, asthma prevention services, dyadic services, clinical laboratory services, medication therapy management services (as specified), blood banks,

occupational therapists, orthotists, podiatrists and prosthetists (effective January 1, 2023), psychologists, medical social workers, speech pathologists, free clinics, outpatient heroin detoxification centers, dispensing opticians, optometrists and optometry groups, acupuncturists, portable imagine services, California Children's Services and Genetically Handicapped Persons Program services, and community clinics, free clinics, surgical clinics, rehabilitation clinics, and non-hospital county-operated community clinics.

102) Authorizes the use of General Fund, in place of funding from Proposition 56 (the California Healthcare, Research and Prevention Tobacco Tax Act of 2016) for supplemental payments for specified Medi-Cal providers, contingent on receipt of federal approvals and the availability of federal financial participation, including:

a. Case management services under the HIV/AIDS Waiver Program;

b. Community-Based Adult Services;

c. Developmental screenings for individuals zero to three years of age;

d. Adverse childhood experiences (ACEs) trauma screenings;

e. Nonemergency medical transportation;

f. Home health providers of medically necessary services for children and adults in Medi-Cal fee-for-service or through the home and community-based services waivers; and

g. Pediatric day health care facilities.

103) Authorizes DHCS to implement this provision through provider bulletins or similar instructions.

104) Requires DHCS to develop the eligibility criteria, methodologies, and parameters for the payments and rate increases maintained, and authorizes revisions.

Federal Public Health Emergency Unwinding

105) Deletes the requirement that a specialty mental health facility's written record, of a voluntarily admitted patient's consent to receive antipsychotic medications, include the patient's signature.

106) Authorizes qualified hospitals to make presumptive Medi-Cal eligibility determinations for individuals who are 65 years of age or older, blind, or disabled, who meet certain income criteria.

107) Continues indefinitely the current Medi-Cal reimbursement rate for intermediate care facilities for the developmentally disabled or facilities providing continuous skilled nursing care to developmentally disabled individuals.

108) Exempts the following providers from 10 percent Medi-Cal reimbursement reductions that took effect June 1, 2011: nurses, alternative birth centers, audiologists, hearing aid dispensers, respiratory care providers, certain durable medical equipment, chronic dialysis clinics, emergency medical air transportation services, nonemergency medical transportation

services, doula services, community health worker services, health care services delivered via remote patient monitoring, asthma prevention services, dyadic services, medication therapy management services, and clinical laboratory services.

109) Requires that Medi-Cal reimbursement for oxygen and respiratory equipment, as determined by the department, not exceed 100% of the lowest maximum allowance for California established by the federal Medicare Program for the same.

110) Makes permanent the requirement in place during the Public Health Emergency that DHCS reimburse the administration of a COVID-19 vaccine at 100% of the Medicare national equivalent rate in effect at the time of administration without geographic adjustment, contingent on federal approvals and that federal financial participation is available and not jeopardized.

Medi-Cal Telehealth Policy

111) Provides that face-to-face contact is not required when covered Medi-Cal services are provided by video synchronous interaction, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, meeting certain criteria.

112) Requires a provider furnishing services through video synchronous interaction or audio-only synchronous interaction to also offer those services through in-person, face-to-face contact or arrange for a referral to in-person care.

113) Authorizes a provider to establish a new patient relationship with a Medi-Cal beneficiary through video synchronous interaction, and prohibits a provider from doing so through other telehealth modalities.

114) Adopts various requirements on DHCS, or a Medi-Cal provider, relating to the use of telehealth modalities, including requirements concerning fee schedules and minimum reimbursement limits, services in border communities, as defined, consent standards, privacy and security compliance, informational notices, and a research and evaluation plan.

115) Expands the definition of patient "visit," for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), to include an encounter between an FQHC or RHC patient and any of specified health care professionals using video synchronous interaction, audio-only synchronous interaction, or asynchronous store and forward modality when the applicable standard of care and other conditions are met.

116) Establishes other requirements on an FQHC or RHC relating to the use of those telehealth modalities, including requirements concerning reimbursement rates, consent standards, privacy and security compliance, the establishment of new patient relationships, and in-person services or referrals.

117) Authorizes reimbursement for additional medically necessary Drug Medi-Cal services and to other authorized individuals when those services are delivered through video synchronous interaction or audio-only synchronous interaction.

