ASSEMBLY BILL No. 4

Introduced by Assembly Members Arambula, Bonta, Chiu, Gipson, Lorena Gonzalez, Reyes, and Santiago
(Coauthor: Assembly Member Carrillo)
(Coauthors: Senators Caballero, Durazo, and Wiener)

December 7, 2020

An act to amend Section 14007.8 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 4, as introduced, Arambula. Medi-Cal: eligibility.

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

Existing law requires individuals under 19 years of age enrolled in restricted-scope Medi-Cal at the time the Director of Health Care Services makes a determination that systems have been programmed for implementation of these provisions to be enrolled in the full scope of Medi-Cal benefits, if otherwise eligible, pursuant to an eligibility and enrollment plan, and extends eligibility for full scope Medi-Cal benefits to individuals who are under 25 years of age, and who are otherwise eligible for those benefits but for their immigration status. Existing law makes the effective date of enrollment for those individuals

the same day that systems are operational to begin processing new applications pursuant to the director's determination. Existing law requires an individual eligible for Medi-Cal under these provisions to enroll in a Medi-Cal managed care health plan. Existing law provides that Medi-Cal benefits for individuals who are 65 years of age or older, and who do not have satisfactory immigration statuses or are unable to establish satisfactory immigration statuses, as specified, are to 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 3 fiscal years that exceeds the cost of providing those individuals full scope Medi-Cal benefits.

Effective January 1, 2022, this bill would instead extend eligibility for full scope Medi-Cal benefits to anyone regardless of age, and who is otherwise eligible for those benefits but for their immigration status, pursuant to an eligibility and enrollment plan. The bill would delete the above-specified provisions regarding individuals who are under 25 years of age or 65 years of age or older and delaying implementation until the director makes the determination described above. The bill would require the eligibility and enrollment plan to ensure that an individual maintains continuity of care with respect to their primary care provider, as prescribed, would provide that an individual is not limited in their ability to select a different health care provider or Medi-Cal managed care health plan, and would require the department to provide monthly updates to the appropriate policy and fiscal committees of the Legislature on the status of the implementation of these provisions. Because counties are required to make Medi-Cal eligibility determinations and this bill would expand Medi-Cal eligibility, the bill would impose a state-mandated local program.

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, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. 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)~~

14007.8. (a) (1) Effective January 1, 2022, an individual 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) An individual enrolled in Medi-Cal pursuant to subdivision (d) of Section 14007.5 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~~ *is not* 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.~~

(b) (1) The eligibility and enrollment plan shall ensure, to the maximum extent possible, and for purposes of the Medi-Cal managed care delivery system, that an individual may maintain their primary care provider as their assigned primary care provider in the Medi-Cal managed care health plan's provider network without disruption if their primary care provider is a contracted in-network provider within that Medi-Cal managed care health plan. For county health care access programs that assign individuals to a medical home or a primary care provider, the department shall work with counties, Medi-Cal managed care health plans, health care providers, consumer advocates, and other interested stakeholders, to ensure that an individual may maintain their primary care provider as their assigned primary care provider upon their enrollment into the Medi-Cal program if their primary care provider is a contracted in-network provider within the applicable Medi-Cal managed care health plan.

(2) This paragraph does not limit the ability of an individual enrolled in Medi-Cal pursuant to this section to select a different

health care provider or, if there is more than one Medi-Cal managed care health plan available in the county where they reside, a different Medi-Cal managed care health plan, consistent with subdivision (g) of Section 14087.305 and paragraph (7) of subdivision (d) of Section 14089.

~~(d)~~

(c) 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~~ *for which* they would otherwise be ~~eligible for.~~ *eligible.*

~~(e)~~

(d) (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)~~

(e) 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)~~

(f) (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)~~

(g) 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.

(h) 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.

SEC. 2. If the Commission on State Mandates determines that this act contains 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.

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ASSEMBLY BILL No. 15

Introduced by Assembly Members Chiu, Bonta, Lorena Gonzalez, Quirk-Silva, Santiago, and Wicks
(Principal coauthors: Assembly Members Friedman, Lee, and Luz Rivas)
(Principal coauthors: Senators Durazo and Wiener)
(Coauthors: Assembly Members Bloom, Kalra, Robert Rivas, and Ting)
(Coauthor: Senator Allen)

December 7, 2020

An act to amend Sections 789.4, 798.56, 1942.5, and 2924.15 of, and to add Sections 1785.20.4 and 1942.5.5 to, the Civil Code, and to amend Sections 116.223, 1161, 1161.2, 1161.2.5, 1179.02, 1179.02.5, 1179.03, 1179.03.5, and 1179.07 of, and to add Section 1179.04.5 to, the Code of Civil Procedure, relating to tenancies, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 15, as introduced, Chiu. COVID-19 relief: tenancy: Tenant Stabilization Act of 2021.

(1) Existing law, the COVID-19 Tenant Relief Act of 2020, establishes certain procedural requirements and limitations on evictions for nonpayment of rent due to COVID-19 rental debt, as defined. The act, among other things, prohibits a tenant that delivers a declaration, under penalty of perjury, of COVID-19-related financial distress from being deemed in default with regard to the COVID-19 rental debt, as specified. Existing law defines COVID-19 rental debt as unpaid rent or any other unpaid financial obligation of a tenant that came due

between March 1, 2020, and January 31, 2021. Existing law repeals the act on February 1, 2025.

This bill would extend the definition of "COVID-19 rental debt" as unpaid rent or any other unpaid financial obligation of a tenant that came due between March 1, 2020, and December 31, 2021. The bill would also extend the repeal date of the act to January 1, 2026. The bill would make other conforming changes to align with these extended dates. By extending the repeal date of the act, the bill would expand the crime of perjury and create a state-mandated local program.

Existing law authorizes a landlord to require a high-income tenant, as defined, to submit additional documentation supporting the claim that the tenant has suffered COVID-19-related financial distress if the landlord provides the tenant with a specified notice.

This bill would provide that a tenant is not required to submit that additional supporting documentation unless the landlord provides the tenant with a copy of the proof of income that demonstrates that the tenant qualifies as a high-income tenant.

Existing law prohibits a landlord from interrupting or terminating utility service furnished to a tenant with the intent to terminate the occupancy of the tenant, and imposes specified penalties on a landlord who violates that prohibition. Existing law, until February 1, 2021, imposes additional damages in an amount of at least $1,000, but not more than $2,500, on a landlord that violates that prohibition, if the tenant has provided a declaration of COVID-19 financial distress, as specified.

This bill would extend the imposition of those additional damages to January 1, 2022, and would remove the condition that the tenant provide a declaration of COVID-19 financial distress.

This bill would additionally prohibit a landlord from taking certain actions with respect to a tenant's COVID-19 rental debt, including, among others, charging or attempting to collect late fees, providing different terms or conditions of tenancy, or withholding a service or amenity.

Existing law, until February 1, 2021, prohibits a landlord from bringing an action for unlawful detainer based on a cause of action other than nonpayment of COVID-19 rental debt for the purpose of retaliating against the lessee because the lessee has COVID-19 rental debt.

This bill would extend that prohibition to January 1, 2022.

Existing law, until February 1, 2025, provides that a small claims court has jurisdiction in any action for recovery of COVID-19 rental debt, as defined, regardless of the amount demanded.

This bill would extend that provision to January 1, 2026.

Existing law prohibits action to recover COVID-19 rental debt from commencing before March 1, 2021.

This bill would extend that prohibition to January 1, 2022, or the end of a local jurisdiction's repayment period, whichever is later.

(2) Existing law, the Consumer Credit Reporting Agencies Act, provides for the regulation of consumer credit reporting agencies that collect credit-related information on consumers and report this information to subscribers and of persons who furnish that information to consumer credit reporting agencies, as provided.

This bill would prohibit a housing provider, credit reporting agency, tenant screening company, or other entity that evaluates tenants on behalf of a housing provider from using an alleged COVID-19 rental debt, as defined, as a negative factor for the purpose of evaluating creditworthiness or as the basis for a negative reference to a prospective housing provider.

(3) Existing law, the Mobilehome Residency Law, requires the management of a mobilehome park to comply with notice and specified other requirements in order to terminate a tenancy in a mobilehome park due to a change of use of the mobilehome park, including giving homeowners at least 15 days' written notice that the management will be appearing before a local governmental board, commission, or body to request permits for the change of use.

This bill would instead require the management to give homeowners at least 60 days' written notice that the management will be appearing before a local governmental board, commission, or body to obtain local approval for the intended change of use of the mobilehome park.

(4) Existing law prescribes various requirements to be satisfied before the exercise of a power of sale under a mortgage or deed of trust. In this regard, existing law requires that a notice of default and a notice of sale be recorded and that specified periods of time elapse between the recording and the sale. Existing law establishes certain requirements in connection with foreclosures on mortgages and deeds of trust, including restrictions on the actions mortgage servicers may take while a borrower is attempting to secure a loan modification or has submitted a loan modification application. Existing law, until January 1, 2023, applies those protections to a first lien mortgage or deed of trust that is

secured by residential real property that is occupied by a tenant, contains no more than four dwelling units, and meets certain criteria, including that a tenant occupying the property is unable to pay rent due to a reduction in income resulting from the novel coronavirus.

The bill, commencing January 1, 2023, would limit the extension of those protections to the above-described first lien mortgages and deeds of trust to instances in which the borrower has been approved for foreclosure prevention, as specified, or the borrower submitted a completed application for a first lien loan modification before January 1, 2023, and, as of January 1, 2023, either the mortgage servicer has not yet determined whether the applicant is eligible, or the appeal period for the mortgage servicer's denial of the application has not yet expired.

(5)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 no reimbursement is required by this act for a specified reason.

(6) This bill would declare that it is to take effect immediately as an urgency statute.

Vote: ⅔. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. This act shall be known, and may be cited, as the Tenant Stabilization Act of 2021.

SEC. 2. The Legislature finds and declares all of the following:

(a) On March 4, 2020, Governor Gavin Newsom proclaimed a state of emergency in response to the COVID-19 pandemic. Measures necessary to contain the spread of COVID-19 have brought about widespread economic and societal disruption, placing the state in unprecedented circumstances. Millions of Californians have unexpectedly, and through no fault of their own, faced new public health requirements and been unable to work and cover many basic expenses, creating tremendous uncertainty and instability.

(b) As part of the state's emergency response to the pandemic, the Judicial Council adopted Emergency Rule 1, effective April 6, 2020, which temporarily halted evictions and supported public health efforts to slow the spread of COVID-19 by ensuring that

tenants remained housed and court personnel were not placed at unnecessary risk of exposure. Emergency Rule 1 expired on September 1, 2020.

(c) With strong evidence that the expiration of Emergency Rule 1 could lead to mass evictions absent legislative action, the Legislature passed and Governor Newsom signed Assembly Bill 3088 (Chapter 37 of the Statutes of 2020), the Tenant, Homeowner, and Small Landlord Relief and Stabilization Act of 2020, which became effective on August 31, 2020. Assembly Bill 3088 included the COVID-19 Tenant Relief Act of 2020, which provides critical protections from eviction for tenants. Those protections are set to expire on February 1, 2021.

(d) In passing Assembly Bill 3088, the Legislature was clear that the bill was intended to provide temporary relief to help stabilize Californians through the state of emergency. That emergency is far from over. Since its passage, the COVID-19 crisis in California has grown worse and millions of renters remain vulnerable to eviction due to circumstances that are beyond their control. While a restoration of Emergency Rule 1 would be justified and desirable in furtherance of public health goals, in the absence of such action by the Judicial Council, the Legislature must act with urgency to avoid the mass eviction of tenants.

(e) Mass evictions would be calamitous both for public health and for the state's economic recovery from this unprecedented crisis. A wave of evictions would force some individuals and families to move in together, often in overcrowded housing conditions that promote the spread of the virus. Many other Californians would likely become homeless. In addition to being a humanitarian calamity, such an outcome would likely facilitate further spread of COVID-19, place even further strain on the state's fiscal resources, and hamper the state's economic recovery

(f) It is the intent of this act to extend the protections of the COVID-19 Tenant Relief Act of 2020 and address areas where the act has created uncertainty or challenges in ensuring that tenants can remain housed. It is critical that tenants have no gap in protections so that they can weather this public health and economic crisis without losing their homes. It is the intent of the Legislature that this act remain in effect only temporarily, until such time as the Legislature enacts and the Governor signs a

long-term solution to the tremendous housing instability caused by this pandemic.

SEC. 3. Section 789.4 of the Civil Code is amended to read:

789.4. (a) In addition to the damages provided in subdivision (c) of Section 789.3 of the Civil Code, a landlord who violates Section 789.3 of the Civil Code, ~~if the tenant has provided a declaration of COVID-19 financial distress pursuant to Section 1179.03 of the Code of Civil Procedure,~~ shall be liable for damages in an amount that is at least one thousand dollars ($1,000) but not more than two thousand five hundred dollars ($2,500), as determined by the trier of fact.

(b) This section shall remain in effect until ~~February 1, 2021,~~ *January 1, 2022,* and as of that date is repealed.

SEC. 4. Section 798.56 of the Civil Code, as amended by Section 4 of Chapter 37 of the Statutes of 2020, is amended to read:

798.56. A tenancy shall be terminated by the management only for one or more of the following reasons:

(a) Failure of the homeowner or resident to comply with a local ordinance or state law or regulation relating to mobilehomes within a reasonable time after the homeowner receives a notice of noncompliance from the appropriate governmental agency.

(b) Conduct by the homeowner or resident, upon the park premises, that constitutes a substantial annoyance to other homeowners or residents.

(c) (1) Conviction of the homeowner or resident for prostitution, for a violation of subdivision (d) of Section 243, paragraph (2) of subdivision (a), or subdivision (b), of Section 245, Section 288, or Section 451, of the Penal Code, or a felony controlled substance offense, if the act resulting in the conviction was committed anywhere on the premises of the mobilehome park, including, but not limited to, within the homeowner's mobilehome.

(2) However, the tenancy may not be terminated for the reason specified in this subdivision if the person convicted of the offense has permanently vacated, and does not subsequently reoccupy, the mobilehome.

(d) Failure of the homeowner or resident to comply with a reasonable rule or regulation of the park that is part of the rental agreement or any amendment thereto.

No act or omission of the homeowner or resident shall constitute a failure to comply with a reasonable rule or regulation unless and until the management has given the homeowner written notice of the alleged rule or regulation violation and the homeowner or resident has failed to adhere to the rule or regulation within seven days. However, if a homeowner has been given a written notice of an alleged violation of the same rule or regulation on three or more occasions within a 12-month period after the homeowner or resident has violated that rule or regulation, no written notice shall be required for a subsequent violation of the same rule or regulation.

Nothing in this subdivision shall relieve the management from its obligation to demonstrate that a rule or regulation has in fact been violated.

(e) (1) Except as provided for in the COVID-19 Tenant Relief Act of 2020 (Chapter 5 (commencing with Section 1179.01) of Title 3 of Part 3 of the Code of Civil Procedure), nonpayment of rent, utility charges, or reasonable incidental service charges; provided that the amount due has been unpaid for a period of at least five days from its due date, and provided that the homeowner shall be given a three-day written notice subsequent to that five-day period to pay the amount due or to vacate the tenancy. For purposes of this subdivision, the five-day period does not include the date the payment is due. The three-day written notice shall be given to the homeowner in the manner prescribed by Section 1162 of the Code of Civil Procedure. A copy of this notice shall be sent to the persons or entities specified in subdivision (b) of Section 798.55 within 10 days after notice is delivered to the homeowner. If the homeowner cures the default, the notice need not be sent. The notice may be given at the same time as the 60 days' notice required for termination of the tenancy. A three-day notice given pursuant to this subdivision shall contain the following provisions printed in at least 12-point boldface type at the top of the notice, with the appropriate number written in the blank:

"Warning: This notice is the (insert number) three-day notice for nonpayment of rent, utility charges, or other reasonable incidental services that has been served upon you in the last 12 months. Pursuant to Civil Code Section 798.56 (e) (5), if you have been given a three-day notice to either pay rent, utility charges, or other reasonable incidental services or to vacate your tenancy on three

or more occasions within a 12-month period, management is not required to give you a further three-day period to pay rent or vacate the tenancy before your tenancy can be terminated."

(2) Payment by the homeowner prior to the expiration of the three-day notice period shall cure a default under this subdivision. If the homeowner does not pay prior to the expiration of the three-day notice period, the homeowner shall remain liable for all payments due up until the time the tenancy is vacated.

(3) Payment by the legal owner, as defined in Section 18005.8 of the Health and Safety Code, any junior lienholder, as defined in Section 18005.3 of the Health and Safety Code, or the registered owner, as defined in Section 18009.5 of the Health and Safety Code, if other than the homeowner, on behalf of the homeowner prior to the expiration of 30 calendar days following the mailing of the notice to the legal owner, each junior lienholder, and the registered owner provided in subdivision (b) of Section 798.55, shall cure a default under this subdivision with respect to that payment.

(4) Cure of a default of rent, utility charges, or reasonable incidental service charges by the legal owner, any junior lienholder, or the registered owner, if other than the homeowner, as provided by this subdivision, may not be exercised more than twice during a 12-month period.

(5) If a homeowner has been given a three-day notice to pay the amount due or to vacate the tenancy on three or more occasions within the preceding 12-month period and each notice includes the provisions specified in paragraph (1), no written three-day notice shall be required in the case of a subsequent nonpayment of rent, utility charges, or reasonable incidental service charges.

In that event, the management shall give written notice to the homeowner in the manner prescribed by Section 1162 of the Code of Civil Procedure to remove the mobilehome from the park within a period of not less than 60 days, which period shall be specified in the notice. A copy of this notice shall be sent to the legal owner, each junior lienholder, and the registered owner of the mobilehome, if other than the homeowner, as specified in paragraph (b) of Section 798.55, by certified or registered mail, return receipt requested, within 10 days after notice is sent to the homeowner.

(6) When a copy of the 60 days' notice described in paragraph (5) is sent to the legal owner, each junior lienholder, and the

registered owner of the mobilehome, if other than the homeowner, the default may be cured by any of them on behalf of the homeowner prior to the expiration of 30 calendar days following the mailing of the notice, if all of the following conditions exist:

(A) A copy of a three-day notice sent pursuant to subdivision (b) of Section 798.55 to a homeowner for the nonpayment of rent, utility charges, or reasonable incidental service charges was not sent to the legal owner, junior lienholder, or registered owner, of the mobilehome, if other than the homeowner, during the preceding 12-month period.

(B) The legal owner, junior lienholder, or registered owner of the mobilehome, if other than the homeowner, has not previously cured a default of the homeowner during the preceding 12-month period.

(C) The legal owner, junior ~~lienholder~~ *lienholder,* or registered owner, if other than the homeowner, is not a financial institution or mobilehome dealer.

If the default is cured by the legal owner, junior lienholder, or registered owner within the 30-day period, the notice to remove the mobilehome from the park described in paragraph (5) shall be rescinded.

(f) Condemnation of the park.

(g) Change of use of the park or any portion thereof, provided:

(1) The management gives the homeowners at least ~~15~~ *60* days' written notice that the management will be appearing before a local governmental board, commission, or body to request permits for a change of use of the mobilehome park.

(2) *(A)* After all required permits requesting a change of use have been approved by the local governmental board, commission, or body, the management shall give the homeowners six months' or more written notice of termination of tenancy.

(B) If the change of use requires no local governmental permits, then notice shall be given 12 months or more prior to the management's determination that a change of use will occur. The management in the notice shall disclose and describe in detail the nature of the change of use.

(3) The management gives each proposed homeowner written notice thereof prior to the inception of the *proposed* homeowner's tenancy that the management is requesting a change of use before

local governmental bodies or that a change of use request has been granted.

(4) The notice requirements for termination of tenancy set forth in ~~Sections 798.56 and~~ *this section and Section* 798.57 shall be followed if the proposed change actually occurs.

(5) A notice of a proposed change of use given prior to January 1, 1980, that conforms to the requirements in effect at that time shall be valid. The requirements for a notice of a proposed change of use imposed by this subdivision shall be governed by the law in effect at the time the notice was given.

(h) The report required pursuant to subdivisions (b) and (i) of Section 65863.7 of the Government Code shall be given to the homeowners or residents at the same time that notice is required pursuant to subdivision (g) of this section.

(i) For purposes of this section, "financial institution" means a state or national bank, state or federal savings and loan association or credit union, or similar organization, and mobilehome dealer as defined in Section 18002.6 of the Health and Safety Code or any other organization that, as part of its usual course of business, originates, owns, or provides loan servicing for loans secured by a mobilehome.

(j) This section remain in effect until ~~February 1, 2025,~~ *January 1, 2026,* and as of that date is repealed.

SEC. 5. Section 798.56 of the Civil Code, as added by Section 5 of Chapter 37 of the Statutes of 2020, is amended to read:

798.56. A tenancy shall be terminated by the management only for one or more of the following reasons:

(a) Failure of the homeowner or resident to comply with a local ordinance or state law or regulation relating to mobilehomes within a reasonable time after the homeowner receives a notice of noncompliance from the appropriate governmental agency.

(b) Conduct by the homeowner or resident, upon the park premises, that constitutes a substantial annoyance to other homeowners or residents.

(c) (1) Conviction of the homeowner or resident for prostitution, for a violation of subdivision (d) of Section 243, paragraph (2) of subdivision (a), or subdivision (b), of Section 245, Section 288, or Section 451, of the Penal Code, or a felony controlled substance offense, if the act resulting in the conviction was committed

anywhere on the premises of the mobilehome park, including, but not limited to, within the homeowner's mobilehome.

(2) However, the tenancy may not be terminated for the reason specified in this subdivision if the person convicted of the offense has permanently vacated, and does not subsequently reoccupy, the mobilehome.

(d) Failure of the homeowner or resident to comply with a reasonable rule or regulation of the park that is part of the rental agreement or any amendment thereto.

No act or omission of the homeowner or resident shall constitute a failure to comply with a reasonable rule or regulation unless and until the management has given the homeowner written notice of the alleged rule or regulation violation and the homeowner or resident has failed to adhere to the rule or regulation within seven days. However, if a homeowner has been given a written notice of an alleged violation of the same rule or regulation on three or more occasions within a 12-month period after the homeowner or resident has violated that rule or regulation, no written notice shall be required for a subsequent violation of the same rule or regulation.

Nothing in this subdivision shall relieve the management from its obligation to demonstrate that a rule or regulation has in fact been violated.

(e) (1) Nonpayment of rent, utility charges, or reasonable incidental service charges; provided that the amount due has been unpaid for a period of at least five days from its due date, and provided that the homeowner shall be given a three-day written notice subsequent to that five-day period to pay the amount due or to vacate the tenancy. For purposes of this subdivision, the five-day period does not include the date the payment is due. The three-day written notice shall be given to the homeowner in the manner prescribed by Section 1162 of the Code of Civil Procedure. A copy of this notice shall be sent to the persons or entities specified in subdivision (b) of Section 798.55 within 10 days after notice is delivered to the homeowner. If the homeowner cures the default, the notice need not be sent. The notice may be given at the same time as the 60 days' notice required for termination of the tenancy. A three-day notice given pursuant to this subdivision shall contain the following provisions printed in at least 12-point

boldface type at the top of the notice, with the appropriate number written in the blank:

"Warning: This notice is the (insert number) three-day notice for nonpayment of rent, utility charges, or other reasonable incidental services that has been served upon you in the last 12 months. Pursuant to Civil Code Section 798.56 (e) (5), if you have been given a three-day notice to either pay rent, utility charges, or other reasonable incidental services or to vacate your tenancy on three or more occasions within a 12-month period, management is not required to give you a further three-day period to pay rent or vacate the tenancy before your tenancy can be terminated."

(2) Payment by the homeowner prior to the expiration of the three-day notice period shall cure a default under this subdivision. If the homeowner does not pay prior to the expiration of the three-day notice period, the homeowner shall remain liable for all payments due up until the time the tenancy is vacated.

(3) Payment by the legal owner, as defined in Section 18005.8 of the Health and Safety Code, any junior lienholder, as defined in Section 18005.3 of the Health and Safety Code, or the registered owner, as defined in Section 18009.5 of the Health and Safety Code, if other than the homeowner, on behalf of the homeowner prior to the expiration of 30 calendar days following the mailing of the notice to the legal owner, each junior lienholder, and the registered owner provided in subdivision (b) of Section 798.55, shall cure a default under this subdivision with respect to that payment.

(4) Cure of a default of rent, utility charges, or reasonable incidental service charges by the legal owner, any junior lienholder, or the registered owner, if other than the homeowner, as provided by this subdivision, may not be exercised more than twice during a 12-month period.

(5) If a homeowner has been given a three-day notice to pay the amount due or to vacate the tenancy on three or more occasions within the preceding 12-month period and each notice includes the provisions specified in paragraph (1), no written three-day notice shall be required in the case of a subsequent nonpayment of rent, utility charges, or reasonable incidental service charges.

In that event, the management shall give written notice to the homeowner in the manner prescribed by Section 1162 of the Code of Civil Procedure to remove the mobilehome from the park within

a period of not less than 60 days, which period shall be specified in the notice. A copy of this notice shall be sent to the legal owner, each junior lienholder, and the registered owner of the mobilehome, if other than the homeowner, as specified in paragraph (b) of Section 798.55, by certified or registered mail, return receipt requested, within 10 days after notice is sent to the homeowner.

(6) When a copy of the 60 days' notice described in paragraph (5) is sent to the legal owner, each junior lienholder, and the registered owner of the mobilehome, if other than the homeowner, the default may be cured by any of them on behalf of the homeowner prior to the expiration of 30 calendar days following the mailing of the notice, if all of the following conditions exist:

(A) A copy of a three-day notice sent pursuant to subdivision (b) of Section 798.55 to a homeowner for the nonpayment of rent, utility charges, or reasonable incidental service charges was not sent to the legal owner, junior lienholder, or registered owner, of the mobilehome, if other than the homeowner, during the preceding 12-month period.

(B) The legal owner, junior lienholder, or registered owner of the mobilehome, if other than the homeowner, has not previously cured a default of the homeowner during the preceding 12-month period.

(C) The legal owner, junior ~~lienholder~~ *lienholder,* or registered owner, if other than the homeowner, is not a financial institution or mobilehome dealer.

If the default is cured by the legal owner, junior lienholder, or registered owner within the 30-day period, the notice to remove the mobilehome from the park described in paragraph (5) shall be rescinded.

(f) Condemnation of the park.

(g) Change of use of the park or any portion thereof, provided:

(1) The management gives the homeowners at least ~~15~~ *60* days' written notice that the management will be appearing before a local governmental board, commission, or body to request permits for a change of use of the mobilehome park.

(2) *(A)* After all required permits requesting a change of use have been approved by the local governmental board, commission, or body, the management shall give the homeowners six months' or more written notice of termination of tenancy.

(B) If the change of use requires no local governmental permits, then notice shall be given 12 months or more prior to the management's determination that a change of use will occur. The management in the notice shall disclose and describe in detail the nature of the change of use.

(3) The management gives each proposed homeowner written notice thereof prior to the inception of the *proposed* homeowner's tenancy that the management is requesting a change of use before local governmental bodies or that a change of use request has been granted.

(4) The notice requirements for termination of tenancy set forth in Sections 798.56 and 798.57 shall be followed if the proposed change actually occurs.

(5) A notice of a proposed change of use given prior to January 1, 1980, that conforms to the requirements in effect at that time shall be valid. The requirements for a notice of a proposed change of use imposed by this subdivision shall be governed by the law in effect at the time the notice was given.

(h) The report required pursuant to subdivisions (b) and (i) of Section 65863.7 of the Government Code shall be given to the homeowners or residents at the same time that notice is required pursuant to subdivision (g) of this section.

(i) For purposes of this section, "financial institution" means a state or national bank, state or federal savings and loan association or credit union, or similar organization, and mobilehome dealer as defined in Section 18002.6 of the Health and Safety Code or any other organization that, as part of its usual course of business, originates, owns, or provides loan servicing for loans secured by a mobilehome.

(j) This section shall become operative on ~~February 1, 2025.~~ *January 1, 2026.*

SEC. 6. Section 1785.20.4 is added to the Civil Code, to read:

1785.20.4. (a) A housing provider, credit reporting agency, tenant screening company, or other entity that evaluates tenants on behalf of a housing provider shall not use an alleged COVID-19 rental debt as a negative factor for the purpose of evaluating creditworthiness or as the basis for a negative reference to a prospective housing provider, regardless of whether a report is received alleging that the tenant has COVID-19 rental debt.

(b) For purposes of this section, "COVID-19 rental debt" shall have the same meaning as defined in Section 1179.02 of the Code of Civil Procedure.

SEC. 7. Section 1942.5 of the Civil Code, as amended by Section 6 of Chapter 37 of the Statutes of 2020, is amended to read:

1942.5. (a) If the lessor retaliates against the lessee because of the exercise by the lessee of the lessee's rights under this chapter or because of the lessee's complaint to an appropriate agency as to tenantability of a dwelling, and if the lessee of a dwelling is not in default as to the payment of rent, the lessor may not recover possession of a dwelling in any action or proceeding, cause the lessee to quit involuntarily, increase the rent, or decrease any services within 180 days of any of the following:

(1) After the date upon which the lessee, in good faith, has given notice pursuant to Section 1942, has provided notice of a suspected bed bug infestation, or has made an oral complaint to the lessor regarding tenantability.

(2) After the date upon which the lessee, in good faith, has filed a written complaint, or an oral complaint which is registered or otherwise recorded in writing, with an appropriate agency, of which the lessor has notice, for the purpose of obtaining correction of a condition relating to tenantability.

(3) After the date of an inspection or issuance of a citation, resulting from a complaint described in paragraph (2) of which the lessor did not have notice.

(4) After the filing of appropriate documents commencing a judicial or arbitration proceeding involving the issue of tenantability.

(5) After entry of judgment or the signing of an arbitration award, if any, when in the judicial proceeding or arbitration the issue of tenantability is determined adversely to the lessor.

In each instance, the 180-day period shall run from the latest applicable date referred to in paragraphs (1) to (5), inclusive.

(b) A lessee may not invoke subdivision (a) more than once in any 12-month period.

(c) To report, or to threaten to report, the lessee or individuals known to the landlord to be associated with the lessee to immigration authorities is a form of retaliatory conduct prohibited

under subdivision (a). This subdivision shall in no way limit the definition of retaliatory conduct prohibited under this section.

(d) Notwithstanding subdivision (a), it is unlawful for a lessor to increase rent, decrease services, cause a lessee to quit involuntarily, bring an action to recover possession, or threaten to do any of those acts, for the purpose of retaliating against the lessee because the lessee has lawfully organized or participated in a lessees' association or an organization advocating lessees' rights or has lawfully and peaceably exercised any rights under the law. It is also unlawful for a lessor to bring an action for unlawful detainer based on a cause of action other than nonpayment of COVID-19 rental debt, as defined in Section 1179.02 of the Code of Civil Procedure, for the purpose of retaliating against the lessee because the lessee has a COVID-19 rental debt. In an action brought by or against the lessee pursuant to this subdivision, the lessee shall bear the burden of producing evidence that the lessor's conduct was, in fact, retaliatory.

(e) To report, or to threaten to report, the lessee or individuals known to the landlord to be associated with the lessee to immigration authorities is a form of retaliatory conduct prohibited under subdivision (d). This subdivision shall in no way limit the definition of retaliatory conduct prohibited under this section.

(f) This section does not limit in any way the exercise by the lessor of the lessor's rights under any lease or agreement or any law pertaining to the hiring of property or the lessor's right to do any of the acts described in subdivision (a) or (d) for any lawful cause. Any waiver by a lessee of the lessee's rights under this section is void as contrary to public policy.

(g) Notwithstanding subdivisions (a) to (f), inclusive, a lessor may recover possession of a dwelling and do any of the other acts described in subdivision (a) within the period or periods prescribed therein, or within subdivision (d), if the notice of termination, rent increase, or other act, and any pleading or statement of issues in an arbitration, if any, states the ground upon which the lessor, in good faith, seeks to recover possession, increase rent, or do any of the other acts described in subdivision (a) or (d). If the statement is controverted, the lessor shall establish its truth at the trial or other hearing.

(h) Any lessor or agent of a lessor who violates this section shall be liable to the lessee in a civil action for all of the following:

(1) The actual damages sustained by the lessee.

(2) Punitive damages in an amount of not less than one hundred dollars ($100) nor more than two thousand dollars ($2,000) for each retaliatory act where the lessor or agent has been guilty of fraud, oppression, or malice with respect to that act.

(i) In any action brought for damages for retaliatory eviction, the court shall award reasonable attorney's fees to the prevailing party if either party requests attorney's fees upon the initiation of the action.

(j) The remedies provided by this section shall be in addition to any other remedies provided by statutory or decisional law.

(k) A lessor does not violate subdivision (c) or (e) by complying with any legal obligation under any federal government program that provides for rent limitations or rental assistance to a qualified tenant.

(*l*) This section shall remain in effect until ~~February 1, 2021,~~ *January 1, 2022,* and as of that date is repealed.

SEC. 8. Section 1942.5 of the Civil Code, as added by Section 7 of Chapter 37 of the Statutes of 2020, is amended to read:

1942.5. (a) If the lessor retaliates against the lessee because of the exercise by the lessee of the lessee's rights under this chapter or because of the lessee's complaint to an appropriate agency as to tenantability of a dwelling, and if the lessee of a dwelling is not in default as to the payment of rent, the lessor may not recover possession of a dwelling in any action or proceeding, cause the lessee to quit involuntarily, increase the rent, or decrease any services within 180 days of any of the following:

(1) After the date upon which the lessee, in good faith, has given notice pursuant to Section 1942, has provided notice of a suspected bed bug infestation, or has made an oral complaint to the lessor regarding tenantability.

(2) After the date upon which the lessee, in good faith, has filed a written complaint, or an oral complaint which is registered or otherwise recorded in writing, with an appropriate agency, of which the lessor has notice, for the purpose of obtaining correction of a condition relating to tenantability.

(3) After the date of an inspection or issuance of a citation, resulting from a complaint described in paragraph (2) of which the lessor did not have notice.

(4) After the filing of appropriate documents commencing a judicial or arbitration proceeding involving the issue of tenantability.

(5) After entry of judgment or the signing of an arbitration award, if any, when in the judicial proceeding or arbitration the issue of tenantability is determined adversely to the lessor.

In each instance, the 180-day period shall run from the latest applicable date referred to in paragraphs (1) to (5), inclusive.

(b) A lessee may not invoke subdivision (a) more than once in any 12-month period.

(c) To report, or to threaten to report, the lessee or individuals known to the landlord to be associated with the lessee to immigration authorities is a form of retaliatory conduct prohibited under subdivision (a). This subdivision shall in no way limit the definition of retaliatory conduct prohibited under this section.

(d) Notwithstanding subdivision (a), it is unlawful for a lessor to increase rent, decrease services, cause a lessee to quit involuntarily, bring an action to recover possession, or threaten to do any of those acts, for the purpose of retaliating against the lessee because the lessee has lawfully organized or participated in a lessees' association or an organization advocating lessees' rights or has lawfully and peaceably exercised any rights under the law. In an action brought by or against the lessee pursuant to this subdivision, the lessee shall bear the burden of producing evidence that the lessor's conduct was, in fact, retaliatory.

(e) To report, or to threaten to report, the lessee or individuals known to the landlord to be associated with the lessee to immigration authorities is a form of retaliatory conduct prohibited under subdivision (d). This subdivision shall in no way limit the definition of retaliatory conduct prohibited under this section.

(f) This section does not limit in any way the exercise by the lessor of the lessor's rights under any lease or agreement or any law pertaining to the hiring of property or the lessor's right to do any of the acts described in subdivision (a) or (d) for any lawful cause. Any waiver by a lessee of the lessee's rights under this section is void as contrary to public policy.

(g) Notwithstanding subdivisions (a) to (f), inclusive, a lessor may recover possession of a dwelling and do any of the other acts described in subdivision (a) within the period or periods prescribed therein, or within subdivision (d), if the notice of termination, rent

increase, or other act, and any pleading or statement of issues in an arbitration, if any, states the ground upon which the lessor, in good faith, seeks to recover possession, increase rent, or do any of the other acts described in subdivision (a) or (d). If the statement is controverted, the lessor shall establish its truth at the trial or other hearing.

(h) Any lessor or agent of a lessor who violates this section shall be liable to the lessee in a civil action for all of the following:

(1) The actual damages sustained by the lessee.

(2) Punitive damages in an amount of not less than one hundred dollars ($100) nor more than two thousand dollars ($2,000) for each retaliatory act where the lessor or agent has been guilty of fraud, oppression, or malice with respect to that act.

(i) In any action brought for damages for retaliatory eviction, the court shall award reasonable attorney's fees to the prevailing party if either party requests attorney's fees upon the initiation of the action.

(j) The remedies provided by this section shall be in addition to any other remedies provided by statutory or decisional law.

(k) A lessor does not violate subdivision (c) or (e) by complying with any legal obligation under any federal government program that provides for rent limitations or rental assistance to a qualified tenant.

(*l*) This section shall become operative on ~~February 1, 2021.~~ *January 1, 2022.*

SEC. 9. Section 1942.5.5 is added to the Civil Code, to read:

1942.5.5. A landlord shall not, with respect to a tenant who has COVID-19 rental debt, as defined in Section 1179.02 of the Code of Civil Procedure, do any of the following:

(1) Charge a tenant, or attempt to collect from a tenant, fees assessed for late payment of COVID-19 rental debt or interest on COVID-19 rental debt.

(2) Increase fees charged to the tenant or charge the tenant fees for services previously provided by the landlord without charge.

(3) Provide different terms or conditions of tenancy or withhold a service or amenity based on whether a tenant has COVID-19 rental debt.

(4) Harass, threaten, or seek to intimidate a tenant in order to obtain a tenant's payment or agreement to pay any COVID-19 rental debt.

(5) Terminate a tenancy, or threaten to terminate a tenancy, in retaliation against a tenant for having COVID-19 rental debt.

SEC. 10. Section 2924.15 of the Civil Code, as amended by Section 11 of Chapter 37 of the Statutes of 2020, is amended to read:

2924.15. (a) Unless otherwise provided, paragraph (5) of subdivision (a) of Section 2924, and Sections 2923.5, 2923.55, 2923.6, 2923.7, 2924.9, 2924.10, 2924.11, and 2924.18 shall apply only to a first lien mortgage or deed of trust that meets either of the following criteria:

(1) (A) The first lien mortgage or deed of trust is secured by owner-occupied residential real property containing no more than four dwelling units.

(B) For purposes of this paragraph, "owner-occupied" means that the property is the principal residence of the borrower and is security for a loan made for personal, family, or household purposes.

(2) The first lien mortgage or deed of trust is secured by residential real property that is occupied by a tenant, contains no more than four dwelling units, and meets all of the conditions described in subparagraph (B).

(A) For the purposes of this paragraph:

(i) "Applicable lease" means a lease entered pursuant to an arm's length transaction before, and in effect on, March 4, 2020.

(ii) "Arm's length transaction" means a lease entered into in good faith and for valuable consideration that reflects the fair market value in the open market between informed and willing parties.

(iii) "Occupied by a tenant" means that the property is the principal residence of a tenant.

(B) To meet the conditions of this ~~subdivision,~~ *subparagraph*, a first lien mortgage or deed of trust shall have all of the following characteristics:

(i) The property is owned by an individual who owns no more than three residential real properties, or by one or more individuals who together own no more than three residential real properties, each of which contains no more than four dwelling units.

(ii) The property is occupied by a tenant pursuant to an applicable lease.

(iii) A tenant occupying the property is unable to pay rent due to a reduction in income resulting from the novel coronavirus.

(C) Relief shall be available pursuant to subdivision (a) of Section 2924 and Sections 2923.5, 2923.55, 2923.6, 2923.7, 2924.9, 2924.10, 2924.11, and 2924.18 for so long as the property remains occupied by a tenant pursuant to a lease entered in an arm's length transaction.

(b) This section shall remain in effect until January 1, 2023, and as of that date is repealed.

SEC. 11. Section 2924.15 of the Civil Code, as added by Section 12 of Chapter 37 of the Statutes of 2020, is amended to read:

2924.15. (a) Unless otherwise provided, paragraph (5) of subdivision (a) of Section 2924 and Sections 2923.5, 2923.55, 2923.6, 2923.7, 2924.9, 2924.10, 2924.11, and 2924.18 shall apply only to a first lien mortgage or deed of trust that *meets either of the following conditions:* ~~is~~

(1) (A) The first lien mortgage or deed of trust is secured by owner-occupied residential real property containing no more than four dwelling units.

~~(b)~~

~~As used in this section,~~ *(B) For purposes of this paragraph,* "owner-occupied" means that the property is the principal residence of the borrower and is security for a loan made for personal, family, or household purposes.

(2) The first lien mortgage or deed of trust is secured by residential real property that is occupied by a tenant and that contains no more than four dwelling units and meets all of the conditions described in subparagraph (B) and one of the conditions described in subparagraph (C).

(A) For purposes of this paragraph:

(i) "Applicable lease" means a lease entered pursuant to an arm's length transaction before, and in effect on, March 4, 2020.

(ii) "Arm's length transaction" means a lease entered into in good faith and for valuable consideration that reflects the fair market value in the open market between informed and willing parties.

(iii) "Occupied by a tenant" means that the property is the principal residence of a tenant.

(B) To meet the conditions of this paragraph, a first lien mortgage or deed of trust shall have all of the following characteristics:

(i) The property is owned by an individual who owns no more than three residential real properties, each of which contains no more than four dwelling units.

(ii) The property shall have been occupied by a tenant pursuant to an applicable lease.

(iii) A tenant occupying the property shall have been unable to pay rent due to a reduction in income resulting from the novel coronavirus.

(C) For a first lien mortgage or deed of trust to meet the conditions of this paragraph, the borrower shall satisfy one of the following characteristics:

(i) The borrower has been approved in writing for a first lien loan modification or other foreclosure prevention alternative.

(ii) The borrower submits a completed application for a first lien loan modification before January 1, 2023, and, as of January 1, 2023, either the mortgage servicer has not yet determined whether the applicant is eligible for a first lien loan modification, or the appeal period for the mortgage servicer's denial of the application has not yet expired.

(D) Relief shall be available pursuant to subdivision (a) of Section 2924 and Sections 2923.5, 2923.55, 2923.6, 2923.7, 2924.9, 2924.10, 2924.11, and 2924.18 for so long as the property remains occupied by a tenant pursuant to a lease entered in an arm's length transaction.

~~(c)~~

(b) This section shall become operative on January 1, 2023.

SEC. 12. Section 116.223 of the Code of Civil Procedure is amended to read:

116.223. (a) The Legislature hereby finds and declares as follows:

(1) There is anticipated to be an unprecedented number of claims arising out of nonpayment of residential rent that occurred between March 1, 2020, and January 31, 2021, related to the COVID-19 pandemic.

(2) These disputes are of special importance to the parties and of significant social and economic consequence collectively as the

people of the State of California grapple with the health, economic, and social impacts of the COVID-19 pandemic.

(3) It is essential that the parties have access to a judicial forum to resolve these disputes expeditiously, inexpensively, and fairly.

(4) It is the intent of the Legislature that landlords of residential real property and their tenants ~~have the option to~~ litigate disputes regarding rent which is unpaid for the time period between March 1, 2020, and ~~January~~ *December* 31, 2021, in the small claims court. It is the intent of the Legislature that the jurisdictional limits of the small claims court not apply to these disputes over COVID-19 rental debt.

(b) (1) Notwithstanding paragraph (1) of subdivision (a) Section 116.220, Section 116.221, or any other law, the small claims court has jurisdiction in any action for recovery of COVID-19 rental debt, as defined in Section 1179.02, and any defenses thereto, regardless of the amount demanded.

(2) In an action described in paragraph (1), the court shall reduce the damages awarded for any amount of COVID-19 rental debt sought by payments made to the landlord to satisfy the COVID-19 rental debt, including payments by the tenant, rental assistance programs, or another third party pursuant to paragraph (3) of subdivision (a) of Section 1947.3 of the Civil Code. *If the landlord refused to accept payments on behalf of the tenant from any governmental or private entity, or refused to cooperate with the tenant's efforts to obtain rental assistance from any governmental or private entity, the damages awarded shall also be reduced by the amount of payments refused.*

(3) An action to recover COVID-19 rental debt, as defined in Section ~~1179.02, brought pursuant to this subdivision~~ *1179.02*, shall not be commenced before ~~March 1, 2021.~~ *January 1, 2022, or before the end of a local jurisdiction's repayment period, whichever is later.*

(c) Any claim for recovery of COVID-19 rental debt, as defined in Section 1179.02, shall not be subject to Section 116.231, notwithstanding the fact that a landlord of residential rental property may have brought two or more small claims actions in which the amount demanded exceeded two thousand five hundred dollars ($2,500) in any calendar year.

(d) This section shall remain in effect until ~~February 1, 2025,~~ *January 1, 2026,* and as of that date is repealed.

SEC. 13. Section 1161 of the Code of Civil Procedure, as amended by Section 15 of Chapter 37 of the Statutes of 2020, is amended to read:

1161. A tenant of real property, for a term less than life, or the executor or administrator of the tenant's estate heretofore qualified and now acting or hereafter to be qualified and act, is guilty of unlawful detainer:

1. When the tenant continues in possession, in person or by subtenant, of the property, or any part thereof, after the expiration of the term for which it is let to the tenant; provided the expiration is of a nondefault nature however brought about without the permission of the landlord, or the successor in estate of the landlord, if applicable; including the case where the person to be removed became the occupant of the premises as a servant, employee, agent, or licensee and the relation of master and servant, or employer and employee, or principal and agent, or licensor and licensee, has been lawfully terminated or the time fixed for occupancy by the agreement between the parties has expired; but nothing in this subdivision shall be construed as preventing the removal of the occupant in any other lawful manner; but in case of a tenancy at will, it shall first be terminated by notice, as prescribed in the Civil Code.

2. When the tenant continues in possession, in person or by subtenant, without the permission of the landlord, or the successor in estate of the landlord, if applicable, after default in the payment of rent, pursuant to the lease or agreement under which the property is held, and three days' notice, excluding Saturdays and Sundays and other judicial holidays, in writing, requiring its payment, stating the amount that is due, the name, telephone number, and address of the person to whom the rent payment shall be made, and, if payment may be made personally, the usual days and hours that person will be available to receive the payment (provided that, if the address does not allow for personal delivery, then it shall be conclusively presumed that upon the mailing of any rent or notice to the owner by the tenant to the name and address provided, the notice or rent is deemed received by the owner on the date posted, if the tenant can show proof of mailing to the name and address provided by the owner), or the number of an account in a financial institution into which the rental payment may be made, and the name and street address of the institution (provided that the

institution is located within five miles of the rental property), or if an electronic funds transfer procedure has been previously established, that payment may be made pursuant to that procedure, or possession of the property, shall have been served upon the tenant and if there is a subtenant in actual occupation of the premises, also upon the subtenant.

The notice may be served at any time within one year after the rent becomes due. In all cases of tenancy upon agricultural lands, if the tenant has held over and retained possession for more than 60 days after the expiration of the term without any demand of possession or notice to quit by the landlord or the successor in estate of the landlord, if applicable, the tenant shall be deemed to be holding by permission of the landlord or successor in estate of the landlord, if applicable, and shall be entitled to hold under the terms of the lease for another full year, and shall not be guilty of an unlawful detainer during that year, and the holding over for that period shall be taken and construed as a consent on the part of a tenant to hold for another year.

An unlawful detainer action under this paragraph shall be subject to the COVID-19 Tenant Relief Act of 2020 (Chapter 5 (commencing with Section 1179.01)) if the default in the payment of rent is based upon the COVID-19 rental debt.

3. When the tenant continues in possession, in person or by subtenant, after a neglect or failure to perform other conditions or covenants of the lease or agreement under which the property is held, including any covenant not to assign or sublet, than the one for the payment of rent, and three days' notice, excluding Saturdays and Sundays and other judicial holidays, in writing, requiring the performance of those conditions or covenants, or the possession of the property, shall have been served upon the tenant, and if there is a subtenant in actual occupation of the premises, also, upon the subtenant. Within three days, excluding Saturdays and Sundays and other judicial holidays, after the service of the notice, the tenant, or any subtenant in actual occupation of the premises, or any mortgagee of the term, or other person interested in its continuance, may perform the conditions or covenants of the lease or pay the stipulated rent, as the case may be, and thereby save the lease from forfeiture; provided, if the conditions and covenants of the lease, violated by the lessee, cannot afterward be performed, then no notice, as last prescribed herein, need be given to the lessee

or the subtenant, demanding the performance of the violated conditions or covenants of the lease.

A tenant may take proceedings, similar to those prescribed in this chapter, to obtain possession of the premises let to a subtenant or held by a servant, employee, agent, or licensee, in case of that person's unlawful detention of the premises underlet to or held by that person.

An unlawful detainer action under this paragraph shall be subject to the COVID-19 Tenant Relief Act of 2020 (Chapter 5 (commencing with Section 1179.01)) if the neglect or failure to perform other conditions or covenants of the lease or agreement is based upon the COVID-19 rental debt.

4. Any tenant, subtenant, or executor or administrator of that person's estate heretofore qualified and now acting, or hereafter to be qualified and act, assigning or subletting or committing waste upon the demised premises, contrary to the conditions or covenants of the lease, or maintaining, committing, or permitting the maintenance or commission of a nuisance upon the demised premises or using the premises for an unlawful purpose, thereby terminates the lease, and the landlord, or the landlord's successor in estate, shall upon service of three days' notice to quit upon the person or persons in possession, be entitled to restitution of possession of the demised premises under this chapter. For purposes of this subdivision, a person who commits or maintains a public nuisance as described in Section 3482.8 of the Civil Code, or who commits an offense described in subdivision (c) of Section 3485 of the Civil Code, or subdivision (c) of Section 3486 of the Civil Code, or uses the premises to further the purpose of that offense shall be deemed to have committed a nuisance upon the premises.

5. When the tenant gives written notice as provided in Section 1946 of the Civil Code of the tenant's intention to terminate the hiring of the real property, or makes a written offer to surrender which is accepted in writing by the landlord, but fails to deliver possession at the time specified in that written notice, without the permission of the landlord, or the successor in estate of the landlord, if applicable.

6. As used in this section:

"COVID-19 rental debt" has the same meaning as defined in Section 1179.02.

"Tenant" includes any person who hires real property except those persons whose occupancy is described in subdivision (b) of Section 1940 of the Civil Code.

7. This section shall remain in effect until ~~February 1, 2025,~~ *January 1, 2026,* and as of that date is repealed.

SEC. 14. Section 1161 of the Code of Civil Procedure, as added by Section 16 of Chapter 37 of the Statutes of 2020, is amended to read:

1161. A tenant of real property, for a term less than life, or the executor or administrator of the tenant's estate heretofore qualified and now acting or hereafter to be qualified and act, is guilty of unlawful detainer:

1. When the tenant continues in possession, in person or by subtenant, of the property, or any part thereof, after the expiration of the term for which it is let to the tenant; provided the expiration is of a nondefault nature however brought about without the permission of the landlord, or the successor in estate of the landlord, if applicable; including the case where the person to be removed became the occupant of the premises as a servant, employee, agent, or licensee and the relation of master and servant, or employer and employee, or principal and agent, or licensor and licensee, has been lawfully terminated or the time fixed for occupancy by the agreement between the parties has expired; but nothing in this subdivision shall be construed as preventing the removal of the occupant in any other lawful manner; but in case of a tenancy at will, it shall first be terminated by notice, as prescribed in the Civil Code.

2. When the tenant continues in possession, in person or by subtenant, without the permission of the landlord, or the successor in estate of the landlord, if applicable, after default in the payment of rent, pursuant to the lease or agreement under which the property is held, and three days' notice, excluding Saturdays and Sundays and other judicial holidays, in writing, requiring its payment, stating the amount that is due, the name, telephone number, and address of the person to whom the rent payment shall be made, and, if payment may be made personally, the usual days and hours that person will be available to receive the payment (provided that, if the address does not allow for personal delivery, then it shall be conclusively presumed that upon the mailing of any rent or notice to the owner by the tenant to the name and address provided, the

notice or rent is deemed received by the owner on the date posted, if the tenant can show proof of mailing to the name and address provided by the owner), or the number of an account in a financial institution into which the rental payment may be made, and the name and street address of the institution (provided that the institution is located within five miles of the rental property), or if an electronic funds transfer procedure has been previously established, that payment may be made pursuant to that procedure, or possession of the property, shall have been served upon the tenant and if there is a subtenant in actual occupation of the premises, also upon the subtenant.

The notice may be served at any time within one year after the rent becomes due. In all cases of tenancy upon agricultural lands, if the tenant has held over and retained possession for more than 60 days after the expiration of the term without any demand of possession or notice to quit by the landlord or the successor in estate of the landlord, if applicable, the tenant shall be deemed to be holding by permission of the landlord or successor in estate of the landlord, if applicable, and shall be entitled to hold under the terms of the lease for another full year, and shall not be guilty of an unlawful detainer during that year, and the holding over for that period shall be taken and construed as a consent on the part of a tenant to hold for another year.

3. When the tenant continues in possession, in person or by subtenant, after a neglect or failure to perform other conditions or covenants of the lease or agreement under which the property is held, including any covenant not to assign or sublet, than the one for the payment of rent, and three days' notice, excluding Saturdays and Sundays and other judicial holidays, in writing, requiring the performance of those conditions or covenants, or the possession of the property, shall have been served upon the tenant, and if there is a subtenant in actual occupation of the premises, also, upon the subtenant. Within three days, excluding Saturdays and Sundays and other judicial holidays, after the service of the notice, the tenant, or any subtenant in actual occupation of the premises, or any mortgagee of the term, or other person interested in its continuance, may perform the conditions or covenants of the lease or pay the stipulated rent, as the case may be, and thereby save the lease from forfeiture; provided, if the conditions and covenants of the lease, violated by the lessee, cannot afterward be performed,

then no notice, as last prescribed herein, need be given to the lessee or the subtenant, demanding the performance of the violated conditions or covenants of the lease.

A tenant may take proceedings, similar to those prescribed in this chapter, to obtain possession of the premises let to a subtenant or held by a servant, employee, agent, or licensee, in case of that person's unlawful detention of the premises underlet to or held by that person.

4. Any tenant, subtenant, or executor or administrator of that person's estate heretofore qualified and now acting, or hereafter to be qualified and act, assigning or subletting or committing waste upon the demised premises, contrary to the conditions or covenants of the lease, or maintaining, committing, or permitting the maintenance or commission of a nuisance upon the demised premises or using the premises for an unlawful purpose, thereby terminates the lease, and the landlord, or the landlord's successor in estate, shall upon service of three days' notice to quit upon the person or persons in possession, be entitled to restitution of possession of the demised premises under this chapter. For purposes of this subdivision, a person who commits or maintains a public nuisance as described in Section 3482.8 of the Civil Code, or who commits an offense described in subdivision (c) of Section 3485 of the Civil Code, or subdivision (c) of Section 3486 of the Civil Code, or uses the premises to further the purpose of that offense shall be deemed to have committed a nuisance upon the premises.

5. When the tenant gives written notice as provided in Section 1946 of the Civil Code of the tenant's intention to terminate the hiring of the real property, or makes a written offer to surrender which is accepted in writing by the landlord, but fails to deliver possession at the time specified in that written notice, without the permission of the landlord, or the successor in estate of the landlord, if applicable.

6. As used in this section, "tenant" includes any person who hires real property except those persons whose occupancy is described in subdivision (b) of Section 1940 of the Civil Code.

7. This section shall become operative on ~~February 1, 2025.~~ *January 1, 2026.*

SEC. 15. Section 1161.2 of the Code of Civil Procedure, as amended by Section 17 of Chapter 37 of the Statutes of 2020, is amended to read:

1161.2. (a) (1) The clerk shall allow access to limited civil case records filed under this chapter, including the court file, index, and register of actions, only as follows:

(A) To a party to the action, including a party's attorney.

(B) To a person who provides the clerk with the names of at least one plaintiff and one defendant and the address of the premises, including the apartment or unit number, if any.

(C) To a resident of the premises who provides the clerk with the name of one of the parties or the case number and shows proof of residency.

(D) To a person by order of the court, which may be granted ex parte, on a showing of good cause.

(E) Except as provided in subparagraph (G), to any person by order of the court if judgment is entered for the plaintiff after trial more than 60 days since the filing of the complaint. The court shall issue the order upon issuing judgment for the plaintiff.

(F) Except as provided in subparagraph (G), to any other person 60 days after the complaint has been filed if *judgment against all defendants has been entered for* the plaintiff ~~prevails in the action~~ within 60 days of the filing of the complaint, in which case the clerk shall allow access to any court records in the action. If a default or default judgment is set aside more than 60 days after the complaint has been filed, this section shall apply as if the complaint had been filed on the date the default or default judgment is set aside.

(G) (i) In the case of a complaint involving residential property based on Section 1161a as indicated in the caption of the complaint, as required in subdivision (c) of Section 1166, to any other person, if 60 days have elapsed since the complaint was filed with the court, and, as of that date, judgment against all defendants has been entered for the plaintiff, after a trial.

(ii) Subparagraphs (E) and (F) shall not apply if the plaintiff filed the action between March 4, 2020, and ~~January 31,~~ *December 31,* 2021, and the action is based on an alleged default in the payment of rent.

(2) This section shall not be construed to prohibit the court from issuing an order that bars access to the court record in an action filed under this chapter if the parties to the action so stipulate.

(b) (1) For purposes of this section, "good cause" includes, but is not limited to, both of the following:

(A) The gathering of newsworthy facts by a person described in Section 1070 of the Evidence Code.

(B) The gathering of evidence by a party to an unlawful detainer action solely for the purpose of making a request for judicial notice pursuant to subdivision (d) of Section 452 of the Evidence Code.

(2) It is the intent of the Legislature that a simple procedure be established to request the ex parte order described in subparagraph (D) of paragraph (1) of subdivision (a).

(c) Upon the filing of a case so restricted, the court clerk shall mail notice to each defendant named in the action. The notice shall be mailed to the address provided in the complaint. The notice shall contain a statement that an unlawful detainer complaint (eviction action) has been filed naming that party as a defendant, and that access to the court file will be delayed for 60 days except to a party, an attorney for one of the parties, or any other person who (1) provides to the clerk the names of at least one plaintiff and one defendant in the action and provides to the clerk the address, including any applicable apartment, unit, or space number, of the subject premises, or (2) provides to the clerk the name of one of the parties in the action or the case number and can establish through proper identification that the person lives at the subject premises. The notice shall also contain a statement that access to the court index, register of actions, or other records is not permitted until 60 days after the complaint is filed, except pursuant to an order upon a showing of good cause for access. The notice shall contain on its face the following information:

(1) The name and telephone number of the county bar association.

(2) The name and telephone number of any entity that requests inclusion on the notice and demonstrates to the satisfaction of the court that it has been certified by the State Bar of California as a lawyer referral service and maintains a panel of attorneys qualified in the practice of landlord-tenant law pursuant to the minimum standards for a lawyer referral service established by the State Bar

of California and Section 6155 of the Business and Professions Code.

(3) The following statement:

"The State Bar of California certifies lawyer referral services in California and publishes a list of certified lawyer referral services organized by county. To locate a lawyer referral service in your county, go to the State Bar's internet website at www.calbar.ca.gov or call 1-866-442-2529."

(4) The name and telephone number of an office or offices funded by the federal Legal Services Corporation or qualified legal services projects that receive funds distributed pursuant to Section 6216 of the Business and Professions Code that provide legal services to low-income persons in the county in which the action is filed. The notice shall state that these telephone numbers may be called for legal advice regarding the case. The notice shall be issued between 24 and 48 hours of the filing of the complaint, excluding weekends and holidays. One copy of the notice shall be addressed to "all occupants" and mailed separately to the subject premises. The notice shall not constitute service of the summons and complaint.

(d) Notwithstanding any other law, the court shall charge an additional fee of fifteen dollars ($15) for filing a first appearance by the plaintiff. This fee shall be added to the uniform filing fee for actions filed under this chapter.

(e) This section does not apply to a case that seeks to terminate a mobilehome park tenancy if the statement of the character of the proceeding in the caption of the complaint clearly indicates that the complaint seeks termination of a mobilehome park tenancy.

(f) This section does not alter any provision of the Evidence Code.

(g) This section shall remain in effect until ~~February 1, 2021,~~ *January 1, 2022,* and as of that date is repealed.

SEC. 16. Section 1161.2 of the Code of Civil Procedure, as added by Section 18 of Chapter 37 of the Statutes of 2020, is amended to read:

1161.2. (a) (1) The clerk shall allow access to limited civil case records filed under this chapter, including the court file, index, and register of actions, only as follows:

(A) To a party to the action, including a party's attorney.

(B) To a person who provides the clerk with the names of at least one plaintiff and one defendant and the address of the premises, including the apartment or unit number, if any.

(C) To a resident of the premises who provides the clerk with the name of one of the parties or the case number and shows proof of residency.

(D) To a person by order of the court, which may be granted ex parte, on a showing of good cause.

(E) To any person by order of the court if judgment is entered for the plaintiff after trial more than 60 days since the filing of the complaint. The court shall issue the order upon issuing judgment for the plaintiff.

(F) Except as provided in subparagraph (G), to any other person 60 days after the complaint has been filed if *judgment against all defendants has been entered for* the plaintiff ~~prevails in the action~~ within 60 days of the filing of the complaint, in which case the clerk shall allow access to any court records in the action. If a default or default judgment is set aside more than 60 days after the complaint has been filed, this section shall apply as if the complaint had been filed on the date the default or default judgment is set aside.

(G) In the case of a complaint involving residential property based on Section 1161a as indicated in the caption of the complaint, as required in subdivision (c) of Section 1166, to any other person, if 60 days have elapsed since the complaint was filed with the court, and, as of that date, judgment against all defendants has been entered for the plaintiff, after a trial.

(2) This section shall not be construed to prohibit the court from issuing an order that bars access to the court record in an action filed under this chapter if the parties to the action so stipulate.

(b) (1) For purposes of this section, "good cause" includes, but is not limited to, both of the following:

(A) The gathering of newsworthy facts by a person described in Section 1070 of the Evidence Code.

(B) The gathering of evidence by a party to an unlawful detainer action solely for the purpose of making a request for judicial notice pursuant to subdivision (d) of Section 452 of the Evidence Code.

(2) It is the intent of the Legislature that a simple procedure be established to request the ex parte order described in subparagraph (D) of paragraph (1) of subdivision (a).

(c) Upon the filing of a case so restricted, the court clerk shall mail notice to each defendant named in the action. The notice shall be mailed to the address provided in the complaint. The notice shall contain a statement that an unlawful detainer complaint (eviction action) has been filed naming that party as a defendant, and that access to the court file will be delayed for 60 days except to a party, an attorney for one of the parties, or any other person who (1) provides to the clerk the names of at least one plaintiff and one defendant in the action and provides to the clerk the address, including any applicable apartment, unit, or space number, of the subject premises, or (2) provides to the clerk the name of one of the parties in the action or the case number and can establish through proper identification that the person lives at the subject premises. The notice shall also contain a statement that access to the court index, register of actions, or other records is not permitted until 60 days after the complaint is filed, except pursuant to an order upon a showing of good cause for access. The notice shall contain on its face the following information:

(1) The name and telephone number of the county bar association.

(2) The name and telephone number of any entity that requests inclusion on the notice and demonstrates to the satisfaction of the court that it has been certified by the State Bar of California as a lawyer referral service and maintains a panel of attorneys qualified in the practice of landlord-tenant law pursuant to the minimum standards for a lawyer referral service established by the State Bar of California and Section 6155 of the Business and Professions Code.

(3) The following statement:

"The State Bar of California certifies lawyer referral services in California and publishes a list of certified lawyer referral services organized by county. To locate a lawyer referral service in your county, go to the State Bar's internet website at www.calbar.ca.gov or call 1-866-442-2529."

(4) The name and telephone number of an office or offices funded by the federal Legal Services Corporation or qualified legal services projects that receive funds distributed pursuant to Section

6216 of the Business and Professions Code that provide legal services to low-income persons in the county in which the action is filed. The notice shall state that these telephone numbers may be called for legal advice regarding the case. The notice shall be issued between 24 and 48 hours of the filing of the complaint, excluding weekends and holidays. One copy of the notice shall be addressed to "all occupants" and mailed separately to the subject premises. The notice shall not constitute service of the summons and complaint.

(d) Notwithstanding any other law, the court shall charge an additional fee of fifteen dollars ($15) for filing a first appearance by the plaintiff. This fee shall be added to the uniform filing fee for actions filed under this chapter.

(e) This section does not apply to a case that seeks to terminate a mobilehome park tenancy if the statement of the character of the proceeding in the caption of the complaint clearly indicates that the complaint seeks termination of a mobilehome park tenancy.

(f) This section does not alter any provision of the Evidence Code.

(g) This section shall become operative on ~~February 1, 2021.~~ *January 1, 2022.*

SEC. 17. Section 1161.2.5 of the Code of Civil Procedure, as added by Section 19 of Chapter 37 of the Statutes of 2020, is amended to read:

1161.2.5. (a) (1) Except as provided in Section 1161.2, the clerk shall allow access to civil case records for actions seeking recovery of COVID-19 rental debt, as defined in Section 1179.02, including the court file, index, and register of actions, only as follows:

(A) To a party to the action, including a party's attorney.

(B) To a person who provides the clerk with the names of at least one plaintiff and one defendant.

(C) To a resident of the premises for which the COVID-19 rental debt is owed who provides the clerk with the name of one of the parties or the case number and shows proof of residency.

(D) To a person by order of the court, which may be granted ex parte, on a showing of good cause.

(2) To give the court notice that access to the records in an action is limited, any complaint or responsive pleading in a case subject to this section shall include on either the first page of the pleading

or a cover page, the phrase "ACTION FOR RECOVERY OF COVID-19 RENTAL DEBT AS DEFINED UNDER SECTION 1179.02" in bold, capital letters, in 12 point or larger font.

(b) (1) For purposes of this section, "good cause" includes, but is not limited to, both of the following:

(A) The gathering of newsworthy facts by a person described in Section 1070 of the Evidence Code.

(B) The gathering of evidence by a party to a civil action solely for the purpose of making a request for judicial notice pursuant to subdivision (d) of Section 452 of the Evidence Code.

(2) It is the intent of the Legislature that a simple procedure be established to request the ex parte order described in subparagraph (D) of paragraph (1) of subdivision (a).

(c) This section does not alter any provision of the Evidence Code.

(d) This section shall remain in effect until ~~February 1, 2021,~~ *January 1, 2022,* and as of that date is repealed.

SEC. 18. Section 1179.02 of the Code of Civil Procedure is amended to read:

1179.02. For purposes of this chapter:

(a) "Covered time period" means the time period between March 1, 2020, and ~~January 31,~~ *December 31,* 2021.

(b) "COVID-19-related financial distress" means any of the following:

(1) Loss of income caused by the COVID-19 pandemic.

(2) Increased out-of-pocket expenses directly related to performing essential work during the COVID-19 pandemic.

(3) Increased expenses directly related to the health impact of the COVID-19 pandemic.

(4) Childcare responsibilities or responsibilities to care for an elderly, disabled, or sick family member directly related to the COVID-19 pandemic that limit a tenant's ability to earn income.

(5) Increased costs for childcare or attending to an elderly, disabled, or sick family member directly related to the COVID-19 pandemic.

(6) Other circumstances related to the COVID-19 pandemic that have reduced a tenant's income or increased a tenant's expenses.

(c) "COVID-19 rental debt" means unpaid rent or any other unpaid financial obligation of a tenant under the tenancy that came due during the covered time period.

(d) "Declaration of COVID-19-related financial distress" means the following written statement:

I am currently unable to pay my rent or other financial obligations under the lease in full because of one or more of the following:

1. Loss of income caused by the COVID-19 pandemic.

2. Increased out-of-pocket expenses directly related to performing essential work during the COVID-19 pandemic.

3. Increased expenses directly related to health impacts of the COVID-19 pandemic.

4. Childcare responsibilities or responsibilities to care for an elderly, disabled, or sick family member directly related to the COVID-19 pandemic that limit my ability to earn income.

5. Increased costs for childcare or attending to an elderly, disabled, or sick family member directly related to the COVID-19 pandemic.

6. Other circumstances related to the COVID-19 pandemic that have reduced my income or increased my expenses.

Any public assistance, including unemployment insurance, pandemic unemployment assistance, state disability insurance (SDI), or paid family leave, that I have received since the start of the COVID-19 pandemic does not fully make up for my loss of income and/or increased expenses.

Signed under penalty of perjury:

Dated:

(e) "Landlord" includes all of the following or the agent of any of the following:

(1) An owner of residential real property.

(2) An owner of a residential rental unit.

(3) An owner of a mobilehome park.

(4) An owner of a mobilehome park space or lot.

(f) "Protected time period" means the time period between March 1, 2020, and August 31, 2020.

(g) "Rental payment" means rent or any other financial obligation of a tenant under the tenancy.

(h) "Tenant" means any natural person who hires real property except any of the following:

(1) Tenants of commercial property, as defined in subdivision (c) of Section 1162 of the Civil Code.

(2) Those persons whose occupancy is described in subdivision (b) of Section 1940 of the Civil Code.

(i) "Transition time period" means the time period between September 1, 2020, and ~~January 31,~~ *December 31,* 2021.

SEC. 19. Section 1179.02.5 of the Code of Civil Procedure is amended to read:

1179.02.5. (a) For purposes of this section:

(1) (A) "High-income tenant" means a tenant with an annual household income of 130 percent of the median income, as published by the Department of Housing and Community Development in the Official State Income Limits for 2020, for the county in which the residential rental property is located.

(B) For purposes of this paragraph, all lawful occupants of the residential rental unit, including minor children, shall be considered in determining household size.

(C) "High-income tenant" shall not include a tenant with a household income of less than one hundred thousand dollars ($100,000).

(2) "Proof of income" means any of the following:

(A) A tax return.

(B) A W-2.

(C) A written statement from a tenant's employer that specifies the tenant's income.

(D) Pay stubs.

(E) Documentation showing regular distributions from a trust, annuity, 401k, pension, or other financial instrument.

(F) Documentation of court-ordered payments, including, but not limited to, spousal support or child support.

(G) Documentation from a government agency showing receipt of public assistance benefits, including, but not limited to, social security, unemployment insurance, disability insurance, or paid family leave.

(H) A written statement signed by the tenant that states the tenant's income, including, but not limited to, a rental application.

(b) (1) This section shall apply only if the landlord has proof of income in the landlord's possession before the service of the notice showing that the tenant is a high-income tenant.

(2) This section does not do any of the following:

(A) Authorize a landlord to demand proof of income from the tenant.

(B) Require the tenant to provide proof of income for the purposes of determining whether the tenant is a high-income tenant.

(C) (i) Entitle a landlord to obtain, or authorize a landlord to attempt to obtain, confidential financial records from a tenant's employer, a government agency, financial institution, or any other source.

(ii) Confidential information described in clause (i) shall not constitute valid proof of income unless it was lawfully obtained by the landlord with the tenant's consent during the tenant screening process.

(3) Paragraph (2) does not alter a party's rights under Title 4 (commencing with Section 2016.010), Chapter 4 (commencing with Section 708.010) of Title 9, or any other law.

(c) A landlord may require a high-income tenant that is served a notice pursuant to subdivision (b) or (c) of Section 1179.03 to submit, in addition to and together with a declaration of COVID-19-related financial distress, documentation supporting the claim that the tenant has suffered COVID-19-related financial distress. Any form of objectively verifiable documentation that demonstrates the COVID-19-related financial distress the tenant has experienced is sufficient to satisfy the requirements of this subdivision, including the proof of income, as defined in subparagraphs (A) to (G), inclusive, of paragraph (2) of subdivision (a), a letter from an employer, or an unemployment insurance record.

(d) *(1)* A high-income tenant is required to comply with the requirements of subdivision (c) only if the landlord has included the following language on the notice served pursuant to subdivision (b) or (c) of Section 1179.03 in at least 12-point font:

"Proof of income on file with your landlord indicates that your household makes at least 130 percent of the median income for the county where the rental property is located, as published by the Department of Housing and Community Development in the Official State Income Limits for 2020. As a result, if you claim that you are unable to pay the amount demanded by this notice because you have suffered COVID-19-related financial distress, you are required to submit to your landlord documentation supporting your claim together with the completed declaration of

COVID-19-related financial distress provided with this notice. If you fail to submit this documentation together with your declaration of COVID-19-related financial distress, and you do not either pay the amount demanded in this notice or deliver possession of the premises back to your landlord as required by this notice, you will not be covered by the eviction protections enacted by the California Legislature as a result of the COVID-19 pandemic, and your landlord can begin eviction proceedings against you as soon as this 15-day notice expires."

(2) A tenant shall not be considered a high-income tenant and shall not be required to comply with the requirements of subdivision (c) unless the landlord has included a copy of the proof of income described in paragraph (1) that demonstrates that the tenant qualifies as a high-income tenant with the notice served pursuant to subdivision (b) or (c) of Section 1179.03.

(e) A high-income tenant that fails to comply with subdivision (c) shall not be subject to the protections of subdivision (g) of Section 1179.03.

(f) (1) A landlord shall be required to plead compliance with this section in any unlawful detainer action based upon a notice that alleges that the tenant is a high-income tenant. If that allegation is contested, the landlord shall be required to submit to the court the proof of income upon which the landlord relied at the trial or other hearing, and the tenant shall be entitled to submit rebuttal evidence.

(2) If the court in an unlawful detainer action based upon a notice that alleges that the tenant is a high-income tenant determines that at the time the notice was served the landlord did not have proof of income establishing that the tenant is a high-income tenant, the court shall award attorney's fees to the prevailing tenant.

SEC. 20. Section 1179.03 of the Code of Civil Procedure is amended to read:

1179.03. (a) (1) Any notice that demands payment of COVID-19 rental debt served pursuant to subdivision (e) of Section 798.56 of the Civil Code or paragraph (2) or (3) of Section 1161 shall be modified as required by this section. A notice which does not meet the requirements of this section, *including by modifying or adding to the language of the notice,* regardless of when the

notice was issued, shall not be sufficient to establish a cause of action for unlawful detainer or a basis for default judgment.

(2) Any case based solely on a notice that demands payment of COVID-19 rental debt served pursuant to subdivision (e) of Section 798.56 of the Civil Code or paragraph (2) or (3) of Section 1161 may be dismissed if the notice does not meet the requirements of this section, regardless of when the notice was issued.

(3) Notwithstanding paragraphs (1) and (2), this section shall have no effect if the landlord lawfully regained possession of the property or obtained a judgment for possession of the property before the operative date of this section.

(b) If the notice demands payment of rent that came due during the protected time period, as defined in Section 1179.02, the notice shall comply with all of the following:

(1) The time period in which the tenant may pay the amount due or deliver possession of the property shall be no shorter than 15 days, excluding Saturdays, Sundays, and other judicial holidays.

(2) The notice shall set forth the amount of rent demanded and the date each amount became due.

(3) The notice shall advise the tenant that the tenant cannot be evicted for failure to comply with the notice if the tenant delivers a signed declaration of COVID-19-related financial distress to the landlord on or before the date that the notice to pay rent or quit or notice to perform covenants or quit expires, by any of the methods specified in subdivision (f).

(4) The notice shall include the following text in at least 12-point font:

"NOTICE FROM THE STATE OF CALIFORNIA: If you are unable to pay the amount demanded in this notice, and have decreased income or increased expenses due to COVID-19, your landlord will not be able to evict you for this missed payment if you sign and deliver the declaration form included with your notice to your landlord within 15 days, excluding Saturdays, Sundays, and other judicial holidays, but you will still owe this money to your landlord. If you do not sign and deliver the declaration within this time period, you may lose the eviction protections available to you. You must return this form to be protected. You should keep a copy or picture of the signed form for your records.

You will still owe this money to your landlord and can be sued for the money, but you cannot be evicted from your home if you

comply with these requirements. *You do not need to enter into a repayment agreement or any other agreement with your landlord to have these protections.* You should keep careful track of what you have paid and any amount you still owe to protect your rights and avoid future disputes. Failure to respond to this notice may result in an unlawful detainer action (eviction) being filed against you.

For information about legal resources that may be available to you, visit lawhelpca.org."

(5) Any language that is altered or added to the notice provided in paragraph (4) shall be void and nonbinding as a matter of public policy.

(c) If the notice demands payment of rent that came due during the transition time period, as defined in Section 1179.02, the notice shall comply with all of the following:

(1) The time period in which the tenant may pay the amount due or deliver possession of the property shall be no shorter than 15 days, excluding Saturdays, Sundays, and other judicial holidays.

(2) The notice shall set forth the amount of rent demanded and the date each amount became due.

(3) The notice shall advise the tenant that the tenant will not be evicted for failure to comply with the notice, except as allowed by this chapter, if the tenant delivers a signed declaration of COVID-19-related financial distress to the landlord on or before the date the notice to pay rent or quit or notice to perform covenants or quit expires, by any of the methods specified in subdivision (f).

(4) The notice shall include the following text in at least 12-point font:

"NOTICE FROM THE STATE OF CALIFORNIA: If you are unable to pay the amount demanded in this notice, and have decreased income or increased expenses due to COVID-19, you may sign and deliver the declaration form included with your notice to your landlord within 15 days, excluding Saturdays, Sundays, and other judicial holidays, and your landlord will not be able to evict you for this missed payment so long as you make the minimum payment (see below). You will still owe this money to your landlord. You should keep a copy or picture of the signed form for your records.

If you provide the declaration form to your landlord as described above AND, on or before ~~January 31,~~ *December 31,* 2021, you

pay an amount that equals at least 25 percent of each rental payment that came due or will come due during the period between September 1, 2020, and ~~January 31,~~ *December 31,* 2021, that you were unable to pay as a result of decreased income or increased expenses due to COVID-19, your landlord cannot evict you. Your landlord may require you to submit a new declaration form for each rental payment that you do not pay that comes due between September 1, 2020, and ~~January 31,~~ *December 31,* 2021.

For example, if you provided a declaration form to your landlord regarding your decreased income or increased expenses due to COVID-19 that prevented you from making your rental payment in September and October of 2020, your landlord could not evict you if, on or before ~~January 31,~~ *December 31,* 2021, you made a payment equal to 25 percent of September's and October's rental payment (i.e., half a month's rent). If you were unable to pay any of the rental payments that came due between September 1, 2020, and ~~January 31,~~ *December 31,* 2021, and you provided your landlord with the declarations in response to each 15-day notice your landlord sent to you during that time period, your landlord could not evict you if, on or before ~~January 31,~~ *December 31,* 2021, you paid your landlord an amount equal to 25 percent of all the rental payments due from September *of 2020* through ~~January~~ *December of 2021* (i.e., ~~one and a quarter~~ *four* month's rent).

You will still owe the full amount of the rent to your landlord, but you cannot be evicted from your home if you comply with these requirements. You should keep careful track of what you have paid and any amount you still owe to protect your rights and avoid future disputes. Failure to respond to this notice may result in an unlawful detainer action (eviction) being filed against you.

For information about legal resources that may be available to you, visit lawhelpca.org."

(d) An unsigned copy of a declaration of COVID-19-related financial distress shall accompany each notice delivered to a tenant to which subdivision (b) or (c) is applicable. If the landlord was required, pursuant to Section 1632 of the Civil Code, to provide a translation of the rental contract or agreement in the language in which the contract or agreement was negotiated, the landlord shall also provide the unsigned copy of a declaration of COVID-19-related financial distress to the tenant in the language in which the contract or agreement was negotiated. The Department

of Real Estate shall make available an official translation of the text required by paragraph (4) of subdivision (b) and paragraph (4) of subdivision ~~(c)~~ *(c), as it read on August 31, 2020,* in the languages specified in Section 1632 of the Civil Code by no later than September 15, 2020. *The Department of Real Estate shall make available an official translation of the text required by paragraph (4) of subdivision (c), as it read on the effective date of the act that added this sentence, in the languages specified in Section 1632 of the Civil Code, within 15 days of the effective date of the act that added this sentence.*

(e) If a tenant owes a COVID-19 rental debt to which both subdivisions (b) and (c) apply, the landlord shall serve two separate notices that comply with subdivisions (b) and (c), respectively.

(f) A tenant may deliver the declaration of COVID-19-related financial distress to the landlord by any of the following methods:

(1) In person, if the landlord indicates in the notice an address at which the declaration may be delivered in person.

(2) By electronic transmission, if the landlord indicates an email address in the notice to which the declaration may be delivered.

(3) Through United States mail to the address indicated by the landlord in the notice. If the landlord does not provide an address pursuant to subparagraph (1), then it shall be conclusively presumed that upon the mailing of the declaration by the tenant to the address provided by the landlord, the declaration is deemed received by the landlord on the date posted, if the tenant can show proof of mailing to the address provided by the landlord.

(4) Through any of the same methods that the tenant can use to deliver the payment pursuant to the notice if delivery of the declaration by that method is possible.

(g) Except as provided in Section 1179.02.5, the following shall apply to a tenant who, within 15 days of service of the notice specified in subdivision (b) or (c), excluding Saturdays, Sundays, and other judicial holidays, demanding payment of COVID-19 rental debt delivers a declaration of COVID-19-related financial distress to the landlord by any of the methods provided in subdivision (f):

(1) With respect to a notice served pursuant to subdivision (b), the tenant shall not then or thereafter be deemed to be in default with regard to that COVID-19 rental debt for purposes of

subdivision (e) of Section 798.56 of the Civil Code or paragraphs (2) and (3) of Section 1161.

(2) With respect to a notice served pursuant to subdivision (c), the following shall apply:

(A) Except as provided by subparagraph (B), the landlord ~~may~~ *shall* not initiate an unlawful detainer action before ~~February 1, 2021.~~ *January 1, 2022.*

(B) A tenant shall not be guilty of unlawful detainer, now or in the future, based upon nonpayment of COVID-19 rental debt that came due during the transition period if, ~~on or before January 31, 2021,~~ *at any point before the end of the transition period,* the tenant tenders one or more payments that, when taken together, are of an amount equal to or not less than 25 percent of each transition period rental payment demanded in one or more notices served pursuant to subsection (c) and for which the tenant complied with this subdivision by timely delivering a declaration of COVID-19-related financial distress to the landlord.

(h) (1) (A) Within the time prescribed in Section 1167, a tenant shall be permitted to file *with the court* a signed declaration of COVID-19-related financial ~~distress with the court.~~ *distress, as defined in subdivision (d) of Section 1179.02. If the case is based on multiple notices, one declaration shall be sufficient for purposes of this subdivision.*

(B) If the tenant files a signed declaration of COVID-19-related financial distress with the court pursuant to this subdivision, the court shall dismiss the case, pursuant to paragraph (2), if the court finds, after a noticed hearing on the matter, that the tenant's failure to ~~return~~ *provide* a declaration of COVID-19-related financial distress within the time required by subdivision ~~(g)~~ *(f)* was the result of mistake, inadvertence, surprise, or excusable neglect, as those terms have been interpreted under subdivision (b) of Section 473.

(C) The noticed hearing required by this paragraph shall be held with not less than five days' notice and not more than 10 days' notice, to be given by the court, and may be held separately or in conjunction with any regularly noticed hearing in the case, other than a trial.

(2) If the court dismisses the case pursuant to paragraph (1), that dismissal shall be without prejudice as follows:

(A) If the case was based in whole or in part upon a notice served pursuant to subdivision (b), the court shall dismiss any cause of action based on the notice served pursuant to subdivision (b).

(B) Before ~~February 1, 2021,~~ *January 1, 2022,* if the case is based in whole or in part on a notice served pursuant to subdivision (c), the court shall dismiss any cause of action based on the notice served pursuant to subdivision (c).

(C) On or after ~~February 1, 2021,~~ *January 1, 2022,* if the case is based in whole or in part on a notice served pursuant to subdivision (c), the court shall dismiss any cause of action based upon the notice served pursuant to subdivision (c) if the tenant, within five days of the court's order to do so, makes the payment required by subparagraph (B) of paragraph (1) of subdivision (g), provided that if the fifth day falls on a Saturday, Sunday, or judicial holiday the last day to pay shall be extended to the next court day.

(3) If the court dismisses the case pursuant to this subdivision, the tenant shall not be considered the prevailing party for purposes of Section 1032, any attorney's fee provision appearing in contract or statute, or any other law.

(i) Notwithstanding any other law, a notice which is served pursuant to subdivision (b) or (c) that complies with the requirements of this chapter and subdivision (e) of Section 798.56 of the Civil Code or paragraphs (2) and (3) of Section 1161, as applicable, need not include specific language required by any ordinance, resolution, regulation, or administrative action adopted by a city, county, or city and county.

SEC. 21. Section 1179.03.5 of the Code of Civil Procedure is amended to read:

1179.03.5. (a) Before ~~February 1, 2021~~ *January 1, 2022,* a court may not find a tenant guilty of an unlawful detainer unless it finds that one of the following applies:

(1) The tenant was guilty of the unlawful detainer before March 1, 2020.

(2) In response to service of a notice demanding payment of COVID-19 rental debt pursuant to subdivision (e) of Section 798.56 of the Civil Code or paragraph (2) or (3) of Section 1161, the tenant failed to comply with the requirements of Section 1179.03.

(3) (A) The unlawful detainer arises because of a termination of tenancy for any of the following:

(i) An at-fault just cause, as defined in paragraph (1) of subdivision (b) of Section 1946.2 of the Civil Code.

(ii) (I) A no-fault just cause, as defined in paragraph (2) of subdivision (b) of Section 1946.2 of the Civil Code, other than intent to demolish or to substantially remodel the residential real property, as defined in subparagraph (D) of paragraph (2) of subdivision (b) of Section 1946.2.

(II) Notwithstanding subclause (I), termination of a tenancy based on intent to demolish or to substantially remodel the residential real property shall be permitted if necessary to maintain compliance with the requirements of Section 1941.1 of the Civil Code, Section 17920.3 or 17920.10 of the Health and Safety Code, or any other applicable law governing the habitability of residential rental units.

(iii) The owner of the property has entered into a contract for the sale of that property with a buyer who intends to occupy the property, and all the requirements of paragraph (8) of subdivision (e) of Section 1946.2 of the Civil Code have been satisfied.

(B) In an action under this paragraph, other than an action to which paragraph (2) also applies, the landlord shall be precluded from recovering COVID-19 rental debt in connection with any award of damages.

(b) (1) This section does not require a landlord to assist the tenant to relocate through the payment of relocation costs if the landlord would not otherwise be required to do so pursuant to Section 1946.2 of the Civil Code or any other law.

(2) A landlord who is required to assist the tenant to relocate pursuant to Section 1946.2 of the Civil Code or any other law, may offset the tenant's COVID-19 rental debt against their obligation to assist the tenant to relocate.

SEC. 22. Section 1179.04.5 is added to the Code of Civil Procedure, to read:

1179.04.5. Notwithstanding Sections 1470, 1947, and 1950 of the Civil Code, or any other law, for the duration of any tenancy that existed during the covered time period, a landlord shall not do either of the following:

(a) Apply a security deposit to satisfy COVID-19 rental debt unless the tenant has agreed in writing to allow the deposit to be so applied. Nothing in this paragraph shall prohibit a landlord from applying a security deposit to satisfy COVID-19 rental debt after

the tenancy ends, in accordance with Section 1950.5 of the Civil Code.

(b) Apply a monthly rental payment to any COVID-19 rental debt other than the prospective month's rent, unless the tenant has agreed in writing to allow the payment to be so applied.

SEC. 23. Section 1179.07 of the Code of Civil Procedure is amended to read:

1179.07. This chapter shall remain in effect until ~~February 1, 2025,~~ *January 1, 2026,* and as of that date is repealed.

SEC. 24. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because 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.

SEC. 25. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the California Constitution and shall go into immediate effect. The facts constituting the necessity are:

To avert economic and social harm by providing a structure for temporary relief to financially distressed tenants, homeowners, and small landlords during the public health emergency, it is necessary that this act take effect immediately.

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AMENDED IN ASSEMBLY JANUARY 12, 2021

CALIFORNIA LEGISLATURE—2021–22 REGULAR SESSION

ASSEMBLY BILL No. 16

Introduced by Assembly Member Chiu

December 7, 2020

An act *to add Chapter 2.9 (commencing with Section 50495) to Part 2 of Division 31 of the Health and Safety Code*, relating to tenancies.

LEGISLATIVE COUNSEL'S DIGEST

AB 16, as amended, Chiu. Tenancies: *COVID-19* Tenant, Small Landlord, and Affordable Housing Provider Stabilization Act of 2021.

Existing law, the COVID-19 Tenant Relief Act of 2020, establishes certain procedural requirements and limitations on evictions for nonpayment of rent due to COVID-19 rental debt, as defined. The act prohibits a tenant that delivers a declaration of COVID-19-related financial distress from being deemed in default with regard to the COVID-19 rental debt, as specified. Existing law defines COVID-19 rental debt as unpaid rent or any other unpaid financial obligation of a tenant that came due between March 1, 2020, and January 31, 2021. Existing law repeals the act on February 1, 2025.

~~This bill would state the intent of the Legislature to enact the Tenant, Small Landlord, and Affordable Housing Provider Stabilization Act of 2021 to address the long-term financial impacts of the COVID-19 pandemic on renters, small landlords, and affordable housing providers, ensure ongoing housing stability for tenants at risk of eviction, and stabilize rental properties at risk of foreclosure. This bill would include legislative findings and declarations in support of the intended legislation.~~

This bill would establish the Tenant, Small Landlord, and Affordable Housing Provider Stabilization Program. The bill would authorize the Director of Housing and Community Development to direct an existing office or program within the Department of Housing and Community Development to implement the program. The bill would establish in the State Treasury the COVID-19 Tenant, Small Landlord, and Affordable Housing Provider Stabilization Fund, and, upon appropriation by the Legislature, distribute all moneys in the fund to the department to carry out the purposes of the program. The bill would require the program be implemented only to the extent that funding is made available through the Budget Act. The bill would specify that it is the intent of the Legislature to prioritize the use of available federal funds before using General Fund moneys for the program.

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: no.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) On March 4, 2020, Governor Gavin Newsom proclaimed a state of emergency in response to the COVID-19 pandemic. Measures necessary to contain the spread of COVID-19 have brought about widespread economic and societal disruption, placing the state in unprecedented circumstances.

(b) In response to the COVID-19 pandemic, on August 31, 2020, the Legislature passed and the Governor signed into law Assembly Bill 3088 (Chapter 37 of the Statutes of 2020) which created the Tenant, Homeowner, and Small Landlord Relief and Stabilization Act of 2020 (hereafter "the Act"). While the Act provided much-needed temporary protections for renters and property owners, the economic repercussions of the pandemic and the necessary public health response on tenants, small landlords, and affordable housing providers may last for years to come, and have disproportionately impacted people and communities of color, exacerbating California's racial justice challenges.

~~(d)~~

(c) The pandemic, its disproportionate effects, and responses to it have also laid bare and exacerbated structural issues related to the planning, development, and disposition of housing that

threaten to impede our state's recovery and leave some groups behind.

~~(e)~~

(d) Whereas in response to the COVID-19 emergency, some local governments have dedicated funds to rental assistance and debt relief for tenants and property owners, a coordinated statewide program does not yet exist.

~~(f)~~

(e) In order to ensure a just recovery from the COVID-19 pandemic, it is therefore necessary to invest public funds to stabilize renters, small landlords, and affordable housing providers. Such funds must be accompanied by policies that address the factors displacing tenants from their homes and communities, which create additional risk of exposure, threaten public health, and threaten to delay recovery if not addressed. A failure to do so could threaten the state's ability to curb transmission of COVID-19 while also creating long-term consequences for the financial stability of all parties.

~~(g)~~

(f) It is, therefore, the intent of the Legislature and the State of California to establish through statute a framework for distributing financial support to ensure long-term stability for renters, small landlords, and affordable housing providers, protect tenants from displacement during the ongoing public health crisis, and ensure an equitable, broadly shared recovery.

~~SEC. 2. This act shall be known, and may be cited, as the Tenant, Small Landlord, and Affordable Housing Provider Stabilization Act of 2021.~~

~~SEC. 3. It is the intent of the Legislature to subsequently amend this measure and enact the Tenant, Small Landlord, and Affordable Housing Provider Stabilization Act of 2021 to address the long-term financial impacts of the COVID-19 pandemic on renters, small landlords, and affordable housing providers, ensure ongoing housing stability for tenants at risk of eviction, and stabilize rental properties at risk of foreclosure.~~

SEC. 2. Chapter 2.9 (commencing with Section 50495) is added to Part 2 of Division 31 of the Health and Safety Code, to read:

Chapter 2.9. COVID-19 Tenant, Small Landlord, and Affordable Housing Provider Stabilization Program

50495. This chapter shall be known, and may be cited, as the COVID-19 Tenant, Small Landlord, and Affordable Housing Provider Stabilization Act of 2021.

50495.1. (a) There is hereby established the COVID-19 Tenant, Small Landlord, and Affordable Housing Provider Stabilization Program, which shall be administered pursuant to this chapter.

(b) The director may direct an existing office or program within the department to implement this chapter.

(c) Any guidelines or policies that the department adopts to implement this chapter shall not be subject to the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

50495.2. For purposes of this chapter:

(a) "Department" means the Department of Housing and Community Development.

(b) "Director" means the Director of Housing and Community Development.

(c) "Program" means the COVID-19 Tenant, Small Landlord, and Affordable Housing Provider Stabilization Program created by this chapter.

50495.3. (a) There is hereby created in the State Treasury the COVID-19 Tenant, Small Landlord, and Affordable Housing Provider Stabilization Fund. Upon appropriation by the Legislature, all moneys in the fund shall be distributed to the department to carry out the purposes of this chapter. Any repayments, interest, or new appropriations shall be deposited in the fund, notwithstanding Section 16305.7 of the Government Code. Moneys in the fund shall not be subject to transfer to any other fund pursuant to any provision of Part 2 (commencing with Section 16300) of Division 4 of Title 2 of the Government Code, except to the Surplus Money Investment Fund.

(b) The program shall be implemented to the extent funding is made available through the Budget Act. It is the intent of the

Legislature to prioritize the use of available federal funds before using General Fund moneys.

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ASSEMBLY BILL No. 19

Introduced by Assembly Members Santiago, Chiu, and Kalra

December 7, 2020

An act to add Section 316.5 to, and to add and repeal Sections 1026.3 and 1280.6 of, the Unemployment Insurance Code, relating to unemployment benefits, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 19, as introduced, Santiago. Unemployment insurance compensation: COVID-19 pandemic: temporary benefits.

(1) Existing law provides for the payment of unemployment compensation benefits to eligible persons who are unemployed through no fault of their own through a federal-state unemployment insurance program administered by the Employment Development Department. Unemployment compensation benefits are paid from the Unemployment Fund, which is continuously appropriated for this purpose. Under existing law, unemployment compensation benefits are based on wages paid in a base period that is calculated according to the month within which the benefit year begins. Existing law provides that a weekly unemployment compensation benefit amount may be paid to an individual whose highest wages in the quarter of their base period exceeded $900, but a weekly benefit amount may not exceed $450. Existing law requires the Director of Employment Development to maintain a separate reserve account for each employer, and to charge unemployment compensation benefits paid to an unemployed individual during any benefit year against the reserve account of that individual's employer during the individual's base period.

Existing law, the federal Coronavirus Aid, Relief, and Economic Security Act (CARES Act), temporarily provides for expanded unemployment benefits through the federal Pandemic Unemployment Assistance (PUA) and Pandemic Emergency Unemployment Compensation (PEUC) provisions of the CARES Act.

This bill would require the department to provide, until July 1, 2022, following the termination of assistance pursuant to PUA and PEUC or any other federal or state supplemental unemployment compensation payments for unemployment due to the COVID-19 pandemic, in addition to an individual's weekly benefit amount as otherwise provided for by existing unemployment compensation law, unemployment compensation benefits equivalent to the terminated federal or state supplemental unemployment compensation payments for the remainder of the duration of time the individual is unemployed due to the COVID-19 pandemic, notwithstanding the weekly benefit cap. The bill would prohibit any unemployment compensation benefits authorized by the bill from being charged against the reserve account of any employer.

Because this bill would authorize additional benefits to be paid from the Unemployment Fund, which is continuously appropriated, it would make an appropriation.

(2) The Dymally-Alatorre Bilingual Services Act, among other things, generally requires every state agency, as defined, directly involved in certain activities involving contact with a substantial number of non-English-speaking people, including administering state benefits, to employ a sufficient number of qualified bilingual persons in public contact positions to ensure provision of information and services to the public in the language of the non-English-speaking person.

This bill would specifically require the Employment Development Department to comply with that provision in order to ensure that non-English-speaking California residents have adequate access to department employees who are qualified to provide information regarding applying for, and receiving, unemployment insurance benefits in the language of the non-English-speaking person.

(3)This bill would declare that it is to take effect immediately as an urgency statute.

Vote: $^2/_3$. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Section 316.5 is added to the Unemployment Insurance Code, to read:

316.5. (a) The department shall comply with Section 7292 of the Government Code in order to ensure that non-English-speaking California residents have adequate access to department employees who are qualified to provide information regarding applying for, and receiving, unemployment insurance benefits in the language of the non-English-speaking person.

SEC. 2. Section 1026.3 is added to the Unemployment Insurance Code, to read:

1026.3. (a) Notwithstanding Section 1026 or any other law, any unemployment compensation benefits paid pursuant to Section 1280.6 shall not be charged against the reserve account of any employer.

(b)This section shall become inoperative on July 1, 2022, and, as of January 1, 2023, is repealed.

SEC. 3. Section 1280.6 is added to the Unemployment Insurance Code, to read:

1280.6. (a) Notwithstanding Section 1280 or any other law, following the termination of assistance pursuant to the federal Pandemic Unemployment Assistance and Pandemic Emergency Unemployment Compensation provisions of Sections 2102 and 2107 of Subtitle A of Title II of Division A of the federal Coronavirus Aid, Relief, and Economic Security Act (Public Law 116-136) or any other federal or state supplemental unemployment compensation payments for unemployment due to the COVID-19 pandemic, the department shall provide, in addition to an individual's weekly benefit amount as otherwise provided for by existing unemployment compensation law, unemployment compensation benefits equivalent to the terminated federal or state supplemental unemployment compensation payments for the remainder of the duration of time the individual is unemployed due to the COVID-19 pandemic.

(b) For the purpose of this section, the department shall determine an individual's eligibility for unemployment compensation benefits equivalent to Pandemic Unemployment Assistance in accordance with Section 2102 of Subtitle A of Title

II of Division A of the federal Coronavirus Aid, Relief, and Economic Security Act (Public Law 116-136).

(c)This section shall become inoperative on July 1, 2022, and, as of January 1, 2023, is repealed.

SEC. 4. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the California Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to facilitate the immediate delivery of unemployment assistance during the COVID-19 public health emergency, it is necessary that this act go into effect immediately.

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ASSEMBLY BILL No. 32

Introduced by Assembly Member Aguiar-Curry
(Coauthors: Assembly Members Arambula, Bauer-Kahan, Burke, Cunningham, Cristina Garcia, Petrie-Norris, Quirk-Silva, Blanca Rubio, and Santiago)

December 7, 2020

An act to amend Section 1374.14 of the Health and Safety Code, to amend Section 10123.855 of the Insurance Code, and to amend Section 14087.95 of, and to add Sections 14092.4 and 14132.722 to, the Welfare and Institutions Code, relating to telehealth.

LEGISLATIVE COUNSEL'S DIGEST

AB 32, as introduced, Aguiar-Curry. Telehealth.

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. Under existing law, Medi-Cal services may be provided pursuant to contracts with various types of managed care health plans, including through a county organized health system. Under existing law, in-person contact between a health care provider and a patient is not required under the Medi-Cal program for services appropriately provided through telehealth. Existing law provides that neither face-to-face contact nor a patient's physical presence on the premises of an enrolled community clinic is required for services provided by the clinic to a Medi-Cal beneficiary during or immediately following a proclamation declaring a state of emergency. Existing law defines "immediately following" for this purpose to mean up to 90 days

following the termination of the proclaimed state of emergency, unless there are extraordinary circumstances.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a contract issued, amended, or renewed on or after January 1, 2021, between a health care service plan or health insurer and a health care provider to require the plan or insurer to reimburse the provider for the diagnosis, consultation, or treatment of an enrollee, subscriber, insured, or policyholder appropriately delivered through telehealth services on the same basis and to the same extent as the same service through in-person diagnosis, consultation, or treatment. Existing law requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2021, to specify that coverage is provided for health care services appropriately delivered through telehealth on the same basis and to the same extent as in-person diagnosis, consultation, or treatment. Existing law exempts Medi-Cal managed care plans that contract with the State Department of Health Care Services under the Medi-Cal program from these provisions, and generally exempts county organized health systems that provide services under the Medi-Cal program from Knox-Keene.

This bill would delete the above-described references to contracts issued, amended, or renewed on or after January 1, 2021, would require these provisions to apply to the plan or insurer's contracted entity, as specified, and would delete the exemption for Medi-Cal managed care plans. The bill would subject county organized health systems, and their subcontractors, that provide services under the Medi-Cal program to the above-described Knox-Keene requirements relative to telehealth. The bill would authorize a provider to enroll or recertify an individual in Medi-Cal programs through telehealth and other forms of virtual communication, as specified.

This bill would require the State Department of Health Care Services to indefinitely continue the telehealth flexibilities in place during the COVID-19 pandemic state of emergency. The bill would require the department, by January 2022, to convene an advisory group with specified membership to provide input to the department on the development of a revised Medi-Cal telehealth policy that promotes specified principles. The bill would require the department, by December 2024, to complete an evaluation to assess the benefits of telehealth in

Medi-Cal, including an analysis of improved access for patients, changes in health quality outcomes and utilization, and best practices for the right mix of in-person visits and telehealth. The bill would require the department to report its findings and recommendations from the evaluation to the appropriate policy and fiscal committees of the Legislature no later than July 1, 2025.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. (a) The Legislature finds and declares all of the following:

(1) The Legislature has recognized the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the provider, and enacted protections in Section 14132.72 of the Welfare and Institutions Code to prevent the State Department of Health Care Services from restricting or limiting telehealth services.

(2) The use of telehealth was expanded during the COVID-19 pandemic public health emergency and has proven to be an important modality for patients to stay connected to their health care providers. Telehealth has been especially critical for California's Medi-Cal patients.

(3) Patients have reported high satisfaction with telehealth, noting how easy it is to connect with their care teams without having to take time off work, find childcare, or find transportation to an in-person appointment.

(4) In addition to video access, audio-only care is essential because many patients have reported challenges accessing video technology due to limitations with data plans and internet access.

(5) Primary care and specialty care providers have found telehealth to be a critical access point to address a variety of health care needs, including helping patients manage chronic disease, adjust pain medications, and for followup visits after a procedure, among others.

(6) Behavioral health providers have found that offering telehealth has engaged patients in necessary care they would never have received if required to walk into a clinic.

(7) Health care providers have reported significant decreases in the number of missed appointments since telehealth became available, helping to ensure that patients receive high-quality care in a timely manner.

(8) Telehealth is widely available to individuals with health insurance in the commercial market, and existing law in Section 1374.14 of the Health and Safety Code and Section 10123.855 of the Insurance Code requires commercial health care service plans and health insurers to pay for services delivered through telehealth services on the same basis as equivalent services furnished in person. Medi-Cal must evolve with the rest of the health care industry to achieve health equity for low-income Californians.

(9) The expanded telehealth options that patients and providers have relied on during the COVID-19 pandemic should continue to be available to Medi-Cal recipients after the public health emergency is over.

(b) It is the intent of the Legislature to continue the provision of telehealth in Medi-Cal, including video and audio-only technology, for the purposes of expanding access and enhancing delivery of health care services for beneficiaries.

SEC. 2. Section 1374.14 of the Health and Safety Code is amended to read:

1374.14. (a) (1) A contract ~~issued, amended, or renewed on or after January 1, 2021,~~ between a health care service plan and a health care provider for the provision of health care services to an enrollee or subscriber shall specify that the health care service plan shall reimburse the treating or consulting health care provider for the diagnosis, consultation, or treatment of an enrollee or subscriber appropriately delivered through telehealth services on the same basis and to the same extent that the health care service plan is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.

(2) This section does not limit the ability of a health care service plan and a health care provider to negotiate the rate of reimbursement for a health care service provided pursuant to a contract subject to this section. Services that are the same, as determined by the provider's description of the service on the claim, shall be reimbursed at the same rate whether provided in person or through telehealth. When negotiating a rate of reimbursement for telehealth services for which no in-person

equivalent exists, a health care service plan and the provider shall ensure the rate is consistent with subdivision (h) of Section 1367.

(3) This section does not require telehealth reimbursement to be unbundled from other capitated or bundled, risk-based payments.

(4) If a health care service plan delegates responsibility for the performance of the duties described in this section to a contracted entity, including a medical group or independent practice association, then the delegated entity shall comply with this section.

(5) The obligation of a health care service plan to comply with this section shall not be waived if the plan delegates services or activities that the plan is required to perform to its provider or another contracting entity. A plan's implementation of this section shall be consistent with the requirements of the Health Care Providers' Bill of Rights, and a material change in the obligations of a plan's contracting network providers shall be considered a material change to the provider contract, within the meaning of subdivision (b) Section 1375.7.