118) Establishes certain requirements relating to privacy and security compliance and the establishment of new patient relationships through telehealth modalities for Drug Medi-Cal.

119) Requires DHCS to adopt regulations by July 1, 2024, to implement telehealth provisions specific to Drug Medi-Cal.

120) Extends from January 1, 2023 to January 1, 2026 certain time, distance, and appointment time standards for specified services to ensure that Medi-Cal managed care covered services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner.

121) Authorizes DHCS to allow a Medi-Cal managed care plan to use clinically appropriate video synchronous interaction as a means of demonstrating compliance with the time or distance standards, and as part of an alternative access standard request, and authorizes DHCS to develop policies for granting credit, as specified.

122) Makes changes to the frequency of alternative access standards request submissions made by Medi-Cal managed care plans when they cannot meet the time and distance standards, and requires the plan to close out any corrective action plan deficiencies in a timely manner to ensure beneficiary access is adequate and to continually work to improve access in its provider network.

FQHC Alternative Payment Methodology Project

123) Makes various changes to the Medi-Cal alternative payment methodology (APM) for FQHCs, with implementation of new provisions under the existing APM pilot project to begin no sooner than January 1, 2024, subject to any necessary federal approvals, and no longer limited to a period of up to 3 years.

124) Removes responsibility-sharing terms currently in place that govern a risk corridor structure for principal health plans, and instead requires DHCS to develop and specify the terms of the risk corridor in a form and manner specified by DHCS through all-plan letters or other technical guidance that would be incorporated into the contracts between each affected principal health plan and DHCS.

125) Eliminates existing formulas used to calculate adjustments to payments that reflect higher than expected utilization, and instead specifies that the participating FQHC site receive an aggregate payment adjustment from the principal health plan or applicable subcontracting payer that is based upon the difference between its actual utilization for the year and the projected utilization for the year.

126) Removes provisions relating to the determination that an FQHC has exceeded the threshold of a lower than expected visit utilization by at least 30 percent, and instead requires DHCS to develop objective criteria for minimum standards for access and quality.

127) Requires a participating FQHC site that does not meet those standards to return a portion of revenue based on a formula developed by DHCS.

128) Conditions any modifications to the APM project on not violating the spirit, purposes, and intent of the APM provisions, and requires DHCS to notify affected FQHCs, principal health plans, and certain legislative committees within 10 business days of any modification.

129) Repeals current law that: a) authorizes DHCS to make payment adjustments in response to an epidemic or similar catastrophic occurrence; b) requires DHCS to contract with an independent entity to perform an evaluation of the APM pilot project; and c) requires that certain reports be submitted to the Legislature.

Qualifying Community-Based Mobile Crisis Intervention Services

130) Requires DHCS to seek federal approval to provide Medi-Cal coverage for community-based mobile crisis intervention services, including those that are furnished by a multidisciplinary mobile crisis team, as specified, available 24 hours per day, every day of the year, and furnished to an individual otherwise eligible for medical assistance under the state plan or waiver pursuant to Medicaid provisions, who is outside of a hospital or other facility setting, and who is experiencing a mental health or substance use disorder crisis.

131) Requires DHCS to comply with any federal requirements and conditions for receipt of an increased federal medical assistance percentage under the above-described federal law.

132) Requires DHCS to establish requirements for the receipt of the services by eligible Medi-Cal beneficiaries and for authorized service providers, and to oversee and enforce the requirements and guidelines.

133) Authorizes DHCS to enter into exclusive or nonexclusive contracts, or to amend existing contracts, for purposes of implementing these provisions.

134) Authorizes DHCS to implement these provisions through plan or county letters or similar instructions without taking any further regulatory action.

135) Requires DHCS to consult with interested stakeholders when issuing guidance, to the extent practicable.

136) Authorizes these provisions to be implemented no sooner than January 1, 2023, up to the end of the 5-year period specified under federal law, and is subject to receipt of any necessary federal approvals and the availability of federal financial participation.

Discontinuation of the Child Health and Disability Prevention Program and Expansion of Children's Presumptive Eligibility

137) Requires DHCS to discontinue the Child Health and Disability Prevention Program, as of July 1, 2024 or the date certified by DHCS, whichever is later, and transition CHDP services to other Medi-Cal services or programs.