(b) (1) A health care service plan contract ~~issued, amended, or renewed on or after January 1, 2021,~~ shall specify that the health care service plan shall provide coverage for health care services appropriately delivered through telehealth services on the same basis and to the same extent that the health care service plan is responsible for coverage for the same service through in-person diagnosis, consultation, or treatment. Coverage shall not be limited only to services delivered by select third-party corporate telehealth providers.

(2) This section does not alter the obligation of a health care service plan to ensure that enrollees have access to all covered services through an adequate network of contracted providers, as required under Sections 1367, 1367.03, and 1367.035, and the regulations promulgated thereunder.

(3) This section does not require a health care service plan to cover telehealth services provided by an out-of-network provider, unless coverage is required under other ~~provisions of~~ law.

(c) A health care service plan may offer a contract containing a copayment or coinsurance requirement for a health care service delivered through telehealth services, provided that the copayment or coinsurance does not exceed the copayment or coinsurance applicable if the same services were delivered through in-person

diagnosis, consultation, or treatment. This subdivision does not require cost sharing for services provided through telehealth.

(d) Services provided through telehealth and covered pursuant to this chapter shall be subject to the same deductible and annual or lifetime dollar maximum as equivalent services that are not provided through telehealth.

(e) The definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code apply to this section.

~~(f) This section shall not apply to Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.~~

SEC. 3. Section 10123.855 of the Insurance Code is amended to read:

10123.855. (a) (1) A contract ~~issued, amended, or renewed on or after January 1, 2021,~~ between a health insurer and a health care provider for an alternative rate of payment pursuant to Section 10133 shall specify that the health insurer shall reimburse the treating or consulting health care provider for the diagnosis, consultation, or treatment of an insured or policyholder appropriately delivered through telehealth services on the same basis and to the same extent that the health insurer is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.

(2) This section does not limit the ability of a health insurer and a health care provider to negotiate the rate of reimbursement for a health care service provided pursuant to a contract subject to this section. Services that are the same, as determined by the provider's description of the service on the claim, shall be reimbursed at the same rate whether provided in person or through telehealth. When negotiating a rate of reimbursement for telehealth services for which no in-person equivalent exists, a health insurer and the provider shall ensure the rate is consistent with subdivision (a) of Section 10123.137.

(3) If a health insurer delegates responsibility for the performance of the duties described in this section to a contracted entity, including a medical group or independent practice association, then the delegated entity shall comply with this section.

(4) The obligation of a health insurer to comply with this section shall not be waived if the insurer delegates services or activities that the insurer is required to perform to its provider or another contracting entity. An insurer's implementation of this section shall be consistent with the requirements of the Health Care Providers' Bill of Rights, and a material change in the obligations of an insurer's contracting network providers shall be considered a material change to the provider contract, within the meaning of subdivision (b) Section 10133.65.

(b) (1) A policy of health insurance ~~issued, amended, or renewed on or after January 1, 2021,~~ that provides benefits through contracts with providers at alternative rates of payment shall specify that the health insurer shall provide coverage for health care services appropriately delivered through telehealth services on the same basis and to the same extent that the health insurer is responsible for coverage for the same service through in-person diagnosis, consultation, or treatment. Coverage shall not be limited only to services delivered by select third-party corporate telehealth providers.

(2) This section does not alter the existing statutory or regulatory obligations of a health insurer to ensure that insureds have access to all covered services through an adequate network of contracted providers, as required by Sections 10133 and 10133.5 and the regulations promulgated thereunder.

(3) This section does not require a health insurer to deliver health care services through telehealth services.

(4) This section does not require a health insurer to cover telehealth services provided by an out-of-network provider, unless coverage is required under other ~~provisions of~~ law.

(c) A health insurer may offer a policy containing a copayment or coinsurance requirement for a health care service delivered through telehealth services, provided that the copayment or coinsurance does not exceed the copayment or coinsurance applicable if the same services were delivered through in-person diagnosis, consultation, or treatment. This subdivision does not require cost sharing for services provided through telehealth.

(d) Services provided through telehealth and covered pursuant to this chapter shall be subject to the same deductible and annual or lifetime dollar maximum as equivalent services that are not provided through telehealth.

(e) The definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code apply to this section.

SEC. 4. Section 14087.95 of the Welfare and Institutions Code is amended to read:

14087.95. ~~Counties~~ *(a) A county* contracting with the department pursuant to this article shall be exempt from ~~the provisions of~~ Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code for purposes of carrying out the contracts.

(b) (1) Notwithstanding subdivision (a), a county contracting with the department pursuant to this article shall comply with Section 1374.14 of the Health and Safety Code.

(2) If a county subcontracts for the provision of services pursuant to this article, as authorized under Section 14087.6, the subcontractor shall comply with Section 1374.14 of the Health and Safety Code.

SEC. 5. Section 14092.4 is added to the Welfare and Institutions Code, immediately following Section 14092.35, to read:

14092.4. For the purposes of enrolling patients in programs administered through Medi-Cal, including the Family Planning, Access, Care, and Treatment (Family PACT), presumptive eligibility Programs, accelerated enrollment programs, and the Medi-Cal Minor Consent program, a provider may determine program eligibility, enroll, and recertify patients remotely through telehealth and other virtual communication modalities, including telephone, based on the current Medi-Cal program criteria. The department may develop program policies and systems to support implementation of offsite eligibility determination, enrollment, and recertification.

SEC. 6. Section 14132.722 is added to the Welfare and Institutions Code, immediately following Section 14132.72, to read:

14132.722. (a) The department shall indefinitely continue the telehealth flexibilities in place during the COVID-19 pandemic, including those implemented pursuant to Section 14132.723.

(b) (1) By January 2022, the department shall convene an advisory group that includes representatives from community health centers, designated public hospitals, Medi-Cal managed

care plans, consumer groups, labor organizations, behavioral health providers, counties, and other Medi-Cal providers.

(2) The advisory group shall provide input to the department on the development of a revised Medi-Cal telehealth policy that promotes all of the following principles:

(A) Telehealth shall be used as a means to promote timely and patient-centered access to health care.

(B) Patients, in conjunction with their providers, shall be offered their choice of service delivery mode. Patients shall retain the right to receive health care in person.

(C) Confidentiality and security of patient information shall be protected.

(D) Usual standard of care requirements shall apply to services provided via telehealth, including quality, safety, and clinical effectiveness.

(E) The department shall consider disparities in the utilization of, and access to, telehealth, and shall support patients and providers in increasing access to the technologies needed to use telehealth.

(F) When the care provided during a telehealth visit is commensurate with what would have been provided in person, payment shall also be commensurate.

(c) (1) By December 2024, the department shall complete an evaluation to assess the benefits of telehealth in Medi-Cal. The evaluation shall analyze improved access for patients, changes in health quality outcomes and utilization, and best practices for the right mix of in-person visits and telehealth.

(2) The department shall report its findings and recommendations on the evaluation to the appropriate policy and fiscal committees of the Legislature no later than July 1, 2025.

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ASSEMBLY BILL No. 65

Introduced by Assembly Member Low
(Coauthor: Senator Wiener)

December 7, 2020

An act relating to public social services.

LEGISLATIVE COUNSEL'S DIGEST

AB 65, as introduced, Low. California Universal Basic Income Program.

Existing law establishes the State Department of Social Services and requires the department to administer various public social services programs, including the California Work Opportunity and Responsibility to Kids (CalWORKs) program, under which each county provides cash assistance and other benefits to qualified low-income families and individuals, and the CalFresh program, under which supplemental nutrition assistance benefits allocated to the state by the federal government are distributed to eligible individuals by each county.

This bill would declare the intent of the Legislature to enact legislation to create a California Universal Basic Income Program, with the intention of ensuring economic security for all Californians.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

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

SECTION 1. It is the intent of the Legislature to enact legislation to create a California Universal Basic Income Program,

with the intention of ensuring economic security for all Californians.

O

AMENDED IN ASSEMBLY JANUARY 12, 2021

CALIFORNIA LEGISLATURE—2021–22 REGULAR SESSION

ASSEMBLY BILL No. 71

Introduced by Assembly Members ~~Luz Rivas and Chiu~~ *Luz Rivas, Bloom, Chiu, and Wicks*
~~(Coauthor: Assembly Member Quirk-Silva)~~

December 7, 2020

An act *to amend Section 23151 of, and to add Sections 17087.7 and 25110.1 to, the Revenue and Taxation Code, and to amend Sections 8255 and 8257 of, to add Sections 8257.1, 8257.2, 8258, and 14133.5 to, and to add Chapter 5.2 (commencing with Section 13050) to Part 3 of Division 9 of, the Welfare and Institutions Code,* relating to ~~homelessness.~~ *homelessness, and making an appropriation therefor.*

LEGISLATIVE COUNSEL'S DIGEST

AB 71, as amended, Luz Rivas. ~~Statewide homelessness solutions program.~~ *Homelessness funding: Bring California Home Act.*

(1) The Personal Income Tax Law, in conformity with federal income tax law, generally defines gross income as income from whatever source derived, except as specifically excluded, and provides various exclusions from gross income. Existing federal law, for purposes of determining a taxpayer's gross income for federal income taxation, requires that a person who is a United States shareholder of any controlled foreign corporation to include in their gross income the global low-taxed income for that taxable year, as provided.

This bill, for taxable years beginning on or after January 1, 2022, would include a taxpayer's global low-taxed income in their gross income for purposes of the Personal Income Tax Law, in modified conformity with the above-described federal provisions. The bill would

exempt any standard, criterion, procedure, determination, rule, notice, or guideline established or issued by the Franchise Tax Board to implement its provisions from the rulemaking provisions of the Administrative Procedure Act.

The Corporation Tax Law imposes, among other taxes, taxes according to or measured by the net income of the taxpayer for the taxable year at a rate of 8.84%, or 10.84% for financial institutions, but not less than the minimum franchise tax of $800, as specified.

This bill, for taxable years beginning on or after January 1, 2022, and with respect to taxpayers with taxable income under the Corporation Tax Law greater than $5,000,000 for the taxable year, would increase these tax rates from 8.84% to 9.6%, or 10.84% to 11.6% for financial institutions, unless the minimum franchise tax is greater.

The Corporation Tax Law, when the income of a taxpayer subject to tax under that law is derived from or attributable to sources both within and without the state, generally requires that the tax be measured by the net income derived from or attributable to sources within this state, as provided. Notwithstanding this requirement, the Corporation Tax Law authorizes a qualified taxpayer, as defined, to elect to determine its income derived from or attributable to sources within this state pursuant to a water's-edge election, as provided. Existing law requires that a water's-edge election be made by contract with the Franchise Tax Board, with an initial term of 84 months, except as specified, and provides for annual renewal of that contract unless the taxpayer provides written notice of nonrenewal at least 90 days before the renewal date.

This bill would require that a taxpayer that makes a water's-edge election under these provisions take into account 50% of the global low-taxed income and 40% of the repatriation income of its affiliated corporations, as those terms are defined. The bill would allow a taxpayer, for calendar year 2022 only, the opportunity to revoke a water's-edge election. The bill would prohibit the total of all business credits, as defined, from reducing the additional tax liability added by this bill's provisions by more than $5,000,000, as provided. The bill would exempt any standard, criterion, procedure, determination, rule, notice, or guideline established or issued by the Franchise Tax Board to implement its provisions from the rulemaking provisions of the Administrative Procedure Act.

This bill would state the intent of the Legislature that any revenue resulting from the above-described changes to the Personal Income

Tax Law and the Corporation Tax Law be used for purposes of the Bring California Home Act, as described below.

~~Existing~~

(2) Existing law requires the Governor to create the Homeless Coordinating and Financing Council ~~(referred to as "the coordinating council") and to appoint up to 19 members of that council, as provided.~~ *(council).* Existing law specifies the duties of the coordinating council, including creating partnerships among state agencies and departments, local government agencies, and specified federal agencies and private entities, for the purpose of arriving at specific strategies to end homelessness. ~~The Personal Income Tax Law and the Corporation Tax Law impose taxes upon taxable income for the taxable year, as specified.~~ *Existing law requires the Governor to appoint up to 19 members of the council, including representatives from specified state agencies and departments, and a formerly homeless person and a formerly homeless youth who both live in California, and requires the Senate Committee on Rules and the Speaker of the Assembly to each appoint one member to the council from 2 different stakeholder organizations.*

~~This bill would state the intent of the Legislature to enact legislation to create a comprehensive, statewide homelessness solutions program. This bill would create the Bring California Home Fund in the State Treasury for the purpose of providing at least $2,400,000 annually to fund a comprehensive, statewide homeless solutions program upon appropriation by the Legislature. The bill would require the Bring California Home Fund to contain revenues derived from specified changes to the Personal Income Tax Law or the Corporation Tax Law that are enacted on or after the effective of the date of this bill.~~

This bill would delete the provisions relating to the appointment authority of the Governor and the Legislature, and would instead restructure the council, including requiring the council to be composed of prescribed individuals, including the directors of specified state agencies and departments, such as the State Department of Public Health. The bill would require the council to seek guidance from, and meet with, an advisory committee composed of specified individuals, including a survivor of gender-based violence who formerly experienced homelessness and a formerly homeless person who lives in California.

This bill would require the council, its technical services provider, or an entity with which the council contracts to identify, analyze, and collect various data in regards to homelessness in this state, including identifying state programs that provide housing or housing-based

services to persons experiencing homelessness, as provided. The bill would require the council to report on this information to specified committees of the Legislature by July 31, 2022. The bill would require the council to seek technical assistance offered by the United States Department of Housing and Urban Development, if available, for purposes of conducting this statewide needs and gaps analysis. The bill would require a state department or agency with a member on the council to assist in data collection for the analysis by responding to data requests within 180 days, as specified.

The bill would require the council to convene a funder's workgroup, composed of specified individuals, including staff of the council and staff working for agencies or departments represented on the council, to accomplish prescribed goals, and would authorize that workgroup to invite philanthropic organizations focused on ending homelessness, reducing health disparities, ending domestic violence, or ensuring Californians do not exit foster care or incarceration to homelessness to participate in specific meetings. The bill would require the workgroup to perform specified duties, including collaborating with state agency staff to develop a universal application for developers, service providers, and other entities to apply to agencies and departments represented on the council for funding for homeless services and housing, and to coordinate state agencies and departments to reduce the risk of long-term homelessness by developing specific protocols and procedures that accomplish prescribed goals, such as assisting individuals reentering communities from jails and prisons with housing navigation, housing acquisition support, and obtaining permanent housing.

Existing law requires agencies and departments administering state programs to collaborate with the council to adopt guidelines to revise or adopt guidelines and regulations to incorporate core components of Housing First, as provided. Existing law defines "state programs" for these purposes to mean any programs a California state agency or department funds, implements, or administers for the purpose of providing housing or housing-based services to people experiencing homelessness or at risk of homelessness, but excludes federally funded programs with inconsistent requirements or programs that fund emergency shelters.

This bill would delete the exclusion for programs that fund emergency shelters from this definition of "state programs," thereby expanding the scope of programs required to incorporate core components of Housing First, as described above.

(3) Existing law establishes, among various other programs intended to address homelessness in this state, the Homeless Housing, Assistance, and Prevention program for the purpose of providing jurisdictions with one-time grant funds to support regional coordination and expand or develop local capacity to address their immediate homelessness challenges informed by a best-practices framework focused on moving homeless individuals and families into permanent housing and supporting the efforts of those individuals and families to maintain their permanent housing. Existing law provides for the allocation of funding under the program among continuums of care, cities, and counties in 2 rounds, the first of which is administered by the Business, Consumer Services, and Housing Agency and the second of which is administered by the coordinating council.

This bill would enact the Bring California Home Act, which would establish the Bring California Home Fund in the State Treasury and continuously appropriate moneys in that fund for the purpose of implementing that act. The bill would require the Controller to annually transfer specified amounts, determined as provided by the Franchise Tax Board based on the above-described changes made by this bill to the Personal Income Tax Law and the Corporation Tax Law, to the Bring California Home Fund. The bill would require the council and the Department of Housing and Community Development (HCD) to jointly administer the fund pursuant to a memorandum of understanding, as provided. The bill would require that recipients and subrecipients under the program ensure that any expenditure of moneys allocated to them serve the eligible population, unless otherwise expressly provided in the bill. The bill would define various terms for these purposes.

The bill would require the council to administer allocations to counties and continuums of care that apply jointly and to large cities, and would require HCD to administer allocations to developers, as provided. The bill would require HCD to allocate $400,000,000 to developers and require the council to set aside $200,000,000 for bonus awards, as provided. Of the remaining amount in the fund, the bill would require the council to allocate 60% to counties and continuums of care applying jointly and 40% to large cities, in accordance with a specified formula and subject to certain requirements. The bill would establish eligibility criteria for a county and continuum of care or a large city to receive an allocation under these provisions and specify the eligible uses for those moneys. The bill would exempt specified activities by a large city under the program relating to the development of a low barrier interim

intervention, affordable housing project, or supportive housing project from the California Environmental Quality Act. The bill, upon the request of a jointly applying county and continuum of care, would require the State Department of Social Services to act as a fiscal agent for the county and continuum of care, as provided. The bill would require HCD to allocate moneys to developers in the same manner as deferred payment loans provided under the Multifamily Housing Program, subject to certain requirements, including a requirement that HCD ensure that at least 25% of the moneys allocated under these provisions be awarded to projects located in unincorporated areas and cities that are not large cities. The bill would require that any project that uses funds received under the program for the purposes specified in connection with the allocations made by HCD be allowed as a permitted use, within the zone in which the structure is located, and not be subject to a conditional use permit, discretionary permit, or any other discretionary review or approval.

The bill would require the council and HCD to allocate available funding in 2-year cycles, with the first round allocated no later than March 31, 2023, and to develop a simple application that an eligible entity may use to apply for funding, as well as common standards for recipients to monitor, report, and ensure accountability, provide services, and subsidize housing. The bill would require the council and each recipient to establish performance outcomes for the initial cycle and to establish outcome goals before each subsequent grant cycle, as provided, and require the council to award bonus funding to a recipient, if the recipient has achieved those performance outcomes, or reduce or deny that bonus funding the if the recipient has not achieved those performance outcomes.

The bill, except as otherwise provided, would require each recipient to contractually obligate 100% of the amount allocated to it within 3 years, for the first grant cycle, or 1 year, for each subsequent cycle, and to expend the entirety of that amount within 4 years, for the first grant cycle, or 2 years, for each subsequent cycle. If a county and continuum of care or a large city fails to comply with these deadlines, uses moneys allocated to it for an unauthorized purpose, or fails to apply for an allocation within the initial award cycle, the bill would require the council to either select an alternative entity to administer the recipient's allocation in accordance with specified requirements or solely establish performance outcomes and program priorities for that recipient jurisdiction and work with local, regional, or statewide entities

to administer the allocation on behalf of the recipient. If a developer fails to comply with these deadlines, the bill would require that the moneys awarded to that recipient revert to the fund.

The bill would require each recipient to annually report to the council and HCD specified information relating to allocations made under these provisions. The bill would require the council to conduct regular monitoring and audits of the activities and outcomes of recipients that are joint county-continuum of care applicants or large cities. No later than January 1, 2024, and every 5th January 1 thereafter, the bill would require the council to evaluate the outcomes of this program and submit a report, containing specified information, to specified committees of the Legislature. The bill would require the council and HCD to each establish an advisory committee to inform state and local policies, practices, and programs with respect to the experiences of specified demographic groups experiencing homelessness.

(4) 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 pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

By January 1, 2025, this bill would require the department to seek federal approval for a Medi-Cal benefit to fund prescribed services, including housing navigation and housing acquisition support services, for beneficiaries experiencing homelessness, to convene a stakeholder advisory group representing counties, health care consumers, and homeless advocates in developing this plan, to work with counties to determine an effective process for funding the state's share of the federal medical assistance percentage, and to pursue philanthropic funding to carry out the administrative duties related to these provisions. The bill would authorize the department to use up to 20% of the county-continuum allocation from the Bring California Home Fund, as described above, to pay for the state's federal medical assistance percentage associated with this benefit.

Vote: ~~majority~~ *2/3*. Appropriation: ~~no~~ *yes*. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Section 17087.7 is added to the Revenue and Taxation Code, to read:

17087.7. (a) For taxable years beginning on or after January 1, 2022, Section 951A of the Internal Revenue Code, relating to Global intangible low-taxed income, as enacted by the federal Tax Cuts and Jobs Act of 2017 (Public Law 115–97), shall apply, except as otherwise provided.

(b) Section 951A of the Internal Revenue Code, relating to Global intangible low-taxed income, is modified as follows:

(1) If a taxpayer that is not a C corporation has income under Section 951A of the Internal Revenue Code, which is formally derived from a corporation that is part of a combined reporting group doing business in this state and has made a water's-edge election under Section 25110, 50 percent of that income shall be apportioned to this state using the same apportionment factor as is used for the combined reporting group.

(2) Section 951A of the Internal Revenue Code shall not apply if either of the following applies:

(A) The taxpayer is not a C corporation and the income under Section 951A of the Internal Revenue Code is formally derived from a corporation that is part of a combined reporting group doing business in this state that does not make a water's-edge election under Section 25110.

(B) The taxpayer is not a C corporation and the income under Section 951A of the Internal Revenue Code is formally derived from a corporation that is not part of a combined reporting group doing business in this state.

(c) If a taxpayer has income under Section 951A of the Internal Revenue Code, relating to Global intangible low-taxed income, included in its gross income pursuant to this section, the taxpayer may submit a petition to the Franchise Tax Board for alternative apportionment pursuant to Section 25137.

(d) Any standard, criterion, procedure, determination, rule, notice, or guideline established or issued by the Franchise Tax Board to implement this section is hereby exempted from the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(e) The provisions of this section are severable. If any provision of this section 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.

(f) It is the intent of the Legislature that the revenue, if any, resulting from application of this section in any taxable year beginning on or after January 1, 2022, be used for purposes of the Bring California Home Act (Chapter 5.2 (commencing with Section 13050) of Part 3 of Division 9 of the Welfare and Institutions Code).

SEC. 2. Section 23151 of the Revenue and Taxation Code is amended to read:

23151. (a) With the exception of banks and financial corporations, every corporation doing business within the limits of this state and not expressly exempted from taxation by the provisions of the Constitution of this state or by this part, shall annually pay to the state, for the privilege of exercising its corporate franchises within this state, a tax according to or measured by its net income, to be computed at the rate of 7.6 percent upon the basis of its net income for the next preceding income year, or if greater, the minimum tax specified in Section 23153.

(b) For calendar or fiscal years ending after June 30, 1973, the rate of tax shall be 9 percent instead of 7.6 percent as provided by subdivision (a).

(c) For calendar or fiscal years ending in 1980 to 1986, inclusive, the rate of tax shall be 9.6 percent.

(d) For calendar or fiscal years ending in 1987 to 1996, inclusive, and for any income year beginning before January 1, 1997, the tax rate shall be 9.3 percent.

(e) For any income year beginning on or after January 1, 1997, and before the income year identified in subparagraph (A) of paragraph (1) of subdivision (f), the tax rate shall be 8.84 percent. The change in rate provided in this subdivision shall be made without proration otherwise required by Section 24251.

(f) (1) For the first taxable year beginning on or after January 1, 2000, the tax imposed under this section shall be the sum of both of the following:

(A) A tax according to or measured by net income, to be computed at the rate of 8.84 percent upon the basis of the net income for the next preceding income year, but not less than the minimum tax specified in Section 23153.

(B) A tax according to or measured by net income, to be computed at the rate of 8.84 percent upon the basis of the net

income for the first taxable year beginning on or after January 1, 2000, but not less than the minimum tax specified in Section 23153.

(2) Except as provided in paragraph (1), for taxable years beginning on or after January 1, 2000, *and before January 1, 2022,* the tax imposed under this section shall be a tax according to or measured by net income, to be computed at the rate of 8.84 percent upon the basis of the net income for that taxable year, but not less than the minimum tax specified in Section 23153.

(g) (1) For taxable years beginning on or after January 1, 2022, the tax imposed under this section shall be a tax according to or measured by net income, to be computed at the following rate, as applicable, upon the basis of the net income for that taxable year, or if greater, the minimum tax specified in Section 23153:

(A) If the taxpayer has taxable income greater than five million dollars ($5,000,000) for the taxable year, 9.6 percent.

(B) If the taxpayer has taxable income less than or equal to five million dollars ($5,000,000) for the taxable year, 8.84 percent.

(2) It is the intent of the Legislature that the revenue, if any, resulting from application of this subdivision in any taxable year beginning on or after January 1, 2022, be used for purposes of the Bring California Home Act (Chapter 5.2 (commencing with Section 13050) of Part 3 of Division 9 of the Welfare and Institutions Code).

SEC. 3. Section 25110.1 is added to the Revenue and Taxation Code, to read:

25110.1. (a) A taxpayer that makes a water's-edge election shall take into account 50 percent of the global intangible low-taxed income, but not the apportionment factors, of its affiliated corporations.

(b) A taxpayer that makes a water's-edge election shall take into account 40 percent of the repatriation income, but not the apportionment factors, of its affiliated corporations.

(c) Any taxpayer that includes repatriation income may choose to apportion 14 percent of that income to California or use the apportionment factor otherwise calculated for the combined group for that taxable year.

(d) For purposes of calculating dividends to be eliminated from the income of the recipient under Section 25106 or any other law, global intangible low-taxed income included by reason of subdivision (a) shall be treated in the same manner as income

included by reason of clause (ii) of subparagraph (A) of paragraph (2) of subdivision (a) of Section 25110.

(e) Any taxpayer that includes repatriated income under subdivision (b) shall be entitled to a credit for any taxes already paid on the repatriated income by reason of Section 24411 or any other law. The credit allowed by this subdivision shall be calculated by multiplying the final tax liability of the taxpayer for the taxable year in which tax was paid on repatriation income by a fraction not to exceed one, the numerator of which is the repatriation income of that corporation for that taxable year and the denominator of which is the total taxable income of that corporation for that taxable year.

(f) Notwithstanding Section 25111, any taxpayer that has made a water's-edge election under Section 25110 shall be permitted, for calendar year 2022 only, an opportunity to revoke this election.

(g) (1) Notwithstanding any provision of this part or Part 10.2 (commencing with Section 18401) to the contrary, for taxpayers not required to be included in a combined report under Section 25101 or 25110, or taxpayers not authorized to be included in a combined report under Section 25101.15, the total of all business credits otherwise allowable, under any provision of Chapter 2 (commencing with Section 17041) of Part 10, including the carryover of any business credit under a former provision of that chapter, but not including the credit permitted by subdivision (e), for the taxable year shall not reduce the additional tax liability added by subdivision (a), (b), or (c) by more than five million dollars ($5,000,000).

(2) Notwithstanding any provision of this part or Part 10.2 (commencing with Section 18401) to the contrary, for taxpayers required to be included in a combined report under Section 25101 or 25110, or taxpayers authorized to be included in a combined report under Section 25101.15, the total of all business credits otherwise allowable under any provision of Chapter 2 (commencing with Section 17041) of Part 10, including the carryover of any business credit under a former provision of that chapter, but not including the credit permitted by subdivision (e), by all members of the combined report shall not reduce the aggregate amount of the additional tax liability of all members of the combined report added by subdivision (a), (b) or (c) by more than five million dollars ($5,000,000).

(3) Any amounts included in an election pursuant to Section 6902.5, relating to an irrevocable election to apply credit amounts under Section 17053.85, 17053.95, 17053.98, 23685, 23695, or 23698 against qualified sales and use tax, as defined in Section 6902.5, shall not be included in the five million dollar ($5,000,000) limitation set forth in paragraphs (1) and (2).

(4) Notwithstanding any provision of this part or Part 10.2 (commencing with Section 18401), the credit amount described in paragraph (3) shall be applied after any business credits, subject to the limitations specified in paragraph (1) or (2), as applicable, are applied.

(h) Any standard, criterion, procedure, determination, rule, notice, or guideline established or issued by the Franchise Tax Board to implement this section is hereby exempted from the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(i) For purposes of this section, all of the following apply.

(1) "Affiliated corporation" means a corporation that is a member of a commonly controlled group, as defined in Section 25105.

(2) "Business credit" means a credit allowable under any provision of Chapter 2 (commencing with Section 17041) of Part 10, other than the following credits:

(A) The credit allowed by Section 17052, relating to credit for earned income.

(B) The credit allowed by Section 17052.1, relating to credit for a young child.

(C) The credit allowed by Section 17052.6, relating to credit for household and dependent care.

(D) The credit allowed by Section 17052.25, relating to credit for adoption costs.

(E) The credit allowed by Section 17053.5, relating to renter's tax credit.

(F) The credit allowed by Section 17054, relating to credit for personal exemption.

(G) The credit allowed by Section 17054.5, relating to credit for qualified joint custody head of household and a qualified taxpayer with a dependent parent.

(H) The credit allowed by Section 17054.7, relating to credit for qualified senior head of household.

(I) The credit allowed by Section 17058, relating to credit for low-income housing.

(J) The credit allowed by Section 17061, relating to refunds pursuant to the Unemployment Insurance Code.

(3) "Global intangible low-taxed income" has the same meaning as defined by Section 951A of the Internal Revenue Code, as enacted by the Tax Cuts and Jobs Act (Public Law 115-97), relating to global intangible low-taxed income, but not taking into account any subtractions made pursuant to Section 1.951A-2(c)(7) of Title 26 of the Code of Federal Regulations.

(4) "Repatriation income" means income that was deemed repatriated under Section 965(a) of the Internal Revenue Code, as amended by the Tax Cuts and Jobs Act (Public Law 115-97), relating to treatment of deferred foreign income as subpart F income, as included in a taxpayer's federal return by operation of the payment schedule of Section 965(h) of the Internal Revenue Code, as amended by the Tax Cuts and Jobs Act (Public Law 115-97), relating to election to pay liability in installments.

(j) The provisions of this section are severable. If any provision of this section 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.

(k) It is the intent of the Legislature that the revenue, if any, resulting from application of this section in any taxable year beginning on or after January 1, 2022, be used for purposes of the Bring California Home Act (Chapter 5.2 (commencing with Section 13050) of Part 3 of Division 9 of the Welfare and Institutions Code).

SEC. 4. Section 8255 of the Welfare and Institutions Code is amended to read:

8255. For purposes of this chapter:

(a) "Coordinating council" means the Homeless Coordinating and Financing Council established pursuant to Section 8257.

(b) "Core components of Housing First" means all of the following:

(1) Tenant screening and selection practices that promote accepting applicants regardless of their sobriety or use of substances, completion of treatment, or participation in services.

(2) Applicants are not rejected on the basis of poor credit or financial history, poor or lack of rental history, criminal convictions unrelated to tenancy, or behaviors that indicate a lack of "housing readiness."

(3) Acceptance of referrals directly from shelters, street outreach, drop-in centers, and other parts of crisis response systems frequented by vulnerable people experiencing homelessness.

(4) Supportive services that emphasize engagement and problem solving over therapeutic goals and service plans that are highly tenant-driven without predetermined goals.

(5) Participation in services or program compliance is not a condition of permanent housing tenancy.

(6) Tenants have a lease and all the rights and responsibilities of tenancy, as outlined in California's Civil, Health and Safety, and Government codes.

(7) The use of alcohol or drugs in and of itself, without other lease violations, is not a reason for eviction.

(8) In communities with coordinated assessment and entry systems, incentives for funding promote tenant selection plans for supportive housing that prioritize eligible tenants based on criteria other than "first-come-first-serve," including, but not limited to, the duration or chronicity of homelessness, vulnerability to early mortality, or high utilization of crisis services. Prioritization may include triage tools, developed through local data, to identify high-cost, high-need homeless residents.

(9) Case managers and service coordinators who are trained in and actively employ evidence-based practices for client engagement, including, but not limited to, motivational interviewing and client-centered counseling.

(10) Services are informed by a harm-reduction philosophy that recognizes drug and alcohol use and addiction as a part of tenants' lives, where tenants are engaged in nonjudgmental communication regarding drug and alcohol use, and where tenants are offered education regarding how to avoid risky behaviors and engage in safer practices, as well as connected to evidence-based treatment if the tenant so chooses.

(11) The project and specific apartment may include special physical features that accommodate disabilities, reduce harm, and promote health and community and independence among tenants.

(c) "Homeless" has the same definition as that term is defined in Section 91.5 of Title 24 of the Code of Federal Regulations.

(d) (1) "Housing First" means the evidence-based model that uses housing as a tool, rather than a reward, for recovery and that centers on providing or connecting homeless people to permanent housing as quickly as possible. Housing First providers offer services as needed and requested on a voluntary basis and that do not make housing contingent on participation in services.

(2) (A) "Housing First" includes time-limited rental or services assistance, so long as the housing and service provider assists the recipient in accessing permanent housing and in securing longer-term rental assistance, income assistance, or employment.

(B) For time-limited, supportive services programs serving homeless youth, programs should use a positive youth development model and be culturally competent to serve unaccompanied youth under 25 years of age. Providers should work with the youth to engage in family reunification efforts, where appropriate and when in the best interest of the youth. In the event of an eviction, programs shall make every effort, which shall be documented, to link tenants to other stable, safe, decent housing options. Exit to homelessness should be extremely rare, and only after a tenant refuses assistance with housing search, location, and move-in assistance.

(e) "State programs" means any programs a California state agency or department funds, implements, or administers for the purpose of providing housing or housing-based services to people experiencing homelessness or at risk of homelessness, with the exception of federally funded programs with requirements inconsistent with this ~~chapter or programs that fund emergency shelters.~~ *chapter.*

(f) "State-funded institutional setting" includes, but is not limited to, a justice, juvenile justice, child welfare, and health care setting.

SEC. 5. Section 8257 of the Welfare and Institutions Code is amended to read:

8257. (a) The Governor shall create a Homeless Coordinating and Financing Council.

(b) The council shall have all of the following goals:

(1) To oversee implementation of this chapter.

(2) To identify mainstream resources, benefits, and services that can be accessed to prevent and end homelessness in California.

(3) To create partnerships among state agencies and departments, local government agencies, participants in the United States Department of Housing and Urban Development's Continuum of Care Program, federal agencies, the United States Interagency Council on Homelessness, nonprofit entities working to end homelessness, homeless services providers, and the private sector, for the purpose of arriving at specific strategies to end homelessness.

(4) To promote systems integration to increase efficiency and effectiveness while focusing on designing systems to address the needs of people experiencing homelessness, including unaccompanied youth under 25 years of age.

(5) To coordinate existing funding and applications for competitive funding. Any action taken pursuant to this paragraph shall not restructure or change any existing allocations or allocation formulas.

(6) To make policy and procedural recommendations to legislators and other governmental entities.

(7) To identify and seek funding opportunities for state entities that have programs to end homelessness, including, but not limited to, federal and philanthropic funding opportunities, and to facilitate and coordinate those state entities' efforts to obtain that funding.

(8) To broker agreements between state agencies and ~~departments~~ *departments*, and between state agencies and departments and local ~~jurisdictions~~ *jurisdictions,* to align and coordinate resources, reduce administrative burdens of accessing existing resources, and foster common applications for services, operating, and capital funding.

(9) To serve as a statewide facilitator, coordinator, and policy development resource on ending homelessness in California.

(10) To report to the Governor, federal Cabinet members, and the Legislature on homelessness and work to reduce homelessness.

(11) To ensure accountability and results in meeting the strategies and goals of the council.

(12) To identify and implement strategies to fight homelessness in small communities and rural areas.

(13) To create a statewide data system or warehouse that collects local data through Homeless Management Information Systems,

with the ultimate goal of matching data on homelessness to programs impacting homeless recipients of state programs, such as ~~Medi-Cal~~ *the Medi-Cal program* (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9) and CalWORKs (Chapter 2 (commencing with Section 11200) of Part 3 of Division 9).

(14) ~~Setting~~ *To set* goals to prevent and end homelessness among California's youth.

(15) ~~Working~~ *To work* to improve the safety, health, and welfare of young people experiencing homelessness in the state.

(16) ~~Increasing~~ *To increase* system integration and coordinating efforts to prevent homelessness among youth who are currently or formerly involved in the child welfare system or the juvenile justice system.

(17) ~~Leading~~ *To lead* efforts to coordinate a spectrum of funding, policy, and practice efforts related to young people experiencing homelessness.

(18) ~~Identifying~~ *To identify* best practices to ensure homeless minors who may have experienced maltreatment, as described in Section 300, are appropriately referred to, or have the ability to self-refer to, the child welfare system.

~~(c) (1) The Governor shall appoint up to 19 members of the council as follows:~~

(c) (1) The council shall be composed of all of the following members:

(A) The Secretary of Business, Consumer Services, and Housing, or the secretary's designee, who shall serve as chair of the council.

(B) ~~A representative from the Department~~ *The Director* of Transportation.

(C) ~~A representative from the Department~~ *The Director* of Housing and Community Development.

(D) ~~A representative of the State Department of~~ *The Director of* Social Services.

(E) ~~A representative of the~~ *The Executive Director of the* California Housing Finance Agency.

(F) ~~A representative of the State Department of~~ *The Director of* Health Care Services.

(G) ~~A representative of the Department~~ *The Director* of Veterans Affairs.

(H) ~~A representative of the~~ *The Secretary of the* Department of Corrections and Rehabilitation.

(I) ~~A representative from the~~ *The Executive Director of the* California Tax Credit Allocation Committee in the Treasurer's office.

(J) The Director of the State Department of Public Health.

~~(J)~~

(K) A representative of the Victim Services Program within the Division of Grants Management within the Office of Emergency Services. *This person shall be appointed by the Director of the Office of Emergency Services.*

~~(K)~~

(L) A representative from the State Department of Education. *This person shall be appointed by the Superintendent of Public Instruction.*

~~(L)~~

(M) A representative of the state public higher education system who shall be from one of the following:

(i) The California Community Colleges.

(ii) The University of California.

(iii) The California State University.

(2) The council shall regularly seek guidance from, and meet with, an advisory committee that reflects racial and gender diversity, and shall include all of the following:

~~(M)~~

(A) A formerly homeless person who lives in California.

~~(N)~~

(B) A formerly homeless youth who lives in California.

(C) A survivor of gender-based violence who formerly experienced homelessness.

~~(O) Two representatives~~

(D) Representatives of local agencies or organizations that participate in the United States Department of Housing and Urban Development's Continuum of Care Program.

~~(P) State advocates or other members of the public or state agencies, at the Governor's discretion.~~

~~(2) The Senate Committee on Rules and the Speaker of the Assembly shall each appoint one member to the council from two different stakeholder organizations.~~

(E) Stakeholders with expertise in solutions to homelessness and best practices from other states.

(F) Representatives of committees on African Americans, youth, and survivors of gender-based violence.

(3) ~~The council may, at its discretion,~~ *At its discretion, the council may* invite stakeholders, individuals who have experienced homelessness, members of philanthropic communities, and experts to participate in meetings or provide information to the council.

(d) The council shall hold public meetings at least once every quarter.

~~(e) The members of the council shall serve at the pleasure of the appointing authority.~~

~~(f)~~

(e) Within existing funding, the council may establish working groups, task forces, or other structures from within its membership or with outside members to assist it in its work. Working groups, task forces, or other structures established by the council shall determine their own meeting schedules.

~~(g)~~

(f) The members of the council shall serve without compensation, except that members of the council who are, or have been, homeless may receive reimbursement for travel, per diem, or other expenses.

~~(h)~~

(g) The Business, Consumer Services, and Housing Agency shall provide staff for the council.

~~(i)~~

(h) The members of the council may enter into memoranda of understanding with other members of the council to achieve the goals set forth in this chapter, as necessary, in order to facilitate communication and cooperation between the entities the members of the council represent.

~~(j)~~

(i) There shall be an executive director of the council under the direction of the Secretary of Business, Consumer Services, and Housing.

~~(k)~~

(j) The council shall be under the direction of the executive director and staffed by employees of the Business, Consumer Services, and Housing Agency.

SEC. 6. Section 8257.1 is added to the Welfare and Institutions Code, to read:

8257.1. (a) The coordinating council, the coordinating council's technical service provider, or an entity the coordinating council contracts with for this purpose, shall do all of the following:

(1) Identify programs in the state that provide housing or housing-based services to persons experiencing homelessness and describe all of the following for each program, to the extent that data is available:

(A) The amount of funding the program receives each year and funding sources for the program.

(B) The number of persons the program serves each year, disaggregated by race, gender, and age range.

(C) Limitations, if any, on the length of stay for housing programs and length of provision of services for service programs.

(D) Limitations, if any, on the length of stay for housing programs and duration of provision of services for service programs.

(E) Specific subpopulations served and limits on eligibility for services.

(F) Referral and prioritization protocols.

(G) If applicable, reasons for the unavailability of data.

(2) Identify the total number and type of subsidized beds or units of permanent housing for people experiencing homelessness statewide.

(3) Analyze the need for supportive housing, rapid rehousing, and affordable housing for people experiencing homelessness.

(4) Analyze the need for services, and the type of services needed, to assist people experiencing homelessness to find housing, move into housing, remain stably housed, and grow income.

(5) Identify the number of and types of interim interventions available to persons experiencing homelessness. The data described in this paragraph shall also include, but is not limited to, all of the following:

(A) The number of year-round shelter beds.

(B) The average length of stay in or use of interim interventions.

(C) The exit rate from an interim intervention to permanent housing.

(6) Analyze the need for additional interim interventions and funding needed to create these interventions, taking into consideration the ideal length of stay set by the United States Department of Housing and Urban Development.

(7) Identify or estimate the total number of people discharged from state-funded institutional settings who fall into homelessness within 72 hours of discharge, disaggregated by race and gender. If data are unavailable, the entity conducting the analysis may extrapolate from national, local, or statewide estimates on the number or percentage of people discharged from specific institutional settings into homelessness.

(8) Collect data on the numbers and demographics of persons experiencing homelessness, including, but not limited to, a quantification of the racial and ethnic disparities in the homeless population relative to the general population, to the extent data is available, in all of the following circumstances:

(A) As a young adult.

(B) As an unaccompanied minor.

(C) As a single adult.

(D) As an adult over 50 years of age.

(E) As a survivor of gender-based violence.

(F) As a veteran.

(G) As a person on parole or probation.

(H) As a member of a family.

(I) As a single adult or family experiencing chronic patterns of homelessness.

(J) As a person living with serious mental illness or a substance use disorder.

(K) As a member of the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community.

(L) As a parenting youth.

(9) Collect data on exits from homelessness to housing, including, but not limited to, the number of people moving into permanent housing and the type of housing being accessed, the type of interventions people exiting homelessness received, if any, and racial and gender characteristics of people accessing each type of housing and receiving each type of intervention.

(10) Assess a sampling of data provided by local jurisdictions regarding the number of people experiencing homelessness who accessed interim interventions, including, but not limited to,

shelters, recuperative care, and motels and hotels, in response to the COVID-19 pandemic, and the number of people who were able to access permanent housing on or before the expiration of interim assistance, disaggregated by race and gender.

(11) Create a financial model that will assess needs for investment in capital, in operating supports in project-based housing, in rental assistance with private-market landlords, and in services costs for purposes of moving persons experiencing homelessness into permanent housing. The financial model shall include an explanation of how these investments will affirmatively reduce and close any racial disparities identified in the homeless population.

(b) (1) To conduct the needs and gaps analysis required by subdivision (a), the coordinating council or other entity conducting the analysis shall evaluate data from agencies and departments with representatives on the council, statewide and local homeless point-in-time counts and housing inventory counts, data from housing exits, data from local gaps and needs analyses from geographically diverse communities, and available statewide information on the number or rate of persons exiting state-funded institutional settings into homelessness.

(2) If specific data are unavailable, the coordinating council or other entity conducting the analysis may calculate estimates based on national or local data. The coordinating council or other entity shall only use data that meets either of the following requirements:

(A) The data is from an evaluation or study from a third-party evaluator or researcher and is consistent with data from evaluations or studies from other third-party evaluators or researchers.

(B) An agency of the federal government cites and refers to the data as evidence-based.

(3) The coordinating council or other entity conducting the analysis may extrapolate data from a geographically diverse sampling of local data analyses to inform the statewide analysis.

(c) The coordinating council shall report on the final needs and gaps analysis by July 31, 2022, to the Assembly Committee on Housing and Community Development, the Assembly Committee on Budget, Senate Committee on Housing, and Senate Committee on Budget and Fiscal Review. The report submitted pursuant to

this paragraph shall comply with Section 9795 of the Government Code.

(d) The coordinating council shall seek technical assistance offered by the United States Department of Housing and Urban Development, if available, for the purpose of conducting the statewide needs and gaps analysis required by this section.

SEC. 7. Section 8257.2 is added to the Welfare and Institutions Code, to read:

8257.2. (a) Notwithstanding any other law, for purposes of designing, collecting data for, and approving the needs and gaps analysis described in Section 8257.1, a state department or agency that has a member on the coordinating council shall, within 180 days of a request for data pertaining to that state department or agency, provide to the coordinating council, or the entity conducting the analysis, the requested data, including, but not limited to, the number or rate of persons exiting state-funded institutional settings into homelessness.

(b) The state department or agency shall remove any personally identifying information provided pursuant to subdivision (a), if any. For purposes of this subdivision, "personally identifying information" has the same meaning as defined in Section 1798.79.8 of the Civil Code.

SEC. 8. Section 8258 is added to the Welfare and Institutions Code, to read:

8258. (a) The council shall convene a funder's workgroup to accomplish the goals of this chapter. The workgroup shall include staff of the council, staff working for agencies or departments represented on the council, and representatives on the committees created pursuant to subdivision (l) of Section 13056. The funder's workgroup may invite philanthropic organizations focused on ending homelessness, reducing health disparities, ending domestic violence, or ensuring Californians do not exit foster care or incarceration to homelessness to participate in specific meetings.

(b) The funder's workgroup shall do all of the following:

(1) Align all request for proposals, all-county letters, and notices of funding proposals with standards following evidence-based housing and housing-based service models.

(2) Coordinate, as appropriate, with staff in the Governor's office to solicit monetary donations or in-kind donations from businesses, nonprofit organizations, or individuals for the purpose

of encouraging innovation in ending homelessness and augmenting funding for evidence-based housing and services.

(3) Work collaboratively with county associations, and staff from county and state departments, including the Department of Corrections and Rehabilitation and the State Department of Health Care Services, to establish discharge protocols and a process for agencies and departments to collectively identify and assist individuals exiting state-funded institutions, including, but not limited to, people leaving prisons, state-funded hospitals or nursing homes, and foster care, who are at risk of homelessness, along with procedures or programs for state agencies and departments to implement to prevent discharges into homelessness.

(4) Collaborate with existing state agency staff to develop a universal application for developers, service providers, local government agencies, and other entities to apply to agencies and departments represented on the council for funding for services and housing for persons experiencing homelessness.

(5) Examine and promote racially equitable and gender-equitable policies for departments and agencies that provide housing and services to individuals experiencing homelessness.

(c) The workgroup shall coordinate relevant state agencies and departments to reduce the risk of long-term homelessness by developing specific protocols and procedures that accomplish all of the following:

(1) (A) Ensure that survivors of domestic violence, sexual assault, and exploitation experiencing homelessness have access to housing navigation, housing acquisition support, and programs funded under this chapter that are specifically designed to meet their needs.

(B) The services described under subparagraph (A) shall be provided by, or in consultation with, domestic violence counselors, as defined in Section 1037.1 of the Evidence Code, and provided in compliance with all applicable state and federal confidentiality laws.

(2) Assist individuals reentering communities from jails and prisons with housing navigation, housing acquisition support, and obtaining permanent housing.

(3) Assist young adults exiting foster care and former foster youth with housing navigation, obtaining permanent housing,

accessing legal assistance, and navigating available public benefits that they may be entitled to receive.

(4) Assist people exiting hospitals, nursing homes, and state hospitals for people with mental illness to obtain permanent housing, or, if an individual needs care and supervision, licensed residential facilities.

(5) Connect older adults to programs and services that assist independent living, including the assisted living waiver program, as described in Section 14132.26, in-home supportive services, as described in Article 7 (commencing with Section 12300) of Chapter 3 of Part 3 of Division 9, Program of All-Inclusive Care for the Elderly (PACE) services, as described in Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9, and other wraparound and personal care services.

SEC. 9. Chapter 5.2 (commencing with Section 13050) is added to Part 3 of Division 9 of the Welfare and Institutions Code, to read:

CHAPTER 5.2. BRING CALIFORNIA HOME ACT

13050. This chapter shall be known, and may be cited, as the Bring California Home Act.

13051. The Legislature finds and declares all of the following:

(a) Homelessness is solvable, and the state has a role to play in rendering homelessness rare, brief, and nonrecurring. In fact, national and other state experiences show that jurisdictions at every level, including homeless continuums of care, cities, counties, and the state, must collaborate to achieve advances in reducing and ultimately solving homelessness.

(b) In January 2019, an estimated 151,278 people experienced homelessness in California at a single point in time, as reported by the United States Department of Housing and Urban Development. This is the highest number since 2007, and represented a 17-percent increase since 2018. Experts predict significant increases in homelessness in 2021 resulting from the COVID-19 economic downturn.

(c) African Americans are disproportionately represented among California's homeless population. While 6.5 percent of Californians identify as Black or African American, almost 40 percent of the state's homeless population is African American.

The rate of homelessness among African Americans is almost twice the rates of poverty among African Americans. Similarly, indigenous populations are over six times more likely to experience homelessness than the general population.

(d) Latinx Californians are least likely to access housing and services available in their communities.

(e) Women have unique precursors and experiences of homelessness. Domestic violence is a primary cause of homelessness for women, and women are more likely to experience domestic violence, sexual assault, and exploitation once they become homeless. Domestic violence is also a common experience and cause of homelessness among families, youth, and people who identify as transgender. Survivors of domestic violence, sexual assault, and exploitation are typically underserved in our homeless systems.

(f) Research suggests homeless populations are at far greater risk for consequences of COVID-19. Early studies estimated people experiencing homelessness are two to three times as likely to die from COVID-19 than the general population. COVID-19 is putting pressure on local homeless systems to open safe sites for people to shelter, in noncongregant settings, to avoid the spread of COVID-19.

(g) Due to the economic impacts of COVID-19, researchers estimate significant increases in homelessness.

(h) COVID-19 has also resulted in increased rates of domestic violence, putting pressure on domestic violence response systems to ensure safe housing for survivors.

(i) People living on the streets typically resided in a surrounding neighborhood prior to falling into homelessness. As examples, 70 percent of the people experiencing homelessness in the City and County of San Francisco lived in the city before becoming homeless and only 8 percent came from out of state; about 75 percent of the homeless population of the County of Los Angeles lived in the region before becoming homeless; and 73 percent of people experiencing homelessness in the County of Tehama were living in the county before becoming homeless.

(j) Homelessness often results from institutionalization, and homelessness often also causes a cycle of institutionalization that generates significant public sector costs. Reversing a cycle of institutionalization and homelessness requires collaboration

between the state, local governments, and the private sector, including collaboration to prevent discharges from institutional settings into homelessness.

(k) Almost 30 years of studies consistently prove housing affordable to people experiencing homelessness and without limits on length of stay, referred to as permanent housing, allows people to exit homelessness and remain stably housed. Recent experiences with investment in permanent housing for veterans shows we can reduce homelessness significantly with appropriate levels of investment in permanent housing. Evidence further shows people cannot recover from a serious mental illness, a substance use disorder, or a chronic medical condition, or reduce their rate or incidence of incarceration, hospitalization, or institutionalization, unless and until housed.

(l) People who move from homelessness to permanent housing are able to reduce the overall costs of public services. Randomized, control-group studies, including studies published in the Journal of the American Medical Association, show that housing with services allows formerly homeless people with serious mental illness to reduce their Medicaid and justice-system costs, often equivalent to the costs of housing and services. Providing housing to people experiencing homelessness is also shown to reduce local and state jurisdictions' expenditures on public safety, health care, and sanitation.

(m) By creating a Bring California Home Fund, it is the intent of the Legislature to make homelessness rare, brief, and nonrecurrent. Toward this end, it is the intent of the Legislature to create a subsidy program to fill gaps within state's response to homelessness, scale evidence-based solutions while promoting innovation to move people quickly into permanent housing, eliminate racial and gender disparities in who becomes homeless and who is able to access housing and housing-based services, establish greater flexibility and a more nimble process in implementing a comprehensive response to homelessness, facilitate critically needed collaboration between different levels of government, align housing and services resources, foster a streamlined process at the local and state levels to fund and build housing opportunities more quickly, and standardize the state's response to homelessness toward a focus on evidence-based

housing and housing-based services solutions through long-term state and local structural changes.

(n) It is the intent of the Legislature that racial disparities in the homeless population be eliminated by December 31, 2032.

(o) Multinational corporations have been shifting income out of the California corporate tax base for decades. To recapture lost revenue on an ongoing basis, it is the intent of the Legislature to conform to certain provisions of the federal Internal Revenue Code governing the taxation of corporations, as provided in the act adding this chapter.

(p) It is further the intent of the Legislature to return corporate tax rates for the wealthiest corporations to historic corporate tax rates, as provided in the act adding this chapter, to save the lives of people experiencing homelessness and resolve one of the greatest moral crises of our state.

13052. (a) (1) The Bring California Home Fund is hereby created in the State Treasury.

(2) (A) (i) No later than June 1, 2022, the Franchise Tax Board, in consultation with the Department of Finance, shall estimate the amount of revenue that would have resulted if Sections 17087.7 and 25110.1 of the Revenue and Taxation Code, as added by the act adding this chapter, and the amendments to Section 23151 of the Revenue and Taxation Code made by the act adding this chapter had applied to taxable years beginning on or after January 1, 2021, and before January 1, 2022, and notify the Controller of that amount.

(ii) No later than June 1, 2023, and annually thereafter, the Franchise Tax Board, in consultation with the Department of Finance, shall estimate the amount of additional revenue resulting from the application of Sections 17087.7 and 25110.1 of the Revenue and Taxation Code, as added by the act adding this chapter, and the amendments to Section 23151 of the Revenue and Taxation Code made by the act adding this chapter for the taxable years beginning on or after January 1 of the calendar year immediately preceding the year in which the estimate is made and before January 1 of the year in which the estimate is made and notify the Controller of that amount.

(B) Upon receiving the notifications from the Franchise Tax Board pursuant to subparagraph (A), the Controller shall transfer an amount, equal to the amount estimated by the Franchise Tax

Board in those notifications, from the General Fund to the Bring California Home Fund.

(3) In addition to the moneys made available pursuant to paragraph (2), moneys in the fund may include, but are not limited to, moneys transferred from other state sources, private or philanthropic donations, and any recoveries or reversions resulting from activities pursuant to this chapter.

(b) Notwithstanding Section 13340 of the Government Code, moneys in the fund are continuously appropriated to the Homeless Coordinating and Financing Council and the Department of Housing and Community Development solely for the purpose of implementing and administering this chapter.

(c) (1) The Homeless Coordinating and Financing Council and the Department of Housing and Community Development shall work collaboratively pursuant to a memorandum of understanding to carry out the functions and duties of this chapter and to address their respective and shared responsibilities in implementing, overseeing, and evaluating this chapter. The council and the department shall leverage the programmatic and administrative expertise of relevant state agencies, as that term is defined in Section 11000 of the Government Code, in implementing the program.

(2) No later than March 31, 2022, the council and the department shall submit a copy of the final memorandum of understanding to the Senate Committee on Budget and Fiscal Review and the Assembly Committee on Budget. The copy of the final memorandum of understanding required to be submitted to committees of the Legislature pursuant to this paragraph shall be submitted in compliance with Section 9795 of the Government Code.

(d) In implementing this chapter, the council shall establish a division to implement the auditing, monitoring, technical assistance, administration, and training activities described in this chapter that is separate from the coordinating activities of the council described in Section 8257.

(e) Notwithstanding any other law, nonstate moneys appropriated from the fund that are not encumbered or liquidated shall revert to the fund.

13053. For purposes of this chapter:

(a) "Affordable housing" means multifamily rental housing receiving public subsidy that allows extremely, extremely low income households, extremely low income households, and very low income households occupying that housing to pay no more than 30 percent of their household income on rent.

(b) "Agency" means the California Health and Human Services Agency.

(c) "Area median income" means the median family income of a geographic area of this state, determined in accordance with Section 50093 of the Health and Safety Code.

(d) "Continuum of care" has the same meaning as defined by the United States Department of Housing and Urban Development at Section 578.3 of Title 24 of the Code of Federal Regulations.

(e) "Coordinated entry system" means a centralized or coordinated process developed pursuant to Section 576.400 or 578.7, as applicable, of Title 24 of the Code of Federal Regulations, as that section read on January 1, 2020, designed to coordinate program participant access, assessment, prioritization, and referrals. For purposes of this chapter, a centralized or coordinated assessment system shall cover the geographic area, be easily accessed by individuals and families seeking housing or services, be well advertised, and include a comprehensive and standardized assessment tool. However, the assessment tool may vary to assess the specific needs of an identified population. The centralized or coordinated assessment system shall also specify how it will address the needs of individuals or families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking.

(f) "Council" means the Homeless Coordinating and Financing Council.

(g) "Department" means the Department of Housing and Community Development.

(h) "Diversion" means services to connect individuals and families to alternate housing arrangements, case management services, and financial assistance to divert the household from shelter use and into permanent housing, including, but not limited to, housing arrangements with friends or family.

(i) "Eligible population" means persons experiencing homelessness and persons exiting rapid rehousing, transitional housing, or an institutional setting who are homeless or were

homeless before their entry and have no other housing options upon exit without assistance.

(j) "Extremely, extremely low income households" means persons and families whose household income does not exceed 20 percent of the area median income, as adjusted for family size and revised annually.

(k) "Extremely low income households" has the same meaning as defined in Section 50106 of the Health and Safety Code.

(l) "Fund" means Bring California Home Fund created pursuant to Section 13052.

(m) "Gender-based violence" includes domestic violence, dating violence, sexual assault, stalking, human trafficking, and commercial sexual exploitation. The term acknowledges that the majority of victims of gender-based violence are women or female-identified people.

(n) "Holding fees" and "vacancy costs" mean payments to private-market landlords as incentives to hold a housing unit as available to an eligible participant while the participant or landlord are waiting for approval to rent the housing unit.

(o) "Homeless," "homelessness," "imminent risk of homelessness," and "chronically homeless" have the same meanings as those terms are each defined in Section 578.3 of Title 24 of the Code of Federal Regulations, as that section read on January 1, 2021.

(p) "Homeless Management Information System" or "HMIS" means the information system designated by a continuum of care to comply with federal reporting requirements as defined in Section 578.3 of Title 24 of the Code of Federal Regulations, as that section read on January 1, 2021. The term "Homeless Management Information System" or "HMIS" also includes the use of a comparable database by a victim services provider or legal services provider that is permitted by the United States Department of Housing and Urban Development under Part 576 of Title 24 of the Code of Federal Regulations, as that part read on January 1, 2021.

(q) "Homeless youth" means an unaccompanied youth between 12 and 24 years of age, inclusive, who is experiencing homelessness, as defined in subsection (2) of Section 725 of the federal McKinney-Vento Homeless Assistance Act (42 U.S.C. Sec. 11434a(2)).

(r) Subject to paragraph (1) of subdivision (t), "Housing First" means adhering to the core components specified in Section 8255, except that recipients may fund recovery housing if the tenant chooses to live in an abstinence-based setting over a harm reduction setting and the housing otherwise complies with all other core components of Housing First described in Section 8255, including requirements that tenants have leases, that they are not evicted for relapse or failure to participate in services, and that they are provided services to relocate to housing offering a harm reduction model if they choose to live in such housing.

(s) "Housing navigation" means services that assist program participants with locating permanent housing with private market landlords or property managers who are willing to accept rental assistance or operating subsidies for the program participants to assist those program participants in obtaining local, state, or federal assistance or subsidies; completing housing applications for permanent housing or housing subsidies and, when applicable, move-in assistance; and obtaining documentation needed to access permanent housing and rental assistance or subsidies.

(t) "Interim intervention" means a safe place to live that is low barrier but does not qualify as permanent housing and includes, but is not limited to, emergency shelters, navigation centers, motel vouchers, recovery-oriented interim interventions, Project Roomkey or Project Homekey sites used as interim housing, a cabin or similar communities, and recuperative or respite care, as those terms may be defined under any other applicable local, state, or federal program. For purposes of this subdivision, an interim intervention shall be deemed to be "low barrier" if all of the following apply:

(1) The interim intervention is a Housing First, service-enriched intervention focused on moving people into permanent housing that provides temporary living facilities while case managers connect individuals experiencing homelessness to permanent housing, income, public benefits, and health services. Notwithstanding subdivision (r), for purposes of interim interventions "Housing First" shall not require a lease.

(2) The interim intervention utilizes best practices to reduce barriers to entry, including, but not limited to, allowing partners and older minors, unless the interim intervention is a population-specific site; allowing pets; allowing storage of

possessions; allowing residents to engage in treatment for substance use disorders including medications for addiction treatment; offering services to connect persons to permanent housing; providing privacy; and providing linkage to a coordinated entry system.

(3) The interim intervention offers a harm reduction approach, except where tenants request an abstinence-based model.

(4) The interim intervention has a system for entering information regarding client stays, demographics, income, and exit destination though a local HMIS or similar system.

(u) "Large city" means a city or city and county, whether general law or chartered, with a population of 300,000 or greater based on the most recent American Community Survey.

(v) "Master leasing" means that a single lease covers multiple properties leased from a landlord or property manager to a recipient or subrecipient that the recipient or subrecipient sublets to program participants. The single lease shall comply with all applicable provisions of this chapter and be subject to the rights and responsibilities of tenancy under the laws of this state.

(w) "Multifamily rental housing" means an improvement on real estate consisting of one or more buildings that contain five or more residential rental units.

(x) "Operating subsidy" means a subsidy that allows an individual or household to occupy a new or existing permanent housing or supportive housing project while paying no more than 30 percent of their income on rent. An "operating subsidy" may include a capitalized operating subsidy reserve for at least 17 years.

(y) "Participant" or "tenant" mean a person or household that is a member of the eligible population and receives assistance under this chapter.

(z) "Permanent housing" means a structure or set of structures with no limit on length of stay, even if accompanied by time-limited rental subsidy, that is subject to applicable landlord-tenant law and has no requirement to participate in supportive services as a condition of access to or continued occupancy in the housing.

(aa) "Point-in-time count" has the same meaning as defined in Section 578.3 of Title 24 of the Code of Federal Regulations, as that section read on January 1, 2021.

(ab) "Populations who face barriers to accessing housing" include, but are not limited to, all of the following:

(1) Survivors of gender-based violence.

(2) Persons who are at least 50 years of age and are experiencing homelessness or exiting nursing care with nowhere to go upon exit.

(3) Persons with high-acuity chronic medical or behavioral health conditions experiencing homelessness or who were homeless when admitted to an institutional setting or who have nowhere to live upon discharge from an institutional setting.

(4) Persons exiting justice settings who were homeless when incarcerated or who have a history of homelessness prior to incarceration and have nowhere to live upon discharge.

(ac) "Prevention and problem-solving" and "rapid resolution" mean using targeted person-centered, short-term housing or services approaches to assist households who are at imminent risk of homelessness or have recently fallen into homelessness to maintain their current housing or identify an immediate and safe housing alternative within their social network.

(ad) "Program" means the Bring California Home Program established and implemented in accordance with this chapter.

(ae) (1) "Rare, brief, and nonrecurrent" means strategies to help the state and communities build lasting systems addressing the immediate crisis of homelessness that are able to respond to housing instability and homelessness quickly and efficiently.

(2) Making homelessness "rare" means incorporating strategies for system building, partnerships with mainstream systems, and diversion and prevention strategies.

(3) Making homelessness "brief" means leveraging strategies to support comprehensive outreach, low barrier emergency shelter, coordinated entry systems, and swift connections to permanent housing, with Housing First practices underpinning every element of the response.

(4) Making homelessness "nonrecurring" means people exit to permanent housing stably and successfully and do not return to homelessness, as they are able to use housing as a platform for accessing services that allow them to stabilize and thrive.

(af) "Reasonable rent" means an amount of rental payments that does not exceed two times the fair market rent and is consistent with the market rent in the community in which the multifamily

rental housing is located. For purposes of this subdivision, "fair market rent" means the rent, including the cost of utilities, as established by the United States Department of Housing and Urban Development pursuant to Parts 888 and 982 of Title 24 of the Code of Federal Regulations, as those parts read on January 1, 2021, for units by number of bedrooms, that must be paid in the market area to rent privately owned, existing, decent, safe, and sanitary rental housing of nonluxury nature with suitable amenities.

(ag) "Recipient" means a large city, developer, or county that applies jointly with a continuum of care and receives funds under the program, as applicable.

(ah) "Recovery housing" means housing geared toward individuals who choose to live in an abstinence-only environment over a harm reduction model, while learning how to sustain long-term recovery from substance use disorders, that allows for medications for addiction treatment, that provides housing navigation services to tenants who wish to leave recovery housing for a harm reduction model, and that otherwise follows the core components of Housing First described in Section 8255 and the provisions of this chapter.

(ai) "Rental assistance" means a tenant-based rental subsidy provided to a landlord or property manager to assist a tenant in paying the difference between 30 percent of the tenant's household income and the reasonable rent for the multifamily rental housing unit, as determined by the recipient.

(aj) "Severe rent burden" means a condition in which a person or family pays more than 50 percent of their total household income, as reported by the American Community Survey.

(ak) "Shared housing" means a type of permanent housing in which tenants have their own lease, with all of the rights and responsibilities of tenancy under the laws of this state, and may share occupancy of that permanent housing with one or more other tenants, or share use of either or both a kitchen and a bathroom with one or more other tenants, subject to the applicable conditions specified in this chapter.

(al) "Subrecipient" means a unit of local government or a private nonprofit organization that the recipient determines is qualified to undertake the eligible activities for which the recipient seeks funds under the program, and that enters into a contract

with the recipient to undertake those eligible activities in accordance with the requirements of the program.

(am) "Supportive housing" means permanent housing that is occupied by an eligible tenant and that is linked to onsite or offsite tenancy transition services and tenancy sustaining services that assist the supportive housing tenants in retaining housing, improving residents' health status, and maximizing residents' ability to live and, when possible, work in the community. "Supportive housing" includes associated facilities if used to provide services to housing residents.

(an) "Tenancy acquisition services" means staff dedicated to engaging property owners to rent housing units to the eligible population through rental assistance.

(af) "Tenancy sustaining services" means, using evidence-based service models, any of the following:

(1) Early identification and intervention of behaviors that may jeopardize housing security.

(2) Education and training on the rights and responsibilities of the tenant and the landlord.

(3) Coaching on developing and maintaining key relationships with landlords or property managers.

(4) Assistance in resolving disputes with landlords and neighbors to reduce the risk of eviction.

(5) Advocacy and linkage with community resources to prevent eviction when housing may become jeopardized.

(6) Care coordination and advocacy with health care professionals.

(7) Assistance with a housing recertification process.

(8) Coordinating with the tenant to review and update a housing support and crisis plan.

(9) Training in being a good tenant and lease compliance.

(10) Benefits advocacy.

(11) Evidence-employment services.

(12) Services connecting individuals to education.

(13) Any other service that supports individuals and families to promote housing stability, foster community integration and inclusion, and develop natural support networks and that are offered through a trauma-informed, culturally-competent approach.

(ao) "Tenancy transition services" means using evidence-based service models to provide any of the following:

(1) Screening and assessing the tenant's preferences and barriers to successful tenancy.

(2) Developing an individualized housing support plan that includes motivational interviewing and goal setting.

(3) Assistance with the housing application and search process.

(4) Identifying resources to cover expenses for move-in and furniture costs.

(5) Ensuring that the living environment is safe and ready for move-in.

(6) Assisting and arranging for the details of the move.

(7) Developing a housing support crisis plan that includes prevention and early intervention when housing is jeopardized.

(8) Engagement services.

(9) Any other evidence-based services that an individual tenant may require to move into permanent housing.

(ap) "Very low income households" has the same meaning as defined in Section 50105 of the Health and Safety Code.

13054. (a) Notwithstanding any other law and to the extent allowable under federal law, assistance, services, or supports received pursuant to this chapter are not income of the participant for purposes of determining eligibility for, or benefits pursuant to, any public assistance program. Participation in other benefits or housing or housing-based services programs shall not disqualify a person or household from being a participant for purposes of housing or services funded pursuant to this chapter.

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

13055. (a) The council shall administer allocations from the fund to counties and continuums of care that apply jointly pursuant to Section 13058 and to large cities that apply pursuant to Section 13059. The department shall administer allocations to developers pursuant to Section 13060. The council and the department shall administer the fund and allocate the moneys in the fund as follows:

(1) The council and the department may expend up to 5 percent of the moneys available in the fund in any calendar year for purposes of administering the program, including for ongoing technical assistance and training to recipients and measuring data and performance.

(2) The department shall allocate four hundred million dollars ($400,000,000) pursuant to Section 13060.

(3) The council shall set aside two hundred million dollars ($200,000,000) for bonus awards to recipients, as provided in subdivision (e) of Section 13056.

(4) (A) The council shall allocate the remaining amount in the fund after the allocations made pursuant to paragraphs (1) through (3), inclusive, as follows:

(i) Sixty percent of the amount described in this paragraph to counties and continuums of care applying jointly, pursuant to Section 13058.

(ii) Forty percent of the amount described in this paragraph to large cities, pursuant to Section 13059.

(B) The council shall allocate funding to eligible recipients in accordance with this paragraph that apply and meet the applicable threshold requirements under Section 13058 or 13059, as applicable, according to the following formula:

(i) The council shall afford 70 percent weight based on the 2019 homeless point-in-time count conducted by the United States Department of Housing and Urban Development for the relevant jurisdiction.

(ii) The council shall afford 30 percent weight based on the number of extremely low income households who are severely rent burdened in the relevant jurisdiction, based on the most recent American Community Survey at the time of the application.

(b) Each recipient and subrecipient shall ensure that any expenditure of moneys allocated to it pursuant to this chapter serves the eligible population, unless otherwise expressly provided in this chapter.

13056. (a) In allocating moneys under the program, the council and the department shall comply with the following:

(1) No later than September 1, 2022, the council shall develop guidelines and draft notices of funding availability or requests for proposal, and the department shall adopt any necessary changes to existing guidelines, in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(2) No later than January 1, 2023, and no later than March 1 of each year thereafter, the council shall issue award notices.

(3) No later than March 31, 2023, and no later than April 1 of every other year thereafter, the council shall allocate all available funding for each two-year cycle.

(4) The council and the department shall issue a notice of funding availability or request for proposal, as applicable, on a consistent basis every two years.

(b) (1) The council and the department shall develop a simple application that an entity eligible to receive an allocation under this chapter may use to apply for that allocation and, consistent with the requirements of this chapter, common standards for recipients to monitor, report, and ensure accountability, provide services, and subsidize housing. The council and the department shall, to the extent feasible and consistent with the requirements of this chapter, ensure that the common standards are the same or similar for each applicant.

(2) To the extent feasible, the council and the department shall work with the agency to connect services available under other programs, including, but not limited to, services provided under the Medi-Cal Act (Chapter 7 (commencing with Section 14000)), to housing opportunities created through the fund.

(c) The council shall issue applications for allocations to counties and continuums of care, pursuant to Section 13058, and to large cities, pursuant to Section 13059, on the same date and subject to the same deadlines. The council shall require that recipients under Sections 13058 and 13059, as applicable, provide the following information in their applications:

(1) The expected outcomes, numeric goals, and performance measures established through consultation between the applicant and council staff pursuant to subdivision (g), as well as a description of policy changes the applicant will take to ensure racial and gender equity in service delivery, housing placements, and housing retention and changes to procurement or other means of affirming racial and ethnic groups that are overrepresented among residents experiencing homelessness have equitable access to housing and services.

(2) A description of the specific actions, including funding allocations, that will be taken to affirmatively eliminate gender disparities in accessing homeless systems.

(3) Evidence that the applicant will adhere to Housing First in housing and housing-based services programs.

(4) Specific roles and responsibilities for each local agency, continuum of care, and providers, including roles and responsibilities in implementing systems improvements.

(5) A description of how the applicant will prevent returns to homelessness among the eligible population.

(6) Goals for cross-agency collaboration, including demonstration of collaboration between large cities, counties, and continuums of care, to foster evidence-based solutions to homelessness, and plans for making the applicants capital projects viable through collaboration with other applicants and funders.

(7) An identification of the agency or agencies that will administer the funding, ensuring agencies have relevant experience.

(8) In the case of a joint application by a county and a continuum of care pursuant to Section 13058, a description of how the recipient will align and leverage state funding with existing resources to create a flexible pool of funds.

(9) In the case of a joint application by a county and a continuum of care pursuant to Section 13058, a description of how the applicant will prevent exits to homelessness from institutional settings, including plans to scale funding from mainstream systems for evidence-based housing and housing-based solutions to homelessness.

(10) A description of how an applicant pursuant to Section 13058 will provide incentives to cities within its territory to enact, or how an applicant pursuant to Section 13059 will enact, land use changes to streamline approval of supportive and affordable housing and low-barrier shelters.

(11) Ways in which the applicant will include people with lived expertise of homelessness in planning and decisionmaking.

(12) Processes to include youth and adults with lived expertise of homelessness in decisionmaking, which may include, but is not be limited to, planning and program delivery, advisory boards, and technical assistance.

(d) (1) Based on the statewide needs and gaps analysis conducted pursuant to Section 8257.1, the council shall establish performance outcomes to make homelessness rare, brief, and nonrecurring, and develop guidelines, with stakeholder input, to include criteria in setting state and recipient performance outcome

goals, informed by United States Department of Housing and Urban Development system performance measures.

(2) The council shall consult with applicants to identify ambitious and achievable performance outcomes that are measurable and consistent with United States Department of Housing and Urban Development performance standards. The council shall work with applicants to achieve more challenging outcomes for each progressive grant cycle.

(3) Applicants shall demonstrate an intent to apply before engaging in consultation with the council pursuant to paragraph (2), and may submit an application once the council approves the applicant's performance outcomes.

(4) Based on criteria in guidelines and data of needs in the recipient's jurisdiction, the council and each recipient shall establish the performance outcomes for the initial cycle within the first year of award. These performance outcomes may include systems changes to help the recipient meet subsequent performance outcomes and reductions in the number of people living in unsheltered settings.

(5) The council and each recipient shall establish outcome goals before each subsequent grant cycle, as follows:

(A) Performance outcomes in subsequent cycles shall include, at minimum, the following:

(i) A specified reduction in the number of people experiencing homelessness.

(ii) Specific outcomes for more equitably serving populations overrepresented among the eligible population.

(iii) Specified reductions in racial and gender disparities among people experiencing homelessness in subsequent grant cycles.

(B) Other performance outcomes may include, but are not limited to, the following:

(i) A minimum number of people experiencing homelessness who are diverted from a homeless shelter or who have successfully accessed permanent housing during the relevant period.

(ii) Minimum reductions in people becoming homeless, including targeted homelessness prevention and reductions in returns to homelessness.

(iii) A minimum number of people exiting homelessness during the relevant period.

(iv) Commitments of funding to solve homelessness from existing resources used to address mental illness, substance use, medical care, the justice system, and child welfare involvement within the jurisdiction.

(v) Meaningful commitments of local housing and homeless services funding toward solving homelessness.

(vi) Memoranda of understanding for interjurisdictional collaboration, with specific agreements to meet performance standards.

(e) The council shall establish a process and guidelines for awarding bonus funding to recipients under Sections 13058 and 13059, from the moneys described in paragraph (3) of subdivision (a) of Section 13055, in accordance with the following:

(1) (A) The council shall award bonus funding to each recipient in the first two-year cycle of the recipient's award.

(B) A recipient shall use bonus funding awarded pursuant to this paragraph for the following purposes:

(i) Conducting or working with a technical assistance provider to conduct or update a countywide homeless gaps and needs analysis.

(ii) Capacity building and workforce development for the jurisdiction's administering staff and providers.

(iii) Funding gaps in existing evidence-based programs serving people experiencing homelessness.

(iv) Investing in data systems to meet reporting requirements or strengthen the recipient's HMIS.

(v) Creating a mechanism for pooling and aligning housing and services funding from existing, mainstream, and new funding.

(vi) Strengthening existing interim interventions to ensure those systems operate safely in the wake of COVID-19 and other public health crises.

(vii) Improving homeless point-in-time counts.

(viii) Improving coordinated entry systems or creating a youth-specific coordinated entry system.

(ix) Funding capitalized operating subsidy reserves in capital projects, if the jurisdiction does not require the above systems improvements.

(2) (A) If, after the first or a subsequent grant cycle, as applicable, a recipient has achieved the performance outcomes

approved by the council pursuant to subdivision (d) for that cycle, the council shall award bonus funding in the next award cycle.

(B) A recipient may use bonus funding awarded pursuant to this paragraph for any purpose, consistent with the following requirements:

(i) The recipient shall use the bonus funding awarded pursuant to this paragraph to serve the eligible population or people at imminent risk of homelessness, as defined in this chapter.

(ii) The recipient shall report to the council on the use of bonus funding awarded pursuant to this paragraph and request approval from the council for that use.

(iii) The recipient may only use bonus funding for the purpose reported pursuant to clause (ii) if the council approves that use of funding. The council shall approve a requested use of funding if, in the council's judgment, the recipient's proposed use would further the purposes of this chapter.

(3) If, by a date determined by the council at the end of the first or a subsequent grant cycle, as applicable, a recipient has failed to achieve the outcomes approved by the council pursuant to subdivision (d) for that cycle, the council shall reduce or deny bonus funding to that recipient in the next award cycle. Any moneys dedicated for bonus funding pursuant to paragraph subdivision (a) of Section 13055 that is not awarded to a recipient in any award cycle for failure to achieve outcomes, as provided in this paragraph, shall revert to the fund and the council shall allocate those moneys as bonus funds to other recipients that have met their approved outcomes in accordance with this subdivision.

(f) The council shall work closely with recipients under Sections 13058 and 13059 to provide technical assistance to those recipients and their subrecipients in complying with the requirements of this chapter and achieving the performance standards approved by the council pursuant to subdivision (d). Technical assistance under this subdivision shall include, but is not limited to, all of the following:

(1) Using data to develop a systems model that identifies investments needed for evidence-based interventions to impact system flow and exits to permanent housing, based on a gaps and needs analysis.

(2) Working regionally to scale up housing and services interventions.

(3) Adopting Housing First core components.

(4) Reducing racial disparities in homelessness and racial and gender disparities in access to housing and services.

(5) Creating a flexible subsidy pool or other mechanism that aligns housing and services funding, including funding under this chapter, as well as existing funding under mainstream programs.

(6) Meeting United States Department of Housing and Urban Development performance metrics and standards for reductions in homelessness.

(g) The council and the department shall develop quality standards with which each recipient shall comply. These quality standards shall include, but are not limited to, the following:

(1) Each unit of new construction or rehabilitated through capital funding or operating reserves shall include a bathroom in each unit and either a kitchenette in each unit or an accessible, shared kitchen space accessible to all tenants, except that, in the case of acquisition and rehabilitation of single-room occupancy settings, each housing unit shall be equipped with a bathroom in the unit or a shared bathroom and kitchen easily accessible to the tenants.

(2) (A) For rental assistance provided to private market or nonprofit landlords, the following shall apply:

(i) Except as otherwise provided in clause (ii), each housing unit shall include a bathroom and an easily accessible kitchen or kitchenette.

(ii) If the tenant resides in a single-room occupancy setting, each housing unit shall be equipped with either a bathroom within the unit or a shared bathroom and a shared kitchen that is easily accessible to tenants.

(B) For purposes of this paragraph, the council shall develop standards for a kitchen or kitchenette to be deemed easily accessible consistent with the requirements of this chapter.

(3) Shared housing units funded under the program shall be subject to the following restrictions:

(A) Before referring a tenant to shared housing, the referring entity shall consider the following:

(i) Any functional limitations of the tenant.

(ii) Whether the proposed housing configuration may put the tenant at risk of gender-based violence, consistent with training on gender-based violence.

(B) Referrals to shared housing shall be consistent with tenant choice in whether to participate in shared housing and with whom the tenant will reside in that shared housing.

(C) A provider of shared housing shall offer services appropriate to meet the needs of tenants living in that shared housing, including services in mitigating conflicts between tenants and services helping tenants move to other housing options, according to tenant choice.

(D) For all shared housing units, each participant, other than a participant who is a minor accompanied by an adult or two adult participants who constitute a single household, shall be offered their own bedroom with a door that has a functioning lock and be required to sign a separate lease agreement.

(4) Supportive housing funded under the program shall comply with the following requirements:

(A) A majority of the services shall be provided onsite, and any offsite services shall be easily accessible to tenants through transportation.

(B) Each tenant shall have a tenancy support specialist that the tenants knows, with a specialist-to-tenant ratio that is consistent with best practices for the population served.

(h) (1) (A) Except as otherwise provided in subparagraph (B), each recipient shall expend moneys allocated to it under the program according to the following schedule:

(i) For the first award cycle, the recipient shall contractually obligate 100 percent of the amount allocated to it pursuant to this chapter within three years, and expend the entirety of that amount within four years, of entering into the initial grant agreement.

(ii) For each award cycle after the first award cycle, each recipient shall contractually obligate 100 percent of the amount allocated to it pursuant to this chapter within one year, and expend the entirety of that amount within two years.

(B) Notwithstanding the time periods specified in subparagraph (A), moneys used to provide a capitalized operating subsidy reserve for permanent housing shall be expended over a period of at least 17 years.

(2) In the case of a recipient that is a developer receiving an allocation pursuant to Section 13060, if the recipient fails to obligate or expend that allocation within the time periods specified

in paragraph (1), any moneys awarded to the recipient shall revert to the fund.

(3) (A) In the case of a recipient that is a county and continuum of care applying jointly pursuant to Section 13058 or a large city applying pursuant to Section 13059, if a recipient fails to obligate or expend moneys allocated to it, uses grant moneys allocated to it under this chapter for a purpose not authorized under the program, or fails to apply for an allocation of grant funds within the initial award cycle under the program, the council shall do either of the following:

(i) Select an alternative entity to administer that recipient's allocation through a competitive application process, in accordance with the requirements of subparagraph (C).

(ii) Solely establish the performance outcomes and program priorities for the recipient jurisdiction, consistent with the requirements and purposes of this chapter, and work with local, regional, or statewide public entities to administer the recipient's allocation on behalf of the recipient.

(B) If the council determines that there is no alternative entity that can effectively administer a recipient's allocation, any moneys previously allocated to that recipient and not expended shall revert to the fund for further allocation to other recipients in accordance with this chapter.

(C) An alternative entity selected pursuant to clause (i) of subparagraph (A) shall be a public entity or a nonprofit entity with relevant experience.

(D) (i) An alternative entity selected pursuant to clause (i) of subparagraph (A) shall administer a recipient's allocation pursuant to this paragraph for a minimum of two grant cycles after entering into a grant agreement.

(ii) After the second grant cycle administered by an alternative entity, the council may reinstate the original recipient to administer moneys allocated in subsequent grant cycles if, in the council's judgment, the recipient has demonstrated the capability to effectively administer those moneys consistent with the purposes of this chapter. The council shall develop a process by which a recipient may seek reinstatement pursuant to this clause.

(i) The council shall establish a process for awarding recipients under Sections 13058 and 13059 grants in subsequent years in accordance with the following:

(1) To the extent feasible, each recipient under Sections 13058 and 13059 shall continue to receive annual allocations on a consistent date selected by the council that aligns favorably with other, similar allocations of state moneys, including, but not limited to, allocations of tax credits by the California Tax Credit Allocation Committee.

(2) If a city that is not a large city at the time of the initial allocation subsequently becomes a large city and meets the threshold criteria under the program after the first year of allocations pursuant to this chapter, the council shall revise the amount of annual allocations to recipients under Section 13059 at least 180 days, but no more than one year, after the date on which the city establishes eligibility under this chapter. Consistent with the requirements of this chapter, the council may establish a revised formula that minimizes the impact on existing recipients.

(j) If deemed appropriate or necessary, the council shall request the repayment of funds from a recipient or pursue any other remedies available by law for failure to comply with the requirements of this chapter.

(k) The council shall identify any properties, including blighted or vacant properties, that may be converted to permanent housing, and work to acquire or secure these properties in coordination with recipients.

(l) The council and the department shall each establish an advisory committee to inform state and local policies, practices, and programs, which shall include individuals with relevant lived experiences, with respect to the following:

(1) The experiences of African Americans and other overrepresented racial and ethnic groups experiencing homelessness.

(2) The experiences of women and female-identified persons experiencing homelessness.

(3) The experiences of youth experiencing homelessness, including a youth advisory board.

(m) A county and continuum of care applying jointly pursuant to Section 13058 may elect in the grant agreement to request that the State Department of Social Services act as a fiscal agent in contracting with local agencies or nonprofit organizations providing the housing and housing-based services described in this chapter. If so requested pursuant to this subdivision, the State

Department of Social Services shall act as a fiscal agent on behalf of the jointly applying county and continuum of care in exchange for a percentage of the allocation to the county and continuum of care for administrative costs under Section 13058, as determined by the State Department of Social Services.

(n) All projects, including interim interventions, funded under the program shall comply with all applicable state laws governing building safety and habitability.

(o) Each recipient and subrecipient shall comply with the core components of Housing First described in subdivision (b) of Section 8255.

(p) The council shall not require recipients to submit invoices for payment, and shall fund the entire grant awarded under Sections 13058 or 13059, as applicable, within 60 days of notice of award.

13057. (a) Each recipient shall annually report to the council and the department, in the form and manner prescribed by the council and the department, on the data reported to the United States Department of Housing and Urban Development and, in addition, the following information:

(1) The amount of fund moneys expended on each eligible activity under Section 13058, 13059, or 13060, as applicable, and the number of people served under the program.

(2) Steps taken to advance racial and gender equity within the recipient's programs and services.

(3) Steps taken to improve systems serving the eligible population.

(b) The council and department shall seek philanthropic funding to augment funding for evaluations under this chapter.

(c) The council shall conduct regular monitoring and audits of the activities and outcomes of recipients under Sections 13058 and 13059. In complying with the requirements of this subdivision, the council shall develop a process for monitoring how recipients are spending allocations and compliance with this chapter and whether each recipient's activities are resulting in pathways to permanent housing, permanent housing placements, and permanent housing retention.

(d) Notwithstanding Section 10231.5 of the Government Code, no later than January 1, 2024, and every fifth January 1 thereafter, the council shall evaluate the outcomes of the program and submit

a report documenting that evaluation to the Assembly Committee on Housing and Community Development and the Senate Committee on Housing in compliance with Section 9795 of the Government Code. The evaluation shall include, but not be limited to, the following:

(1) Data reported by recipients pursuant to this section, including data on the number of people served and the number of participants accessing permanent housing.

(2) The status of coordinated entry systems and training or capacity building programs across a sample of geographically diverse communities.

(3) Innovations developed to reduce exits from institutional settings to homelessness and the outcomes of these innovations.

(4) The progress of recipient coordination and collaboration and housing stability outcomes.

(5) Any agreements reached and coordination brokered between jointly applying counties and continuums of care and cities to use funds in a consistent manner, to prioritize specific populations jointly, to scale up interventions by working across regions, and to offer housing and housing-based services.

(6) The extent to which racial and ethnic demographic groups of persons overrepresented in the homeless population are served under the program, including housing opportunities, housing placements, and housing retention.

(7) The extent to which women and female-identified people are served under the program, including access to housing opportunities, housing placements, and housing retention.

(8) To the extent feasible, impacts on other state programs, including, but not limited to, the utilization of acute care or skilled nursing facilities funded through the Medi-Cal Act (Chapter 7 (commencing with Section 14000)), recidivism to prison, and avoidance of foster care placements, as well as reductions or avoidance of other institutional settings, among the eligible population.

13058. (a) A county and continuum of care that submit a joint application and meet the requirements of this section shall be eligible to receive an allocation of moneys from the fund.

(b) A county and continuum of care that jointly receive an allocation pursuant to this chapter may use up to 10 percent of the amount of that allocation for the costs of administering the

allocation. For purposes of this subdivision, "costs of administering" do not include costs associated with staffing to provide services, data collection, or reporting or costs to subrecipients to provide housing or services to the eligible population. Recipients shall pay a reasonable administrative rate to all subrecipients.

(c) (1) A county and continuum of care applying jointly for an allocation shall provide the following evidence of collaboration to the council:

(A) Either of the following:

(i) Evidence that the board of supervisors of the county and the governing body of the continuum of care each approved the joint funding plan before the submission of the application.

(ii) A memorandum of understanding between the chief executive officer, or equivalent officer, of the county and of the continuum of care that establishes the allocation plan for the use of the moneys allocated under this chapter.

(B) Evidence of collaborative planning between the county and the continuum of care, which may include, but is not limited to, meeting agenda or minutes of the board of supervisors of the county and the governing body of the continuum of care.

(2) If the geographic area of a continuum of care covers territory located in more than one county, each of those counties shall submit a single application that includes a plan outlining the roles, functions, identified uses, and processes for cross-jurisdictional housing referrals between each county.

(d) Recipients under this section shall use the allocation of moneys provided under this chapter for one or more of the following eligible activities:

(1) Rental assistance and master leasing for permanent housing.

(2) Operating subsidies for permanent housing.

(3) Transitional housing projects serving persons under 25 years of age that comply with the core components of Housing First described in subdivision (b) of Section 8255.

(4) Incentives to landlords to provide permanent housing, including, but not limited to, payment of security deposits, holding fees, signing bonuses, repairs made in advance of occupancy to ensure compliance with habitability standards, and contractors to assist the landlord in making repairs.

(5) Move-in assistance, including, but not limited to, security deposits, utility assistance, furniture, and other household goods.

(6) Housing navigation, housing acquisition support, housing transition, and tenancy support services to help participants move into housing and remain stably housed, housing-based employment services, and linkages to education.

(7) For persons at imminent risk of homelessness, homelessness prevention, problem solving, and other rapid resolution programs to assist these persons in becoming or remaining stably housed, so long as these interventions are targeted to people likely to become homeless, based on data.

(8) Systems improvements, including, but not limited to, strengthening coordinated entry systems and assessment systems, collaboration between city and county agencies to coordinate resources and prevent discharges from institutional settings into homelessness, and HMIS system and data matching advances.

(9) (A) Subject to subparagraph (B), to provide assistance to the eligible population or persons residing in supportive housing who require care and supervision in licensed residential facilities due to high vulnerability and complex needs, through the nonmedical out of home care rate for individuals without incomes and the enhanced services rates for those with incomes.

(B) The recipient shall use no more than ___ percent of its allocation for the activities described in this paragraph.

(10) (A) Subject to subparagraph (B), one or more of the following:

(i) Shelter diversion and operating support for interim interventions.

(ii) Safe parking programs, including safe parking programs for college students experiencing homelessness.

(iii) Site improvements to congregate shelters or to convert congregate sites to noncongregate shelter for the purposes of complying with public health guidance during and after the COVID-19 pandemic and other future public health emergencies where public health officials recommend social distancing to mitigate disease spread.

(B) (i) Except as otherwise provided in clause (ii), the recipient shall use no more than 50 percent of its allocation in the first grant cycle, and no more than 30 percent of each subsequent grant cycle, for the activities described in this paragraph.

(ii) The council may waive or increase the limitation specified in this subparagraph with respect to the activities described in clause (i) of subparagraph (A) if the recipient demonstrates, to the satisfaction of the council, that the recipient is funding a similar ratio of permanent housing to interim housing units, consistent with data and reflected in the intent of this section and the council's guidelines.

(e) During the term of any allocation provided to a county and continuum of care that apply jointly pursuant to this section, the recipient shall do all of the following:

(1) Offer robust services in supportive housing, as well as housing navigation, housing acquisition support, and housing transition services, through a standardized contract that the county and the continuum of care develop in collaboration with homeless service providers, using evidence-based standards.

(2) Funnel resources through a mechanism or develop a mechanism within 180 days of entering into a grant agreement to combine moneys allocated under this chapter with local private and existing local, state, and federal public moneys across the continuum of care, the county, or a multicounty region toward common standards for funding permanent housing, services, and, if necessary, interim interventions.

(3) Allocate funding for rental assistance and operating subsidies through an agency with experience administering housing subsidies and recruiting landlords. The agency may be a housing authority formed pursuant to the Housing Authorities Law (Chapter 1 (commencing with Section 34200) of Part 2 of Division 24 of the Health and Safety Code), a nonprofit organization, or another public entity that administers other moneys for purposes similar to those described in this chapter.

(4) Adopt, and require any subrecipients to adopt, the core components of Housing First described in subdivision (b) of Section 8255 for purposes of administering moneys allocated pursuant to this chapter and implement low-barrier policies for interim interventions funded under this chapter.

(5) Utilize a process for referral of participants to housing through a coordinated entry system, or an alternative process that ensures that persons and areas with the greatest vulnerabilities receive priority for supportive housing, or, in the absence of an established process, develop a plan for funding systems

improvements to create a system in compliance with this paragraph within one year of receiving the allocation, subject to the following:

(A) If the recipient uses funding to pay for operating or services costs of housing converted from existing hotels, motels, or apartments, the recipient may continue to house residents of the existing property, even if not referred through a coordinated entry or similar system.

(B) The recipient may use funding to house participants outside of the boundaries of the county or continuum of care, if housing is available, the referral is based on participant choice, and the referring county or continuum of care funds the housing and any necessary services, or the receiving county or continuum of care notifies the referring agency within two weeks of intent to fund the costs of housing and any necessary services.

(C) To the extent feasible, referrals to housing should take into account participant choice, and services should include efforts to assist people to move into communities in which they are residing, if consistent with participant choice, and where the participant has access to services and community amenities.

(6) Use HMIS data for all outcomes reporting.

(7) Establish or use an existing process for training services and property management staff in evidence-based and best practices.

(8) Ensure that survivors of gender-based violence are able to access housing and housing-based services.

(9) Prioritize a portion of resources to populations experiencing homelessness who face barriers to accessing housing or who make up a disproportionate number of people experiencing homelessness, based on data from a needs and gaps analysis or an amendment updating an existing needs and gaps analysis, consistent with the following:

(A) Prioritizing specific populations for resources under this paragraph shall not exclude serving other populations.

(B) The recipient shall ensure that prioritization pursuant to this paragraph does not result in a disproportionate impact on African American or indigenous populations or other persons of color.

(10) Ensure that at least 10 percent of the amount of allocation it receives under this chapter serves participants who are youth

experiencing homelessness, in accordance with the following requirements:

(A) The continuum of care applying jointly with the county shall ensure that the coordinated entry system used to assess and refer youth to housing created with funding provided under the program includes a youth-specific coordinated entry access point and uses screening and assessment tools that contemplate the specific needs of youth experiencing homelessness.

(B) Recipients and subrecipients shall offer supportive services designed to meet the unique needs of youth experiencing homelessness, which may include, but is not limited to, the following:

(i) Problem-solving services to maintain existing housing.

(ii) Housing navigation and housing acquisition support.

(iii) Substance use disorder education, prevention, or treatment services, including group supports.

(iv) Access to education and employment assistance, including, but not limited to, literacy and graduation equivalent diploma programs, vocational training, and supports to enroll and participate in institutions providing secondary or postsecondary education, including supports to applying for financial aid.

(v) Independent living skill development, economic stability, and mobility services.

(vi) Counseling, tenancy support, and case management services.

(vii) Screening, assessment, and treatment or referral of behavioral and physical health care services.

(viii) Services for pregnant and parenting youth.

(ix) Services for lesbian, gay, bisexual, transgender, and questioning youth.

(x) Family support, including family reunification, when safe and appropriate, and engagement and intervention, when appropriate.

(xi) Family finding services to identify appropriate family members.

(xii) Outreach to youth who are experiencing homelessness.

(xiii) Legal representation and connection to public benefits for which the unaccompanied homeless youth are eligible or entitled to receive, including foster care.

(C) Providers with which a recipient contracts to provide services to youth in accordance with this paragraph shall proactively engage youth experiencing homelessness to determine which supportive services meet the needs of each participant and, if appropriate, the participant's family.

(D) Providers with whom recipients contract to provide services to youth shall work with colleges and universities to market programs to students experiencing homelessness.

(f) (1) Upon the request of a large city located within a recipient county, that county allocate a portion of the moneys allocated to it under this chapter for support services and operating subsidies for supportive housing units that the large city develops, provided that the county recipient obligates and uses the moneys allocated to it within the time periods specified in subdivision (h) of Section 13056. The amount provided to a large city pursuant to this paragraph shall not exceed 40 percent of the large city's proportionate share of the county's most recent homeless point-in-time count, unless the recipient county, in its discretion, determines that greater amount is appropriate.

(2) The recipient county's obligation to fund support services and operating subsidies pursuant to this subdivision shall be proportionate to the share of capital funding used for those purposes from the total amount allocated to the recipient under this chapter.

(3) Nothing in this subdivision shall be construed to require a county or continuum of care to allocate moneys provided under this chapter to a large city to fund services provided at a new interim intervention that the city funded or created.

(4) Notwithstanding any other provision of this chapter, in committing operating subsidies to a supportive housing project funded by a large city pursuant to this subdivision, a recipient may commit a capitalized operating subsidy reserve that includes at least 17 years for those operating subsidies.

13059. (a) A large city that submits an application and meets the requirements of this section shall be eligible to receive an allocation from the fund.

(b) A large city that receives an allocation pursuant to this chapter may use up to 10 percent of the amount of that allocation for the costs of administering the allocation. For purposes of this subdivision, "costs of administering" do not include costs

associated with staffing to provide services, data collection, or reporting or costs to subrecipients to provide housing or services to the eligible populations. Recipients shall pay a reasonable administrative rate to all subrecipients.

(c) Recipients under this section shall use the allocation of moneys provided under this chapter for one or more of the following eligible activities:

(1) Operating subsidy reserves, capitalized over at least 17 years, for affordable housing projects that serve the eligible population.

(2) Capital funds for development, acquisition, preservation, or motel conversion to create either affordable housing or supportive housing for the eligible population.

(3) Rental assistance in permanent housing.

(4) Transitional housing projects serving persons under 25 years of age that follow the core components of Housing First.

(5) Prevention and problem-solving.

(4) (A) Subject to subparagraph (B), one or more of the following:

(i) Interim interventions based on an annual needs assessment and taking into consideration commitments made over the five years prior to the date of the recipient's application to shelter beds that have not yet been constructed or created.

(ii) Site improvements to congregate shelters or to convert congregate sites to noncongregate shelters for the purposes of complying with public health guidance during and after the COVID-19 pandemic and future public health emergencies where social distancing is recommended to mitigate disease spread.

(iii) Outreach, engagement, and other services to assist persons in connecting to permanent housing.

(iv) Health interventions, including, but not limited to, hygiene centers.

(v) Storage of belongings.

(vi) Safe parking and overnight, warm places where persons can sleep, including safe parking sites for college students experiencing homelessness.

(B) (i) Except as otherwise provided in clause (ii), the recipient shall use no more than 50 percent of its allocation in the first grant cycle, and no more than 35 percent of each subsequent grant cycle, for the activities described in this paragraph.

(ii) The council may waive or increase the limitation specified in this subparagraph with respect to the activities described in clause (i) of subparagraph (A) if the recipient demonstrates, to the satisfaction of the council, that the recipient is funding a similar ratio of permanent housing to interim housing units, consistent with local data on need.

(d) Any activity approved or carried out or action taken by a large city to lease, convey, or encumber land that the large city owns, any action taken by a large city to facilitate the lease, conveyance, or encumbrance of land that the large city owns, or any action taken by a large city to provide financial assistance in furtherance of providing, or to otherwise approve or construct, a low barrier interim intervention, affordable housing project, or supportive housing project in the large city using moneys allocated under this chapter shall not be subject to the California Environmental Quality Act (Division 13 (commencing with Section 21000) of the Public Resources Code). If the large city takes any action that is exempt from Division 13 (commencing with Section 21000) of the Public Resources Code, it shall file a notice of exemption with the Office of Planning and Research and the clerk of the county in which the large city is located in the manner specified in subdivisions (b) and (c) of Section 21152 of the Public Resources Code, except that the notice of determination required by that section shall instead specify that the project is not subject to Division 13 (commencing with Section 21000) of the Public Resources Code pursuant to this subdivision.

(e) During the term of any allocation provided to a large city that applies pursuant to this section, the recipient shall do all of the following:

(1) (A) Refer tenants to supportive housing units through a coordinated entry system, or an alternative process that ensures that persons with the greatest vulnerabilities receive priority. To the extent feasible, referrals shall take into account participant choice, and referral services shall include efforts to place persons in a community in which they choose to reside and have access to community-based services and natural supports.

(B) If a recipient uses funding to pay for operating or services costs of housing converted from existing hotels, motels, or apartments, the recipient may continue to house residents of the

existing property, even if not referred through a coordinated entry or similar system.

(C) A recipient may use funding to house participants outside of the boundaries of the city, provided that housing is available, referral is based on participant choice, and the referring city funds the housing and any necessary services, or the receiving city or county, if within an unincorporated area, notifies the referring agency within two weeks of intent to fund the costs of housing and any necessary services.

(D) To the extent feasible, referrals to housing should take into account participant choice, and services should include efforts to assist people to move into communities in which they are residing, if consistent with participant choice, and where the participant has access to services and community amenities.

(2) Notwithstanding any inconsistent provision of the Permit Streamlining Act (Chapter 4.5 (commencing with Section 65920) of Division 1 of Title 7 of the Government Code), streamline permitting for projects developed with moneys allocated under this chapter to expedite the permitting and approval process to no more than 180 days and provide other incentives to developers to create affordable housing.

(3) Allocate funding through a local competitive application process.

(4) Either of the following:

(A) Use HMIS data for all outcomes reporting.

(B) Use a coordinated entry system to enter and share data across the homelessness system.

(5) Prioritize a portion of resources to populations experiencing homelessness who face barriers to accessing housing or who make up a disproportionate number of people experiencing homelessness, based on data from a needs and gaps analysis or an amendment updating an existing needs and gaps analysis, consistent with the following:

(A) Prioritizing specific populations for resources under this paragraph shall not exclude serving other populations.

(B) The recipient shall ensure that prioritization pursuant to this paragraph does not result in a disproportionate impact on African American or indigenous populations or other persons of color.

(6) Ensure that at least 10 percent of the amount of allocation it receives under this chapter serves participants who are youth experiencing homelessness, in accordance with the following requirements:

(A) The large city shall ensure that the coordinated entry system used to assess and refer youth to housing created with funding provided under the program includes a youth-specific coordinated entry access point and uses screening and assessment tools that contemplate the specific needs of youth experiencing homelessness.

(B) Recipients and subrecipients shall offer supportive services designed to meet the unique needs of youth experiencing homelessness, which may include, but is not limited to, the following:

(i) Problem-solving services to maintain existing housing.

(ii) Housing navigation and housing acquisition support.

(iii) Substance use disorder education, prevention, or treatment services, including group supports.

(iv) Access to education and employment assistance, including, but not limited to, literacy and graduation equivalent diploma programs, vocational training, and supports to enroll and participate in institutions providing secondary or postsecondary education, including supports to applying for financial aid.

(v) Independent living skill development, economic stability, and mobility services.

(vi) Counseling, tenancy support, and case management services.

(vii) Screening, assessment, and treatment or referral of behavioral and physical health care services.

(viii) Services for pregnant and parenting youth.

(ix) Services for lesbian, gay, bisexual, transgender, and questioning youth.

(x) Family support, including family reunification, when safe and appropriate, and engagement and intervention, when appropriate.

(xi) Family finding services to identify appropriate family members.

(xii) Outreach to youth who are experiencing homelessness.

(xiii) Legal representation and connection to public benefits for which the unaccompanied homeless youth are eligible or entitled to, including foster care.

(C) Providers with which a recipient contracts to provide services to youth in accordance with this paragraph shall proactively engage youth experiencing homelessness to determine which supportive services meet the needs of each participant and, if appropriate, the participant's family.

(D) Providers with whom recipients contract to provide services to youth shall work with colleges and universities to market programs to students experiencing homelessness.

13060. (a) The department shall allocate the amount described in paragraph (2) of Section 13055 in accordance with this section. The department shall allocate those moneys in the same manner as deferred payment loans provided under the Multifamily Housing Program (Chapter 6.7 (commencing with Section 50675) of Part 2 of Division 31 of the Health and Safety Code). For purposes of distributing grants under this section, to the extent that there is any conflict between the provisions of this chapter and Chapter 6.7 (commencing with Section 50675) of Part 2 of Division 31 of the Health and Safety Code, the provisions of this chapter shall prevail.

(b) The department shall ensure that at least 25 percent of the moneys allocated pursuant to this section are awarded to projects located in unincorporated areas and cities that are not large cities.

(c) Moneys allocated pursuant to this section shall be available for development, acquisition, rehabilitation, preservation, motel conversion, and capitalized operating subsidy reserves, in accordance with the following:

(1) Funds under this section shall be used to create affordable housing for the eligible population and for target populations with extremely low incomes at imminent risk of homelessness, targeted based on data of likelihood to fall within homelessness.

(2) Projects funded under this section shall comply with the quality standards set forth in subdivision (g) of Section 13056.