138) Requires DHCS to seek federal approval to implement these provisions.

139) Requires DHCS, prior to July 1, 2024 to do the following:

a. Conduct a stakeholder engagement process, including specified stakeholders and subject matter experts, to inform DHCS on the development and implementation of a transition plan and defined milestones to guide the transition of CHDP services to other Medi-Cal programs.

b. Strive to ensure the stakeholder engagement process reflects participation from the various regions throughout the state, including large urban and rural jurisdictions.

c. Launch the stakeholder engagement process no later than October 1, 2022.

d. Develop a transition plan, including: i) post transition oversight and monitoring plan of children currently served through CHDP; ii) a plan for how managed care plans will monitor providers serving children, as specified; iii) a plan to fund the Health Care Program for Children in Foster Care; and iv) an analysis and plan for retaining existing local CHDP positions.

140) Requires DHCS to:

a. Provide an update to the Legislature during the 2023-24 budget hearings on the proposed transition plan;

b. Take actions necessary to continue Medi-Cal presumptive eligibility for children under 19 years of age, including expanding access within the Children's Presumptive Eligibility Program to include all eligible Medi-Cal providers;

c. Take actions necessary, in consultation with the State Department of Social Services, to continue the Health Care Program for Children in Foster Care;

d. Continue the Childhood Lead Poisoning Prevention Program activities in consultation with the State Department of Public Health; and

e. Seek any federal approvals DHCS deems necessary to implement this section.

141) Requires that this section shall be implemented only to the extent that any necessary federal approvals are obtained and DHCS determines that federal financial participation is available and not otherwise jeopardized.

142) Requires all CHDP providers, as of June 30, 2024, to be automatically enrolled as providers under the Children's Presumptive Eligibility Program.

143) Requires DHCS to issue a declaration certifying the date that all activities required pursuant to this section have been completed, and requires DHCS to post the declaration on its internet website and provide a copy of the declaration to Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

144) Requires DHCS to implement the Children's Presumptive Eligibility Program for the pre-enrollment of children into the Medi-Cal program, and authorizes DHCS to designate Medi-Cal providers as qualified entities to determine eligibility for pre-enrollment into Medi-Cal.

145) Requires Medi-Cal providers to assist the parent or guardian with the pre-enrollment application for enrollment of their child in Medi-Cal.

146) Deletes obsolete provisions relating to the former Healthy Families Program and former Managed Risk medical Insurance Board, and makes other technical, non-substantive changes to related provisions.

147) Shifts responsibility for seeking federal financial participation from the Department of Social Services to DHCS, for a public health nursing program within child welfare services, and requires DHCS, counties, and cities to maximize the use of federal funds in implementing this program.

148) Authorizes DHCS to enter into contracts with a California county, city, or city and county to facilitate local administration of this program.

149) Authorizes DHCS to implement this section without taking regulatory action.

Medi-Cal Share of Cost Reform

150) Authorizes Medi-Cal eligibility for certain medically needy persons with higher incomes, without a share of cost, as compared to current law which requires inclusion of a share of cost.

151) Authorizes this Medi-Cal eligibility for individuals who are 65 years of age or older or are disabled.

152) Requires federal authorization for this change to the "maintenance of income" level, and requires DHCS to adopt, amend, or repeal any necessary regulations within two calendar years of implementation.

153)

Requires that implementation of this section be contingent on all of the following conditions:

a. All necessary federal approvals have been obtained by the department; and

b. The Legislature has appropriated funding to implement this section after a determination that ongoing General Fund resources are available to support the ongoing implementation of this section in the 2024-25 fiscal year and subsequent fiscal years.

154) Requires DHCS to issue a declaration certifying the date that all of the above conditions have been met and shall post the declaration on its internet website and provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

Continuous Medi-Cal Coverage for Children zero through four.

155) Establishes that a child under five years of age shall be continuously eligible for Medi-Cal, including without regard to income, until the child reaches five years of age.

156) Prohibits the redetermination of Medi-Cal eligibility before the child reaches 5 years of age, unless DHCS or the county possesses facts indicating that the family has requested the child's voluntary disenrollment, the child is deceased, the child is no longer a state resident, or the child's original enrollment was based on a state or county error or on fraud, abuse, or perjury, as specified.