(3) The department shall impose leverage requirements to ensure viability and promote the rapid development of quality housing. However, these leverage requirements shall not factor into a competitive score for the allocation of moneys under this section.

(4) A recipient may use moneys allocated under this section for construction financing.

(5) Referrals to housing units funded through a grant under this section shall be made through a coordinated entry system.

(d) Notwithstanding any other law, any project that uses funds received under this chapter for any of the purposes specified in this section shall be deemed consistent and in conformity with any applicable local plan, standard, or requirement, and allowed as a permitted use, within the zone in which the structure is located, and shall not be subject to a conditional use permit, discretionary permit, or any other discretionary review or approval.

SEC. 10. Section 14133.5 is added to the Welfare and Institutions Code, immediately following Section 14133.45, to read:

14133.5. (a) By January 1, 2025, the department shall seek federal approval for a Medi-Cal benefit to fund all of the following services for beneficiaries experiencing homelessness:

(1) Housing navigation and housing acquisition support services.

(2) Tenancy transition services.

(3) Tenancy sustaining services.

(4) Housing-based employment services.

(b) The department shall convene a stakeholder advisory group representing counties, health care consumers, and homeless advocates in developing the plan.

(c) The department shall work with counties to determine an effective process for funding the state's share of the federal medical assistance percentage. Pursuant to an agreement with organizations representing California counties, the department may use up to 20 percent of the county-continuum allocation, as set forth under Section 13058, to pay for the state's federal medical assistance percentage associated with the benefit identified in subdivision (a) for Medi-Cal beneficiaries experiencing homelessness.

(d) The department shall pursue philanthropic funding to carry out the administrative duties of this section. The Homeless Coordinating and Financing Council may allocate a portion of the administrative funds, pursuant to paragraph (1) of subdivision (a) of Section 13055, to create and pursue the plan in this section, and that portion shall equal no more than 1 percent of the Bring California Home Fund.

~~SECTION 1. The Legislature finds and declares all of the following:~~

~~(a) In January 2019, an estimated 151,278 people experienced homelessness in California at a single point in time, as reported by the United States Department of Housing and Urban Development. This is the highest number since 2007, and represented a 17-percent increase since 2018. Experts predict significant increases in homelessness in 2021 resulting from the COVID-19 economic downturn.~~

~~(b) African Americans are disproportionately represented among California's homeless population. While 6.5 percent of Californians identify as Black or African-American, almost 40 percent of the state's homeless population is African-American. Indigenous populations are over six times more likely to experience homelessness than the general population. Latinx Californians are least likely to access housing and services available in their communities.~~

~~(c) Research suggests homeless populations are at far greater risk for consequences of COVID-19. Early studies estimated people experiencing homelessness are two to three times as likely to die from COVID-19 than the general population. COVID-19 is putting pressure on local homeless systems to open safe sites for people to shelter, in noncongregant settings, to avoid the spread of COVID-19.~~

~~(d) Homeless is a statewide crisis in California which requires a statewide, comprehensive solution that meets its scale.~~

~~(e) While California has made significant one-time investments in local homelessness solutions through the successful Home Energy Assistance Program (HEAP), Homeless Housing, Assistance, and Prevention (HHAP) Program, and Homekey program, multi-year, predictable investments are needed to support a sustained strategy.~~

~~(f) The state must lead in coordinating with local governments and the private sector to solve homelessness and to prevent discharges from institutional settings into homelessness.~~

~~(g) It is the intent of the Legislature to enact legislation to create a comprehensive, statewide homelessness solutions program. This program will fill gaps within the state's response to homelessness, scale evidence-based solutions while promoting innovation to move people quickly into permanent housing, establish greater flexibility and a more nimble process in implementing a comprehensive response to homelessness, facilitate critically~~

~~needed collaboration between different levels of government, foster a streamlined process at the local and state levels to fund and build housing opportunities more quickly, hold local governments and the state accountable for achieving results, and focus on evidence-based housing and housing-based services solutions and long-term state and local structural changes.~~

~~(h) Furthermore, it is the intent of the Legislature that through the adoption of these strategies, the state and local governments will achieve measurable reductions in homelessness, ensuring that it becomes brief, rare, and nonrecurrent.~~

~~(i) Furthermore, it is the intent of the Legislature to enact legislation to fund this comprehensive program with new, ongoing revenues of at least $2.4 billion per year from one or more of the following sources:~~

~~(1) An increase in the personal income tax on incomes over $1 million.~~

~~(2) An increase in the corporate income tax to historical rates, a more progressive corporate income tax, and conformity with the federal Tax Cuts and Jobs Act, including the inclusion of Global Intangible Low-Taxed Income (GILTI).~~

~~(3) Eliminating or limiting corporate tax loopholes, including the water's edge election.~~

~~(4) Marking to market unrealized capital gains and the repeal of stepped-up in basis of inherited assets.~~

~~SEC. 2. (a) The Bring California Home Fund is hereby created in the State Treasury for the purpose of providing at least two million four hundred thousand dollars ($2,400,000) annually to fund a comprehensive, statewide homeless solutions program upon appropriation by the Legislature.~~

~~(b) The Bring California Home Fund shall contain revenues derived from any of following changes to the Personal Income Tax Law (Part 10 (commencing with Section 17001) of Division 2 of the Revenue and Taxation Code) or the Corporation Tax Law (Part 11 (commencing with Section 23001) of Division 2 of the Revenue and Taxation Code) that are enacted on or after the effective of the date of the act adding this section:~~

~~(1) An increase in the personal income tax on incomes over one million dollars ($1,000,000).~~

~~(2) An increase in the corporate income tax to historical rates, a more progressive corporate income tax, and conformity with the~~

~~federal Tax Cuts and Jobs Act, including the inclusion of Global Intangible Low-Taxed Income (GILTI).~~

~~(3) Eliminating or limiting corporate tax loopholes, including the water's edge election.~~

~~(4) Marking to market unrealized capital gains and the repeal of stepped-up in basis of inherited assets.~~

O

ASSEMBLY BILL No. 77

Introduced by Assembly Member Petrie-Norris
(Principal coauthor: Senator Stern)

December 7, 2020

An act relating to substance use disorder treatment services.

LEGISLATIVE COUNSEL'S DIGEST

AB 77, as introduced, Petrie-Norris. Substance use disorder treatment services.

Existing law consolidated within the State Department of Health Care Services all substance use disorder functions and programs from the former State Department of Alcohol and Drug Programs.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides for various benefits under the Medi-Cal program, including substance use disorder treatment and mental health services that are delivered through the Drug Medi-Cal Treatment Program, the Drug Medi-Cal organized delivery system, and the Medi-Cal Specialty Mental Health Services Program.

This bill would declare the intent of the Legislature to enact Jarrod's Law, a licensure program for inpatient and outpatient programs providing substance use disorder treatment services, under the administration of the department.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

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

SECTION 1. It is the intent of the Legislature to enact Jarrod's Law, a licensure program for inpatient and outpatient programs providing substance use disorder treatment services, under the administration of the State Department of Health Care Services.

O

ASSEMBLY BILL No. 218

Introduced by Assembly Member Ward

January 11, 2021

An act to amend Sections 1276 and 1277 of the Code of Civil Procedure, and to amend Sections 103400, 103425, and 103426 of, to amend the heading of Article 7 (commencing with Section 103425) of Chapter 11 of Part 1 of Division 102 of, to add Section 103431 to, and to repeal and add Sections 103430, 103435, and 103440 of, the Health and Safety Code, relating to vital records.

LEGISLATIVE COUNSEL'S DIGEST

AB 218, as introduced, Ward. Change of gender and sex identifier.

(1) Existing law authorizes a person to file a petition with the superior court seeking a judgment recognizing their change of gender to female, male, or nonbinary, including a person who is under 18 years of age. The judgment may include an order for a new birth certificate, and the new birth certificate is required to include the change of gender and any name change specified in the court order. Existing law also authorizes a procedure for a person born in this state to obtain a new birth certificate directly from the State Registrar to reflect their change of gender to female, male, or nonbinary without a court order. Existing law prohibits a new birth certificate issued under these provisions from indicating that it is not the original birth certificate and requires a local registrar or the county recorder to either forward the original birth certificate to the State Registrar or seal a cover over the birth certificate, as specified.

This bill would recast these provisions relating to new birth certificates to provide for a change in gender and sex identifier and to specify that

a person who was issued a birth certificate by this state, rather than a person born in this state, may obtain a new birth certificate.

This bill would authorize a person to file a petition with the superior court for a court order to issue a new marriage license and certificate, confidential marriage license and certificate, or birth certificate for their minor or adult child to reflect the person's change in gender and sex identifier to female, male, or nonbinary. The bill also would authorize a person who does not reside within this state to file a petition with the superior court for a change in name or a change of gender and sex identifier to female, male, or nonbinary if the person lives in a jurisdiction that does not provide these changes by court order and the person is also seeking to change their birth certificate, marriage license and certificate, confidential marriage license and certificate, or the birth certificate of their legal child that was issued by this state. The bill would provide a process for parties who are also identified on these vital records to be given notice and an opportunity respond to the petition, as specified.

The bill would authorize a person to obtain a new marriage license and certificate, confidential marriage license and certificate, or birth certificate for their minor or adult child directly from the State Registrar or county clerk, as applicable, to reflect the person's change of gender and sex identifier to female, male, or nonbinary without a court order, if the person submits specific supporting documentation. The bill would require the supporting documentation to include, as applicable, a stipulation by the adult child to change their birth certificate and a stipulation by the spouse who is not requesting a change on their marriage license and certificate or confidential marriage license and certificate. The bill would authorize supporting documentation to include an affidavit, attested under penalty of perjury, that the changes are to conform to the person's gender identity and not for any fraudulent purpose. By expanding the crime of perjury in this manner, this bill would impose a state-mandated local program.

The bill would require a new marriage license and certificate, confidential marriage license and certificate, or birth certificate issued under these provisions to supplant the previous vital record and would specifically direct how a county clerk should seal these original vital records. By creating new duties of a county clerk relating to sealing a marriage license and certificate or a confidential marriage license and certificate under these provisions, this bill would impose a state-mandated local program.

(2) 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.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. Section 1276 of the Code of Civil Procedure is amended to read:

1276. (a) All applications for change of names shall be made to the superior court of the county where the person whose name is proposed to be changed resides, except as specified in subdivision ~~(e),~~ *(e) or (g),* either (1) by petition signed by the person or, if the person is under 18 years of age, by one of the person's parents, by any guardian of the person or as specified in subdivision (e), or, if both parents are deceased and there is no guardian of the person, then by some near relative or friend of the ~~person~~ *person,* or (2) as provided in Section 7638 of the Family Code.

The petition or pleading shall specify the place of birth and residence of the person, ~~his or her~~ *the person's* present name, the name proposed, and the reason for the change of name.

(b) In a proceeding for a change of name commenced by the filing of a petition, if the person whose name is to be changed is under 18 years of age, the petition shall, if neither parent of the person has signed the petition, name, as far as known to the person proposing the name change, the parents of the person and their place of residence, if living, or if neither parent is living, near relatives of the person, and their place of residence.

(c) In a proceeding for a change of name commenced by the filing of a petition, if the person whose name is proposed to be changed is under 18 years of age and the petition is signed by only one parent, the petition shall specify the address, if known, of the

other parent if living. If the petition is signed by a guardian, the petition shall specify the name and address, if known, of the parent or parents, if living, or the grandparents, if the addresses of both parents are unknown or if both parents are deceased, of the person whose name is proposed to be changed.

(d) In a proceeding for a change of name commenced by the filing of a petition, if the person whose name is proposed to be changed is 12 years of age or older, has been relinquished to an adoption agency by ~~his or her~~ *the person's* parent or parents, and has not been legally adopted, the petition shall be signed by the person and the adoption agency to which the person was relinquished. The near relatives of the person and their place of residence shall not be included in the petition unless they are known to the person whose name is proposed to be changed.

(e) All petitions for the change of the name of a minor submitted by a guardian appointed by the juvenile court or the probate court, or by a court-appointed dependency attorney appointed as guardian ad litem shall be made pursuant to rules adopted under Section 326.5 of the Welfare and Institutions Code. All petitions for the change of name of a nonminor dependent may be made in the juvenile court.

(f) If the petition is signed by a guardian, the petition shall specify relevant information regarding the guardianship, the likelihood that the child will remain under the guardian's care until the child reaches the age of majority, and information suggesting that the child will not likely be returned to the custody of ~~his or her~~ *the child's* parents.

(g) (1) An application for change of name may be made to a superior court for a person whose name is proposed to be changed and who does not reside within the State of California if the person whose name is proposed to be changed resides in a jurisdiction that does not provide name changes by court order and the person is seeking to change their name on at least one of the following documents:

(A) A birth certificate that was issued within this state to the person whose name is proposed to be changed.

(B) A birth certificate that was issued within this state to the legal child of the person whose name is proposed to be changed.

(C) A marriage license and certificate or a confidential marriage license and certificate that was issued within this state to the person whose name is proposed to be changed.

(2) For the purposes of this subdivision, the superior court in the county where the birth under subparagraph (A) or (B) occurred or marriage under subparagraph (C) was entered shall be a proper venue for the proceeding. The name change shall be adjudicated in accordance with California law.

SEC. 2. Section 1277 of the Code of Civil Procedure is amended to read:

1277. (a) (1) If a proceeding for a change of name is commenced by the filing of a petition, except as provided in subdivisions (b), (c), and (e), or Section 1277.5, the court shall thereupon make an order reciting the filing of the petition, the name of the person by whom it is filed, and the name proposed. The order shall direct all persons interested in the matter to appear before the court at a time and place specified, which shall be not less than 6 weeks nor more than 12 weeks from the time of making the order, unless the court orders a different time, to show cause why the application for change of name should not be granted. The order shall direct all persons interested in the matter to make known any objection that they may have to the granting of the petition for change of name by filing a written objection, which includes the reasons for the objection, with the court at least two court days before the matter is scheduled to be heard and by appearing in court at the hearing to show cause why the petition for change of name should not be granted. The order shall state that, if no written objection is timely filed, the court may grant the petition without a hearing.

(2) *(A)* A copy of the order to show cause shall be published pursuant to Section 6064 of the Government Code in a newspaper of general circulation to be designated in the order published in the county. If a newspaper of general circulation is not published in the county, a copy of the order to show cause shall be posted by the clerk of the court in three of the most public places in the county in which the court is located, for a like period. Proof shall be made to the satisfaction of the court of this publication or posting at the time of the hearing of the application.

(B) If the person seeking the name change does not live in the county where the petition is filed, pursuant to subdivision (g) of

Section 1276, the copy of the order to show cause shall be published pursuant to Section 6064 of the Government Code in a newspaper of general circulation published in the county of the person's residence. If a newspaper of general circulation is not published in the county of the person's residence, a copy of the order to show cause shall be posted by the clerk of the court in the county of the person's residence or a similarly situated local official in three of the most public places in the county of the person's residence, for a like period. If the place where the person seeking the name change lives does not have counties, publication shall be made according to the requirements of this paragraph in the local subdivision or territory of the person's residence. Proof shall be made to the satisfaction of the court of this publication or posting at the time of the hearing of the application.

(3) Four weekly publications shall be sufficient publication of the order to show cause. If the order is published in a daily newspaper, publication once a week for four successive weeks shall be sufficient.

(4) If a petition has been filed for a minor by a parent and the other parent, if living, does not join in consenting thereto, the petitioner shall cause, not less than 30 days before the hearing, to be served notice of the time and place of the hearing or a copy of the order to show cause on the other parent pursuant to Section 413.10, 414.10, 415.10, or 415.40. If notice of the hearing cannot reasonably be accomplished pursuant to Section 415.10 or 415.40, the court may order that notice be given in a manner that the court determines is reasonably calculated to give actual notice to the nonconsenting parent. In that case, if the court determines that notice by publication is reasonably calculated to give actual notice to the nonconsenting parent, the court may determine that publication of the order to show cause pursuant to this subdivision is sufficient notice to the nonconsenting parent.

(b) (1) If the petition for a change of name alleges a reason or circumstance described in paragraph (2), and the petitioner has established that the petitioner is an active participant in the address confidentiality program created pursuant to Chapter 3.1 (commencing with Section 6205) of Division 7 of Title 1 of the Government Code, and that the name the petitioner is seeking to acquire is on file with the Secretary of State, the action for a change of name is exempt from the requirement for publication of the

order to show cause under subdivision (a), and the petition and the order of the court shall, in lieu of reciting the proposed name, indicate that the proposed name is confidential and is on file with the Secretary of State pursuant to the provisions of the address confidentiality program.

(2) The procedure described in paragraph (1) applies to petitions alleging any of the following reasons or circumstances:

(A) To avoid domestic violence, as defined in Section 6211 of the Family Code.

(B) To avoid stalking, as defined in Section 646.9 of the Penal Code.

(C) To avoid sexual assault, as defined in Section 1036.2 of the Evidence Code.

(D) To avoid human trafficking, as defined in Section 236.1 of the Penal Code.

(3) For any petition under this subdivision, the current legal name of the petitioner shall be kept confidential by the court and shall not be published or posted in the court's calendars, indexes, or register of actions, as required by Article 7 (commencing with Section 69840) of Chapter 5 of Title 8 of the Government Code, or by any means or in any public forum, including a hardcopy or an electronic copy, or any other type of public media or display.

(4) Notwithstanding paragraph (3), the court may, at the request of the petitioner, issue an order reciting the name of the petitioner at the time of the filing of the petition and the new legal name of the petitioner as a result of the court's granting of the petition.

(5) A petitioner may request that the court file the petition and any other papers associated with the proceeding under seal. The court may consider the request at the same time as the petition for name change, and may grant the request in any case in which the court finds that all of the following factors apply:

(A) There exists an overriding interest that overcomes the right of public access to the record.

(B) The overriding interest supports sealing the record.

(C) A substantial probability exists that the overriding interest will be prejudiced if the record is not sealed.

(D) The proposed order to seal the records is narrowly tailored.

(E) No less restrictive means exist to achieve the overriding interest.

(c) A proceeding for a change of name for a witness participating in the state Witness Relocation and Assistance Program established by Title 7.5 (commencing with Section 14020) of Part 4 of the Penal Code who has been approved for the change of name by the program is exempt from the requirement for publication of the order to show cause under subdivision (a).

(d) If an application for change of name is brought as part of an action under the Uniform Parentage Act (Part 3 (commencing with Section 7600) of Division 12 of the Family Code), whether as part of a petition or cross-complaint or as a separate order to show cause in a pending action thereunder, service of the application shall be made upon all other parties to the action in a like manner as prescribed for the service of a summons, as set forth in Article 3 (commencing with Section 415.10) of Chapter 4 of Title 5 of Part 2. Upon the setting of a hearing on the issue, notice of the hearing shall be given to all parties in the action in a like manner and within the time limits prescribed generally for the type of hearing (whether trial or order to show cause) at which the issue of the change of name is to be decided.

(e) If a guardian files a petition to change the name of the guardian's minor ward pursuant to Section 1276:

(1) The guardian shall provide notice of the hearing to any living parent of the minor by personal service at least 30 days before the hearing.

(2) If either or both parents are deceased or cannot be located, the guardian shall cause, not less than 30 days before the hearing, to be served a notice of the time and place of the hearing or a copy of the order to show cause on the child's grandparents, if living, pursuant to Section 413.10, 414.10, 415.10, or 415.40.

(f) This section shall become operative on September 1, 2018.

SEC. 3. Section 103400 of the Health and Safety Code is amended to read:

103400. Whenever a person ~~born in~~ *who has a birth certificate issued by* this state has ~~his or her~~ *that person's* name changed by order of a court of this state, another state, the District of Columbia, ~~or~~ any territory of the United States, *or any foreign court* an application including an affidavit of this fact may be filed with the office of the State Registrar upon a form provided for that purpose.

SEC. 4. The heading of Article 7 (commencing with Section 103425) of Chapter 11 of Part 1 of Division 102 of the Health and Safety Code is amended to read:

Article 7. Revision of Birth *and Marriage* Records to Reflect Change of Gender *and Sex Identifier*

SEC. 5. Section 103425 of the Health and Safety Code is amended to read:

103425. (a) A person may file a petition with the superior court in any county seeking a judgment recognizing the change of gender *and sex identifier* to female, male, or nonbinary.

(b) If requested, the judgment shall include an order that a new birth certificate be prepared for the person reflecting the change of gender and *sex identifier and* any change of name accomplished by an order of a court of this state, another state, the District of Columbia, ~~or~~ any territory of the United ~~States.~~ *States, or any foreign court.*

(c) ~~This section shall become operative on September 1, 2018.~~ *Subject to the requirements of Section 103430, if requested, the judgment shall include an order that a new marriage license and certificate or confidential marriage license and certificate be prepared for the person reflecting the change to the designation of the person as bride, groom, or having neither box checked on the marriage license and certificate or confidential marriage license and certificate and any change of name accomplished by an order of a court of this state, another state, the District of Columbia, any territory of the United States, or any foreign court.*

(d) Subject to the requirements of Section 103430, if requested, the judgment shall include an order that a new birth certificate be prepared for the person's child or children reflecting the change to the designation of the person as mother, father, or parent and any change of name of the petitioner accomplished by an order of a court of this state, another state, the District of Columbia, or any territory of the United states, or foreign court.

(e) A petition seeking a judgment recognizing the change of gender and sex identifier to female, male, or nonbinary may be made to a superior court within this state, even if the person whose gender and sex identifier is proposed to be changed does not reside within the State of California if both of the following apply:

(1) The person whose gender and sex identifier is proposed to be changed resides in a jurisdiction that does not provide judgments recognizing the change of gender and sex identifier to female, male, or nonbinary to conform to the petitioner's gender identity by court order.

(2) The person is seeking to change the designation to reflect their gender on at least one of the following documents:

(A) A birth certificate that was issued within this state to the person whose gender and sex identifier is proposed to be changed.

(B) A birth certificate that was issued within this state to the legal child of the person whose gender and sex identifier is proposed to be changed.

(C) A marriage license and certificate or confidential marriage license and certificate that was issued within this state to the person whose gender and sex identifier is proposed to be changed.

SEC. 6. Section 103426 of the Health and Safety Code is amended to read:

103426. *(a)* The State Registrar shall issue a new birth certificate reflecting a change of gender *and sex identifier* to female, male, or nonbinary without a court order for any person ~~born in~~ *who has a birth certificate issued by* this state who submits directly to the State Registrar an application to change the gender *and sex identifier* on the birth certificate and an affidavit attesting under penalty of perjury that the request for a change of gender *and sex identifier* to ~~(female,~~ *female,* male, or ~~nonbinary)~~ *nonbinary* is to conform the person's legal gender *and sex identifier* to the person's gender identity and is not made for any fraudulent purpose. Upon receipt of the documentation and the fee prescribed by Section 103725, the State Registrar shall establish a new birth certificate reflecting the gender *and sex identifier* stated in the application and any change in name, if accompanied by a court order for a change of name.

(b) (1) The State Registrar shall issue a new birth certificate for the minor child or children who have a birth certificate issued by this state without a further court order when a parent submits directly to the State Registrar all of the following:

(A) An application for a new birth certificate for their minor child or children reflecting the change of the designation of the petitioner as mother, father, or parent, and if applicable, any change of name of the parent.

(B) A copy of at least one of the following documents:

(i) The court-ordered change of gender.

(ii) The parent's new birth certificate reflecting a change of gender and sex identifier.

(iii) A government-issued identity document reflecting the parent's change of gender and sex identifier.

(iv) An affidavit attesting under penalty of perjury that the request for a change of the designation of the petitioner as mother, father, or parent is to conform to the person's gender identity and is not made for any fraudulent purpose.

(C) The fee prescribed by Section 103725.

(D) If applicable, a copy of the court-ordered change of name.

(2) The new birth certificate shall reflect the change of the designation of the parent whose gender and sex identifier has been changed as mother, father, or parent, and if applicable, any change of name that the parent has legally obtained.

(c) (1) The State Registrar shall issue a new birth certificate for an adult child who has a birth certificate issued by this state without a further court order when the parent submits directly to the State Registrar all of the following:

(A) An application for a new birth certificate for their adult child reflecting the change of the designation of the petitioner as mother, father, or parent, and if applicable, any change of name of the parent.

(B) A copy of at least one of the following documents:

(i) The court-ordered change of gender.

(ii) The parent's new birth certificate reflecting a change of gender and sex identifier.

(iii) A government-issued identity document reflecting the parent's change of gender and sex identifier.

(iv) An affidavit attesting under penalty of perjury that the request for a change of the designation of the petitioner as mother, father, or parent is to conform to the person's gender identity and is not made for any fraudulent purpose.

(C) A notarized letter from the adult child stipulating to the change to the adult child's birth certificate.

(D) The fee prescribed by Section 103725.

(E) If applicable, a copy of the court-ordered change of name.

(2) The notarized letter from the adult child shall be accepted if it contains substantially the following language: "I, (adult child's

full name), stipulate to an issuance of a new birth certificate for me that reflects my parent's legal gender and name."

(3) The new birth certificate shall reflect the change of the designation of the parent whose gender and sex identifier has been changed as mother, father, or parent, and if applicable, any change of name that the parent has legally obtained.

(d) (1) The county clerk shall issue a new marriage license and certificate or confidential marriage license and certificate for any person who has a marriage license and certificate or confidential marriage license and certificate that was issued from their county without a further court order when the person submits directly to the State Registrar all of the following, which the State Registrar shall send as a notice to the county clerk:

(A) An application from the spouse who has legally changed their gender and sex identifier for a new marriage license and certificate or confidential marriage license and certificate reflecting the change to the designation of the person as bride, groom, or having neither box checked on the marriage license and certificate or confidential marriage license and certificate, and if applicable, any change of name of the spouse.

(B) A copy of at least one of the following documents:

(i) The court-ordered change of gender.

(ii) The spouse's new birth certificate reflecting a change of gender and sex identifier.

(iii) A government-issued identity document reflecting the spouse's change of gender and sex identifier.

(iv) An affidavit attesting under penalty of perjury that the request for a change of the designation of the petitioner as bride, groom, or having neither box checked on the marriage license and certificate is to conform to the person's gender identity and is not made for any fraudulent purpose.

(C) A notarized letter from the spouse who is not requesting the new marriage license and certificate or confidential marriage license and certificate stipulating to the change in the marriage license and certificate or confidential marriage license and certificate.

(D) The fee prescribed by Section 26840 of the Government Code.

(E) If applicable, a copy of the court-ordered change of name.

(2) The notarized letter from the spouse who is not requesting the new marriage license and certificate or confidential marriage license and certificate shall be accepted if it contains substantially the following language: "I, (spouse's full name), stipulate to an issuance of a new marriage license and certificate or confidential marriage license and certificate for me that reflects my spouse's legal gender and sex identifier and name."

(3) The new marriage license and certificate or confidential marriage license and certificate shall reflect the change to the designation of the person as bride, groom, or having neither box checked on the marriage license and certificate or confidential marriage license and certificate, and if applicable, any change of name that the spouse has legally obtained.

(4) For purposes of this section, a court-ordered change of gender or name shall include a change of gender or name accomplished by an order of a court of this state, another state, the District of Columbia, any territory of the United States, or any foreign court.

SEC. 7. Section 103430 of the Health and Safety Code is repealed.

~~103430. (a) A petition for a court order to recognize a change in the petitioner's gender as female, male, or nonbinary shall be accompanied by an affidavit from the petitioner and a certified copy of the court order changing the petitioner's name, if applicable. The petitioner's affidavit shall be accepted as conclusive proof of gender change if it contains substantially the following language: "I, (petitioner's full name), hereby attest under penalty of perjury that the request for a change in gender to (female, male, or nonbinary) is to conform my legal gender to my gender identity and is not for any fraudulent purpose."~~

~~(b) (1) Except as provided in subdivision (e), the court shall grant the petition without a hearing if no written objection is timely filed within 28 days of the filing of the petition.~~

~~(2) (A) If an objection showing good cause is timely filed, the court may set a hearing at a time designated by the court. Objections based solely on concerns over the petitioner's actual gender identity or gender assigned at birth shall not constitute good cause.~~

~~(B) At the hearing, the court may examine under oath the petitioner and any other person having knowledge of the facts~~

~~relevant to the petition. At the conclusion of the hearing, the court shall grant the petition if the court determines that the petition is not made for any fraudulent purpose.~~

~~(c) If the judgment includes an order for a new birth certificate and if the petitioner was born in this state, a certified copy of the decree of the court ordering the new birth certificate, shall, within 30 days from the date of the decree, be filed with the State Registrar. Upon receipt thereof together with the fee prescribed by Section 103725, the State Registrar shall establish a new birth certificate for the petitioner.~~

~~(d) The new birth certificate shall reflect the gender of the petitioner, as specified in the judgment of the court, and shall reflect any change of name, as specified in the court order, as prescribed by Section 103425. No reference shall be made in the new birth certificate, nor shall its form in any way indicate, that it is not the original birth certificate of the petitioner.~~

~~(e) (1) If the person whose gender is to be changed is under 18 years of age, the petition shall be signed either (i) by at least one of the minor's parents, any guardian of the minor, or a person specified in subdivision (f); or (ii) if both parents are deceased and there is no guardian of the minor, by either a near relative or friend of the minor. The affidavit pursuant to subdivision (a) may be signed by the minor.~~

~~(A) A petition that does not include the signatures of both living parents shall be served on the parent who did not sign the petition with notice and an order to show cause pursuant to Section 413.10, 414.10, 415.10, or 415.40 of the Code of Civil Procedure at least 30 days before the date for hearing set in the order to show cause. If service cannot reasonably be accomplished pursuant to Section 415.10 or 415.40, the court may order that service be accomplished in a manner that the court determines is reasonably calculated to give actual notice to the parent who did not sign the petition.~~

~~(B) The order to show cause shall direct the living parent who did not sign the petition to appear before the court at a time and place specified, which shall be not less than 6 weeks nor more than 12 weeks from the time of making the order to show cause, unless the court orders a different time, to show cause why the petition for a court order to recognize a change in the petitioner's gender of a minor to female, male, or nonbinary should not be granted. The order to show cause shall direct the living parent who did not~~

~~sign the petition to make known any objection to the granting of the petition by filing a written objection that includes the reasons for the objection with the court at least two court days before the matter is scheduled to be heard and by appearing in court at the hearing to show cause why the petition should not be granted. The order to show cause shall state that if the living parent who did not sign the petition does not timely file a written objection and appear in the court hearing, the court shall grant the petition without a hearing.~~

~~(2) The court shall grant the petition without a hearing, unless a living parent who was required to be served with notice and an order to show cause timely filed a written objection. Upon a timely objection, the court may hold a hearing on the matter and may deny the petition if it finds that the change of gender is not in the best interest of the minor. At the hearing, the court may examine under oath the minor and any other person having knowledge of the facts relevant to the petition.~~

~~(f) (1) All petitions to recognize a change of the gender of a minor signed by a guardian appointed by the juvenile court or the probate court, or by a court-appointed dependency attorney appointed as guardian ad litem pursuant to rules adopted under Section 326.5 of the Welfare and Institutions Code shall be made in the appointing court. All petitions to recognize a change of the gender of a nonminor dependent may be made in the juvenile court.~~

~~(2) For a petition filed under subdivision (1), if either or both parents are deceased or cannot be located, the guardian or guardian ad litem shall cause, not less than 30 days before the hearing, a notice of the time and place of the hearing or a copy of the order to show cause to be served on the child's grandparents, if living and if known to petitioner, pursuant to Section 413.10, 414.10, 415.10, or 415.40.~~

~~(g) (1) If the petition is signed by a guardian, the petition shall specify relevant information regarding the guardianship, the likelihood that the child will remain under the guardian's care until the child reaches the age of majority, and information suggesting that the child will not likely be returned to the custody of the child's parents.~~

~~(2) Before granting such a petition, the court shall first find that the ward is likely to remain in the guardian's care until the age of~~

~~majority and that the ward is not likely to be returned to the custody of the parents.~~

SEC. 8. Section 103430 is added to the Health and Safety Code, to read:

103430. (a) A petition for a court order to recognize a change in the petitioner's gender and sex identifier as female, male, or nonbinary and to direct the issuance of new administrative documents to reflect those changes shall be accompanied by an affidavit from the petitioner and a certified copy of the court order changing the petitioner's name, if applicable. The petitioner's affidavit shall be accepted as conclusive proof of gender change if it contains substantially the following language: "I, (petitioner's full name), hereby attest under penalty of perjury that the request for a change in gender to (female, male, or nonbinary) is to conform my legal gender to my gender identity and is not for any fraudulent purpose."

(b) (1) If the person whose gender is to be changed is under 18 years of age, the petition shall be signed either (A) by at least one of the minor's parents, any guardian of the minor, or a person specified in subdivision (c); or (B) if both parents are deceased and there is no guardian of the minor, by either a near relative or friend of the minor. The affidavit pursuant to subdivision (a) may be signed by the minor.

(2) If the person whose gender is to be changed requests in their petition the issuance of a new marriage license and certificate or confidential marriage license and certificate pursuant to subdivision (d) of Section 103425, the petition shall be signed by the spouse who shares the marriage license and certificate or confidential marriage license and certificate that would be changed by granting the petition if the spouse is living and capable of signing the petition.

(3) If the person whose gender is to be changed requests in their petition the issuance of a new birth certificate for their adult child pursuant to subdivision (e) of Section 103425, the petition shall be signed by the child whose birth certificate would be changed by granting the petition if the child is 18 years of age or older. A petition that requests a new birth certificate for an adult child pursuant to subdivision (e) of Section 103425 that does not include the signature of the adult child shall not be granted with respect

to the new birth certificate for that child if the child is living and capable of providing a signature.

(4) If the person whose gender is to be changed requests in their petition the issuance of a new birth certificate for their minor child pursuant to subdivision (e) of Section 103425, the petition need not include the signature of the petitioner's child if the child is under 18 years of age.

(c) (1) All petitions to recognize a change of the gender of a minor signed by a guardian appointed by the juvenile court or the probate court, or by a court-appointed dependency attorney appointed as guardian ad litem pursuant to rules adopted under Section 326.5 of the Welfare and Institutions Code, shall be made in the appointing court. All petitions to recognize a change of the gender of a nonminor dependent may be made in the juvenile court.

(2) For a petition filed under paragraph (1), if either or both parents are deceased or cannot be located, the guardian or guardian ad litem shall cause, not less than 30 days before the hearing, a notice of the time and place of the hearing or a copy of the order to show cause to be served on the child's grandparents, if living and if known to the petitioner, pursuant to Section 413.10, 414.10, 415.10, or 415.40 of the Code of Civil Procedure.

(d) (1) If the petition is signed by a guardian, the petition shall specify relevant information regarding the guardianship, the likelihood that the child will remain under the guardian's care until the child reaches the age of majority, and information suggesting that the child will not likely be returned to the custody of the child's parents.

(2) Before granting a petition in accordance with this subdivision, the court shall first find that the ward is likely to remain in the guardian's care until the age of majority and that the ward is not likely to be returned to the custody of the parents.

(e) (1) If a petition pursuant to this section does not include a signature required by paragraph (1) of subdivision (b), then upon receipt of the petition, the court shall thereupon make an order directing the person or persons whose required signatures are not on the petition to show cause why the petition for a court order to recognize a change in the minor's gender and sex identifier to female, male, or nonbinary should not be granted by filing a written objection, which includes any reasons for the objection, within six weeks of the making of the order, and shall state that if no objection

showing good cause to oppose the gender recognition is timely filed, the court shall, without hearing, enter the order that the gender and sex identifier recognition is granted.

(2) If a petition pursuant to this section does not include any signature required by paragraph (2) of subdivision (b), then upon receipt of the petition, the court shall thereupon make an order reciting the filing of the petition, the proposed changes to the petitioner's marriage license and certificate or confidential marriage license and certificate, and the name of the person by whom it is filed. The order shall direct the spouse of the petitioner who appears on the marriage license and certificate or confidential marriage license and certificate to make known any objection to the changes requested on the marriage license and certificate or confidential marriage license and certificate by filing a written objection, which includes any reasons why the requested changes would be fraudulent, within six weeks of the making of the order, and shall state that if no objection showing good cause to oppose the changes to the marriage license and certificate or confidential marriage license and certificate is timely filed, the court shall, without hearing, enter the order that the gender and sex identifier recognition is granted.

(f) The petition and the order to show cause made in accordance with subdivision (e) shall be served on the required person or persons who did not sign the petition, pursuant to Section 413.10, 414.10, 415.10, or 415.40 of the Code of Civil Procedure, within 30 days from the date on which the order is made by the court. If service cannot reasonably be accomplished pursuant to Section 415.10 or 415.40 of the Code of Civil Procedure, the court may order that service be accomplished in a manner that the court determines is reasonably calculated to give actual notice to the person who did not sign the petition.

(g) If no service is required on any party pursuant this section, the court shall grant the petition without a hearing if no written objection is timely filed within six weeks of the filing of the petition.

(h) The court shall grant the petition without a hearing, unless a timely objection showing good cause is filed. If an objection showing good cause is timely filed, the court may set a hearing at a time designated by the court. Objections based solely on concerns

over the petitioner's actual gender identity or gender assigned at birth shall not constitute good cause.

(1) If a timely objection showing good cause is filed by anyone other than a parent who objects to changes to their minor child's birth certificate, at the hearing, the court may examine under oath the petitioner and any other person having knowledge of the facts relevant to the petition. At the conclusion of the hearing, the court shall grant the petition if the court determines that the petition is not made for any fraudulent purpose.

(2) If the objection was timely filed by a parent who objects to changes to their minor child's birth certificate, after holding a hearing on the matter, the court may deny the petition if the court finds that the change of gender and sex identifier is not in the best interest of the minor. At the hearing, the court may examine under oath the minor and any other person having knowledge of the facts relevant to the petition.

SEC. 9. Section 103431 is added to the Health and Safety Code, to read:

103431. (a) (1) If a judgment pursuant to Section 103430 includes an order for a new birth certificate for the petitioner and if the petitioner has a birth certificate issued by this state, a certified copy of the judgment of the court ordering the new birth certificate, shall, within 30 days from the date of the judgment, be filed by the petitioner with the State Registrar. Upon receipt thereof, together with the fee prescribed by Section 103725, the State Registrar shall establish a new birth certificate for the petitioner.

(2) The new birth certificate shall reflect the gender of the petitioner, as specified in the judgment of the court, and shall reflect any change of name, as specified in the court order, as prescribed by Section 103425. No reference shall be made in the new birth certificate, nor shall its form in any way indicate, that it is not the original birth certificate of the petitioner.

(b) (1) If a judgment pursuant to Section 103430 includes an order for a new marriage license and certificate or new confidential marriage license and certificate and the original marriage license and certificate or original confidential license and certificate was issued within this state, a certified copy of the judgment of the court ordering the new marriage license and certificate or new confidential marriage license and certificate shall, within 30 days from the date of the judgment, be filed by the petitioner with the

State Registrar, along with the fee established by the county clerk, not to exceed the fee for any other marriage license and certificate or confidential marriage license and certificate issued by the county clerk and not to exceed the reasonable cost to provide the marriage license and certificate or confidential marriage license and certificate. The State Registrar shall send a notice to the county clerk in which the original marriage license and certificate or original confidential marriage license and certificate was issued along with the fee. Upon receipt thereof, the county clerk shall issue a new marriage license and certificate or confidential marriage license and certificate for the petitioner.

(2) If a new marriage license and certificate or confidential marriage license and certificate is requested under subdivision (d) of Section 103425, the new marriage license and certificate or new confidential marriage license and certificate shall reflect any change in the designation of the person as bride, groom, or having neither box checked as requested, and shall reflect any change of name, as specified in the court order, as prescribed by Section 103425. If the "New Names" section of the original marriage license and certificate or original confidential marriage license and certificate that refers to the person whose gender and sex identifier was changed pursuant to Section 103430 does not match any change of name, as specified in the court order, then the "New Names" section for that person shall be left blank on the new marriage license and certificate or new confidential marriage license and certificate of marriage. A new marriage license and certificate or new confidential marriage license and certificate issued pursuant to this article shall not entitle the parties to the marriage to change their names using the procedures in Section 306.5 of the Family Code at the time of the issuance of the new marriage license and certificate or confidential marriage license and certificate. Notwithstanding Sections 103235 and 103255, no reference shall be made in the new marriage license and certificate or new confidential marriage license and certificate, nor shall its form in any way indicate, that it is not the original marriage license and certificate or original confidential marriage license and certificate of the petitioner.

(c) (1) If a judgment pursuant to Section 103430 includes an order for a new birth certificate for the petitioner's child and if the petitioner's child has a birth certificate issued by this state, a

certified copy of the judgment of the court ordering the new birth certificate, shall, within 30 days from the date of the judgment, be filed by the petitioner with the State Registrar. Upon receipt thereof, together with the fee prescribed by Section 103725, the State Registrar shall establish a new birth certificate for the petitioner's child.

(2) If a new birth certificate is requested under subdivision (e) of Section 103425, the new birth certificate for the petitioner's child shall reflect the change of the designation of the petitioner as mother, father, or parent and, if applicable, any change of name of the petitioner, as specified in the court order and as prescribed by Section 103425. No reference shall be made in the new birth certificate, nor shall its form in any way indicate, that it is not the original birth certificate of the petitioner's child.

SEC. 10. Section 103435 of the Health and Safety Code is repealed.

~~103435. In lieu of separate proceedings, a single petition may be filed with the superior court to change the petitioner's name and recognize the change to petitioner's gender and, if requested, to order the issuance of a new birth certificate. With respect to such a petition, the court shall follow the procedure set forth in Title 8 (commencing with Section 1275) of Part III of the Code of Civil Procedure; however, the order to show cause shall not include the petition to recognize the change of gender. A certified copy of the decree of the court issued pursuant to this section shall, within 30 days, be filed with both the Secretary of State and, if the judgment includes an order for a new birth certificate and if the petitioner was born in this state, the State Registrar. Upon its receipt, the State Registrar shall establish a new birth certificate as provided in this article.~~

SEC. 11. Section 103435 is added to the Health and Safety Code, to read:

103435. (a) In lieu of separate proceedings, a single petition may be filed with the superior court to change the petitioner's name and recognize the change to the petitioner's gender and sex identifier and, if requested, to order the issuance of a new birth certificate, marriage license and certificate, confidential marriage license and certificate, or birth certificate of the petitioner's child. With respect to a single petition, the court shall comply with both of the following:

(1) The procedure set forth in Title 8 (commencing with Section 1275) of Part 3 of the Code of Civil Procedure; however, the order to show cause shall not include the petition to recognize the change of gender and sex identifier.

(2) The procedure set forth in Section 103430 if there is a request for a new marriage license and certificate, confidential marriage license and certificate, or for a new birth certificate for any child of the petitioner.

(b) (1) A certified copy of the judgment of the court issued pursuant to this section shall, within 30 days, be filed by the petitioner with the Secretary of State.

(2) A certified copy of the judgment of the court issued pursuant to this section shall, within 30 days, be filed by the petitioner with the State Registrar, if any of the following conditions are met:

(A) The judgment includes an order for a new birth certificate and the petitioner has a birth certificate issued by this state.

(B) The judgment includes an order for a new marriage license and certificate or new confidential marriage license and certificate and the original marriage license and certificate or original confidential license and certificate was issued within this state.

(C) The judgment includes an order for a new birth certificate for the petitioner's child and the petitioner's child has a birth certificate issued by this state.

(c) Upon receipt of a certified copy of a judgment of the court issued pursuant to this section, the State Registrar shall establish a new birth certificate as provided in this article.

(d) Upon receipt of a certified copy of a judgment of the court issued pursuant to this section, the State Registrar shall direct the county clerk to issue a new marriage license and certificate or confidential marriage license and certificate as provided in this article.

SEC. 12. Section 103440 of the Health and Safety Code is repealed.

~~103440. The new birth certificate established pursuant to this article shall supplant any birth certificate previously registered for the registrant and shall be the only birth certificate open to public inspection. The application and supporting affidavit filed pursuant to Section 103426 shall be filed with the original record of birth, that shall remain as a part of the records of the State Registrar. All records and information specified in this article, other than the~~

~~newly issued birth certificate, shall be available only upon written request of the registrant or an order of a court of record.~~

~~When a new birth certificate is established under this article, the State Registrar shall transmit copies of the newly established birth certificate for filing to the local registrar and the county recorder whose records contain copies of the original certificate, who shall forward the copies of the original certificate to the State Registrar for filing with the original certificate, if it is practical for the local registrar or the county recorder to do so. If it is impractical for the local registrar or the county recorder to forward the copy to the State Registrar, the local registrar or the county recorder shall effectually seal a cover over the copy of the original certificate in a manner as not to deface or destroy the copy and forward a verified statement of the action to the State Registrar. Thereafter the information contained in the record shall be available only upon written request of the registrant or on order of a court of record.~~

SEC. 13. Section 103440 is added to the Health and Safety Code, to read:

103440. (a) The new birth certificate, marriage license and certificate, or confidential marriage license and certificate established pursuant to this article shall supplant any birth certificate, marriage license and certificate, or confidential marriage license and certificate previously registered for the registrant and shall be the only birth certificate, marriage license and certificate, or confidential marriage license and certificate open to public inspection. The application and supporting affidavit filed pursuant to subdivision (a) of Section 103426 and the applications, supporting affidavits, and stipulations filed pursuant to subdivisions (b) and (c) of Section 103426 shall be filed with the original record of birth, which shall remain as a part of the records of the State Registrar. The applications, supporting affidavits, and stipulations filed pursuant to subdivision (d) of Section 103426 for a marriage license and certificate shall be filed with the original record of marriage, which shall remain as a part of the records of the State Registrar. The applications, supporting affidavits, and stipulations filed pursuant to subdivision (d) of Section 103426 for a confidential marriage license and certificate shall be transmitted by the State Registrar to the county clerk, for filing, in the county in which the original confidential marriage license and certificate was filed. All records and information specified in this article,

other than the newly issued birth certificate or marriage license and certificate, shall be available only upon written request of the registrant or an order of a court of record. Nothing in this section shall change the confidentiality of or access to a confidential marriage certificate.

(b) When a new birth certificate is established under this article, the State Registrar shall transmit copies of the newly established birth certificate for filing to the local registrar and the county recorder whose records contain copies of the original certificate, who shall forward the copies of the original certificate to the State Registrar for filing with the original certificate, if it is practical for the local registrar or the county recorder to do so. If it is impractical for the local registrar or the county recorder to forward the copy to the State Registrar, the local registrar or the county recorder shall effectually seal a cover over the copy of the original certificate in a manner as not to deface or destroy the copy and forward a verified statement of the action to the State Registrar. Thereafter the information contained in the record shall be available only upon written request of the registrant or on order of a court of record.

(c) After the county clerk issues the new marriage license and certificate pursuant to subdivision (d) of Section 103426, the county clerk shall transmit the new marriage license and certificate to the county recorder. The State Registrar shall direct the county recorder to effectually seal a cover over the original marriage certificate in a manner as not to deface or destroy the copy and to file the new license and certificate in its place. Thereafter the information contained in the record shall be available only upon written request of the registrant or an order of a court of record.

(d) When a new confidential marriage license and certificate is ordered under this article, the State Registrar shall direct the county clerk to effectually seal a cover over the original certificate in a manner as not to deface or destroy the copy, to issue a new confidential marriage license and certificate, and to file the new confidential marriage license and certificate in its place. Thereafter the information contained in the record shall be available only upon written request of the registrant or on order of a court of record.

SEC. 14. 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.

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ASSEMBLY BILL No. 245

Introduced by Assembly Member Chiu
(Coauthors: Assembly Members Lee, Levine, and Santiago)
(Coauthor: Senator Wiener)

January 13, 2021

An act to add Section 66271.4 to the Education Code, relating to educational equity.

LEGISLATIVE COUNSEL'S DIGEST

AB 245, as introduced, Chiu. Educational equity: student records: name and gender changes.

Existing law establishes the University of California, under the administration of the Regents of the University of California, the California State University, under the administration of the Trustees of the California State University, and the California Community Colleges, under the administration of the Board of Governors of the California Community Colleges, as the 3 segments of public postsecondary education in this state. The Equity in Higher Education Act provides that it is the policy of the state to afford all persons, regardless of specified characteristics, including gender identity and gender expression, equal rights and opportunities in the postsecondary educational institutions of the state.

This bill would require a campus of the University of California, California State University, or California Community Colleges to update a former student's records to include the student's updated legal name or gender if the institution receives government-issued documentation, as described, from the student demonstrating that the former student's legal name or gender has been changed. The bill would require the

institution to reissue specified documents conferred upon, or issued to, the former student with the former student's updated legal name or gender, if requested by the former student. Commencing with the 2023–24 graduating class, the bill would require an institution to provide an option for a graduating student to request that the diploma to be conferred by the institution list the student's chosen name, as specified. Because this bill imposes new duties on community college districts, it would constitute a state-mandated local program.

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, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. Section 66271.4 is added to the Education Code, to read:

66271.4. (a) For purposes of this section, "public postsecondary educational institution" or "institution" means a campus of the University of California, the California State University, or the California Community Colleges.

(b) If a public postsecondary educational institution receives government-issued documentation, as described in subdivision (c), from a former student demonstrating that the former student's legal name or gender has been changed, the institution shall update the former student's records to include the updated legal name or gender. If requested by the former student, the institution shall reissue any documents conferred upon the former student with the former student's updated legal name or gender. Documents that shall be reissued by the institution upon request include, but are not necessarily limited to, a transcript or a diploma conferred by the institution.

(c) The documentation of a former student sufficient to demonstrate a legal name or gender change includes, but is not necessarily limited to, any of the following:

(1) State-issued driver's license.
(2) Birth certificate.
(3) Passport.
(4) Social security card.
(5) Court order indicating a name change or a gender change, or both.

(d) This section does not require the institution to modify records that the former student has not requested for modification or reissuance.

(e) Commencing with the 2023–24 graduating class, an institution shall provide an option for a graduating student to request that the diploma to be conferred by the institution list the student's chosen name. Commencing with the 2023–24 graduating class, an institution shall not require a graduating student to provide legal documentation sufficient to demonstrate a legal name or gender change in order to have the student's chosen name listed on the student's diploma.

(f) Notwithstanding Section 67400, this section shall apply to a campus of the University of California.

SEC. 2. If the Commission on State Mandates determines that this act contains 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.

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ASSEMBLY BILL No. 328

Introduced by Assembly Members Chiu, Kalra, and Wicks (Coauthors: Assembly Members Bonta, Burke, Carrillo, Lee, and Luz Rivas)
(Coauthor: Senator Wiener)

January 26, 2021

An act to add Chapter 2.9 (commencing with Section 50492) to Part 2 of Division 31 of the Health and Safety Code, relating to housing.

LEGISLATIVE COUNSEL'S DIGEST

AB 328, as introduced, Chiu. Reentry Housing Program.

Existing law establishes the Department of Housing and Community Development in the Business, Consumer Services, and Housing Agency and makes the department responsible for administering various housing programs throughout the state, including, among others, the Multifamily Housing Program, the Housing for a Healthy California Program, and the California Emergency Solutions Grants Program.

This bill would establish the Reentry Housing Program. The bill would require the department to, on or before July 1, 2022, take specified actions to, upon appropriation by the Legislature, provide grants to counties and continuums of care, as defined, for evidence-based housing and housing-based services interventions to allow people with recent histories of incarceration to exit homelessness and remain stably housed.

The bill would require the department to score applicants to the program competitively according to specified criteria. The bill would require recipients of funds from the program to use those funds for, among other things, long-term rental assistance in permanent housing,

incentives to landlords, and services to assist participants in accessing permanent supportive housing. The bill would require the department to distribute funds allocated by executing contracts with awarded entities for a term of 5 years.

The bill would require a recipient of the program to submit an annual report to the department. The bill would require the department to hire an independent evaluator to assess outcomes from the program and would require the department to submit that analysis to specified committees of the Legislature.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) People on parole are seven times more likely to recidivate when homeless than when housed.

(b) Evidence shows that "supportive housing," or housing that is affordable to people on parole living in extreme poverty that does not limit length of stay and offers tenants services promoting housing stability, reduces recidivism. In fact, data show evidence-based housing decreases recidivism rates by 60%, when compared to control groups, and reduces rearrests by 40%.

(c) About half of people experiencing homelessness report a history of incarceration.

(d) Formerly incarcerated people are 27 times more likely to be unstably housed or homeless than the general public.

(e) African Americans are almost seven times more likely to be homeless than the general population in California, driven by systemic racism that includes disproportionate incarceration, and discharges from prisons and jails into homelessness.