157) Removes the requirement for providing income information at the end of 12 months postpartum for individuals within the Medi-Cal Access Program and instead requires that

infants remain continuously eligible for the Medi-Cal program until they are five years of age.

158) Requires that the application for County Health Initiative Matching Fund funding specify that the county-applicant will provide continuous eligibility for a child under the program until the child is five years of age if the child is not determined to be eligible for Medi-Cal during that time.

159) Conditions implementation of these provisions on receipt of any necessary federal approvals and on the availability of federal financial participation and on all of the following conditions:

- o The Legislature has appropriated funding to implement this section after a determination that ongoing General Fund resources are available to support the ongoing implementation of this section in the 2024-25 fiscal year and subsequent fiscal years; and

- o DHCS has determined that systems have been programmed to implement this section.

160) Requires DHCS to issue a declaration certifying the date that all conditions described above have been met, post the declaration on its internet website, and provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

161) Makes this section operative on January 1, 2025, or the date certified by the department, whichever is later.

Hospital and Nursing Facility Worker Retention Payments

162) Finds and declares that:

- o Stability in the California health care workforce will further its efforts to manage the COVID-19 pandemic and address other public health issues that face Californians; and

- o Providing California health care workers in 24 hour care facilities with retention payments, as appropriated and available, will advance California's effort to promote stability and retention in California's health care workforce.

163) Requires DHCS, upon appropriation from the Legislature, to provide funding to participant covered entities, covered services employers, and physician entities to make retention payments to their eligible employees or eligible physicians, and to make retention payments directly to eligible physicians who are not employees of a covered entity or physician entity, with the goal of advancing California's effort to promote stability and retention in California's health care workforce.

164) Authorizes DHCS to provide up to $1,500 for each eligible full-time employee, $1,250 for each eligible part-time employee, or $1,000 for each eligible physician, subject to the established methodology and total amount of funding available for this purpose.

165) Requires a covered entity, as a condition of receipt of funding, to provide specified information about its employees and other information required by DHCS.

166) Establishes a process for DHCS to calculate the amount of the retention payments to be made to each covered entity and eligible physician, including:

a. For an eligible full-time employee, the state payment amount shall be $1,000 plus the amount of matching retention payment paid to the eligible full-time employee by the covered entity or covered services employer, up to a total maximum state payment of $1,500.

b. For an eligible part-time employee, the state payment amount shall be $750 plus the amount of matching retention payment paid to the eligible part-time employee by the covered entity or covered services employer, up to a total maximum state payment of $1,250.

c. For an eligible physician, the state payment amount shall be $1,000.

167) Authorizes DHCS to reduce the payment amounts to reflect the total amount of funding appropriated to DHCS and the total number of eligible employees and physicians.

168) Requires DHCS, to the extent feasible, to adopt a methodology to ensure that no employee or physician receives more than one retention payment.

169) Requires DHCS to determine the conditions and data reporting requirements for participant covered entities to be eligible to receive funding for retention payments.

170) Requires all covered entities to provide all funding to their eligible employees and eligible physicians within 60 days of receipt from DHCS, and return to DHCS any funding that is not distributed within 60 days of receipt from DHCS.

171) Requires all covered entities to report to DHCS the details of the payments made within 90 days of receipt of funds.

172) Prohibits the use of these funds to supplant other payments to employees or physicians.

173) Stipulates that these payments shall not be considered payment for patient care or medical services.

174) Establishes a dispute resolution process specific to these payments for both employees and physicians.

175) Requires, if the Labor Commissioner finds that the covered entity or covered services employer is liable for failing to make a required retention payment, the covered entity or covered services employer to be ordered to make full payment of the unpaid amount plus interest.

176) Makes a covered entity or covered services employer that willfully fails to make a full retention payment after receiving a request for review liable to the employee for liquidated damages in an amount equal to the unpaid amount.

177) Provides that, if the covered entity or covered services employer does not conclude the retention payment review within 30 days of receipt of the review request, or does not cure the alleged deficiency within 30 days of receipt of the review request, and the alleged deficiency

is greater than $500, the employee may file a complaint with the Labor Commissioner or the employee may file a civil action in court to recover the deficiency.

178) Stipulates that DHCS shall not be liable for any payment, interest, liquidated damages or attorney's fees and costs awarded to an employee pursuant to this section, and shall not be required to indemnify a covered entity or covered services employer for any such liability they incur pursuant to this section.

179) Requires the Labor Commission to enforce this part of this Act.

180) Stipulates that this part of the Act does not create a private right of action in any civil litigation against covered entities, covered services employers and physician entities regarding the administration of the retention payment program and in the receipt and transmittal of retention payment program funds.

181) Requires that, except as provided in Sections 1493 and 1494, and notwithstanding any other law, covered entities, covered services employers, physician entities, and DHCS shall not be liable for damages awarded under Section 3294 of the Civil Code, Sections 2698 to 2699.5 of the Labor Code, or other damages imposed primarily for the sake of example and by way of punishing the defendant, in any civil litigation related to the retention payments described in this part.

182) Defines, for purposes of this Act, the following terms: covered entity, covered services employer, date of record, eligible full-time employee, eligible part-time employee, eligible physician, managers and supervisors, matching retention payments, physician entity, qualifying facility, qualifying work period, and state facility.

183) Declares that the provisions of the Act are severable.

Future of Public Health

184) Requires CDPH, upon appropriation by the Legislature for this purpose, to develop and implement a program to fund and support vital public health activities and services to be provided by the 61 local health jurisdictions (LHJs) in California.

185) Requires each local health jurisdiction, by December 30, 2023, and by July 1 every three years thereafter, as a condition of funding, to submit a public health plan to CDPH that should be informed by the Community Health Assessment and Community Health Improvement Plan, including proposed evaluation methods and metrics.

186) Prohibits the supplanting of other funding with this funding by LHJs.

187) Requires each LHJ to certify that 70 percent of these funds will be used to support staff, and that the remaining funds, not to exceed 30 percent, may be used for equipment, supplies, and other administrative purposes.

188) Requires that each LHJ receive a base grant of $350,000, and requires the remaining funding be distributed based on population, poverty, and demographics.

189) Requires LHJs, that do not have a completed community health needs assessment, community health improvement plan, and/or strategic plan commence coordination and

planning activities by no later than October 1, 2022 and complete its triennial public health plan by December 30, 2023.

190) Requires CDPH to work in collaboration with the County Health Executives Association of California, California Conference of Local Health Officers, and Service Employees International Union to determine any minimum requirements for the funding and to establish statewide metrics to evaluate the impact of the investment of these funds on public health outcomes.

191) Authorizes an LHJ, upon submission of a letter of support to CDPH with a description of the regional capability being provided, direct a portion of its funds to another LHJ in support of regional capacity.

192) Requires, as a condition of this funding, an LHJ to annually update its Board of Supervisors (or city council), on the State of the County's (or City's) Public Health, including the most prevalent causes of morbidity and mortality, and an update on progress addressing these issues.

193) Requires this update to identify the county's most prevalent causes of morbidity and mortality, causes of morbidity and mortality with the most rapid three year growth rate, health disparities, and an update on progress addressing these issues through the strategies and programs identified in the LHJs triennial public health planning document, including identification of policy recommendations and fiscal estimates for addressing these issues.

194) Requires the State Public Health Officer, on or before February 1 of every other year, to submit a written report to the Governor and both houses of the Legislature on the state of public health in California, and requires the State Public Health Officer to present an update annually to the Assembly and Senate Budget Committees, or relevant subcommittees, during legislative budget hearings.

195) Requires this annual report to include specified data, including: information on public health indicators, health disparities, leading causes of morbidity and mortality, and incidence and prevalence of communicable and non-communicable chronic diseases and conditions, intentional and unintentional injuries, suicide, gun violence, mental illness and substance use disorders.

196) Requires CDPH to annually seek input from stakeholders, including legislative staff, on the contents of the required report.

HCV and STI Prevention

197) Expands the activities that CDPH may allocate funding for related to the monitoring, prevention, testing, and linkage to Hepatitis C Virus (HCV) and sexually transmitted infections (STIs) care to include integrated services for HCV, STIs, human immunodeficiency virus (HIV) infection, and drug overdose, and other activities that improve HCV and STI health outcomes.