(f) Projected population decline in California's state prisons in the next few years is expected to reduce future cost growth for the Department of Corrections and Rehabilitation (CDCR) both through a reduction in inmates and staff, as well as the closure of two state facilities. In the short term, the CDCR will save several hundreds of millions of dollars due to a decrease in prison population, which decreases per person costs for clothing, food, etc. The closure of at least two state correctional facilities between

2021 and 2024 would yield savings in utilities, staffing, and equipment, as well as a reduction in the inmate and ward population. The Legislative Analyst's Office estimates $1.5 billion in total savings by 2025 as a result of these changes, freeing valuable resources that can be repurposed for sustainable criminal justice solutions through the CDCR.

(g) It is the intent of the Legislature to repurpose funding from the closure of state prisons to provide evidence-based solutions to house people experiencing homelessness with histories of incarceration.

(h) The Department of Housing and Community Development, with its expertise in overseeing grant programs for housing and services, and counties and continuums of care, which often have experience providing housing and services to people exiting incarceration, is an appropriate entity to administer programs offering evidence-based housing and services interventions to people on parole experiencing homelessness.

SEC. 2. Chapter 2.9 (commencing with Section 50492) is added to Part 2 of Division 31 of the Health and Safety Code, to read:

Chapter 2.9. Reentry Housing Program

50492. For purposes of this article, the following definitions apply:

(a) "Applicant" means a county or continuum of care that has applied to receive funds under the program.

(b) "Chronically homeless" has the same meaning as in Parts 91 and 578 of Title 24 of the Code of Federal Regulations, as those parts read on January 1, 2021, except that people who were chronically homeless before entering an institution would continue to be defined as chronically homeless upon discharge, regardless of length of institutional stay.

(c) "County" shall include a city that is also a county or cities working with counties to apply for grant funds.

(d) "Continuum of Care" means a group organized to provide services under this chapter that is composed of representatives of organizations, including nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals,

universities, affordable housing developers, law enforcement, organizations that serve homeless and formerly homeless veterans, and homeless and formerly homeless persons to the extent these groups are represented within the geographic area and are available to participate.

(e) "Department" means the Department of Housing and Community Development, unless otherwise identified.

(f) "Fair market rent" means the rent, including the cost of utilities, as established by the United States Department of Housing and Urban Development, pursuant to Part 888 and Part 982 of Title 24 of the Code of Federal Regulations, as those parts read on January 1, 2021, for units by number of bedrooms, that must be paid in the market area to rent privately owned, existing, decent, safe, and sanitary rental housing of nonluxury nature with suitable amenities.

(g) "Homeless" has the same meaning as in Section 91.5 of Subpart A of Part 91 of Subtitle A of Title 24 of the Code of Federal Regulations, except that people exiting prison who were homeless when incarcerated and who have no identified residence upon exit, will also be considered "homeless" or "likely to become homeless upon release."

(h) "Homeless service provider" means an organization that qualifies as an exempt organization under Section 501(c)(3) of the Internal Revenue Code and that contracts with a participating county for the purpose of providing services to people experiencing homelessness.

(i) "Housing First" has the same meaning as in Section 8255 of the Welfare & Institutions Code.

(j) "Interim Interventions" means housing that does not qualify as permanent housing as defined under subdivision (*l*), including, but not limited to, emergency shelters, motel vouchers, or navigation centers as defined under other federal, state, or local programs. All programs providing interim housing funded pursuant to this chapter shall have partnerships or other linkages to homeless services to connect individuals and families to income, public benefits, health services, and permanent housing.

(k) "Likely to become homeless upon release" means the potential participant has a history of experiencing "homelessness" as that term is used in Section 11302(a) of Title 42 of the United States Code and who meets either of the following:

(1) The person has not identified a fixed, regular, and adequate nighttime residence for release.

(2) The person has an identified residence that includes a supervised publicly or privately operated shelter designed to provide temporary living accommodations, or a public or private place not designed for, or is not ordinarily used as, a regular sleeping accommodation for human beings.

(*l*) "Permanent housing" means a structure or set of structures with subsidized or unsubsidized rental housing units subject to applicable landlord-tenant law, with no limit on length of stay and no requirement to participate in supportive services as a condition of access to or continued occupancy in the housing.

(m) "Program" means the Reentry Housing Program.

(n) "Reasonable rent" means up to two times the fair market rent that is also consistent with market rent in the community in which the rental unit is located.

(o) "Rental assistance" means a rental subsidy provided to a housing provider, including a developer leasing affordable or supportive housing, to assist a tenant to pay the difference between 30 percent of the tenant's income and either fair market rent or reasonable rent as determined by the grant recipient and approved by the department.

(p) "Subrecipient" means a unit of local government or a private nonprofit organization that the recipient determines is qualified to undertake the eligible activities for which the recipient seeks funds under the program, and that enters into a contract with the recipient to undertake those eligible activities in accordance with the requirements of the program.

(q) "Supportive housing" means permanent housing with no limit on the length of stay that is linked to onsite or offsite services that assist the supportive housing residents in retaining the housing, improving their health status, and maximizing their ability to live and, when possible, work in the community. "Permanent supportive housing" includes associated facilities if used to provide services to housing residents.

(r) "Voluntary services" means services offered in conjunction with housing where the housing is not contingent on participation in services, tenants are not evicted based on failure to participate in services, the service provider encourages the tenant to participate

in services to participate in services using evidence-based engagement models, and services are flexible and tenant-centered.

50492.1. (a) There is hereby created the Reentry Housing Program. It is the intent of the Legislature that the Department of Corrections and Rehabilitation will calculate the annual savings that result from the closure of prisons and to redirect those savings to the Reentry Housing Program.

(b) On or before July 1, 2022, the department shall do all of the following to create the program to, upon appropriation by the Legislature, provide grants for evidence-based housing and housing-based services interventions to allow people with recent histories of incarceration to exit homelessness and remain stably housed:

(1) Establish a process for referral of eligible participants into the program.

(2) Work with the Department of Corrections and Rehabilitation to establish protocols to prevent discharges from prison into homelessness.

(3) Issue guidelines establishing the grant program and a notice of funding availability or request for proposals for five-year renewable grants to counties and homeless continuums of care, based on criteria to score applicants for grant funds competitively. Scoring criteria shall include, but not be limited to, the following:

(A) Need, which includes consideration of the number of individuals experiencing homelessness, people on parole, and people with recent histories of incarceration, to the extent data are available.

(B) The extent of coordination and collaboration between the county, the homeless continuum of care covering the geographic area, and homeless service providers with a history of serving people reentering communities from incarceration.

(C) Experience using Housing First core components to address the needs of the eligible population.

(D) The ability of the applicant or proposed subrecipients to administer or partner to administer funding for rental assistance and evidence-based services interventions.

(E) The applicant’s documented partnerships with affordable and supportive housing providers in the jurisdiction.

(F) Demonstrated commitment to address the needs of people experiencing homelessness and recent incarceration through

existing programs or programs planned to be implemented within 12 months.

(G) Proposed use of funds, the extent to which those uses are evidence based, and the extent to which the proposed use will lead to overall reductions in homelessness and recidivism.

(H) In counties overseeing housing authorities, the extent to which an applicant demonstrates housing authorities have eliminated or plan to eliminate restrictions against people with arrests or criminal convictions to access publicly funded housing subsidies, notwithstanding restrictions mandated by the United States Department of Housing and Urban Development.

(c) Applicants to the program shall also provide the following:

(1) A viable plan to provide permanent housing with services based on evidence-based practices, as described in Section 50492.3.

(2) Performance metrics and goals the counties will achieve through this program.

(3) A description of experience in successfully administering or overseeing the activities the recipient plans to fund through the program.

(d) (1) Individuals or families are eligible for participation in a program funded pursuant to a grant through this chapter if they meet all of the following conditions:

(A) They voluntarily choose to participate.

(B) One of the following applies:

(i) They have been assigned a date of release within 60 to 180 days and they are likely to become homeless upon release.

(ii) They are currently experiencing homelessness as a person on parole.

(iii) They are currently experiencing homelessness and were incarcerated in state prison within the last five years.

(2) A participant shall continue to receive housing and services funded under the program after discharge from parole, so long as the participant needs this assistance.

50492.2. (a) A recipient in the program shall use program funds for the following eligible activities:

(1) Long-term rental assistance in permanent housing.

(2) Operating subsidies in new and existing affordable or supportive housing units, in an amount the applicant identifies, but no more than fair market rent for the community in which the

project is located. Operating subsidies may include capitalized operating subsidy reserves.

(3) Incentives to landlords, including, but not limited to, security deposits and holding fees.

(4) Services to assist participants in accessing permanent supportive housing and to promote housing stability in supportive housing, including services identified in subdivision (c).

(5) If necessary, operating support for interim interventions with services to meet the specific needs of the eligible population.

(b) Recipients shall ensure service providers offer evidence-based voluntary services in conjunction with housing to obtain and maintain health and housing stability while participants are on parole and after discharge from parole, for as long as the participant needs the services or until the grant period ends.

(c) The services shall be offered to participants in their home, or be made as easily accessible to participants as possible, and shall include, but are not limited to, all of the following:

(1) Case management services.

(2) Parole discharge planning.

(3) Linkage to other services, including education and employment services, as needed.

(4) Benefit entitlement application and appeal assistance, as needed.

(5) Transportation assistance to obtain services and health care, as needed.

(6) Assistance obtaining appropriate identification, as needed.

(7) Linkage to Medi-Cal funded mental health treatment, substance use disorder treatment, and medical treatment, as medically necessary.

(d) For participants identified prior to release from prison, upon the provider's receipt of referral and in collaboration with the parole agent and, if appropriate, staff, the intake coordinator or case manager of the provider shall, when possible:

(1) Receive all prerelease assessments and discharge plans.

(2) Draft a plan for the participant's transition into affordable or supportive housing.

(3) Engage the participant to actively participate in services upon release on a voluntary basis.

(4) Assist in obtaining identification for the participant, if necessary.

(5) Assist in applying for any benefits for which the participant is eligible.

50492.3. (a) Recipients and providers shall adhere to the core components of Housing First.

(b) Providers shall identify and locate housing opportunities for participants prior to release from state prison or as quickly upon release from state prison as possible.

(c) Housing identified pursuant to subdivision (b) shall satisfy all of the following:

(1) The housing is located in an apartment building, townhouse, or single-family home, including rent-subsidized apartments leased in the open market or set aside within privately owned buildings, or affordable or supportive housing receiving a publicly funded subsidy.

(2) The housing is not subject to community care licensing requirements or is exempt from licensing under Section 1504.5 of the Health and Safety Code.

50492.4. (a) The department shall distribute funds allocated by executing contracts with awarded entities that shall be for a term of five years, subject to renewal. After a contract has expired pursuant to this subdivision, any funds not expended for eligible activities shall revert to the department for use for the program.

(b) A recipient shall submit to the department an annual report on a form issued by the department, pertaining to the recipient's program or project selection process, contract expenditures, and progress toward meeting state and local goals, as demonstrated by the performance measures set forth in the application. Recipients shall, along with any other data as required by the department, report all of the following:

(1) The number of participants served.

(2) The types of services that were provided to program participants.

(3) Whether the recipient met performance metrics identified in their application.

(4) The outcomes for participants, including the number who remain permanently housed, the number who ceased to participate in the program and the reason why, the number who returned to state prison or were incarcerated in county jail, the number of arrests among participants, and the number of days in jail or prison among participants, to the extent data are available.

(c) As part of the annual report required pursuant to subdivision (b), the recipient shall report to the department on the expenditures and activities of any subrecipients for each year of the term of the contract with the department until all funds awarded to a subrecipient have been expended.

(d) The department shall design an evaluation and hire an independent evaluator to assess outcomes from the program, which shall include, but not be limited to, the following:

(1) The total number of parolees served and the type of interventions provided.

(2) The housing status of participants at 12, 24, and 36 months after entering the program, to the extent data are available, including how many participants remain in permanent housing.

(3) Recidivism among participants, including the number of arrests, days incarcerated, and incarceration in jail or prison.

(e) The department may monitor the expenditures and activities of the recipient, as the department deems necessary, to ensure compliance with program requirements.

(f) The department may, as it deems appropriate or necessary, request the repayment of funds from an administrative entity or pursue any other remedies available to it by law for failure to comply with program requirements.

(g) The department shall submit, on or before February 1, 2025, the analysis prepared pursuant to subdivision (d) to the chairs of the Joint Legislative Budget Committee, the Senate Committee on Budget and Fiscal Review, the Assembly Committee on Budget, the Senate and Assembly Committees on Public Safety, the Senate Committee on Housing, and the Assembly Committee on Housing and Community Development.

O

ASSEMBLY BILL No. 369

Introduced by Assembly Member Kamlager
(Coauthors: Assembly Members Carrillo, Cristina Garcia, Gipson, Santiago, and Stone)
(Coauthor: Senator Wiener)

February 1, 2021

An act to add Sections 14011.67 and 14133.55 to, and to add and repeal Section 14133.02 of, the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 369, as introduced, Kamlager. Medi-Cal: street medicine and utilization controls.

Existing law provides for the Medi-Cal program, 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. Under existing law, Medi-Cal covered benefits are generally subject to utilization controls, including prior authorization requirements.

This bill, until January 1, 2026, would prohibit the Director of the State Department of Health Care Services from imposing prior authorization or other utilization controls on an item, service, or immunization that is intended to test for, prevent, treat, or mitigate COVID-19.

Existing law requires the department to provide presumptive Medi-Cal eligibility to pregnant women and children. Existing law authorizes a qualified hospital to make presumptive eligibility determinations if it complies with specified requirements. Existing law authorizes the

department, on a regional pilot project basis, to issue a benefits identification card to a person who is eligible for Medi-Cal program benefits, but does not possess a valid California driver's license or identification card issued by the Department of Motor Vehicles.

This bill would require the department to implement a program of presumptive eligibility for individuals experiencing homelessness, under which an individual would receive full-scope Medi-Cal benefits without a share of cost. The bill would authorize a qualified hospital to make a presumptive eligibility determination for an individual experiencing homelessness if the individual gives their informed consent to receive Medi-Cal benefits. The bill would require a county to determine if an individual experiencing homelessness who has presumptive eligibility is eligible for Medi-Cal benefits. By creating new duties for counties, the bill would impose a state-mandated local program.

This bill would require the department to develop a payment mechanism for street medicine, which is a program to provide health care services directly to those living on the streets or who are otherwise unsheltered. The bill would prohibit the department from requiring an individual experiencing homelessness to receive primary care services from their primary care physician or to receive a referral to be able to receive specialist care. The bill would require the department to reimburse for those services and to allow providers to receive fee-for-service Medi-Cal reimbursement for services provided through street medicine. The bill would require the department to issue a benefits identification card to an individual experiencing homelessness who is not in possession of a valid driver's license or identification card. The bill would also make related findings and declarations.

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, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) People experiencing homelessness have poorer health outcomes and increased mortality rates compared to the general population. This has been attributed to competing priorities, such as finding food and shelter and maintaining safety, which detract from prioritizing health care, independent of health care coverage status.

(b) People experiencing homelessness have poor access to primary care, with only 8 percent of people experiencing homelessness having a primary care provider versus 82 percent of the general population.

(c) People experiencing homelessness with Medi-Cal coverage rely on referrals from their primary care providers to access specialty care. Lack of access to primary care furthers lack of access to specialty care and necessitates at least two visits, each one difficult to accomplish, when only one might be necessary.

(d) Poor health outcomes have been attributed to institutional trauma in the traditional health care system, such as distrust of the health care system, institutional discrimination, and feeling unwelcome, leading to an unwillingness to seek medical care.

(e) Unsheltered homeless individuals are 3 times more likely to die than those who were homeless but sheltered, and 10 times more likely to die than the housed population.

(f) Deaths in the homeless population in the County of Los Angeles have doubled in the last five years, according to a report from the State Department of Public Health.

(g) Homelessness and homeless deaths disproportionately affect people of color, accounting for 68 percent of deaths and demonstrating a gross health inequity.

(h) The COVID-19 pandemic has increased reliance on telemedicine, but people experiencing homelessness often lack access to telephones, furthering health inequities and increasing isolation.

(i) Rates of COVID-19 have been increasing substantially for people experiencing homelessness. They are largely unable to follow the Governor’s safer at home orders, wash hands regularly, and keep face masks clean.

(j) Barriers to care prevent COVID-19 diagnosis and treatment, increasing morbidity and mortality, increasing rates of community transmission, and ultimately putting the general population at increased risk.

(k) Street medicine, which is the provision of health care directly to those living on the streets, including health and social services, was developed specifically to address the unique needs and circumstances of unsheltered homeless individuals onsite where they reside.

(*l*) Street medicine decreases barriers to care by providing medical care for acute and chronic health conditions, behavioral health care treatment, and treatment for substance use disorders, dispensing common medications, and drawing blood work.

(m) Less than 30 percent of people experiencing homelessness who are insured have ever seen their primary care physician, versus 70 percent of those treated by street medicine, who are actively engaged in primary care within one week of referral.

(n) Street medicine has demonstrated a decrease in hospital admissions by two-thirds with a hospital-based consult service.

(o) Unsheltered homeless individuals have twice the length of stay while hospitalized compared to the housed population, and spend 740 percent more days in the hospital at a 170-percent greater cost per day than people who are housed.

(p) Street medicine has demonstrated improved placement in housing after a hospital admission with a hospital-based consult service.

(q) Direct care delivery to people experiencing homelessness has taken an important role during the COVID-19 response in shelters and encampments across the state, but has been limited due to small existing infrastructure before the pandemic.

(r) The COVID-19 pandemic has forced direct care providers to ration resources, either choosing to provide COVID-19 surveillance and testing, or needed ongoing primary care. Lack of infrastructure has made it impossible to do both well.

SEC. 2. Section 14011.67 is added to the Welfare and Institutions Code, to read:

14011.67. (a) To the extent federal financial participation is available, the department shall implement a program of presumptive eligibility for individuals experiencing homelessness.

(b) The presumptive eligibility benefits provided under this section shall be identical to the benefits provided to individuals who receive full-scope Medi-Cal benefits without a share of cost, and shall only be made available through a Medi-Cal provider.

(c) Upon implementation of the presumptive eligibility program for individuals experiencing homelessness, the department shall issue a declaration, which shall be retained by the director, stating that implementation of the program has commenced.

(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 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 any necessary 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.

(e) A hospital may make a presumptive eligibility determination for an individual experiencing homelessness in compliance with Section 14011.66 if the individual gives their informed consent to receive Medi-Cal benefits.

(f) Upon the receipt of a timely and complete Medi-Cal application for an individual experiencing homelessness who has coverage pursuant to the presumptive eligibility program authorized by this section, a county shall determine whether the individual is eligible for Medi-Cal benefits. If the county determines that the individual does not meet the eligibility requirements for participation in the Medi-Cal program, the county shall timely report this finding to the Medical Eligibility Data System so that presumptive eligibility benefits are discontinued.

SEC. 3. Section 14133.02 is added to the Welfare and Institutions Code, to read:

14133.02. (a) The director shall not impose prior authorization or any other utilization controls on an item, service, or immunization that is intended to test for, prevent, treat, or mitigate COVID-19.

(b) This section shall remain in effect only until January 1, 2026, and as of that date is repealed.

SEC. 4. Section 14133.55 is added to the Welfare and Institutions Code, to read:

14133.55. (a) The department shall, in consultation with street medicine providers and people with lived expertise in homelessness, develop a payment mechanism for street medicine.

(b) The department shall allow health care providers to receive fee-for-service Medi-Cal reimbursement for services provided through street medicine.

(c) (1) Notwithstanding Sections 14017 and 14017.5, the department shall issue a benefits identification card to an individual experiencing homelessness who is a Medi-Cal beneficiary or receives full-scope Medi-Cal benefits pursuant to Section 14011.67, but is not in possession of a valid California driver's license or identification card issued by the Department of Motor Vehicles.

(2) The department shall not require a provider to match the name and signature on the benefits identification card issued by the department to an individual experiencing homelessness or that individual's valid California driver's license or California identification card against a signature executed at the time of service, or require a provider to visually verify the likeness of an individual experiencing homelessness to the photograph on the identification car or driver's license.

(d) (1) If an individual experiencing homelessness is a Medi-Cal beneficiary or receives full-scope Medi-Cal benefits pursuant to Section 14011.67, the department shall not require primary care services to be provided by the individual's established primary care physician. The department shall reimburse a provider for covered primary care services provided to an individual experiencing homelessness regardless of the care setting.

(2) If an individual experiencing homelessness is a Medi-Cal beneficiary or receives full-scope Medi-Cal benefits pursuant to Section 14011.67, the department shall not require that individual to receive a referral from their primary care physician to be able to receive specialist care. The department shall reimburse a specialist care provider for services provided to an individual experiencing homelessness without a referral from a primary care physician.

(e) The department shall seek all federal waivers necessary to allow federal financial participation in expenditures under this section.

(f) For purposes of this section, “street medicine” means a program to provide health care services directly to those living on the streets or who are otherwise unsheltered.

SEC. 5. If the Commission on State Mandates determines that this act contains 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.

O

ASSEMBLY BILL No. 453

Introduced by Assembly Member Cristina Garcia

February 8, 2021

An act to amend Section 1708.5 of the Civil Code, relating to civil law.

LEGISLATIVE COUNSEL'S DIGEST

AB 453, as introduced, Cristina Garcia. Sexual battery: nonconsensual condom removal.

Existing law provides that a person commits a sexual battery who, among other things, acts with the intent to cause a harmful or offensive contact, as defined, with an intimate part, as defined, of another that directly or indirectly results in a sexually offensive contact with that person. The law makes a person who commits a sexual battery pursuant to those provisions liable for damages and equitable relief.

This bill would additionally provide that a person commits a sexual battery who causes contact between a penis, from which a condom has been removed, and the intimate part of another who did not verbally consent to the condom being removed.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

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

SECTION 1. Section 1708.5 of the Civil Code is amended to read:

1708.5. (a) A person commits a sexual battery who does any of the following:

(1) Acts with the intent to cause a harmful or offensive contact with an intimate part of another, and a sexually offensive contact with that person directly or indirectly results.

(2) Acts with the intent to cause a harmful or offensive contact with another by use of ~~his or her~~ *the person's* intimate part, and a sexually offensive contact with that person directly or indirectly results.

(3) Acts to cause an imminent apprehension of the conduct described in paragraph (1) or (2), and a sexually offensive contact with that person directly or indirectly results.

(4) Causes contact between a penis, from which a condom has been removed, and the intimate part of another who did not verbally consent to the condom being removed.

(b) A person who commits a sexual battery upon another is liable to that person for damages, including, but not limited to, general damages, special damages, and punitive damages.

(c) The court in an action pursuant to this section may award equitable relief, including, but not limited to, an injunction, costs, and any other relief the court deems proper.

(d) For the purposes of this ~~section "intimate part" means the sexual organ, anus, groin, or buttocks of any person, or the breast of a female.~~ *section:*

(1) "Intimate part" means the sexual organ, anus, groin, or buttocks of any person, or the breast of a female.

(2) "Offensive contact" means contact that offends a reasonable sense of personal dignity.

(e) The rights and remedies provided in this section are in addition to any other rights and remedies provided by law.

~~(f) For purposes of this section "offensive contact" means contact that offends a reasonable sense of personal dignity.~~

O

ASSEMBLY BILL No. 789

Introduced by Assembly Members Low and Gipson
(Coauthor: Assembly Member Chiu)

February 16, 2021

An act to add Section 1316.7 to the Health and Safety Code, relating to health facilities.

LEGISLATIVE COUNSEL'S DIGEST

AB 789, as introduced, Low. Health care facilities.

Existing law provides for the licensure and regulation of health facilities and clinics, including primary care clinics, by the State Department of Public Health. A violation of these provisions is a crime.

This bill would require a primary care services in an outpatient department of a health facility or a primary care clinic, as specified, to offer a patient receiving health services a hepatitis B screening test and a hepatitis C screening test, as specified. The bill would also require the practitioner to offer the patient followup health care or refer the patient to a health care provider who can provide followup health care if the screening test is positive or reactive, as specified.

By expanding the definition of a crime, this bill would impose a state-mandated local program.

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 no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. Section 1316.7 is added to the Health and Safety Code, to read:

1316.7. (a) A patient who receives primary care services in an outpatient department of a health facility or receives primary care from a primary care clinic, as specified by subdivision (a) of Section 1204, shall be offered a hepatitis B screening test and a hepatitis C screening test according to the latest recommendations from the United States Preventive Services Task Force, unless the practitioner reasonably believes that one of the following conditions applies:

(1) The patient is being treated for a life-threatening emergency.

(2) (A) The patient has previously been offered or has been the subject of a hepatitis B or C screening test.

(B) This paragraph does not apply if the practitioner determines that the one or both of the tests should be offered again.

(3) The patient lacks capacity to consent to a hepatitis B or hepatitis C screening test, or both.

(b) (1) If a patient accepts the offer of the hepatitis B screening test and the test is hepatitis B surface antigen (HBsAg) positive, the health care provider shall offer the patient followup health care or refer the patient to a health care provider who can provide followup health care.

(2) If a patient accepts the offer of the hepatitis C screening test and the test is reactive, the health care provider shall offer the patient followup health care or refer the patient to a health care provider who can provide followup health care. The followup health care shall include a hepatitis C diagnostic test (HCV RNA).

(c) The offering of hepatitis B and hepatitis C screening testing under this section shall be culturally and linguistically appropriate.

(d) This section shall not affect the scope of practice of any health care practitioner or diminish any authority or legal or professional obligation of any health care practitioner to offer a hepatitis B or hepatitis C screening test, or both, or hepatitis B or hepatitis C diagnostic test, or both, or to provide services or care for the subject of a hepatitis B or hepatitis C screening test, or both, or hepatitis B or hepatitis C diagnostic test, or both.

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

(1) "Hepatitis B screening test" includes any laboratory tests or tests that detect the presence of hepatitis B surface antigen (HBsAg) and provides confirmation of whether the patient has a chronic hepatitis B infection.

(2) "Hepatitis C screening test" includes any laboratory screening test or tests that detect the presence of hepatitis C virus antibodies in the blood and provides confirmation of whether the patient has ever been infected with the hepatitis C virus.

(3) "Hepatitis C diagnostic test" includes any laboratory test or tests that detect the presence of the hepatitis C virus in the blood and provides confirmation of whether the patient has an active hepatitis C virus infection.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because 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.

O

ASSEMBLY BILL No. 1344

Introduced by Assembly Member Arambula

February 19, 2021

An act to amend Section 121349 of the Health and Safety Code, relating to public health.

LEGISLATIVE COUNSEL'S DIGEST

AB 1344, as introduced, Arambula. State Department of Public Health: needle and syringe exchange services.

Existing law authorizes the State Department of Public Health to authorize certain entities to apply to the department to provide hypodermic needle and syringe exchange services in any location where the department determines that the conditions exist for the rapid spread of human immunodeficiency virus (HIV), viral hepatitis, or any other potentially deadly or disabling infections that are spread through the sharing of used hypodermic needles and syringes, and requires the department to provide for a period of public comment during that application process, as specified. Existing law prescribes the standards that apply to an entity that has been authorized to provide these services.

Existing law defines a public nuisance as one that affects an entire community or neighborhood at the same time, or any considerable number of persons, although the extent of the annoyance or damage inflicted upon individuals may be unequal, and provides that a public nuisance may be remedied by an indictment or information, a civil action, or abatement. Existing law, the California Environmental Quality Act, requires a lead agency, as defined, to prepare, or cause to be prepared, and certify the completion of, an environmental impact report on a project that it proposes to carry out or approve that may have a

significant effect on the environment, or to adopt a negative declaration if it finds that the project will not have that effect.

This bill would expressly exempt the above-described needle and syringe exchange services application submissions, authorizations, and operations from review under the California Environmental Quality Act. The bill would provide that the services provided by an entity authorized to provide those needle and syringe exchange services, and any foreseeable and reasonable consequences of providing those services, do not constitute a public nuisance under specified existing law.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Section 121349 of the Health and Safety Code is amended to read:

121349. (a) The Legislature finds and declares that scientific data from needle exchange programs in the United States and in Europe have shown that the exchange of used hypodermic needles and syringes for clean hypodermic needles and syringes does not increase drug use in the population, can serve as an important bridge to treatment and recovery from drug abuse, and can curtail the spread of human immunodeficiency virus (HIV) infection among the intravenous drug user population.

(b) In order to reduce the spread of HIV infection and bloodborne hepatitis among the intravenous drug user population within California, the Legislature hereby authorizes a clean needle and syringe exchange project pursuant to this chapter in any city, county, or city and county upon the action of a county board of supervisors and the local health officer or health commission of that county, or upon the action of the city council, the mayor, and the local health officer of a city with a health department, or upon the action of the city council and the mayor of a city without a health department.

(c) In order to reduce the spread of HIV infection, viral hepatitis, and other potentially deadly bloodborne infections, the State Department of Public Health may, notwithstanding any other law, authorize entities that provide services set forth in paragraph (1) of subdivision (d), and that have sufficient staff and capacity to

provide the services described in Section 121349.1, as determined by the department, to apply for authorization under this chapter to provide hypodermic needle and syringe exchange services consistent with state standards in any location where the department determines that the conditions exist for the rapid spread of HIV, viral hepatitis, or any other potentially deadly or disabling infections that are spread through the sharing of used hypodermic needles and syringes. Authorization shall be made after consultation with the local health officer and local law enforcement leadership, and after a period of public comment, as described in subdivision (e). In making the determination, the department shall balance the concerns of law enforcement with the public health benefits. The authorization shall not be for more than two years. Before the end of the two-year period, the department may reauthorize the program in consultation with the local health officer and local law enforcement leadership.

(d) In order for an entity to be authorized to conduct a project pursuant to this chapter, its application to the department shall demonstrate that the entity complies with all of the following minimum standards:

(1) The entity provides, directly or through referral, all of the following services:

(A) Drug abuse treatment services.

(B) HIV or hepatitis screening.

(C) Hepatitis A and hepatitis B vaccination.

(D) Screening for sexually transmitted infections.

(E) Housing services for the homeless, for victims of domestic violence, or other similar housing services.

(F) Services related to provision of education and materials for the reduction of sexual risk behaviors, including, but not limited to, the distribution of condoms.

(2) The entity has the capacity to commence needle and syringe exchange services within three months of authorization.

(3) The entity has adequate funding to do all of the following at reasonably projected program participation levels:

(A) Provide needles and syringe exchange services for all of its participants.

(B) Provide HIV and viral hepatitis prevention education services for all of its participants.

(C) Provide for the safe recovery and disposal of used syringes and sharps waste from all of its participants.

(4) The entity has the capacity, and an established plan, to collect evaluative data in order to assess program impact, including, but not limited to, all of the following:

(A) The total number of persons served.

(B) The total number of syringes and needles distributed, recovered, and disposed of.

(C) The total numbers and types of referrals to drug treatment and other services.

(e) If the application is provisionally deemed appropriate by the department, the department shall, at least 45 days prior to approval of the application, provide for a period of public comment as follows:

(1) Post on the department's internet website the name of the applicant, the nature of the services, and the location where the applying entity will provide the services.

(2) Send a written and an email notice to the local health officer of the affected jurisdiction.

(3) Send a written and an email notice to the chief of police, the sheriff, or both, as appropriate, of the jurisdictions in which the program will operate.

(f) The department shall establish and maintain on its internet website the address and contact information of programs providing hypodermic needle and syringe exchange services pursuant to this chapter.

(g) The authorization provided under this section is only for a clean needle and syringe exchange project as described in Section 121349.1.

(h) Needle and syringe exchange services application submissions, authorizations, and operations performed pursuant to this chapter shall be exempt from review under the California Environmental Quality Act, Division 13 (commencing with Section 21000) of the Public Resources Code. The services set forth in subdivision (d) provided by an authorized entity, and any foreseeable and reasonable consequences of providing those services, including improperly discarded syringes or needles, shall not constitute a public nuisance, consistent with Section 3482 of the Civil Code, and shall not be considered a public nuisance for

purposes of Section 3479, 3480, or 3481 of the Civil Code and Section 731 of the Code of Civil Procedure.

~~(h)~~

(i) If the department, in its discretion, determines that a state authorized syringe exchange program continues to meet all standards set forth in subdivision (d) and that a public health need exists, it may administratively approve amendments to a program's operations including, but not limited to, modifications to the time, location, and type of services provided, including the designation as a fixed site or a mobile site. The amendment approval is not subject to the noticing requirements of subdivision (e).

~~(i)~~

(j) The department shall have 30 business days to review and respond to the applicant's request for amendment of the authorization. If the department does not respond in writing within 30 business days, the request shall be deemed denied.

O

ASSEMBLY BILL No. 1400

Introduced by Assembly Members Kalra, Lee, and Santiago
(Principal coauthors: Assembly Members Chiu and Ting)
(Principal coauthors: Senators Gonzalez, McGuire, and Wiener)
(Coauthors: Assembly Members Friedman, Kamlager, McCarty, Nazarian, Luz Rivas, and Wicks)
(Coauthors: Senators Becker, Cortese, Laird, and Wieckowski)

February 19, 2021

An act to add Title 23 (commencing with Section 100600) to the Government Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 1400, as introduced, Kalra. Guaranteed Health Care for All.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. PPACA defines a "qualified health plan" as a plan that, among other requirements, provides an essential health benefits package. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance.

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.

This bill, the California Guaranteed Health Care for All Act, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. The bill, among other things, would provide that CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and state provisions, including the federal Children's Health Insurance Program, Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare program. The bill would require the board to seek all necessary waivers, approvals, and agreements to allow various existing federal health care payments to be paid to CalCare, which would then assume responsibility for all benefits and services previously paid for with those funds.

This bill would create the CalCare Board to govern CalCare, made up of 9 voting members with demonstrated and acknowledged expertise in health care, and appointed as provided, plus the Secretary of California Health and Human Services or their designee as a nonvoting, ex officio member. The bill would provide the board with all the powers and duties necessary to establish CalCare, including determining when individuals may start enrolling into CalCare, employing necessary staff, negotiating pricing for covered pharmaceuticals and medical supplies, establishing a prescription drug formulary, and negotiating and entering into necessary contracts. The bill would require the board to convene a CalCare Public Advisory Committee with specified members to advise the board on all matters of policy for CalCare. The bill would establish an 11-member Advisory Commission on Long-Term Services and Supports to advise the board on matters of policy related to long-term services and supports.

This bill would provide for the participation of health care providers in CalCare, including the requirements of a participation agreement between a health care provider and the board, provide for payment for health care items and services, and specify program participation standards. The bill would prohibit a participating provider from

discriminating against a person by, among other things, reducing or denying a person's benefits under CalCare because of a specified characteristic, status, or condition of the person.

This bill would prohibit a participating provider from billing or entering into a private contract with an individual eligible for CalCare benefits regarding a covered benefit, but would authorize contracting for a health care item or service that is not a covered benefit if specified criteria are met. The bill would authorize health care providers to collectively negotiate fee-for-service rates of payment for health care items and services using a 3rd-party representative, as provided. The bill would require the board to annually determine an institutional provider's global budget, to be used to cover operating expenses related to covered health care items and services for that fiscal year, and would authorize payments under the global budget.

This bill would state the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for CalCare. The bill would create the CalCare Trust Fund in the State Treasury, as a continuously appropriated fund, consisting of any federal and state moneys received for the purposes of the act. Because the bill would create a continuously appropriated fund, it would make an appropriation.

This bill would prohibit specified provisions of this act from becoming operative until the Secretary of California Health and Human Services gives written notice to the Secretary of the Senate and the Chief Clerk of the Assembly that the CalCare Trust Fund has the revenues to fund the costs of implementing the act. The California Health and Human Services Agency would be required to publish a copy of the notice on its internet website.

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

This bill would make legislative findings to that effect.

Vote: majority. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. (a) The Legislature finds and declares all of the following:

(1) Although the federal Patient Protection and Affordable Care Act (PPACA) brought many improvements in health care and health care coverage, PPACA still leaves many Californians without coverage or with inadequate coverage.

(2) Californians, as individuals, employers, and taxpayers, have experienced a rise in the cost of health care and health care coverage in recent years, including rising premiums, deductibles, and copayments, as well as restricted provider networks and high out-of-network charges.

(3) Businesses have also experienced increases in the costs of health care benefits for their employees, and many employers are shifting a larger share of the cost of coverage to their employees or dropping coverage entirely.

(4) Individuals often find that they are deprived of affordable care and choice because of decisions by health benefit plans guided by the plan's economic needs rather than patients' health care needs.

(5) To address the fiscal crisis facing the health care system and the state, and to ensure Californians get the health care they need, comprehensive health care coverage needs to be provided.

(6) Billions of dollars that could be spent on providing equal access to health care are wasted on administrative costs necessary in a multipayer health care system. Resources and costs spent on administration would be dramatically reduced in a single-payer system, allowing health care professionals and hospitals to focus on patient care instead.

(7) It is the intent of the Legislature to establish a comprehensive universal single-payer health care coverage program and a health care cost control system for the benefit of all residents of the state.

(b) (1) It is further the intent of the Legislature to establish the California Guaranteed Health Care for All program to provide universal health coverage for every Californian, funded by broad-based revenue.

(2) It is the intent of the Legislature to work to obtain waivers and other approvals relating to Medi-Cal, the federal Children's Health Insurance Program, Medicare, PPACA, and any other

federal programs pertaining to the provision of health care so that any federal funds and other subsidies that would otherwise be paid to the State of California, Californians, and health care providers would be paid by the federal government to the State of California and deposited in the CalCare Trust Fund.

(3) Under those waivers and approvals, those funds would be used for health care coverage that provides health care benefits equal to or exceeded by those programs as well as other program modifications, including elimination of cost sharing and insurance premiums.

(4) Those programs would be replaced and merged into CalCare, which will operate as a true single-payer program.

(5) If any necessary waivers or approvals are not obtained, it is the intent of the Legislature that the state use state plan amendments and seek waivers and approvals to maximize, and make as seamless as possible, the use of funding from federally matched public health programs and other federal health programs in CalCare.

(6) Even if other programs, including Medi-Cal or Medicare, may contribute to paying for care, it is the goal of this act that the coverage be delivered by CalCare, and, as much as possible, that the multiple sources of funding be pooled with other CalCare program funds.

(c) This act does not create an employment benefit, nor does the act require, prohibit, or limit providing a health care employment benefit.

(d) (1) It is not the intent of the Legislature to change or impact in any way the role or authority of a licensing board or state agency that regulates the standards for or provision of health care and the standards for health care providers as established under current law, including the Business and Professions Code, the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code.

(2) This act would in no way authorize the CalCare Board, the California Guaranteed Health Care for All program, or the Secretary of California Health and Human Services to establish or revise licensure standards for health care professionals or providers.

(e) It is the intent of the Legislature that neither health information technology nor clinical practice guidelines limit the

effective exercise of the professional judgment of physicians, registered nurses, and other licensed health care professionals. Physicians, registered nurses, and other licensed health care professionals shall be free to override health information technology and clinical practice guidelines if, in their professional judgment and in accordance with their scope of practice and licensure, it is in the best interest of the patient and consistent with the patient's wishes.

(f) (1) It is the intent of the Legislature to prohibit CalCare, a state agency, a local agency, or a public employee acting under color of law from providing or disclosing to anyone, including the federal government, any personally identifiable information obtained, including a person's religious beliefs, practices, or affiliation, national origin, ethnicity, or immigration status, for law enforcement or immigration purposes.

(2) This act would also prohibit law enforcement agencies from using CalCare's funds, facilities, property, equipment, or personnel to investigate, enforce, or assist in the investigation or enforcement of a criminal, civil, or administrative violation or warrant for a violation of any requirement that individuals register with the federal government or any federal agency based on religion, national origin, ethnicity, immigration status, or other protected category as recognized in the Unruh Civil Rights Act (Part 2 (commencing with Section 51) of Division 1 of the Civil Code).

(g) It is the further intent of the Legislature to address the high cost of prescription drugs and ensure they are affordable for patients.

SEC. 2. Title 23 (commencing with Section 100600) is added to the Government Code, to read:

TITLE 23. THE CALIFORNIA GUARANTEED HEALTH CARE FOR ALL ACT

Chapter 1. General Provisions

100600. This title shall be known, and may be cited, as the California Guaranteed Health Care for All Act.

100601. There is hereby established in state government the California Guaranteed Health Care for All program, or CalCare,

to be governed by the CalCare Board pursuant to Chapter 2 (commencing with Section 100610).

100602. For the purposes of this title, the following definitions apply:

(a) "Activities of daily living" means basic personal everyday activities including eating, toileting, grooming, dressing, bathing, and transferring.

(b) "Advisory commission" means the Advisory Commission on Long-Term Services and Supports established pursuant to Section 100614.

(c) "Affordable Care Act" or "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance issued under, those acts.

(d) "Allied health practitioner" means a group of health professionals who apply their expertise to prevent disease transmission and diagnose, treat, and rehabilitate people of all ages and in all specialties, together with a range of technical and support staff, by delivering direct patient care, rehabilitation, treatment, diagnostics, and health improvement interventions to restore and maintain optimal physical, sensory, psychological, cognitive, and social functions. Examples include audiologists, occupational therapists, social workers, and radiographers.

(e) "Board" means the CalCare Board described in Section 100610.

(f) "CalCare" or "California Guaranteed Health Care for All" means the California Guaranteed Health Care for All program established in Section 100601.

(g) "Capital expenditures" means expenses for the purchase, lease, construction, or renovation of capital facilities, health information technology, artificial intelligence, and major equipment, including costs associated with state grants, loans, lines of credit, and lease-purchase arrangements.

(h) "Carrier" means either a private health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner or a health care service plan, as defined under subdivision (f) of Section 1345 of the Health and Safety Code, licensed by the Department of Managed Health Care.

(i) "Committee" means the CalCare Public Advisory Committee established pursuant to Section 100611.

(j) "County organized health system" means a health system implemented pursuant to Part 4 (commencing with Section 101525) of Division 101 of the Health and Safety Code, and Article 2.8 (commencing with Section 14087.5) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(k) "Essential community provider" means a provider, as defined in Section 156.235(c) of Title 45 of the Code of Federal Regulations, as published February 27, 2015, in the Federal Register (80 FR 10749), that serves predominantly low-income, medically underserved individuals and that is one of the following:

(1) A community clinic, as defined in subparagraph (A) of paragraph (1) of subdivision (a) of Section 1204 of the Health and Safety Code.

(2) A free clinic, as defined in subparagraph (B) of paragraph (1) of subdivision (a) of Section 1204 of the Health and Safety Code.

(3) A federally qualified health center, as defined in Section 1395x(aa)(4) or Section 1396d(*l*)(2)(B) of Title 42 of the United States Code.

(4) A rural health clinic, as defined in Section 1395x(aa)(2) or 1396d(*l*)(1) of Title 42 of the United States Code.

(5) An Indian Health Service Facility, as defined in subdivision (v) of Section 2699.6500 of Title 10 of the California Code of Regulations.

(*l*) "Federally matched public health program" means the state's Medi-Cal program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and the federal Children's Health Insurance Program under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(m) "Fund" means the CalCare Trust Fund established pursuant to Article 2 (commencing with Section 100665) of Chapter 7.

(n) "Global budget" means the payment negotiated between an institutional provider and the board pursuant to Section 100641.

(o) "Group practice" means a professional corporation under the Moscone-Knox Professional Corporation Act (Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code) that is a single corporation or partnership composed of licensed doctors of medicine, doctors of osteopathy,

or other licensed health care professionals, and that provides health care items and services primarily directly through physicians or other health care professionals who are either employees or partners of the organization.

(p) "Health care professional" means a health care professional licensed 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, who, in accordance with the professional's scope of practice, may provide health care items and services under this title.

(q) "Health care item or service" means a health care item or service that is included as a benefit under CalCare.

(r) "Health professional education expenditures" means expenditures in hospitals and other health care facilities to cover costs associated with teaching and related research activities.

(s) "Home- and community-based services" means an integrated continuum of service options available locally for older individuals and functionally impaired persons who seek to maximize self-care and independent living in the home or a home-like environment, which includes the home- and community-based services that are available through Medi-Cal pursuant to the home- and-community based waiver program under Section 1915 of the federal Social Security Act (42 U.S.C. Sec. 1396n) as of January 1, 2019.

(t) "Implementation period" means the period under paragraph (6) of subdivision (e) of Section 100612 during which CalCare is subject to special eligibility and financing provisions until it is fully implemented under that section.

(u) "Institutional provider" means an entity that provides health care items and services and is licensed pursuant to any of the following:

(1) A health facility, as defined in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(2) A clinic licensed pursuant to Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code.

(3) A long-term health care facility, as defined in Section 1418 of the Health and Safety Code, or a program developed pursuant to paragraph (1) of subdivision (i) of Section 100612.

(4) A county medical facility licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(5) A residential care facility for persons with chronic, life-threatening illness licensed pursuant to Chapter 3.01 (commencing with Section 1568.01) of Division 2 of the Health and Safety Code.

(6) An Alzheimer's day care resource center licensed pursuant to Chapter 3.1 (commencing with Section 1568.15) of Division 2 of the Health and Safety Code.

(7) A residential care facility for the elderly licensed pursuant to Chapter 3.2 (commencing with Section 1569) of Division 2 of the Health and Safety Code.

(8) A hospice licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code.

(9) A pediatric day health and respite care facility licensed pursuant to Chapter 8.6 (commencing with Section 1760) of Division 2 of the Health and Safety Code.

(10) A mental health care provider licensed pursuant to Division 4 (commencing with Section 4000) of the Welfare and Institutions Code.

(11) A federally qualified health center, as defined in Section 1395x(aa)(4) or 1396d(*l*)(2)(B) of Title 42 of the United States Code.

(v) "Instrumental activities of daily living" means activities related to living independently in the community, including meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.

(w) "Local initiative" means a prepaid health plan that is organized by, or designated by, a county government or county governments, or organized by stakeholders, of a region designated by the department to provide comprehensive health care to eligible Medi-Cal beneficiaries, including the entities established pursuant to Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.96 of the Welfare and Institutions Code.

(x) "Long-term services and supports" means long-term care, treatment, maintenance, or services related to health conditions, injury, or age, that are needed to support the activities of daily living and the instrumental activities of daily living for a person with a disability, including all long-term services and supports as defined in Section 14186.1 of the Welfare and Institutions Code,

home- and community-based services, additional services and supports identified by the board to support people with disabilities to live, work, and participate in their communities, and those as defined by the board.

(y) "Medicaid" or "medical assistance" means a program that is one of the following:

(1) The state's Medi-Cal program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(2) The federal Children's Health Insurance Program under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(z) "Medically necessary or appropriate" means the health care items, services, or supplies needed or appropriate to prevent, diagnose, or treat an illness, injury, condition, or disease, or its symptoms, and that meet accepted standards of medicine as determined by a patient's treating physician or other individual health care professional who is treating the patient, and, according to that health care professional's scope of practice and licensure, is authorized to establish a medical diagnosis and has made an assessment of the patient's condition.

(aa) "Medicare" means Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.) and the programs thereunder.

(ab) "Member" means an individual who is enrolled in CalCare.

(ac) "Out-of-state health care service" means a health care item or service provided in person to a member while the member is temporarily, for no more than 90 days, and physically located out of the state under either of the following circumstances:

(1) It is medically necessary or appropriate that the health care item or service be provided while the member physically is out of the state.

(2) It is medically necessary or appropriate, and cannot be provided in the state, because the health care item or service can only be provided by a particular health care provider physically located out of the state.

(ad) "Participating provider" means an individual or entity that is a health care provider qualified under Section 100630 that has a participation agreement pursuant to Section 100631 in effect with the board to furnish health care items or services under CalCare.

(ae) "Prescription drugs" means prescription drugs as defined in subdivision (n) of Section 130501 of the Health and Safety Code.

(af) "Resident" means an individual whose primary place of abode is in this state, without regard to the individual's immigration status, who meets the California residence requirements adopted by the board pursuant to subdivision (k) of Section 100610. The board shall be guided by the principles and requirements set forth in the Medi-Cal program under Article 7 (commencing with Section 50320) of Chapter 2 of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations.

(ag) "Rural or medically underserved area" has the same meaning as a "health professional shortage area" in Section 254e of Title 42 of the United States Code.

100603. This title does not preempt a city, county, or city and county from adopting additional health care coverage for residents in that city, county, or city and county that provides more protections and benefits to California residents than this title.

100604. To the extent any law is inconsistent with this title or the legislative intent of the California Guaranteed Health Care for All Act, this title shall apply and prevail, except when explicitly provided otherwise by this title.

Chapter 2. Governance

100610. (a) CalCare shall be governed by an executive board, known as the CalCare Board, consisting of nine voting members who are residents of California. The CalCare Board shall be an independent public entity not affiliated with an agency or department. Of the members of the board, five shall be appointed by the Governor, two shall be appointed by the Senate Committee on Rules, and two 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 nonvoting, ex officio member of the board.

(b) (1) A member 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. These members may be reappointed for succeeding four-year terms.

(2) 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. Vacancies shall be filled by appointment for the unexpired term. The board shall elect a chairperson on an annual basis.

(c) (1) Each person appointed to the board shall have demonstrated and acknowledged expertise in health care policy or delivery.

(2) Appointing authorities shall also 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 in the various aspects of health care and the diversity of various regions within the state.

(3) Appointments to the board shall be made as follows:

(A) Two health care professionals who practice medicine.

(B) One registered nurse.

(C) One public health professional.

(D) One mental health professional.

(E) One member with an institutional provider background.

(F) One representative of a not-for-profit organization that advocates for individuals who use health care in California

(G) One representative of a labor organization.

(H) One member of the committee established pursuant to Section 100611, who shall serve on a rotating basis to be determined by the committee.

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

(e) In making appointments to the board, the appointing authorities shall take into consideration the racial, ethnic, gender, 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 board shall not be employed by, a consultant to, a member of the board of

directors of, affiliated with, or otherwise a representative of, a health care professional, institutional provider, or group practice while serving on the board or on the staff of the board, except board members who are practicing health care professionals may be employed by an institutional provider or group practice. A member of the board or of the staff of the board shall not be a board member or an employee of a trade association of health professionals, institutional providers, or group practices while serving on the board or on the staff of the board. A member of the board or of the staff of the board may be a health care professional if that member does not have an ownership interest in an institutional provider or a professional health care practice.

(2) Notwithstanding Section 11009, a board member shall receive compensation for service on the board. A board member 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.

(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 member or a person in the member's immediate family, or on either of the following:

(1) Any 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 before the decision is made.

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

(h) There shall not be liability in a private capacity on the part of the board or a member of the board, or an officer or employee of the board, 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 board. The executive director shall be exempt from civil service and shall serve at the pleasure of the board.

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

(k) The board may adopt rules and regulations as necessary to implement and administer this title in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2).

100611. (a) The board shall convene a CalCare Public Advisory Committee to advise the board on all matters of policy for CalCare. The committee shall consist of members who are residents of California.

(b) Members of the committee shall be appointed by the board for a term of two years. These members may be reappointed for succeeding two-year terms.

(c) The members of the committee shall be as follows:

(1) Four health care professionals.

(2) One registered nurse.

(3) One representative of a licensed health facility.

(4) One representative of an essential community provider

(5) One representative of a physician organization or medical group.

(6) One behavioral health provider.

(7) One dentist or oral care specialist.

(8) One representative of private hospitals.

(9) One representative of public hospitals.

(10) One individual who is enrolled in and uses health care items and services under CalCare.

(11) Two representatives of organizations that advocate for individuals who use health care in California, including at least one representative of an organization that advocates for the disabled community.

(12) Two representatives of organized labor, including at least one labor organization representing registered nurses.

(d) In convening the committee pursuant to this section, the board shall make good faith efforts to ensure that their appointments, as a whole, reflect, to the greatest extent feasible, the social and geographic diversity of the state.

(e) Members of the committee shall serve without compensation, but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties to the extent that reimbursement for those expenses is not otherwise provided or payable by another public agency or agencies, and shall receive one hundred fifty dollars ($150) for each full day of attending meetings of the committee. For purposes of this section, "full day of attending a meeting" means presence at, and participation in, not less than 75 percent of the total meeting time of the committee during any particular 24-hour period.

(f) The committee shall meet at least once every quarter, and shall solicit input on agendas and topics set by the board. All meetings of the committee shall be open to the public, pursuant 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).

(g) The committee shall elect a chairperson who shall serve for two years and who may be reelected for an additional two years.

(h) Committee members, or their assistants, clerks, or deputies, shall not use for personal benefit any information that is filed with, or obtained by, the committee and that is not generally available to the public.

100612. (a) The board shall have all powers and duties necessary to establish and implement CalCare. The board shall provide, under CalCare, comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state.

(b) The board shall, to the maximum extent possible, organize, administer, and market CalCare and services as a single-payer program under the name "CalCare" or any other name as the board determines, regardless of which law or source the definition of a benefit is found, including, on a voluntary basis, retiree health benefits. In implementing this title, the board shall avoid jeopardizing federal financial participation in the programs that

are incorporated into CalCare and shall take care to promote public understanding and awareness of available benefits and programs.