198) Authorizes local health jurisdictions and community-based organizations to use these funds to provide material support, including, among other things, sleeping bags, clothing items, and shelter.

199) Authorizes CDPH to use these funds to support capacity building assistance, including integrated services for HCV, HIV, STIs, and drug overdose, to the extend they improve health outcomes for individuals living with, or at high risk for, HCV or STI infection.

Cost of Care Treatment

200) Requires the Department of State Hospitals (DSH) to develop and implement a financial assistance program that may reduce or cancel the amount that a patient owes for the cost of care and treatment at a state hospital.

201) Requires DSH to make its financial assistance program policy available to the public on DSH's internet website.

202) Authorizes DSH to develop reasonable payment plans suitable to the patient's ability to pay.

203) Deletes the following existing statutory provisions that authorize:

a. The court to direct the guardian or conservator of a patient who has insufficient funds to cover their cost of state hospital care, to sell the patient's personal or real property to pay for the care.

b. DSH to apply to become appointed as guardian or conservator of a patient's estate if the patient lacks legal capacity to make decisions, has no guardian or conservator, and is the owner of any property.

c. DSH to invest funds held as executor, administrator, or conservator of estates, or trustee, in specified bonds or obligations, and to establish one or more common trusts for investment of those funds.

d. DSH, upon the death of a patient, to make proper disposition of the remains and pay for the disposition of the remains.

Incompetent to Stand Trial (IST) Workgroup Proposals

204) Revises the role of a licensed psychologist or psychiatrist in the process of determining a defendant's mental competency to stand trial, as follows:

a. Establishes that if the court finds specified conditions to be true, and if pursuant to the opinion offered to the court, a psychiatrist has opined that treatment with antipsychotic medication is appropriate for the defendant, the court shall issue an order authorizing administration of antipsychotic medication as needed, including on an involuntary basis, to be administered under the direction and supervision of a licensed psychiatrist.

b. Establishes that if the court finds specified conditions to be true, and if pursuant to the opinion offered to the court, a licensed psychologist has opined that treatment with antipsychotic medication may be appropriate for the defendant, the court shall issue an order authorizing treatment by a licensed psychiatrist on an involuntary basis.

c. Authorizes such treatment to include the administration of antipsychotic medication as needed, to be administered under the direction and supervision of a licensed psychiatrist.

205) Authorizes such treatment to include the administration of antipsychotic medication as needed, to be administered under the direction and supervision of a licensed psychiatrist.

206) Requires, effective July 1, 2023, that a mentally incompetent defendant first be considered for placement in an outpatient treatment program, a community treatment program, or a diversion program, if available, unless the court finds that the clinical needs of the defendant, or the risk to community safety, warrant placement in a State Hospital.

207) Revises the requirement that a court, prior to ordering a defendant to be committed to a treatment facility, to hear and determine whether the defendant lacks the capacity to make decisions regarding the administration of antipsychotic medication, and increases documentation requirements.

208) Repeals the authorization for the administration of antipsychotic medications in a county jail.

209) Authorizes DSH to contract for medical, evaluation, and other services for felony defendants in county jail deemed incompetent to stand trial.

210) Authorizes DSH to conduct reevaluations of those defendants awaiting admission any time after commitment has been ordered.

211) Authorizes a court to order the involuntary administration of antipsychotic medication based upon a reevaluation.

212) Requires local county jails to cooperate with evaluators.

213) Requires DSH to implement a cap on the number of mentally incompetent persons committed to State Hospitals in each county per year and assess a penalty rate for commitments exceeding that cap

214) Requires the penalty funds to be collected by DSH and deposited into the Mental Health Diversion Fund, a continuously appropriated fund in the State Treasury created by this bill.

215) Requires the penalty funds to be dispersed to each county in amounts equal to the penalty payments made for the purpose of supporting county mental health services and activities.

216) Establishes, until June 30, 2026, a statewide panel of independent evaluators to identify and evaluate state hospital patients who are appropriate for participation in the Forensic Conditional Release Program which provides outpatient and community-based treatment to individuals committed to State Hospitals.

217) Permits disclosure of specified records to parties in specified judicial and administrative proceedings and to district attorneys in commitment, recommitment, or petition for release proceedings.