(c) The board shall consider any matter to effectuate the provisions and purposes of this title. The board shall not have executive, administrative, or appointive duties except as otherwise provided by law.

(d) The board shall designate the executive director to employ necessary staff and authorize reasonable, necessary expenditures from the CalCare Trust Fund to pay program expenses and to administer CalCare. The executive director shall hire or designate another to hire staff, who shall not be exempt from civil service, to implement fully the purposes and intent of CalCare. The executive director, or the executive director's designee, shall give preference in hiring to all individuals displaced or unemployed as a direct result of the implementation of CalCare, including as set forth in Section 100615.

(e) The board shall do or delegate to the executive director all of the following:

(1) Determine goals, standards, guidelines, and priorities for CalCare.

(2) Annually assess projected revenues and expenditures and assure financial solvency of CalCare.

(3) Develop CalCare's budget pursuant to Section 100667 to ensure adequate funding to meet the health care needs of the population, and review all budgets annually to ensure they address disparities in service availability and health care outcomes and for sufficiency of rates, fees, and prices to address disparities.

(4) Establish standards and criteria for the development and submission of provider operating and capital expenditure requests pursuant to Article 2 (commencing with Section 100640) of Chapter 5.

(5) Establish standards and criteria for the allocation of funds from the CalCare Trust Fund pursuant to Section 100667.

(6) Determine when individuals may begin enrolling in CalCare. There shall be an implementation period that begins on the date that individuals may begin enrolling in CalCare and ends on a date determined by the board.

(7) Establish an enrollment system that ensures all eligible California residents, including those who travel out of state, those who have disabilities that limit their mobility, hearing, vision or

mental or cognitive capacity, those who cannot read, and those who do not speak or write English, are aware of their right to health care and are formally enrolled in CalCare.

(8) Negotiate payment rates, set payment methodologies, and set prices involving aspects of CalCare and establish procedures thereto, including procedures for negotiating fee-for-service payment to certain participating providers pursuant to Chapter 8 (commencing with Section 100675).

(9) Oversee the establishment, as part of the administration of CalCare, of the committee pursuant to Section 100611.

(10) Implement policies to ensure that all Californians receive culturally, linguistically, and structurally competent care, pursuant to Chapter 6 (commencing with Section 100650), ensure that all disabled Californians receive care in accordance with the federal Americans with Disabilities Act (42 U.S.C. Sec. 12101 et seq.) and Section 504 of the federal Rehabilitation Act of 1973 (29 U.S.C. Sec. 794), and develop mechanisms and incentives to achieve these purposes and a means to monitor the effectiveness of efforts to achieve these purposes.

(11) Establish standards for mandatory reporting by participating providers and penalties for failure to report, including reporting of data pursuant to Section 100616 and to Section 100631.

(12) Implement policies to ensure that all residents of this state have access to medically appropriate, coordinated mental health services.

(13) Ensure the establishment of policies that support the public health.

(14) Meet regularly with the committee.

(15) Determine an appropriate level of, and provide support during the transition for, training and job placement for persons who are displaced from employment as a result of the initiation of CalCare pursuant to Section 100615.

(16) In consultation with the Department of Managed Health Care, oversee the establishment of a system for resolution of disputes pursuant to Section 100627 and a system for independent medical review pursuant to Section 100627.

(17) Establish and maintain an internet website that provides information to the public about CalCare that includes information that supports choice of providers and facilities and informs the public about meetings of the board and the committee.

(18) Establish a process that is accessible to all Californians for CalCare to receive the concerns, opinions, ideas, and recommendations of the public regarding all aspects of CalCare.

(19) (A) Annually prepare a written report on the implementation and performance of CalCare functions during the preceding fiscal year, that includes, at a minimum:

(i) The manner in which funds were expended.

(ii) The progress toward and achievement of the requirements of this title.

(iii) CalCare's fiscal condition.

(iv) Recommendations for statutory changes.

(v) Receipt of payments from the federal government and other sources.

(vi) Whether current year goals and priorities have been met.

(vii) Future goals and priorities.

(B) The report shall be transmitted to the Legislature and the Governor, on or before October 1 of each year and at other times pursuant to this division, and shall be made available to the public on the internet website of CalCare.

(C) A report made to the Legislature pursuant to this subdivision shall be submitted pursuant to Section 9795 of the Government Code.

(f) The board may do or delegate to the executive director all of the following:

(1) Negotiate and enter into any necessary contracts, including contracts with health care providers and health care professionals.

(2) Sue and be sued.

(3) Receive and accept gifts, grants, or donations of moneys from any agency of the federal government, any agency of the state, and any municipality, county, or other political subdivision of the state.

(4) Receive and accept gifts, grants, or donations from individuals, associations, private foundations, and corporations, in compliance with the conflict-of-interest provisions to be adopted by the board by regulation.

(5) Share information with relevant state departments, consistent with the confidentiality provisions in this title, necessary for the administration of CalCare.

(g) A carrier may not offer benefits or cover health care items or services for which coverage is offered to individuals under

CalCare, but may, if otherwise authorized, offer benefits to cover health care items or services that are not offered to individuals under CalCare. However, this title does not prohibit a carrier from offering either of the following:

(1) Benefits to or for individuals, including their families, who are employed or self-employed in the state, but who are not residents of the state.

(2) Benefits during the implementation period to individuals who enrolled or may enroll as members of CalCare.

(h) After the end of the implementation period, a person shall not be a board member unless the person is a member of CalCare, except the ex officio member.

(i) No later than two years after the effective date of this section, the board shall develop proposals for both of the following:

(1) Accommodating employer retiree health benefits for people who have been members of the Public Employees' Retirement System, but live as retirees out of the state.

(2) Accommodating employer retiree health benefits for people who earned or accrued those benefits while residing in the state before the implementation of CalCare and live as retirees out of the state.

(j) The board shall develop a proposal for CalCare coverage of health care items and services currently covered under the workers' compensation system, including whether and how to continue funding for those item and services under that system and how to incorporate experience rating.

100613. The board may contract with not-for-profit organizations to provide both of the following:

(a) Assistance to CalCare members with respect to selection of a participating provider, enrolling, obtaining health care items and services, disenrolling, and other matters relating to CalCare.

(b) Assistance to a health care provider providing, seeking, or considering whether to provide health care items and services under CalCare.

100614. (a) There is hereby established in state government an Advisory Commission on Long-Term Services and Supports, to advise the board on matters of policy related to long-term services and supports for CalCare.

(b) The advisory commission shall consist of eleven members who are residents of California. Of the members of the advisory

commission, five shall be appointed by the Governor, three shall be appointed by the Senate Committee on Rules, and three shall be appointed by the Speaker of the Assembly. The members of the advisory commission shall include all of the following:

(1) At least two people with disabilities who use long-term services and supports.

(2) At least two older adults who use long-term services and supports.

(3) At least two providers of long-term services and supports, including one family attendant or family caregiver.

(4) At least one representative of a disability rights organization.

(5) At least one representative or member of a labor organization representing workers who provide long-term services and supports.

(6) At least one representative of a group representing seniors.

(7) At least one researcher or academic in long-term services and supports.

(c) In making appointments pursuant to this section, the Governor, the Senate Committee on Rules, and the Speaker of the Assembly shall make good faith efforts to ensure that their appointments, as a whole, reflect, to the greatest extent feasible, the diversity of the population of people who use long-term services and supports, including their race, ethnicity, national origin, primary language use, age, disability, sex, including gender identity and sexual orientation, geographic location, and socioeconomic status.

(d) (1) A member of the board may continue to serve until the appointment and qualification of that member's successor. Vacancies shall be filled by appointment for the unexpired term.

(2) Members of the advisory commission 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. These members may be reappointed for succeeding four-year terms.

(3) Vacancies that occur shall be filled within 30 days after the occurrence of the vacancy, and shall be filled in the same manner in which the vacating member was initially selected or appointed. The Secretary of California Health and Human Services shall notify the appropriate appointing authority of any expected vacancies on the long-term services and supports advisory commission.

(e) Members of the advisory commission shall serve without compensation, but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties to the extent that reimbursement for those expenses is not otherwise provided or payable by another public agency or agencies. Members shall also receive one hundred fifty dollars ($150) for each full day of attending meetings of the advisory commission. For purposes of this section, "full day of attending a meeting" means presence at, and participation in, not less than 75 percent of the total meeting time of the advisory commission during any particular 24-hour period.

(f) The advisory commission shall meet at least six times per year in a place convenient to the public. All meetings of the advisory commission shall be open to the public, pursuant 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).

(g) The advisory commission shall elect a chairperson who shall serve for two years and who may be reelected for an additional two years.

(h) It is unlawful for the advisory commission members or any of their assistants, clerks, or deputies to use for personal benefit any information that is filed with, or obtained by, the advisory commission and that is not generally available to the public.

100615. (a) The board shall provide funds from the CalCare Trust Fund or funds otherwise appropriated for this purpose to the Secretary of Labor and Workforce Development for program assistance to individuals employed or previously employed in the fields of health insurance, health care service plans, or other third-party payments for health care, individuals providing services to health care providers to deal with third-party payers for health care, individuals who may be affected by and who may experience economic dislocation as a result of the implementation of this title, and individuals whose jobs may be or have been ended as a result of the implementation of CalCare, consistent with otherwise applicable law.

(b) Assistance described in subdivision (a) shall include job training and retraining, job placement, preferential hiring, wage replacement, retirement benefits, and education benefits.

100616. (a) The board shall utilize the data collected pursuant to Chapter 1 (commencing with Section 128675) of Part 5 of

Division 107 of the Health and Safety Code to assess patient outcomes and to review utilization of health care items and services paid for by CalCare.

(b) As applicable to the type of provider, the board shall require and enforce the collection and availability of all of the following data to promote transparency, assess quality of care, compare patient outcomes, and review utilization of health care items and services paid for by CalCare, which shall be reported to the board and, as applicable, the Office of Statewide Health Planning and Development or the Medical Board of California:

(1) Inpatient discharge data, including severity of illness and risk of mortality, with respect to each discharge.

(2) Emergency department, ambulatory surgical center, and other outpatient department data, including cost data, charge data, length of stay, and patients' unit of observation with respect to each individual receiving health care items and services.

(3) For hospitals and other providers receiving global budgets, annual financial data, including all of the following:

(A) Community benefit activities, including charity care, to which Section 501(r) of Title 26 of the United States Code applies, provided by the provider in dollar value at cost.

(B) Number of employees by employee classification or job title and by patient care unit or department.

(C) Number of hours worked by the employees in each patient care unit or department.

(D) Employee wage information by job title and patient care unit or department.

(E) Number of registered nurses per staffed bed by patient care unit or department.

(F) A description of all information technology, including health information technology and artificial intelligence, used by the provider and the dollar value of that information technology.

(G) Annual spending on information technology, including health information technology, artificial intelligence, purchases, upgrades, and maintenance.

(4) Risk-adjusted and raw outcome data, including:

(A) Risk-adjusted outcome reports for medical, surgical, and obstetric procedures selected by the Office of Statewide Health Planning and Development pursuant to Sections 128745 to 128750, inclusive, of the Health and Safety Code.

(B) Any other risk-adjusted outcome reports that the board may require for medical, surgical, and obstetric procedures and conditions as it deems appropriate.

(5) A disclosure made by a provider as set forth in Article 6 (commencing with Section 650) of Chapter 1 of Division 2 of the Business and Professions Code.

(c) (1) The Medical Board of California shall collect data for the outpatient surgery settings that the medical board regulates that meets the Ambulatory Surgery Data Record requirements of Section 128737 of the Health and Safety Code, and shall submit that data to the CalCare board.

(2) The CalCare board shall make that data available as required pursuant to subdivision (d).

(d) The board shall make all disclosed data collected under this section publicly available and searchable through an internet website and through the Office of Statewide Health Planning and Development public data sets.

(e) Consistent with state and federal privacy laws, the board shall make available data collected through CalCare to the Office of Statewide Health Planning and Development and the California Health and Human Services Agency, consistent with this title and otherwise applicable law, to promote and protect public, environmental, and occupational health.

(f) Before full implementation of CalCare, and, for providers seeking to receive global budgets or salaried payments under Article 2 (commencing with Section 100640) of Chapter 5, as applicable, before the negotiation of initial payments, the board shall provide for the collection and availability of the following data:

(1) The number of patients served.

(2) The dollar value of the care provided, at cost, for all of the following categories of Office of Statewide Health Planning and Development data items:

(A) Patients receiving charity care.

(B) Contractual adjustments of county and indigent programs, including traditional and managed care.

(C) Bad debts or any other unpaid charges for patient care that the provider sought, but was unable to collect.

(g) The board shall regularly analyze information reported under this section and shall establish rules and regulations to allow

researchers, scholars, participating providers, and others to access and analyze data for purposes consistent with this title, without compromising patient privacy.

(h) (1) The board shall establish regulations for the collection and reporting of data to promote transparency, assess patient outcomes, and review utilization of services provided by physicians and other health care professionals, as applicable, and paid for by CalCare.

(2) In implementing this section, the board shall utilize data that is already being collected pursuant to other state or federal laws and regulations whenever possible.

(3) Data reporting required by participating providers under this section shall supplement the data collected by the Office of Statewide Health Planning and Development and shall not modify or alter other reporting requirements to governmental agencies.

(i) The board shall not utilize quality or other review measures established under this section for the purposes of establishing payment methods to providers.

(j) The board may coordinate and cooperate with the Office of Statewide Health Planning and Development or other health planning agencies of the state to implement the requirements of this section.

100617. (a) The board shall establish and use a process to enter into participation agreements with health care providers and other contracts with contractors. A contract entered into pursuant to this title shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of the Department of General Services. The board shall adopt a CalCare Contracting Manual incorporating procurement and contracting policies and procedures that shall be followed by CalCare. The policies and procedures in the manual shall be substantially similar to the provisions contained in the State Contracting Manual.

(b) The adoption, amendment, or repeal of a regulation by the board to implement this section, including the adoption of a manual pursuant to subdivision (a) and any procurement process conducted by CalCare in accordance with the manual, is exempt from the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

100618. (a) Notwithstanding any other law, CalCare, a state or local agency, or a public employee acting under color of law shall not provide or disclose to anyone, including the federal government, any personally identifiable information obtained, including a person's religious beliefs, practices, or affiliation, national origin, ethnicity, or immigration status, for law enforcement or immigration purposes.

(b) Notwithstanding any other law, law enforcement agencies shall not use CalCare moneys, facilities, property, equipment, or personnel to investigate, enforce, or assist in the investigation or enforcement of a criminal, civil, or administrative violation or warrant for a violation of a requirement that individuals register with the federal government or a federal agency based on religion, national origin, ethnicity, immigration status, or other protected category as recognized in the Unruh Civil Rights Act (Section 51 of the Civil Code).

Chapter 3. Eligibility and Enrollment

100620. (a) Every resident of the state shall be eligible and entitled to enroll as a member of CalCare.

(b) (1) A member shall not be required to pay a fee, payment, or other charge for enrolling in or being a member of CalCare.

(2) A member shall not be required to pay a premium, copayment, coinsurance, deductible, or any other form of cost sharing for all covered benefits under CalCare.

(c) A college, university, or other institution of higher education in the state may purchase coverage under CalCare for a student, or a student's dependent, who is not a resident of the state.

(d) An individual entitled to benefits through CalCare may obtain health care items and services from any institution, agency, or individual participating provider.

(e) The board shall establish a process for automatic CalCare enrollment at the time of birth in California.

100621. (a) All residents of this state, no matter what their sex, race, color, religion, ancestry, national origin, disability, age, previous or existing medical condition, genetic information, marital status, familial status, military or veteran status, sexual orientation, gender identity or expression, pregnancy, pregnancy-related medical condition, including termination of pregnancy, citizenship,

primary language, or immigration status, are entitled to full and equal accommodations, advantages, facilities, privileges, or services in all health care providers participating in CalCare.

(b) Subdivision (a) prohibits a participating provider, or an entity conducting, administering, or funding a health program or activity pursuant to this title, from discriminating based upon the categories described in subdivision (a) in the provision, administration, or implementation of health care items and services through CalCare.

(c) Discrimination prohibited under this section includes the following:

(1) Exclusion of a person from participation in or denial of the benefits of CalCare, except as expressly authorized by this title for the purposes of enforcing eligibility standards in Section 100620.

(2) Reduction of a person's benefits.

(3) Any other discrimination by any participating provider or any entity conducting, administering, or funding a health program or activity pursuant to this title.

(d) Section 52 of the Civil Code shall apply to discrimination under this section.

(e) Except as otherwise provided in this section, a participating provider or entity is in violation of subdivision (b) if the complaining party demonstrates that any of the categories listed in subdivision (a) was a motivating factor for any health care practice, even if other factors also motivated the practice.

Chapter 4. Benefits

100625. (a) Individuals enrolled for benefits under CalCare are entitled to have payment made by CalCare to a participating provider for the health care items and services in subdivision (c), if medically necessary or appropriate for the maintenance of health or for the prevention, diagnosis, treatment, or rehabilitation of a health condition.

(b) The determination of medical necessity or appropriateness shall be made by the member's treating physician or by a health care professional who is treating that individual and is authorized to make that determination in accordance with the scope of practice, licensing, the program standards established in Chapter 6

(commencing with Section 100650) and by the board, and other laws of the state.

(c) Covered health care benefits for members include all of the following categories of health care items and services:

(1) Inpatient and outpatient medical and health facility services, including hospital services and 24-hour-a-day emergency services.

(2) Inpatient and outpatient health care professional services and other ambulatory patient services.

(3) Primary and preventive services, including chronic disease management.

(4) Prescription drugs and biological products.

(5) Medical devices, equipment, appliances, and assistive technology.

(6) Mental health and substance abuse treatment services, including inpatient and outpatient care.

(7) Diagnostic imaging, laboratory services, and other diagnostic and evaluative services.

(8) Comprehensive reproductive, maternity, and newborn care.

(9) Pediatrics.

(10) Oral health, audiology, and vision services.

(11) Rehabilitative and habilitative services and devices, including inpatient and outpatient care.

(12) Emergency services and transportation.

(13) Early and periodic screening, diagnostic, and treatment services as defined in Section 1396d(r) of Title 42 of the United States Code.

(14) Necessary transportation for health care items and services for persons with disabilities or who may qualify as low income.

(15) Long-term services and supports described in Section 100626, including long-term services and supports covered under Medi-Cal (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code) or the federal Children's Health Insurance Program (Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.))

(16) Any additional health care items and services the board authorizes to be added to CalCare benefits.

(d) The categories of covered health care items and services under subdivision (c) include all the following:

(1) Prosthetics, eyeglasses, and hearing aids and the repair, technical support, and customization needed for their use by an individual.

(2) Child and adult immunizations.

(3) Hospice care.

(4) Care in a skilled nursing facility.

(5) Home health care, including health care provided in an assisted living facility.

(6) Prenatal and postnatal care.

(7) Podiatric care.

(8) Blood and blood products.

(9) Dialysis.

(10) Community-based adult services as defined under Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code as of January 1, 2021.

(11) Dietary and nutritional therapies determined appropriate by the board.

(12) Therapies that are shown by the National Center for Complementary and Integrative Health in the National Institutes of Health to be safe and effective, including chiropractic care and acupuncture.

(13) Health care items and services previously covered by county integrated health and human services programs pursuant to Chapter 12.96 (commencing with Section 18990) and Chapter 12.991 (commencing with Section 18991) of Part 6 of Division 9 of the Welfare and Institutions Code.

(14) Health care items and services previously covered by a regional center for persons with developmental disabilities pursuant to Chapter 5 (commencing with Section 4620) of Division 4.5 of the Welfare and Institutions Code.

(15) Language interpretation and translation for health care items and services, including sign language and braille or other services needed for individuals with communication barriers.

(e) Covered health care items and services under CalCare include all health care items and services required to be covered under the following provisions, without regard to whether the member would be eligible for or covered by the source referred to:

(1) The federal Children’s Health Insurance Program (Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.)).

(2) Medi-Cal (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(3) The federal Medicare program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(4) Health care service plans pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(5) Health insurers, as defined in Section 106 of the Insurance Code, pursuant to Part 2 (commencing with Section 10110) of Division 2 of the Insurance Code.

(6) All essential health benefits mandated by the federal Patient Protection and Affordable Care Act as of January 1, 2017.

(f) Health care items and services covered under CalCare shall not be subject to prior authorization or a limitation applied through the use of step therapy protocols.

100626. (a) Subject to the other provisions of this title, individuals enrolled for benefits under CalCare are entitled to have payment made by CalCare to an eligible provider for long-term services and supports, in accordance with the standards established in this title, for care, services, diagnosis, treatment, rehabilitation, or maintenance of health related to a medically determinable condition, whether physical or mental, of health, injury, or age, that either:

(1) Causes a functional limitation in performing one or more activities of daily living or in instrumental activities of daily living.

(2) Is a disability, as defined in Section 12102(1)(A) of Title 42 of the United States Code, that substantially limits one or more of the member's major life activities.

(b) The board shall adopt regulations that provide for the following:

(1) The determination of individual eligibility for long-term services and supports under this section.

(2) The assessment of the long-term services and supports needed for an eligible individual.

(3) The automatic entitlement of an individual who receives or is approved to receive disability benefits from the federal Social Security Administration under the federal Social Security Disability Insurance program established in Title II or Title XVI of the federal Social Security Act to the long-term services and supports under this section.

(c) Long-term services and supports provided pursuant to this section shall do all of the following:

(1) Include long-term nursing services for a member, whether provided in an institution or in a home- and community-based setting.

(2) Provide coverage for a broad spectrum of long-term services and supports, including home- and community-based services, other care provided through noninstitutional settings, and respite care.

(3) Provide coverage that meets the physical, mental, and social needs of a member while allowing the member the member's maximum possible autonomy and the member's maximum possible civic, social, and economic participation.

(4) Prioritize delivery of long-term services and supports through home- and community-based services over institutionalization.

(5) Unless a member chooses otherwise, ensure that the member receives home- and community-based long-term services and supports regardless of the recipient's type or level of disability, service need, or age.

(6) Have the goal of enabling persons with disabilities to receive services in the least restrictive and most integrated setting appropriate to the member's needs.

(7) Be provided in a manner that allows persons with disabilities to maintain their independence, self-determination, and dignity.

(8) Provide long-term services and supports that are of equal quality and equitably accessible across geographic regions.

(9) Ensure that long-term services and supports provide recipients the option of self-direction of service, including under the Self-Directed Services Program described in Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code, from either the recipient or care coordinators of the recipient's choosing.

(d) In developing regulations to implement this section, the board shall consult the advisory commission established pursuant to Section 100614.

100627. (a) (1) The board shall, on a regular basis and at least annually, evaluate whether the benefits under CalCare should be expanded or adjusted to promote the health of members and California residents, account for changes in medical practice or

new information from medical research, or respond to other relevant developments in health science.

(2) In implementing this section, the board shall not remove or eliminate covered health care items and services under CalCare that are listed in this chapter.

(b) The board shall establish a process by which health care professionals, other clinicians, and members may petition the board to add or expand benefits to CalCare.

(c) The board shall establish a process by which individuals may bring a disputed health care item or service or a coverage decision for review to the Independent Medical Review System established in the Department of Managed Health Care pursuant to Article 5.55 (commencing with Section 1374.30) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(d) For the purposes of this chapter:

(1) "Coverage decision" means the approval or denial of health care items or services by a participating provider or a health care professional who is employed by or otherwise receives compensation or payment for items and services furnished under CalCare from a participating provider, substantially based on a finding that the provision of a particular service is included or excluded as a covered item or service under CalCare. A "coverage decision" does not encompass a decision regarding a disputed health care item or service.

(2) "Disputed health care item or service" means a health care item or service eligible for coverage and payment under CalCare that has been denied, modified, or delayed by a decision of a participating provider or a health care professional who is employed by or otherwise receives compensation or payment for health care items and services furnished under CalCare from a participating provider, in whole or in part, due to a finding that the service is not medically necessary or appropriate. A decision regarding a disputed health care item or service relates to the practice of medicine, including early discharge from an institutional provider, and is not a coverage decision.

Chapter 5. Delivery of Care

Article 1. Health Care Providers

100630. (a) (1) A health care provider or entity is qualified to participate as a provider in CalCare if the health care provider furnishes health care items and services while the provider, or, if the provider is an entity, the individual health care professional of the entity furnishing the health care items and services, is physically present within the State of California, and if the provider meets all of the following:

(A) The provider or entity is a health care professional, group practice, or institutional health care provider licensed to practice in California.

(B) The provider or entity agrees to accept CalCare rates as payment in full for all covered health care items and services.

(C) The provider or entity has filed with the board a participation agreement described in Section 100631.

(D) The provider or entity is otherwise in good standing.

(2) The board shall establish and maintain procedures and standards for recognizing health care providers located out of the state for purposes of providing coverage under CalCare for members who require out-of-state health care services while the member is temporarily located out of the state.

(b) A provider or entity shall not be qualified to furnish health care items and services under CalCare if the provider or entity does not provide health care items or services directly to individuals, including the following:

(1) Entities or providers that contract with other entities or providers to provide health care items and services shall not be considered a qualified provider for those contracted items and services.

(2) Entities that are approved to coordinate care plans under the Medicare Advantage program established in Part C of Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1851 et seq.) as of January 1, 2020, but do not directly provide health care items and services.

(c) A health care provider qualified to participate under this section may provide covered health care items or services under CalCare, as long as the health care provider is legally authorized

to provide the health care item or service for the individual and under the circumstances involved.

(d) The board shall establish and maintain procedures for members and individuals eligible to enroll in CalCare to enroll onsite at a participating provider.

(e) The board shall establish and maintain procedures and standards for members to select a primary care physician, which may be an internist, a pediatrician, a physician who practices family medicine, a gynecologist, a physician who practices geriatric medicine, or, at the option of a member who has a chronic condition that requires specialty care, a specialist health care professional who regularly and continually provides treatment to the member for that condition.

(f) A referral from a primary care provider is not required for a member to see a participating provider.

(g) A member may choose to receive health care items and services under CalCare from a participating provider, subject to the willingness or availability of the provider, and consistent with the provisions of this title relating to discrimination, and the appropriate clinically relevant circumstances and standards.

100631. (a) A health care provider shall enter into a participation agreement with the board to qualify as a participating provider under CalCare.

(b) A participation agreement between the board and a health care provider shall include provisions for at least the following, as applicable to each provider:

(1) Health care items and services to members shall be furnished by the provider without discrimination, as required by Section 100621. This paragraph does not require the provision of a type or class of health care items or services that are outside the scope of the provider's normal practice.

(2) A charge shall not be made to a member for a covered health care item or service, other than for payment authorized by this title. Except as described in Section 100634, a contract shall not be entered into with a patient for a covered health care item or service.

(3) The provider shall follow the policies and procedures in the CalCare Contracting Manual established pursuant to Section 100617.

(4) The provider shall furnish information reasonably required by the board and shall meet the reporting requirements of Sections 100616 and 100651 for at least the following:

(A) Quality review by designated entities.

(B) Making payments, including the examination of records as necessary for the verification of information on which those payments are based.

(C) Statistical or other studies required for the implementation of this title.

(D) Other purposes specified by the board.

(5) If the provider is not an individual, the provider shall not employ or use an individual or other provider that has had a participation agreement terminated for cause to provide covered health care items and services.

(6) If the provider is paid on a fee-for-service basis for covered health care items and services, the provider shall submit bills and required supporting documentation relating to the provision of covered health care items or services within 30 days after the date of providing those items or services.

(7) The provider shall submit information and any other required supporting documentation reasonably required by the board on a quarterly basis that relates to the provision of covered health care items and services and describes health care items and services furnished with respect to specific individuals.

(8) (A) If the provider receives payment based on provider data on diagnosis-related coding, procedure coding, or other coding system or data, the provider shall disclose the following to the board:

(i) Any case mix indexes, diagnosis coding software, procedure coding software, or other coding system utilized by the provider for the purposes of meeting payment, global budget, or other disclosure requirements under this title.

(ii) Any case mix indexes, diagnosis coding guidelines, procedure coding guidelines, or coding tip sheets used by the provider for the purposes of meeting payment or disclosure requirements under this title.

(B) If the provider receives payment based on provider data on diagnosis-related coding, procedure coding, or other coding system or data, the provider shall not do the following:

(i) Use proprietary case mix indexes, diagnosis coding software, procedure coding software, or other coding system for the purposes of meeting payment, global budget, or other disclosure requirements under this title.

(ii) Require another health care professional to apply case mix indexes, diagnosis coding software, procedure coding software, or other coding system in a manner that limits the clinical diagnosis, treatment process, or a treating health care professional's judgment in determining a diagnosis or treatment process, including the use of leading queries or prohibitions on using certain codes.

(iii) Provide financial incentives or disincentives to physicians, registered nurses, or other health care professionals for particular coding query results or code selections.

(iv) Use case mix indexes, diagnosis coding software, procedure coding software, or other coding system that make suggestions for higher severity diagnoses or higher cost procedure coding.

(9) The provider shall comply with the duty of patient advocacy and reporting requirements described in Section 100651.

(10) If the provider is not an individual, the provider shall ensure that a board member, executive, or administrator of the provider shall not receive compensation from, own stock or have other financial investments in, or receive services as a board member of an entity that contracts with or provides health care items or services, including pharmaceutical products and medical devices or equipment, to the provider.

(11) If the provider is a not-for-profit hospital subject to Article 2 (commencing with Section 127340) of Chapter 2 of Part 2 of Division 107 of the Health and Safety Code, the hospital shall submit to the board the community benefits plan developed pursuant to Article 2 (commencing with Section 127340) of the Health and Safety Code.

(12) Health care items and services to members shall be furnished by a health care professional while the professional is physically present within the State of California.

(13) The provider shall not enter into risk-bearing, risk-sharing, or risk-shifting agreements with other health care providers or entities other than CalCare.

(c) This section does not limit the formation of group practices.

100632. (a) A participation agreement may be terminated with appropriate notice by the board for failure to meet the requirements of this title or may be terminated by a provider.

(b) A participating provider shall be provided notice and a reasonable opportunity to correct deficiencies before the board terminates an agreement, unless a more immediate termination is required for public safety or similar reasons.

(c) The procedures and penalties under the Medi-Cal program for fraud or abuse pursuant to Sections 14107, 14107.11, 14107.12, 14107.13, 14107.2, 14107.3, 14107.4, 14107.5, and 14108 of the Welfare and Institutions Code shall apply to an applicant or provider under CalCare.

(d) For purposes of this section:

(1) "Applicant" means an individual, including an ordering, referring, or prescribing individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents thereof, that apply to the board to participate as a provider in CalCare.

(2) "Provider" means an individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents of a partnership, group association, corporation, institution, or entity, that provides services, goods, supplies, or merchandise, directly or indirectly, including all ordering, referring, and prescribing, to CalCare program members.

100633. (a) A person shall not discharge or otherwise discriminate against an employee on account of the employee or a person acting pursuant to a request of the employee for any of the following:

(1) Notifying the board, executive director, or employee's employer of an alleged violation of this title, including communications related to carrying out the employee's job duties.

(2) Refusing to engage in a practice made unlawful by this title, if the employee has identified the alleged illegality to the employer.

(3) Providing, causing to be provided, or being about to provide or cause to be provided to the provider, the federal government, or the Attorney General information relating to a violation of, or an act or omission the provider or representative reasonably believes to be a violation of, this title.

(4) Testifying before or otherwise providing information relevant for a state or federal proceeding regarding this title or a proposed amendment to this title.

(5) Commencing, causing to be commenced, or being about to commence or cause to be commenced a proceeding under this title.

(6) Testifying or being about to testify in a proceeding.

(7) Assisting or participating, or being about to assist or participate, in a proceeding or other action to carry out the purposes of this title.

(8) Objecting to, or refusing to participate in, an activity, policy, practice, or assigned task that the employee or representative reasonably believes to be in violation of this title or any order, rule, regulation, standard, or ban under this title.

(b) An employee covered by this section who alleges discrimination by an employer in violation of subdivision (a) may bring an action governed by the rules and procedures, legal burdens of proof, and remedies applicable under the False Claims Act (Article 9 (commencing with Section 12650) of Chapter 6 of Part 2 of Division 3 of Title 2) or Section 12990, or an action against unfair competition pursuant to Chapter 5 (commencing with Section 17200) of Part 2 of Division 7 of the Business and Professions Code.

(c) (1) This section does not diminish the rights, privileges, or remedies of an employee under any other law, regulation, or collective bargaining agreement. The rights and remedies in this section shall not be waived by an agreement, policy, form, or condition of employment.

(2) This section does not preempt or diminish any other law or regulation against discrimination, demotion, discharge, suspension, threats, harassment, reprimand, retaliation, or any other manner of discrimination.

(d) For purposes of this section:

(1) “Employer” means a person engaged in profit or not-for-profit business or industry, including one or more individuals, partnerships, associations, corporations, trusts, professional membership organization including a certification, disciplinary, or other professional body, unincorporated organizations, nongovernmental organizations, or trustees, and who is subject to liability for violating this title.

(2) "Employee" means an individual performing activities under this title on behalf of an employer.

100634. (a) This section shall be effective on the date the implementation period ends pursuant to paragraph (6) of subdivision (e) of Section 100612.

(b) (1) An institutional or individual provider with a participation agreement in effect shall not bill or enter into a private contract with an individual eligible for benefits through CalCare for a health care item or service that is a covered benefit through CalCare.

(2) An institutional or individual provider with a participation agreement in effect may bill or enter into a private contract with an individual eligible for benefits through CalCare for a health care item or service that is not a covered benefit through CalCare if the following requirements are met:

(A) The contract and provider meet the requirements specified in paragraphs (3) and (4).

(B) The health care item or service is not payable or available through CalCare.

(C) The provider does not receive reimbursement, directly or indirectly, from CalCare for the health care item or service, and does not receive an amount for the health care item or service from an organization that receives reimbursement, directly or indirectly, for the health care item or service from CalCare.

(3) (A) A contract described in paragraph (2) shall be in writing and signed by the individual, or authorized representative of the individual, receiving the health care item or service before the health care item or service is furnished pursuant to the contract, and shall not be entered into at a time when the individual is facing an emergency health care situation.

(B) A contract described in paragraph (2) shall clearly indicate to the individual receiving the health care item or service that by signing the contract, the individual agrees to all of the following:

(i) The individual shall not submit a claim or request that the provider submit a claim to CalCare for the health care item or service.

(ii) The individual is responsible for payment of the health care item or service and understands that reimbursement shall not be provided under CalCare for the health care item or service.

(iii) The individual understands that the limits under CalCare do not apply to amounts that may be charged for the health care item or service.

(iv) The individual understands that the provider is providing services outside the scope of CalCare.

(4) A participating provider that enters into a contract described in paragraph (2) shall have in effect, during the period a health care item or service is to be provided pursuant to the contract, an affidavit, which shall be filed with the board no later than 10 days after the first contract to which the affidavit applies is entered into. The affidavit shall identify the provider who is to furnish the noncovered health care item or service, state that the provider will not submit a claim to CalCare for a noncovered health care item or service provided to a member, and be signed by the provider.

(5) If a provider signing an affidavit described in paragraph (4) knowingly and willfully submits a claim to CalCare for a noncovered health care item or service or receives reimbursement or an amount for a health care item or service provided pursuant to a private contract, all of the following apply:

(A) A contract described in paragraph (2) shall be void.

(B) A payment shall not be made under CalCare for a health care item or service furnished by the provider during the two-year period beginning on the date the affidavit was signed or the date the claim was submitted, whichever is later. A payment made by CalCare to the provider during that two-year period shall be remitted to CalCare, plus interest.

(C) A payment received by the provider from the member, CalCare, or other payer for a health care item or service furnished during the period described in subparagraph (B) shall be remitted to the payer, and damages shall be available to the payer pursuant to Section 3294 of the Civil Code.

(6) An institutional or individual provider with a participation agreement in effect may bill or enter into a private contract with an individual ineligible for benefits under CalCare for a health care item or service. Consistent with Section 100618, the institutional or individual provider shall report to the board, on an annual basis, aggregate information regarding services furnished to ineligible individuals.

(c) (1) An institutional or individual provider without a participation agreement in effect may bill or enter into a private

contract with an individual eligible for benefits under CalCare for a health care item or service that is a covered benefit through CalCare only if the contract and provider meet the requirements specified in paragraphs (2) and (3).

(2) (A) A contract described in paragraph (1) shall be in writing and signed by the individual, or authorized representative of the individual, receiving the health care item or service before the item or service is furnished pursuant to the contract, and shall not be entered into at a time when the individual is facing an emergency health care situation.

(B) A contract described in paragraph (1) shall clearly indicate to the individual receiving the health care item or service that by signing the contract, the individual agrees to all of the following:

(i) The individual understands that the individual has the right to have the health care item or service provided by another provider for which payment would be made under CalCare.

(ii) The individual shall not submit a claim or request that the provider submit a claim to CalCare for the health care item or service, even if the health care item or service is otherwise covered under CalCare.

(iii) The individual is responsible for payment of the health care item or service and understands that reimbursement shall not be provided under CalCare for the health care item or service.

(iv) The individual understands that the limits under CalCare do not apply to amounts that may be charged for the health care item or service.

(v) The individual understands that the provider is providing services outside the scope of CalCare.

(3) A provider that enters into a contract described in paragraph (1) shall have in effect, during the period a health care item or service is to be provided pursuant to the contract, an affidavit, which shall be filed with the board no later than 10 days after the first contract to which the affidavit applies is entered into. The affidavit shall identify the provider who is to furnish the health care item or service, state that the provider will not submit a claim to CalCare for a health care item or service provided to a member during a two-year period beginning on the date the affidavit was signed, and be signed by the provider.

(4) If a provider who signed an affidavit described in paragraph (3) knowingly and willfully submits a claim to CalCare for a health

care item or service or receives reimbursement or an amount for a health care item or service provided pursuant to a private contract described in an affidavit signed pursuant to paragraph (3), all of the following apply:

(A) A contract described in paragraph (1) shall be void.

(B) A payment shall not be made under CalCare for a health care item or service furnished by the provider during the two-year period beginning on the date the affidavit was signed or the date the claim was submitted, whichever is later. A payment made by CalCare to the provider during that two-year period shall be remitted to CalCare, plus interest.

(C) A payment received by the provider from the member, CalCare program, or other payer for a health care item or service furnished during the period described in subparagraph (B) shall be remitted to the payer, and damages shall be available to the payer pursuant to Section 3294 of the Civil Code.

(5) An institutional or individual provider without a participation agreement in effect may bill or enter into a private contract with an individual for a health care item or service that is not a benefit under CalCare.

Article 2. Payment for Health Care Items and Services

100640. (a) The board shall adopt regulations regarding contracting for, and establishing payment methodologies for, covered health care items and services provided to members under CalCare by participating providers. All payment rates under CalCare shall be reasonable and reasonably related to all of the following:

(1) The cost of efficiently providing the health care items and services.

(2) Ensuring availability and accessibility of CalCare health care services, including compliance with state requirements regarding network adequacy, timely access, and language access.

(3) Maintaining an optimal workforce and the health care facilities necessary to deliver quality, equitable health care.

(b) (1) Payment for health care items and services shall be considered payment in full.

(2) A participating provider shall not charge a rate in excess of the payment established through CalCare for a health care item or

service furnished under CalCare and shall not solicit or accept payment from any member or third party for a health care item or service furnished under CalCare, except as provided under a federal program.

(3) This section does not preclude CalCare from acting as a primary or secondary payer in conjunction with another third-party payer when permitted by a federal program.

(c) Not later than the beginning of each fiscal quarter during which an institutional provider of care, including a hospital, skilled nursing facility, and chronic dialysis clinic, is to furnish health care items and services under CalCare, the board shall pay to each institutional provider a lump sum to cover all operating expenses under a global budget as set forth in Section 100641. An institutional provider receiving a global budget payment shall accept that payment as payment in full for all operating expenses for health care items and services furnished under CalCare, whether inpatient or outpatient, by the institutional provider.

(d) (1) A group practice, county organized health system, or local initiative may elect to be paid for health care items and services furnished under CalCare either on a fee-for-service basis under Section 100644 or on a salaried basis.

(2) A group practice, county organized health system, or local initiative that elects to be paid on a salaried basis shall negotiate salaried payment rates with the board annually, and the board shall pay the group practice, county organized health system, or local initiative at the beginning of each month.

(e) Health care items and services provided to members under CalCare by individual providers or any other providers not paid under subdivision (c) or (d) shall be paid for on a fee-for-service basis under Section 100644.

(f) Capital-related expenses for specifically identified capital expenditures incurred by participating providers shall meet the requirements under Section 100645.

(g) Payment methodologies and payment rates shall include a distinct component of reimbursement for direct and indirect costs incurred by the institutional provider for graduate medical education, as applicable.

(h) The board shall adopt, by regulation, payment methodologies and procedures for paying for out-of-state health care services.

(i) (1) This article does not regulate, interfere with, diminish, or abrogate a collective bargaining agreement, established employee rights, or the right, obligation, or authority of a collective bargaining representative under state or local law.

(2) This article does not compel, regulate, interfere with, or duplicate the provisions of an established training program that is operated under the terms of a collective bargaining agreement or unilaterally by an employer or bona fide labor union.

(j) The board shall determine the appropriate use and allocation of the special projects budget for the construction, renovation, or staffing of health care facilities in rural, underserved, or health professional or medical shortage areas, and to address health disparities, including those based on race, ethnicity, national origin, primary language use, age, disability, sex, including gender identity and sexual orientation, geography, and socioeconomic status.

100641. (a) An institutional provider's global budget shall be determined before the start of a fiscal year through negotiations between the provider and the board. The global budget shall be negotiated annually based on the payment factors described in subdivision (d).

(b) An institutional provider's global budget shall be used only to cover operating expenses associated with direct care for patients for health care items and services covered under CalCare. An institutional provider's global budget shall not be used for capital expenditures, and capital expenditures shall not be included in the global budget.

(c) The board, on a quarterly basis, shall review whether requirements of the institutional provider's participation agreement and negotiated global budget have been performed and shall determine whether adjustment to the institutional provider's payment is warranted.

(d) A payment negotiated pursuant to subdivision (a) shall take into account, with respect to each provider, all of the following:

(1) The historical volume of services provided for each health care item and service in the previous three-year period.

(2) The actual expenditures of a provider in the provider's most recent Medicare cost report for each health care item and service, or other cost report that may otherwise be adopted by the board, compared to the following:

(A) The expenditures of other comparable institutional providers in the state.

(B) The normative payment rates established under the comparative payment rate systems pursuant to Section 100643, including permissible adjustments to the rates for the health care items and services.

(C) Projected changes in the volume and type of health care items and services to be furnished.

(D) Employee wages.

(E) The provider's maximum capacity to provide the health care items and services.

(F) Education and prevention programs.

(G) Permissible adjustments to the provider's operating budget from the previous fiscal year due to factors including an increase in primary or specialty care access, efforts to decrease health care disparities in rural or medically underserved areas, a response to emergent conditions, and proposed changes to patient care programs at the institutional level.

(H) Any other factor determined appropriate by the board.

(3) In a rural or medically underserved area, the need to mitigate the impact of the availability and accessibility of health care services through increased global budget payment.

(e) A payment negotiated pursuant to subdivision (a) or payment methodology shall not do any of the following:

(1) Take into account capital expenditures of the provider or any other expenditure not directly associated with furnishing health care items and services under CalCare.

(2) Be used by a provider for capital expenditures or other expenditures associated with capital projects.

(3) Exceed the provider's capacity to furnish health care items and services covered under CalCare.

(4) Be used to pay or otherwise compensate a board member, executive, or administrator of the institutional provider who has an interest or relationship prohibited under paragraph (10) of subdivision (b) of Section 100631 or paragraph (3) of subdivision (c) of Section 100651.

(f) The board may negotiate changes to an institutional provider's global budget based on factors not prohibited under subdivision (e) or any other provision of this title.

(g) Subject to subdivision (i) of Section 100640, compensation costs for an employee, contractor employee, or subcontractor employee of an institutional provider receiving a global budget shall meet the compensation cap established in Section 4304(a)(16) of Title 41 of the United States Code and its implementing regulations, except that the board may establish one or more narrowly targeted exceptions for scientists, engineers, or other specialists upon a determination that those exceptions are needed to ensure CalCare continued access to needed skills and capabilities.

(h) A payment to an institutional provider pursuant to this section shall not allow a participating provider to retain revenue generated from outsourcing health care items and services covered under CalCare, unless that revenue was considered part of the global budget negotiation process. This subdivision shall apply to revenue from outsourcing health care items and services that were previously furnished by employees of the participating provider who were subject to a collective bargaining agreement.

(i) For the purposes of this section, "operating expenses" of a provider include the following:

(1) The costs associated with covered health care items and services under CalCare, including the following:

(A) Compensation for health care professionals, ancillary staff, and services employed or otherwise paid by an institutional provider.

(B) Pharmaceutical products administered by health care professionals at the institutional provider's facility or facilities.

(C) Purchasing supplies.

(D) Maintenance of medical devices and health care technologies, including diagnostic testing equipment, except that health information technology and artificial intelligence shall be considered capital expenditures, unless otherwise determined by the board.

(E) Incidental services necessary for safe patient care.

(F) Patient care, education, and preventive health programs, and necessary staff to implement those programs.

(G) Occupational health and safety programs and public health programs, and necessary staff to implement those programs for the continued education and health and safety of clinicians and other individuals employed by the institutional provider.

(H) Infectious disease response preparedness, including the maintenance of a one-year or 365-day stockpile of personal protective equipment, occupational testing and surveillance, and contact tracing.

(2) Administrative costs of the institutional provider.

100642. (a) The board shall consider an appeal of payments and the global budget, filed by an institutional provider that is subject to the payments or global budget, based on the following:

(1) The overall financial condition of the institutional provider, including bankruptcy or financial solvency.

(2) Excessive risks to the ongoing operation of the institutional provider.

(3) Justifiable differences in costs among providers, including providing a service not available from other providers in the region, or the need for health care services in rural areas with a shortage of health professionals or medically underserved areas and populations.

(4) Factors that led to increased costs for the institutional provider that can reasonably be considered to be unanticipated and out of the control of the provider. Those factors may include:

(A) Natural disasters.

(B) Outbreaks of epidemics or infectious diseases.

(C) Unanticipated facility or equipment repairs or purchases.

(D) Significant and unanticipated increases in pharmaceutical or medical device prices.

(5) Changes in state or federal laws that result in a change in costs.

(6) Reasonable increases in labor costs, including salaries and benefits, and changes in collective bargaining agreements, prevailing wage, or local law.

(b) (1) The payments set and global budget negotiated by the board to be paid to the institutional provider shall stay in effect during the appeal process, subject to interim relief provisions.

(2) The board shall have the power to grant interim relief based on fairness. The board shall develop regulations governing interim relief. The board shall establish uniform written procedures for the submission, processing, and consideration of an interim relief appeal by an institutional provider. A decision on interim relief shall be granted within one month of the filing of an interim relief appeal. An institutional provider shall certify in its interim relief

appeal that the request is made on the basis that the challenged amount is arbitrary and capricious, or that the institutional provider has experienced a bona fide emergency based on unanticipated costs or costs outside the control of the entity, including those described in paragraph (4) of subdivision (a).

(c) (1) In accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2), the board may delegate the conduct of a hearing to an administrative law judge, who shall issue a proposed decision with findings of fact and conclusions of law.

(2) The administrative law judge may hold evidentiary hearings and shall issue a proposed decision with findings of fact and conclusions of law, including a recommended adjusted payment or global budget, within four months of the filing of the appeal.

(3) Within 30 days of receipt of the proposed decision by the administrative law judge, the board may approve, disapprove, or modify the decision, and shall issue a final decision for the appealing institutional provider.

(d) A final determination by the commission shall be subject to judicial review pursuant to Section 1094.5 of the Code of Civil Procedure.

100643. (a) The board shall use existing Medicare prospective payment systems to establish and serve as the comparative payment rate system in global budget negotiations described in subparagraph (B) of paragraph (2) of subdivision (d) of Section 100641. The board shall update the comparative payment rate system annually.

(b) To develop the comparative payment rate system, the board shall use only the operating base payment rates under each Medicare prospective payment system with applicable adjustments.

(c) The comparative rate system shall not include value-based purchasing adjustments or capital expenses base payment rates that may be included in Medicare prospective payment systems.

(d) In the first year that global budget payments are available to institutional providers, and for purposes of selecting a comparative payment rate system used during initial global budget negotiations for an institutional provider, the board shall take into account the appropriate Medicare prospective payment system from the most recent year to determine what operating base payment the institutional provider would have been paid for covered health care items and services furnished the preceding

year with applicable adjustments, excluding value-based purchasing adjustments, based on the prospective payment system.

100644. (a) The board shall engage in good faith negotiations with health care providers' representatives under Chapter 8 (commencing with Section 100800) to determine rates of fee-for-service payment for health care items and services furnished under CalCare.

(b) There shall be a rebuttable presumption that the Medicare fee-for-service rates of reimbursement constitute reasonable fee-for-service payment rates. The fee schedule shall be updated annually.

(c) Payments to individual providers under this article shall not include payments to individual providers in salaried positions at institutional providers receiving global budgets under Section 100641 or individual health care professionals who are employed by or otherwise receive compensation or payment for health care items and services furnished under CalCare from group practices, county organized health systems, or local initiatives that receive payment under CalCare on a salaried basis.

(d) To establish the fee-for-service payment rates, the board shall ensure that the fee schedule compensates physicians and other health care professionals at a rate that reflects the value for health care items and services furnished.

(e) In a rural or medically underserved area, the board may mitigate the impact of the availability and accessibility of health care services through increased individual provider payment.

100645. (a) (1) The board shall adopt, by regulation, payment methodologies for the payment of capital expenditures for specifically identified capital projects incurred by not-for-profit or governmental entities that are health facilities pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(2) The board shall prioritize allocation of funding under this subdivision to projects that propose to use the funds to improve service in a rural or medically underserved area, or to address health disparities, including those based on race, ethnicity, national origin, primary language use, age, disability, sex, including gender identity and sexual orientation, geography, and socioeconomic status. The board shall consider the impact of any prior reduction

in services or facility closure by a not-for-profit or governmental entity as part of the application review process.

(3) For the purposes of funding capital expenditures under this section, health care facilities and governmental entities shall apply to the board in a time and manner specified by the board. All capital-related expenses generated by a capital project shall have received prior approval from the board to be paid under CalCare.

(b) Approval of an application for capital expenditures shall be based on achievement of the program standards described in Chapter 6 (commencing with Section 100650).

(c) The board shall not grant funding for capital expenditures for capital projects that are financed directly or indirectly through the diversion of private or other non-CalCare program funding that results in reductions in care to patients, including reductions in registered nursing staffing patterns and changes in emergency room or primary care services or availability.

(d) A participating provider shall not use operating funds or payments from CalCare for the operating expenses associated with a capital asset that was not funded by CalCare without the approval of the board.

(e) A participating provider shall not do either of the following:

(1) Use funds from CalCare designated for operating expenses or payments for capital expenditures.

(2) Use funds from CalCare designated for capital expenditures or payments for operating expenses.

100646. (a) (1) A margin generated by a participating provider receiving a global budget under CalCare may be retained and used to meet the health care needs of CalCare members.

(2) A participating provider shall not retain a margin if that margin was generated through inappropriate limitations on access to health care, compromises in the quality of care, or actions that adversely affected or are likely to adversely affect the health of the persons receiving services from an institutional provider, group practice, or other participating provider under CalCare.

(3) The board shall evaluate the source of margin generation.

(b) A payment under CalCare, including provider payments for operating expenses or capital expenditures, shall not take into account, include a process for the funding of, or be used by a provider for any of the following:

(1) Marketing, which does not include education and prevention programs paid under a global budget.

(2) The profit or net revenue, or increasing the profit, net revenue, or financial result of the provider.

(3) An incentive payment, bonus, or compensation based on patient utilization of health care items or services or any financial measure applied with respect to the provider or a group practice or other entity that contracts with or provides health care items or services, including pharmaceutical products and medical devices or equipment, to the provider.

(4) A bonus, incentive payment, or incentive adjustment from CalCare to a participating provider.

(5) A bonus, incentive payment, or compensation based on the financial results of any other health care provider with which the provider has a pecuniary interest or contractual relationship, including employment or other compensation-based relationship.

(6) A bonus, incentive payment, or compensation based on the financial results of an integrated health care delivery system, group practice, or other provider.

(7) State political contributions.

(c) (1) The board shall establish and enforce penalties for violations of this section, consistent with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 1l340) of Part 1 of Division 3 of Title 2).