Investment in Mental Health Wellness Act (SB 82) Flexibilities

218) Authorizes the California Health Facilities Financing Authority (CHFFA) and the Mental Health Services Oversight and Accountability Commission (Commission) to use a sole-

source contracting process for grant-making within the Investment in Mental Health Wellness Act of 2013 when it is determined that it is in the public's best interest to do so.

219) Expands the types of entities that qualify for these grants from just county and city health departments to also include other local government agencies, community-based organizations, health care providers, hospitals, health systems, childcare providers, and other entities.

220) Expands the purpose of this Act from supporting only responses to mental health crises and triage personnel to also support crisis prevention, early intervention, and crisis response strategies.

221) Adds education, training, and innovative, best practice, evidence-based, and related approaches to support crisis prevention, early intervention, and crisis response to the services that may be supported with these funds.

222) Authorizes the Commission to require matching funds from entities in order to qualify for these grants, which shall not be designated in a manner that will prevent participation by any particular entity.

Covered California Premium Subsidy Program

223) Eliminates the sunset of January 1, 2023, and extends indefinitely a program of health care coverage financial assistance to help low-income and middle-income Californians, and permanently exempts the program from the requirements of the Administrative Procedure Act.

COMMENTS

This bill is a budget trailer bill within the overall 2022-23 budget package to implement actions taken affecting health-related departments and other state entities. This bill implements major new initiatives and expansions to health services and programs, including the expansion of Medi-Cal to all income-eligible adults 26 – 49 years of age, regardless of immigration status, establishes the Office of Health Care Affordability, and makes significant investments in health care workforce programs. This bill implements numerous other health-related provisions associated with the Budget Bill of 2022.

According to the Author

Arguments in Support
None on file.

Arguments in Opposition
None on file.

FISCAL COMMENTS

This bill implements many health programs and policies that are tied to expenditures in the budget bill. The following are expenditures for some of the items included in this bill:

1) Full Scope Medi-Cal Coverage for All Adults Over the Age of 26:

    a) $67 million total funds ($53 million General Fund) in FY 2021-22 and $745 million total funds ($628 General Fund) in FY 2022-23,

    b) 834 million total funds ($625 million General Fund) in FY 2023-24, and

    c) On-going out-year costs of $2.6 billion total funds ($2.1 billion General Fund), including In-Home Supportive Services costs budgeted with the Department of Social Services

2) Access to abortion and reproductive health care: $205 million.

3) Reduction to premiums in Medi-Cal: $53 million ($19 million General Fund).

4) Restoration of the state premium assistance program in Covered California: $304 million.

5) Development of low-cost biosimilar insulin: $100 million.

6) Behavioral health bridge housing: $1.5 billion.

7) Strategies to address urgent behavioral health needs of youth: $290 million.

8) Strategies to address the waiting list of individuals incompetent to stand trial: $489.3 million.

9) Ongoing COVID-19 response activities: $1.8 billion.

10) New ongoing investments in state and local public health infrastructure: $300 million.

11) Health care workforce investments: $1.5 billion.

VOTES:

ASSEMBLY FLOOR: 56-18-5
YES: Aguiar-Curry, Arambula, Bauer-Kahan, Bennett, Berman, Bloom, Boerner Horvath, Bonta, Burke, Calderon, Carrillo, Cervantes, Chau, Chiu, Cooley, Cooper, Daly, Friedman, Gabriel, Cristina Garcia, Eduardo Garcia, Gipson, Lorena Gonzalez, Gray, Grayson, Holden, Irwin, Jones-Sawyer, Kalra, Lee, Levine, Low, Maienschein, McCarty, Medina, Mullin, Muratsuchi, Nazarian, O'Donnell, Petrie-Norris, Quirk-Silva, Ramos, Reyes, Luz Rivas, Robert Rivas, Rodriguez, Blanca Rubio, Salas, Santiago, Stone, Ting, Villapudua, Ward, Wicks, Wood, Rendon
NO: Bigelow, Chen, Choi, Cunningham, Megan Dahle, Davies, Flora, Fong, Gallagher, Kiley, Lackey, Mathis, Nguyen, Patterson, Seyarto, Smith, Voepel, Waldron
ABS, ABST OR NV: Frazier, Kamlager, Mayes, Quirk, Valladares

UPDATED

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