(2) Penalty payments collected for violations of this section shall be remitted to the CalCare Trust Fund for use in CalCare.

100647. (a) The board shall, in consultation with the Department of General Services, the Department of Health Care Services, and other relevant state agencies, negotiate prices to be paid for pharmaceuticals, medical supplies, medical technology, and medically necessary assistive equipment covered through CalCare. Negotiations by the board shall be on behalf of the entire CalCare program. A state agency shall cooperate to provide data and other information to the board.

(b) The board shall, in consultation with the Department of General Services, the Department of Health Care Services, the CalCare Public Advisory Committee, patient advocacy organizations, physicians, registered nurses, pharmacists, and other health care professionals, establish a prescription drug formulary

system. To establish the prescription drug formulary system, the board shall do all of the following:

(1) Promote the use of generic and biosimilar medications.

(2) Consider the clinical efficacy of medications.

(3) Update the formulary frequently and allow health care professionals, other clinicians, and members to petition the board to add new pharmaceuticals or to remove ineffective or dangerous medications from the formulary.

(4) Consult with patient advocacy organizations, physicians, nurses, pharmacists, and other health care professionals to determine the clinical efficacy and need for the inclusion of specific medications in the formulary.

(c) The prescription drug formulary system shall not require a prior authorization determination for coverage under CalCare and shall not apply treatment limitations through the use of step therapy protocols.

(d) The board shall promulgate regulations regarding the use of off-formulary medications that allow for patient access.

Chapter 6. Program Standards

100650. CalCare shall establish a single standard of safe, therapeutic, and effective care for all residents of the state by the following means:

(a) The board shall establish requirements and standards, by regulation, for CalCare and health care providers, consistent with this title and consistent with the applicable professional practice and licensure standards of health care providers and health care professionals established pursuant to the Business and Professions Code, the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code, including requirements and standards for, as applicable:

(1) The scope, quality, and accessibility of health care items and services.

(2) Relations between participating providers and members.

(3) Relations between institutional providers, group practices, and individual health care organizations, including credentialing for participation in CalCare and clinical and admitting privileges, and terms, methods, and rates of payment.

(b) The board shall establish requirements and standards, by regulation, under CalCare that include provisions to promote all of the following:

(1) Simplification, transparency, uniformity, and fairness in the following:

(A) Health care provider credentialing for participation in CalCare.

(B) Health care provider clinical and admitting privileges in health care facilities.

(C) Clinical placement for educational purposes, including clinical placement for prelicensure registered nursing students without regard to degree type, that prioritizes nursing students in public education programs.

(D) Payment procedures and rates.

(E) Claims processing.

(2) In-person primary and preventive care, efficient and effective health care items and services, quality assurance, and promotion of public, environmental, and occupational health.

(3) Elimination of health care disparities.

(4) Nondiscrimination pursuant to Section 100621.

(5) Accessibility of health care items and services, including accessibility for people with disabilities and people with limited ability to speak or understand English.

(6) Providing health care items and services in a culturally, linguistically, and structurally competent manner.

(c) The board shall establish requirements and standards, to the extent authorized by federal law, by regulation, for replacing and merging with CalCare health care items and services and ancillary services currently provided by other programs, including Medicare, the Affordable Care Act, and federally matched public health programs.

(d) A participating provider shall furnish information as required by the Office of Statewide Health Planning and Development pursuant to Sections 100616 and 100631, and to Division 107 (commencing with Section 127000) of the Health and Safety Code, and permit examination of that information by the board as reasonably required for purposes of reviewing accessibility and utilization of health care items and services, quality assurance, cost containment, the making of payments, and statistical or other

studies of the operation of CalCare or for protection and promotion of public, environmental, and occupational health.

(e) The board shall use the data furnished under this title to ensure that clinical practices meet the utilization, quality, and access standards of CalCare. The board shall not use a standard developed under this chapter for the purposes of establishing a payment incentive or adjustment under CalCare.

(f) To develop requirements and standards and making other policy determinations under this chapter, the board shall consult with representatives of members, health care providers, health care organizations, labor organizations representing health care employees, and other interested parties.

100651. (a) (1) As part of a health care practitioner's duty to advocate for medically appropriate health care for their patients pursuant to Sections 510 and 2056 of the Business and Professions Code, a participating provider has a duty to act in the exclusive interest of the patient.

(2) The duty described in paragraph (1) applies to a health care professional who may be employed by a participating provider or otherwise receive compensation or payment for health care items and services furnished under CalCare.

(b) Consistent with subdivision (a) and with Sections 510 and 2056 of the Business and Professions Code:

(1) An individual's treating physician, or other health care professional who is authorized to diagnose the individual in accordance with all applicable scope of practice and other license requirements and is treating the individual, is responsible for the determination of the medically necessary or appropriate care for the individual.

(2) A participating provider or health care professional who may be employed by CalCare or otherwise receive compensation or payment for health care items and services furnished under CalCare from a participating provider or other person participating in CalCare shall use reasonable care and diligence in safeguarding an individual under the care of the provider or professional and shall not impair an individual's treating physician or other health care provider treating the individual from advocating for medically necessary or appropriate care under this section.

(c) A health care provider or health care professional described in subdivision (a) violates the duty established under this section for any of the following:

(1) Having a pecuniary interest or relationship, including an interest or relationship disclosed under subdivision (d), that impairs the provider's ability to provide medically necessary or appropriate care.

(2) Accepting a bonus, incentive payment, or compensation based on any of the following:

(A) A patient's utilization of services.

(B) The financial results of another health care provider with which the participating provider has a pecuniary interest or contractual relationship, including employment or other compensation-based relationship, or of a person that contracts with or provides health care items or services, including pharmaceutical products and medical devices or equipment, to the provider.

(C) The financial results of an institutional provider, group practice, or person that contracts with, provides health care items or services under, or otherwise receives payment from CalCare.

(3) Having a board member, executive, or administrator that receives compensation from, owns stock or has other financial investments in, or serves as a board member of an entity that contracts with or provides health care items or services, including pharmaceutical products and medical devices or equipment, to the provider.

(d) To evaluate and review compliance with this section, a participating provider shall report, at least annually, to the Office of Statewide Health Planning and Development all of the following:

(1) A beneficial interest required to be disclosed to a patient pursuant to Section 654.2 of the Business and Professions Code.

(2) A membership, proprietary interest, coownership, or profit-sharing arrangement, required to be disclosed to a patient pursuant to Section 654.1 of the Business and Professions Code.

(3) A subcontract entered into that contains incentive plans that involve general payments, including capitation payments or shared risk agreements, that are not tied to specific medical decisions involving specific members or groups of members with similar medical conditions.

(4) Bonus or other incentive arrangements used in compensation agreements with another health care provider or an entity that contracts with or provides health care items or services, including pharmaceutical products and medical devices or equipment, to the provider.

(5) An offer, delivery, receipt, or acceptance of rebates, refunds, commission, preference, patronage dividend, discount, or other consideration for a referral made in exception to Section 650 of the Business and Professions Code.

(e) The board may adopt regulations as necessary to implement and enforce this section and may adopt regulations to expand reporting requirements under this section.

(f) For purposes of this section, "person" means an individual, partnership, corporation, limited liability company, or other organization, or any combination thereof, including a medical group practice, independent practice association, preferred provider organization, foundation, hospital medical staff and governing body, or payer.

100652. (a) An individual's treating physician, nurse, or other health care professional, in implementing a patient's medical or nursing care plan and in accordance with their scope of practice and licensure, may override health information technology or clinical practice guidelines, including standards and guidelines implemented by a participating provider through the use of health information technology, including electronic health record technology, clinical decision support technology, and computerized order entry programs.

(b) An override described in subdivision (a) shall, in the independent professional judgment of the treating physician, nurse or other health care professional, meet all of the following requirements:

(1) The override is consistent with the treating physician's, nurse's or other health care professional's determination of medical necessity or appropriateness or nursing assessment.

(2) The override is in the best interest of the patient.

(3) The override is consistent with the patient's wishes.

Chapter 7. Funding

Article 1. Federal Health Programs and Funding

100660. (a) (1) The board is authorized to and shall seek all federal waivers and other federal approvals and arrangements and submit state plan amendments as necessary to operate CalCare consistent with this title.

(2) The board is authorized to apply for a federal waiver or federal approval as necessary to receive funds to operate CalCare pursuant to paragraph (1), including a waiver under Section 18052 of Title 42 of the United States Code.

(3) The board shall apply for federal waivers or federal approval pursuant to paragraph (1) by January 1, 2023.

(b) (1) The board shall apply to the United States Secretary of Health and Human Services or other appropriate federal official for all waivers of requirements, and make other arrangements, under Medicare, any federally matched public health program, the Affordable Care Act, and any other federal programs or laws, as appropriate, that are necessary to enable all CalCare members to receive all benefits under CalCare through CalCare, to enable the state to implement this title, and to allow the state to receive and deposit all federal payments under those programs, including funds that may be provided in lieu of premium tax credits, cost-sharing subsidies, and small business tax credits, in the State Treasury to the credit of the CalCare Trust Fund, created pursuant to Section 100665, and to use those funds for CalCare and other provisions under this title.

(2) To the fullest extent possible, the board shall negotiate arrangements with the federal government to ensure that federal payments are paid to CalCare in place of federal funding of, or tax benefits for, federally matched public health programs or federal health programs. To the extent any federal funding is not paid directly to CalCare, the state shall direct the funding and moneys to CalCare.

(3) The board may require members or applicants to provide information necessary for CalCare to comply with any waiver or arrangement under this title. Information provided by members to the board for the purposes of this subdivision shall not be used for any other purpose.

(4) The board may take any additional actions necessary to effectively implement CalCare to the maximum extent possible as an independent single-payer program consistent with this title. It is the intent of the legislature to establish CalCare, to the fullest extent possible, as an independent agency.

(c) The board may take actions consistent with this article to enable CalCare to administer Medicare in California. CalCare shall be a provider of supplemental insurance coverage and shall provide premium assistance for drug coverage under Medicare Part D for eligible members of CalCare.

(d) The board may waive or modify the applicability of any provisions of this title relating to any federally matched public health program or Medicare, as necessary, to implement any waiver or arrangement under this section or to maximize the federal benefits to CalCare under this section.

(e) The board may apply for coverage for, and enroll, any eligible member under any federally matched public health program or Medicare. Enrollment in a federally matched public health program or Medicare shall not cause a member to lose a health care item or service provided by CalCare or diminish any right the member would otherwise have.

(f) (1) Notwithstanding any other law, the board, by regulation, shall increase the income eligibility level, increase or eliminate the resource test for eligibility, simplify any procedural or documentation requirement for enrollment, and increase the benefits for any federally matched public health program and for any program in order to reduce or eliminate an individual's coinsurance, cost-sharing, or premium obligations or increase an individual's eligibility for any federal financial support related to Medicare or the Affordable Care Act.

(2) The board may act under this subdivision, upon a finding approved by the Director of Finance and the board that the action does all of the following:

(A) Will help to increase the number of members who are eligible for and enrolled in federally matched public health programs, or for any program to reduce or eliminate an individual's coinsurance, cost-sharing, or premium obligations or increase an individual's eligibility for any federal financial support related to Medicare or the Affordable Care Act.

(B) Will not diminish any individual's access to a health care item or service or right the individual would otherwise have.

(C) Is in the interest of CalCare.

(D) Does not require or has received any necessary federal waivers or approvals to ensure federal financial participation.

(g) To enable the board to apply for coverage for, and enroll, any eligible member under any federally matched public health program or Medicare, the board may require that every member or applicant provide the information necessary to enable the board to determine whether the applicant is eligible for a federally matched public health program or for Medicare, or any program or benefit under Medicare.

(h) As a condition of continued eligibility for health care items and services under CalCare, a member who is eligible for benefits under Medicare shall enroll in Medicare, including Parts A, B, and D.

(i) The board shall provide premium assistance for all members enrolling in a Medicare Part D drug coverage plan under Section 1860D of Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395w-101 et seq.), limited to the low-income benchmark premium amount established by the federal Centers for Medicare and Medicaid Services and any other amount the federal agency establishes under its de minimis premium policy, except that those payments made on behalf of members enrolled in a Medicare Advantage plan may exceed the low-income benchmark premium amount if determined to be cost effective to CalCare.

(j) If the board has reasonable grounds to believe that a member may be eligible for an income-related subsidy under Section 1860D-14 of Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395w-114), the member shall provide, and authorize CalCare to obtain, any information or documentation required to establish the member's eligibility for that subsidy. The board shall attempt to obtain as much of the information and documentation as possible from records that are available to it.

(k) The board shall make a reasonable effort to notify members of their obligations under this section. After a reasonable effort has been made to contact the member, the member shall be notified in writing that the member has 60 days to provide the required information. If the required information is not provided within the 60-day period, the member's coverage under CalCare may be

suspended until the issue is resolved. Information provided by a member to the board for the purposes of this section shall not be used for any other purpose.

(*l*) The board shall assume responsibility for all benefits and services paid for by the federal government with those funds.

Article 2. CalCare Trust Fund

100665. (a) The CalCare Trust Fund is hereby created in the State Treasury for the purposes of this title to be administered by the CalCare Board. Notwithstanding Section 13340, all moneys in the fund shall be continuously appropriated without regard to fiscal year for the purposes of this title. Any moneys in the fund that are unexpended or unencumbered at the end of a fiscal year may be carried forward to the next succeeding fiscal year.

(b) Notwithstanding any other law, moneys deposited in the fund shall not be loaned to, or borrowed by, any other special fund or the General Fund, a county general fund or any other county fund, or any other fund.

(c) The board shall establish and maintain a prudent reserve in the fund to enable it to respond to costs including those of an epidemic, pandemic, natural disaster, or other health emergency, or market-shift adjustments related to patient volume.

(d) The board or staff of the board shall not utilize any funds intended for the administrative and operational expenses of the board for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modifications.

(e) Notwithstanding Section 16305.7, all interest earned on the moneys that have been deposited into the fund shall be retained in the fund and used for purposes consistent with the fund.

(f) The fund shall consist of all of the following:

(1) All moneys obtained pursuant to legislation enacted as proposed under Section 100670.

(2) Federal payments received as a result of any waiver of requirements granted or other arrangements agreed to by the United States Secretary of Health and Human Services or other appropriate federal officials for health care programs established under Medicare, any federally matched public health program, or the Affordable Care Act.

(3) The amounts paid by the State Department of Health Care Services that are equivalent to those amounts that are paid on behalf of residents of this state under Medicare, any federally matched public health program, or the Affordable Care Act for health benefits that are equivalent to health benefits covered under CalCare.

(4) Federal and state funds for purposes of the provision of services authorized under Title XX of the federal Social Security Act (42 U.S.C. Sec. 1397 et seq.) that would otherwise be covered under CalCare.

(5) State moneys that would otherwise be appropriated to any governmental agency, office, program, instrumentality, or institution that provides health care items or services for services and benefits covered under CalCare. Payments to the fund pursuant to this section shall be in an amount equal to the money appropriated for those purposes in the fiscal year beginning immediately preceding the effective date of this title.

(g) All federal moneys shall be placed into the CalCare Federal Funds Account, which is hereby created within the CalCare Trust Fund.

(h) Moneys in the CalCare Trust Fund shall only be used for the purposes established in this title.

100667. (a) The board annually shall prepare a budget for CalCare that specifies a budget for all expenditures to be made for covered health care items and services and shall establish allocations for each of the budget components under subdivision (b) that shall cover a three-year period.

(b) The CalCare budget shall consist of at least the following components:

(1) An operating budget.

(2) A capital expenditures budget.

(3) A special projects budget.

(4) Program standards activities.

(5) Health professional education expenditures.

(6) Administrative costs.

(7) Prevention and public health activities.

(c) The board shall allocate the funds received among the components described in subdivision (b) to ensure the following:

(1) The operating budget allows for participating providers to meet the health care needs of the population.

(2) A fair allocation to the special projects budget to meet the purposes described in subdivision (f) in a reasonable timeframe.

(3) A fair allocation for program standards activities.

(4) The health professional education expenditures component is sufficient to meet the need for covered health care items and services.

(d) The operating budget described in paragraph (1) of subdivision (b) shall be used for payments to providers for health care items and services furnished by participating providers under CalCare.

(e) The capital expenditures budget described in paragraph (2) of subdivision (b) shall be used for the construction or renovation of health care facilities, excluding congregate or segregated facilities for individuals with disabilities who receive long-term services and supports under CalCare, and other capital expenditures.

(f) (1) The special projects budget shall be used for the payment to not-for-profit or governmental entities that are health facilities pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code for the construction or renovation of health care facilities, major equipment purchases, staffing in a rural or medically underserved area, and to address health disparities, including those based on race, ethnicity, national origin, primary language use, age, disability, sex, including gender identity and sexual orientation, geography, and socioeconomic status.

(2) To mitigate the impact of the payments on the availability and accessibility of health care services, the special projects budget may be used to increase payment to providers in a rural or medically underserved area.

(g) For up to five years following the date on which benefits first become available under CalCare, at least 1 percent of the budget shall be allocated to programs providing transition assistance pursuant to Section 100615.

Article 3. CalCare Financing

100670. (a) It is the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for CalCare. In developing

the revenue plan, it is the intent of the Legislature to consult with appropriate officials and stakeholders.

(b) It is the intent of the Legislature to enact legislation that would require all state revenues from CalCare to be deposited in an account within the CalCare Trust Fund to be established and known as the CalCare Trust Fund Account.

Chapter 8. Collective Negotiation by Health Care Providers with CalCare

Article 1. Definitions

100675. For purposes of this chapter, the following definitions apply:

(a) (1) "Health care provider" means a person who is licensed, certified, registered, or authorized to practice a health care profession pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code and who is either of the following:

(A) An individual who practices that profession as a health care professional or as an independent contractor.

(B) An owner, officer, shareholder, or proprietor of a health care group practice that has elected to receive fee-for-service payments from CalCare pursuant to subdivision (d) of Section 100640.

(2) A health care provider licensed, certified, registered, or authorized to practice a health care profession pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code who practices as an employee of a health care provider is not a health care provider for purposes of this chapter.

(b) "Health care provider's representative" means a third party that is authorized by a health care provider to negotiate on their behalf with CalCare over terms and conditions affecting those health care providers.

Article 2. Authorized Collective Negotiation

100676. (a) Health care providers may meet and communicate for the purpose of collectively negotiating with CalCare on any matter relating to CalCare fee-for-service rates of payment for

health care items and services or procedures related to fee-for-service payment under CalCare.

(b) This chapter does not allow a strike of CalCare by health care providers related to the collective negotiations.

(c) This chapter does not allow or authorize terms or conditions that would impede the ability of CalCare to comply with applicable state or federal law.

Article 3. Collective Negotiation Requirements

100677. (a) Collective negotiation under this chapter shall meet all of the following requirements:

(1) A health care provider may communicate with other health care providers regarding the terms and conditions to be negotiated with CalCare.

(2) A health care provider may communicate with a health care provider's representative.

(3) A health care provider's representative is the only party authorized to negotiate with CalCare on behalf of the health care providers as a group.

(4) A health care provider can be bound by the terms and conditions negotiated by the health care provider's representative.

(b) This chapter does not affect or limit the right of a health care provider or group of health care providers to collectively petition a governmental entity for a change in a law, rule, or regulation.

(c) This chapter does not affect or limit collective action or collective bargaining on the part of a health care provider with the health care provider's employer or any other lawful collective action or collective bargaining.

100678. (a) Before engaging in collective negotiations with CalCare on behalf of health care providers, a health care provider's representative shall file with the board, in the manner prescribed by the board, information identifying the representative, the representative's plan of operation, and the representative's procedures to ensure compliance with this chapter.

(b) A person who acts as the representative of negotiating parties under this chapter shall pay a fee to the board to act as a representative. The board, by regulation, shall set fees in amounts deemed reasonable and necessary to cover the costs incurred by the board in administering this chapter.

Article 4. Prohibited Collective Action

100679. (a) This chapter does not authorize competing health care providers to act in concert in response to a health care provider's representative's discussions or negotiations with CalCare, except as authorized by other law.

(b) A health care provider's representative shall not negotiate an agreement that excludes, limits the participation or reimbursement of, or otherwise limits the scope of services to be provided by a health care provider or group of health care providers with respect to the performance of services that are within the health care provider's scope of practice, license, registration, or certificate.

Chapter 9. Operative Date

100680. (a) Notwithstanding any other law, this title, except for Chapter 1 (commencing with Section 100600) and Chapter 2 (commencing with Section 100610), shall not become operative until the date the Secretary of California Health and Human Services notifies the Secretary of the Senate and the Chief Clerk of the Assembly in writing that the secretary has determined that the CalCare Trust Fund has the revenues to fund the costs of implementing this title.

(b) The California Health and Human Services Agency shall publish a copy of the notice on its internet website.

SEC. 3. 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. 4. The Legislature finds and declares that Section 2 of this act, which adds Sections 100610, 100616, and 100618 to the Government Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to protect private, confidential, and proprietary information, it is necessary for that information to remain confidential.

O

ASSEMBLY BILL No. 1407

Introduced by Assembly Member Burke

February 19, 2021

An act relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 1407, as introduced, Burke. Health care: discrimination.

Existing law requires the State Department of Public Health Office of Health Equity to perform strategic planning to develop plans for implementation of goals and objectives to close the gaps in health status and access to care for the state's diverse racial and ethnic communities, women, persons with disabilities, and the lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQQ) communities.

This bill would state the intent of the Legislature to enact legislation that would address discrimination in health care.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

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

SECTION 1. It is the intent of the Legislature to enact legislation that would address discrimination in health care.

O

Assembly Bill No. 2218

CHAPTER 181

An act to add Division 119 (commencing with Section 150900) to the Health and Safety Code, relating to access to health services.

[Approved by Governor September 26, 2020. Filed with Secretary of State September 26, 2020.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2218, Santiago. Transgender Wellness and Equity Fund.

Existing law establishes an Office of Health Equity in the State Department of Public Health for purposes of aligning state resources, decisionmaking, and programs to accomplish certain goals related to health equity and protecting vulnerable communities. Existing law requires the office to develop department-wide plans to close the gaps in health status and access to care among the state's diverse racial and ethnic communities, women, persons with disabilities, and the lesbian, gay, bisexual, transgender, queer, and questioning communities, as specified.

This bill would establish the Transgender Wellness and Equity Fund, under the administration of the office, for the purpose of funding grants, upon appropriation by the Legislature, to organizations serving people that identify as transgender, gender nonconforming, or intersex (TGI), to create or fund TGI-specific housing programs and partnerships with hospitals, health care clinics, and other medical providers to provide TGI-focused health care, as defined, and related education programs for health care providers.

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

SECTION 1. The Legislature finds and declares the following:

(a) At least 218,400 people in California identify as transgender.

(b) In California, 27 percent, or 796,000, of youth 12 to 17, inclusive, years of age are viewed as gender nonconforming by their peers at school.

(c) An estimated 1.7 percent of the population is born with intersex traits.

(d) One in five transgender adults in California have attempted suicide—a rate six times that of the state's adult cisgender population.

(e) Transgender adults are significantly more likely to report having a disability due to a physical, mental, or emotional condition, 60 percent compared to 27 percent of cisgender adults.

(f) Transgender adults are more likely to delay or not get needed doctor-prescribed medicine, at a rate of 32 percent compared to 11 percent of cisgender adults.

(g) Transgender, gender nonconforming, and intersex (TGI) people face serious barriers to care. Transgender patients report that the largest barrier to care is a lack of transgender-competent providers.

(h) TGI people's inability to access care paired with a high risk of serious COVID-19 complications has resulted in an urgent need for TGI-competent health care.

SEC. 2. Division 119 (commencing with Section 150900) is added to the Health and Safety Code, to read:

DIVISION 119. TRANSGENDER WELLNESS AND EQUITY

150900. (a) The Transgender Wellness and Equity Fund is established in the State Treasury.

(b) The State Department of Public Health's Office of Health Equity shall administer the Transgender Wellness and Equity Fund for purposes of funding grants to create programs, or funding existing programs, focused on coordinating trans-inclusive health care for individuals who identify as transgender, gender nonconforming, or intersex (TGI).

(c) Upon appropriation by the Legislature, moneys in the Transgender Wellness and Equity Fund may be used to fund grants for the following purposes:

(1) The grants shall be available to TGI-serving organizations for the purpose of increasing the capacity of health care professionals to effectively provide TGI health care and institute TGI-inclusive best practices. This includes the creation of educational materials or facilitation of capacity building trainings.

(2) The grants shall be available to TGI-serving organizations for the purpose of facilitating therapeutic arts programs, such as dancing, painting, or writing.

(3) The grants shall be available to TGI-serving organizations for purposes of assisting, identifying, and referring TGI people to access supportive housing. This includes case management opportunities, financial assistance, and assisting TGI people in receiving and utilizing housing vouchers. If a TGI-serving organization has already implemented a TGI-specific housing program, funding may be utilized to maintain or expand existing housing programs.

(4) The grants shall be available to a hospital, health care clinic, or other medical provider that currently provides gender-affirming health care services, such as hormone therapy or gender reassignment surgery, to continue providing those services, or to a hospital, health care clinic, or other medical provider that will establish a program that offers gender-affirming health care services and has an established relationship with a TGI-serving organization that will lead in establishing the program.

(d) A hospital, health care clinic, or other medical provider that applies for a grant must apply in partnership with a TGI-serving organization and

consult with the TGI-serving organization throughout the process of creating and implementing its trans-inclusive health care program.

(e) This section does not limit or impact payer coverage requirements of health care or other social services.

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

(1) "Health care" means all of the following:

(A) Medical, behavioral, and spiritual care, which includes, but is not limited to, guided meditation and nondenominational therapy.

(B) Therapeutic arts programs, which includes, but is not limited to, dancing, painting, and writing classes.

(C) Services related to substance use disorder or substance abuse.

(D) Supportive housing as a mechanism to support TGI-identified individuals in accessing other social services.

(2) A "TGI-serving organization" is an organization with a mission statement that centers around serving transgender, gender nonconforming, and intersex people, and where at least 65 percent of the clients of the organization are TGI.

O

SENATE BILL No. 17

Introduced by Senator Pan
(Principal coauthors: Assembly Members Arambula and Chiu)
(Coauthor: Senator Durazo)
(Coauthors: Assembly Members Robert Rivas and Weber)

December 7, 2020

An act relating to public health.

LEGISLATIVE COUNSEL'S DIGEST

SB 17, as introduced, Pan. Public health crisis: racism.

Existing law establishes an Office of Health Equity in the State Department of Public Health for purposes of aligning state resources, decisionmaking, and programs to accomplish certain goals related to health equity and protecting vulnerable communities. Existing law requires the office to develop department-wide plans to close the gaps in health status and access to care among the state's diverse racial and ethnic communities, women, persons with disabilities, and the lesbian, gay, bisexual, transgender, queer, and questioning communities, as specified. Existing law requires the office to work with the Health in All Policies Task Force to assist state agencies and departments in developing policies, systems, programs, and environmental change strategies that have population health impacts by, among other things, prioritizing building cross-sectoral partnerships within and across departments and agencies to change policies and practices to advance health equity.

This bill would state the intent of the Legislature to enact legislation to require the department, in collaboration with the Health in All Policies Program, the Office of Health Equity, and other relevant departments, agencies, and stakeholders, to address racism as a public health crisis.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) Racism is the systemic subordination of members of targeted racial groups who have historically had relatively little social power in the United States by members of the racial groups who have more social power. Racism in the United States is informed by over 400 years of Black slavery, settler colonialism, and American neoimperialism.

(b) Racism, as a negative social system, is supported by the actions of individuals, cultural norms and values, institutional structures, practices of society, and laws and regulations imposed by government.

(c) Through the "Three-Fifths Compromise," racism was embedded as a founding principle in the United States Constitution. It is an ugly stain that continues to haunt our nation and that we must confront and actively dismantle.

(d) Public health is the science of protecting and improving the health of people and their communities by promoting healthy lifestyles, researching disease and injury prevention, and detecting, preventing, and responding to infectious diseases.

(e) Many government policies, institutional practices, and individual actions continue to be imbued, both consciously and unconsciously, with racist assumptions and practices that have created unhealthy physical and social conditions for Black, Indigenous, and people of color (BIPOC) and thereby prevent BIPOC communities from achieving good public health.

(f) For instance, the legacy of slavery, Jim Crow, and discriminatory housing policies against Black people have restricted the ability of Black families to build generational wealth, in comparison to White families, leading to income inequality. Income inequality and poverty have been well researched to be negative social determinants of health. Children who grow up in poverty, and especially those who are BIPOC, are more likely to be exposed to risk factors for obesity, elevated blood lead levels, and experience more adverse childhood experiences (ACEs).

(g) Racism in government policies, institutional practices, and income inequality also results in BIPOC communities being more likely to live near polluters, breathe polluted air, and be impacted disproportionately by the effects of climate change. Breathing in dangerous substances in the air has been linked to asthma, other chronic respiratory illnesses, and some cancers. In California, Black and Native American individuals have a significantly higher prevalence of asthma and are more likely to experience an avoidable hospitalization due to asthma.

(h) BIPOC communities experience racial disparities in accessing health care and receiving quality care. For example, Black women are three to four times more likely to die from pregnancy-related causes than White women. Research indicates these disparities persist in spite of income differences and can often be attributed to Black women receiving discriminatory care, such as health care providers dismissing symptoms raised by Black women or racist assumptions about pain thresholds experienced by Black people.

(i) Black transwomen suffer from employment, housing, and educational discrimination and police brutality that result in the most acute health disparities. Government policies, such as recent federal actions that encourage homeless shelters, social services, educational institutions, and health care providers to discriminate against transgender people and overlook the deleterious impacts of racism, actively prevent Black transwomen from accessing services critical to achieving optimal health.

(j) On an individual physiological level, studies show that chronic stress from individual and systemic acts of racism and discrimination trigger high blood pressure, heart disease, immunodeficiency, and result in accelerated aging.

(k) The COVID-19 pandemic, the ensuing economic crisis, and recent protests against institutional violence committed against Black communities again highlight the racial injustices and health disparities that have long threatened BIPOC communities.

(*l*) In California, Black and Latino individuals are more likely to have existing health conditions that make them more susceptible to contracting COVID-19, experience more severe symptoms, and suffer from higher mortality rates. BIPOC tend to work in essential jobs that may lead to a higher likelihood of being exposed to

COVID-19, or in jobs that have an inability to work remotely and, therefore, are more severely impacted by the economic crisis.

(m) Racism results in the underinvestment of social, health, and educational services in BIPOC communities and an overinvestment of disproportionate and inappropriate policing by law enforcement. Racism threatens to endanger the health of individuals, the community, and public health.

(n) Accordingly, California, joining a growing list of cities and counties across the state and country to acknowledge the long-standing impacts of systemic racism, declares racism as a public health crisis. In order to advance and improve public health for all Californians, the state must approach laws and regulations with an antiracist, Health in All policy equity-driven focus that interrogates whether policies play a role in upholding or dismantling racist systems, and must secure adequate resources to address the crisis.

SEC. 2. It is the intent of the Legislature to enact legislation to require the State Department of Public Health, in collaboration with the Health in All Policies Program, the Office of Health Equity, and other relevant departments, agencies, and stakeholders, to address racism as a public health crisis.

O

SENATE BILL No. 56

Introduced by Senator Durazo
(Principal coauthor: Assembly Member Arambula)

December 7, 2020

An act to amend Section 14007.8 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 56, as introduced, Durazo. Medi-Cal: eligibility.

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

Existing law requires individuals under 19 years of age enrolled in restricted-scope Medi-Cal at the time the Director of Health Care Services makes a determination that systems have been programmed for implementation of these provisions to be enrolled in the full scope of Medi-Cal benefits, if otherwise eligible, and extends eligibility for full-scope Medi-Cal benefits to individuals under 25 years of age, and who are otherwise eligible for those benefits but for their immigration status. Existing law makes the effective date of enrollment for those individuals the same day that systems are operational to begin processing new applications pursuant to the director's determination, and requires the department to maximize federal financial participation for purposes of implementing the requirements. Existing law provides that Medi-Cal benefits for 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, 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 3 fiscal years that exceeds the cost of providing those individuals full scope Medi-Cal benefits.

This bill would, subject to an appropriation by the Legislature, and effective July 1, 2022, extend eligibility for full-scope Medi-Cal benefits to individuals who are 65 years of age or older, and who are otherwise eligible for those benefits but for their immigration status. The bill would delete provisions delaying implementation until the director makes the determination described above. The bill would require the department to seek federal approvals to obtain federal financial participation to implement these requirements. Because counties are required to make Medi-Cal eligibility determinations and this bill would expand Medi-Cal eligibility, the bill would impose a state-mandated local program.

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, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. 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~~ *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) No sooner than July 1, 2021, 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.

(3) (A) Effective July 1, 2022, an individual who is 65 years of age or older, and who does not have satisfactory immigrant status or is unable to establish satisfactory immigration status as required by Section 14011.2, shall be eligible for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(B) Implementation of this paragraph shall be subject to an appropriation in the annual Budget Act or any other act approved by the Legislature for the express purpose of this paragraph.

(4) (A) An individual enrolled in the Medi-Cal program pursuant to this section and subdivision (d) of Section 14007.5 shall not be required to file a new application for the Medi-Cal program.

~~(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,~~

(B) The enrollment specified in subparagraph (A) shall be complete pursuant to an eligibility and enrollment ~~plan. This plan~~ *plan, and* shall include outreach strategies developed by the department in consultation with interested stakeholders, including, but not limited to, counties, health care service plans, *health care providers*, consumer advocates, and the Legislature. ~~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~~*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)~~

(b) 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)~~

(c) 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)~~

(d) The department shall ~~maximize~~ *seek any necessary federal approvals to obtain* 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.~~ *section. Benefits for services under this section shall*

be provided with state-only funds if federal financial participation is unavailable for those services.

~~(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)~~

(e) 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)~~

(f) (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~~ *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)~~

(g) 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. 2. If the Commission on State Mandates determines that this act contains 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.

O

SENATE BILL No. 57

Introduced by Senator Wiener
(Principal coauthors: Assembly Members Chiu, Friedman, and Kamlager)
(Coauthor: Senator Eggman)
(Coauthors: Assembly Members Bonta, Carrillo, Ting, and Wicks)

December 7, 2020

An act to add and repeal Section 11376.6 of the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

SB 57, as introduced, Wiener. Controlled substances: overdose prevention program.

Existing law makes it a crime to possess specified controlled substances or paraphernalia. Existing law makes it a crime to use or be under the influence of specified controlled substances. Existing law additionally makes it a crime to visit or be in any room where specified controlled substances are being unlawfully used with knowledge that the activity is occurring, or to open or maintain a place for the purpose of giving away or using specified controlled substances. Existing law makes it a crime for a person to rent, lease, or make available for use any building or room for the purpose of storing or distributing any controlled substance. Existing law authorizes forfeiture of property used for specified crimes involving controlled substances.

This bill would, until January 1, 2027, authorize the City and County of San Francisco, the County of Los Angeles, and the City of Oakland to approve entities to operate overdose prevention programs for persons that satisfy specified requirements, including, among other things, providing a hygienic space supervised by trained staff where people who use drugs can consume preobtained drugs, providing sterile

consumption supplies, and providing access or referrals to substance use disorder treatment. The bill would require the City and County of San Francisco, the County of Los Angeles, and the City of Oakland, prior to authorizing an overdose prevention program in its jurisdiction, to provide local law enforcement officials, local public health officials, and the public with an opportunity to comment in a public meeting. The bill would require an entity operating a program to provide an annual report to the city or the city and county, as specified. The bill would exempt a person from, among other things, civil liability, professional discipline, or existing criminal sanctions, solely for actions, conduct, or omissions in compliance with an overdose prevention program authorized by the city or the city and county.

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

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) Overdose deaths in California are an urgent public health crisis. Overdose has been the leading cause of accidental death in the United States and in California each year since 2011.

(b) The COVID-19 pandemic has been associated with a rapid increase in drug overdose deaths. According to data published in the article “Drug overdoses are soaring during the coronavirus pandemic” by the Washington Post, overdoses increased every month in fall of 2020 compared to the prior year. In May 2020, the increase was 42 percent compared to the prior year.

(c) Overdose prevention programs (OPPs) are an evidence-based harm reduction strategy that allows individuals to consume drugs in a hygienic environment under the supervision of staff trained to intervene if the individual overdoses. OPPs also provide sterile consumption equipment and offer general medical advice and referrals to substance use disorder treatment, housing, medical care, and other community social services.

(d) There are approximately 165 overdose prevention programs operating in 10 countries around the world. Numerous

peer-reviewed studies have confirmed that OPPs are effective in reducing overdose deaths and HIV transmission, and in increasing access to counseling, treatment, and other risk reduction services. Research has also demonstrated that OPPs decrease use of emergency medical services, reduce public drug use, reduce syringe debris, and do not increase crime or drug use.

(e) In July 2020, the American Medical Association (AMA) joined several associations representing health officials and public health, drug policy, and substance use disorder treatment specialists, in an amicus brief supporting an OPP in Philadelphia, Pennsylvania. The AMA and others wrote that, "Supervised consumption sites are an evidence-based medical and public health intervention with the potential to improve individual and community health."

(f) On July 8, 2020, the New England Journal of Medicine published a study on the outcomes of an unsanctioned OPP operating in the United States from 2014 to 2019, inclusive. The study and supplemental material show that not only were there no deaths resulting from over 10,000 injections, but that it was not once necessary in five years to call for paramedic services or use an outside medical facility. The authors conclude that, "sanctioned safe consumption sites in the United States could reduce mortality from opioid-involved overdose. Sanctioning sites could allow persons to link to other medical and social services, including treatment for substance use, and facilitate rigorous evaluation of their implementation and effect on reducing problems such as public injection of drugs and improperly discarded syringes."

(g) An analysis published in the Journal of Drug Issues in 2016 found that, based on the experience of an OPP in Vancouver, a proposed program in San Francisco would reduce government expenses associated with health care, emergency services, and crime, saving $2.33 for every dollar spent. It is estimated that one OPP would save the City and County of San Francisco $3,500,000 in other costs.

(h) As demands for reform of the criminal justice and legal system reverberate around the country, OPPs offer an alternative framework for addressing both drug use as well as the enforcement of drug laws that disproportionately injures communities of color. OPPs bring people inside to a safe and therapeutic space, instead

of leaving them vulnerable to police intervention, arrest, and incarceration.

(i) In July 2020, California law enforcement leadership, including district attorneys of the Counties of Los Angeles, San Francisco, Santa Clara, and Contra Costa, signed onto an amicus brief in support of an OPP in Philadelphia, Pennsylvania, writing, "The issues are particularly acute at this current moment, with a global pandemic and fractured relations between law enforcement and communities. There is an urgent need to fortify trust in the justice system. Failing to address the loss of life resulting from drug overdose-and criminalizing a community based public health organization working to save lives-will further erode trust. If there were ever a time to demonstrate that the justice system values the dignity of human life, that time is now."

(j) Also in July 2020, California Attorney General Xavier Becerra joined an amicus brief with eight other states and the District of Columbia, in support of an OPP. In the brief, the attorneys general wrote, "After studying SIS [safe injection services] interventions in other countries, many states and cities are considering them as a means of saving lives. The studies predict that the sites will reduce deaths, the spread of bloodborne diseases, and costs. And they are a unique solution to the common problem in many urban areas of rapid, unintended overdoses of heroin or fentanyl."

(k) It is the intent of the Legislature to promote the health and safety of communities by evaluating the health impacts of OPPs in San Francisco, Los Angeles, and Oakland.

(*l*) It is the intent of the Legislature to prevent fatal and nonfatal drug overdoses, reduce drug use by providing a pathway to drug treatment, as well as medical and social services for high-risk drug users, many of whom are homeless, uninsured, or very low income, prevent the transmission of HIV and hepatitis C, reduce nuisance and public safety problems related to public use of controlled substances, and reduce emergency room use and hospital utilization related to drug use, reserving precious space, including intensive care beds for treatment of COVID-19 and other life-threatening conditions.

(m) It is the intent of the Legislature that OPPs should be evaluated in California cities that authorize them, as OPPs show great promise to save lives, enhance public safety, improve access

to substance use disorder treatment, medical care, and related services, reduce emergency department and hospital utilization related to drug overdose, and reduce the human, social, and financial costs of the triple epidemics of drug misuse, homelessness, and COVID-19.

SEC. 2. Section 11376.6 is added to the Health and Safety Code, to read:

11376.6. (a) Notwithstanding any other law, the City and County of San Francisco, the County of Los Angeles, and the City of Oakland may approve entities within their jurisdictions to establish and operate overdose prevention programs that satisfy the requirements set forth in subdivision (c).

(b) Prior to approving an entity within its jurisdiction pursuant to subdivision (a), the City and County of San Francisco, the County of Los Angeles, or the City of Oakland shall provide local law enforcement officials, local public health officials, and the public with an opportunity to comment in a public meeting. The notice of the meeting to the public shall be sufficient to ensure adequate participation in the meeting by the public. The meeting shall be noticed in accordance with all state laws and local ordinances, and as local officials deem appropriate.

(c) In order for an entity to be approved to operate an overdose prevention program pursuant to this section, the entity shall demonstrate that it will, at a minimum:

(1) Provide a hygienic space to consume controlled substances under supervision of staff trained to prevent and treat drug overdoses.

(2) Provide sterile consumption supplies, collect used equipment, and provide secure hypodermic needle and syringe disposal services.

(3) Monitor participants for potential overdose and provide care as necessary to prevent fatal overdose.

(4) Provide access or referrals to substance use disorder treatment services, primary medical care, mental health services, and social services.

(5) Educate participants on preventing transmission of HIV and viral hepatitis.

(6) Provide overdose prevention education and access to or referrals to obtain naloxone hydrochloride or another overdose

reversal medication approved by the United States Food and Drug Administration.

(7) Educate participants regarding proper disposal of hypodermic needles and syringes and provide participants with approved biohazard containers for syringe disposal.

(8) Provide reasonable security of the program site.

(9) Establish operating procedures for the program including, but not limited to, standard hours of operation, training standards for staff, a minimum number of personnel required to be onsite during those hours of operation, the maximum number of individuals who can be served at one time, and an established relationship with the nearest emergency department of a general acute care hospital, as well as eligibility criteria for program participants.

(10) Establish and make public a good neighbor policy that facilitates communication from and to local businesses and residences, to the extent they exist, to address any neighborhood concerns and complaints.

(d) An entity operating an overdose prevention program under this section shall provide an annual report to the authorizing jurisdiction that shall include all of the following:

(1) The number of program participants.

(2) Aggregate information regarding the characteristics of program participants.

(3) The number of overdoses experienced and the number of overdoses reversed onsite.

(4) The number of persons referred to substance use disorder treatment, primary medical care, and other services.

(e) Notwithstanding any other law, a person or entity, including, but not limited to, property owners, managers, employees, volunteers, clients or participants, and employees of the City and County of San Francisco, the County of Los Angeles, or the City of Oakland acting in the course and scope of employment, shall not be arrested, charged, or prosecuted pursuant to Section 11350, 11364, 11365, 11366, 11366.5, or 11377, or subdivision (a) of Section 11550, including for attempt, aiding and abetting, or conspiracy to commit a violation of any of those sections, or be subjected to any civil or administrative penalty or liability, including property forfeiture or disciplinary action by a professional licensing board, or otherwise be penalized solely for actions,

conduct, or omissions related to the operation of and on the site of an overdose prevention program approved by the City and County of San Francisco, the County of Los Angeles, or the City of Oakland, or for conduct relating to the approval of an entity to operate an overdose prevention program, or the inspection, licensing, or other regulation of an overdose prevention program approved by the City and County of San Francisco, the County of Los Angeles, or the City of Oakland pursuant to subdivision (a).

(f) This section shall remain in effect only until January 1, 2027, and as of that date is repealed.

SEC. 3. The Legislature finds and declares that a special statute is necessary and that a general statute cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because of the unique needs of the City and County of San Francisco, the County of Los Angeles, and the City of Oakland.

O

SENATE BILL No. 110

Introduced by Senator Wiener
(Principal coauthor: Assembly Member Chiu)
(Coauthor: Assembly Member Friedman)

January 6, 2021

An act to add Section 14021.38 to the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 110, as introduced, Wiener. Substance use disorder services: contingency management services.

Existing law provides for 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, including substance use disorder services that are delivered through the Drug Medi-Cal Treatment Program and the Drug Medi-Cal organized delivery system. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

To the extent funds are made available in the annual Budget Act, this bill would expand substance use disorder services to include contingency management services, as specified, subject to utilization controls. The bill would require the department to issue guidance and training to providers on their use of contingency management services for Medi-Cal beneficiaries who access substance use disorder services under any Medi-Cal delivery system, including the Drug Medi-Cal Treatment Program and the Drug Medi-Cal organized delivery system. The bill would provide that contingency management services are not a rebate, refund, commission preference, patronage dividend, discount, or any other gratuitous consideration. The bill would authorize the department to implement these provisions by various means, including provider

bulletin, without taking regulatory action, and would condition the implementation of these provisions to the extent permitted by federal law, the availability of federal financial participation, and the department securing federal approval.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Section 14021.38 is added to the Welfare and Institutions Code, immediately following Section 14021.37, to read:

14021.38. (a) To the extent funds are made available in the annual Budget Act for this express purpose, substance use disorder services shall include contingency management services as a covered benefit, subject to utilization controls, as described in Section 14133. Contingency management services shall include all of the following components:

(1) Periodic urinalysis on patients.

(2) An incentive structure, which includes scaling rewards for continued evidence of specified behaviors or adherence to treatment goals, that rewards participants for specified behaviors, such as a negative urinalysis.

(3) Other supportive substance use disorder services, including counseling, therapy, or other proven medical alternatives, as necessary to meet the health needs of Medi-Cal beneficiaries.

(b) The department shall issue guidance and training to providers on their use of contingency management services for Medi-Cal beneficiaries who access substance use disorder services under any Medi-Cal delivery system, including, but not limited to, the Drug Medi-Cal Treatment Program and the Drug Medi-Cal organized delivery system.

(c) Contingency management services are not a rebate, refund, commission preference, patronage dividend, discount, or any other gratuitous consideration, as described in Section 51478 of Title 22 of the California Code of Regulations.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of a provider bulletin or similar instruction, without taking regulatory action.

(e) For purposes of implementing this section, the department shall seek any necessary federal approvals, including approvals of any state plan amendments or federal waivers, by the federal Centers for Medicare and Medicaid Services.

(f) (1) This section shall only be implemented to the extent permitted by federal law.

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

O

SENATE BILL No. 221

Introduced by Senator Wiener
(Coauthors: Senators Leyva and Newman)
(Coauthors: Assembly Members Arambula, Kamlager, and Waldron)

January 13, 2021

An act to amend Section 1367.031 of, and to add Section 1367.032 to, the Health and Safety Code, and to amend Section 10133.53 of, and to add Section 10133.54 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 221, as introduced, Wiener. Health care coverage: timely access to care.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires each department to develop and adopt regulations to ensure that enrollees and insureds have access to needed health care services in a timely manner.

Existing regulations require a health care service plan or an insurer to ensure that their contracted provider networks have adequate capacity and availability of licensed health care providers to offer enrollees and insureds appointments that meet specified timeframes. Existing regulations require a health care service plan or an insurer to ensure that for an enrollee requesting a nonurgent appointment with a nonphysician mental health care provider, or an insured requesting a nonurgent appointment with a nonphysician mental health care or substance use disorder provider, appointments are offered within 10 business days of the request for an appointment. Existing regulations

also authorize appointments for preventive care services and periodic followup care, including periodic office visits to monitor and treat mental health or substance use disorder conditions, as specified, to be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the provider's scope of practice. These regulations of the Department of Managed Care are limited in application to mental health care providers, while those regulations of the Department of Insurance are applicable to both mental health care and substance use disorder providers.

This bill would codify the regulations adopted by the Department of Managed Health Care and the Department of Insurance to provide timely access standards for health care service plans and insurers for nonemergency health care services. The bill would require both a health care service plan and a health insurer to ensure that appointments with nonphysician mental health and substance use disorder providers are subject to the timely access requirements. The bill would additionally require a health care service plan or a health insurer to ensure that an enrollee or insured that is undergoing a course of treatment for an ongoing mental health or substance use disorder condition is able to get a followup appointment with a nonphysician mental health care or substance use disorder provider within 10 business days of the prior appointment. By imposing new requirements on health care service plans, the willful violation of which would be a crime, the bill would impose a state-mandated local program.

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 no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) It is the intent of the Legislature to ensure that all enrollees of health care service plans and health insurers who require ongoing courses of medically necessary treatment for mental health and

substance use disorders are able to obtain followup appointments with nonphysician providers of mental health and substance use disorder services within timeframes that are clinically appropriate to care for their diagnoses.

(b) Existing law and regulations have been interpreted to set clear timely access standards for health care service plans and health insurers to meet enrollees' requests for initial appointments with nonphysician providers of mental health and substance use disorder services, but not to set similarly clear timely access standards for the provision of followup appointments with these providers for the many enrollees who need them.

(c) This loophole in existing law and regulations has resulted in failures to provide enrollees followup appointments with nonphysician providers of mental health and substance use disorder services within the timeframes consistent with generally accepted standards of care.

(d) Closing this loophole is urgently necessary to address the widespread and lengthy delays in access to followup appointments with nonphysician providers of mental health and substance use disorder services experienced by thousands of Californians, including individuals suffering from major disorders and reporting suicidal ideation.

(e) Closing this loophole has grown even more urgent as the prevalence of mental health and substance use disorders has increased dramatically during the COVID-19 pandemic, and efforts to meet increased demand have focused on providing initial appointments while timely access to appropriate followup care has further diminished.

SEC. 2. Section 1367.031 of the Health and Safety Code is amended to read:

1367.031. (a) A health care service plan contract that is issued, renewed, or amended on or after July 1, 2017, shall provide information to an enrollee regarding the standards for timely access to care adopted pursuant to Section 1367.03 and the information required by this section, including information related to receipt of interpreter services in a timely manner, no less than annually.

(b) A health care service plan contract that is issued, renewed, or amended on or after July 1, 2022, shall provide information to an enrollee regarding the standards for timely access to care required by Section 1367.032, adopted pursuant to Section

1367.03, and the information required by this section, including information related to receipt of interpreter services in a timely manner, no less than annually.

~~(b)~~

(c) A health care service plan at a minimum shall provide information regarding appointment wait times for urgent care, nonurgent primary care, nonurgent specialty care, and telephone screening established *in Section 1367.032 or* pursuant to Section 1367.03 to enrollees and contracting providers. The information shall also include notice of the availability of interpreter services at the time of the appointment pursuant to Section 1367.04. A health care service plan may indicate that exceptions to appointment wait times may apply if the department has found exceptions to be permissible.

~~(c)~~

(d) The information required to be provided pursuant to this section shall be provided to an enrollee with individual coverage upon initial enrollment and annually thereafter upon renewal, and to enrollees and subscribers with group coverage upon initial enrollment and annually thereafter upon renewal. A health care service plan may include this information with other materials sent to the enrollee. The information shall also be provided in the following manner:

(1) In a separate section of the evidence of coverage titled "Timely Access to Care."

(2) At least annually, in or with newsletters, outreach, or other materials that are routinely disseminated to the plan's enrollees.

(3) Commencing January 1, 2018, in a separate section of the provider directory published and maintained by the health care service plan pursuant to Section 1367.27. The separate section shall be titled "Timely Access to Care."

(4) On the ~~Internet Web site~~ *internet website* published and maintained by the health care service plan, in a manner that allows enrollees and prospective enrollees to easily locate the information.

~~(d)~~

(e) (1) A health care service plan shall provide the information required by this section to contracting providers on no less than an annual basis.

(2) A health care service plan shall also inform a contracting provider of all of the following:

(A) Information about a health care service plan's obligation under California law to provide or arrange for timely access to care.

(B) How a contracting provider or enrollee can contact the health care service plan to obtain assistance if a patient is unable to obtain a timely referral to an appropriate provider.

(C) The toll-free telephone number for the Department of Managed Health Care where providers and enrollees can file a complaint if they are unable to obtain a timely referral to an appropriate provider.

(3) A health care service plan may comply with this subdivision by including the information with an existing communication with a contracting provider.

~~(e)~~

(f) This section shall apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 3. Section 1367.032 is added to the Health and Safety Code, to read:

1367.032. (a) Notwithstanding Section 1367.03, a health care service plan that provides or arranges for the provision of hospital or physician services, including a specialized mental health plan that provides physician or hospital services, or that provides mental health services pursuant to a contract with a full service plan, shall comply with the following timely access requirements:

(1) A health care service plan shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. A plan shall establish and maintain provider networks, policies, procedures, and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.

(2) A health care service plan shall ensure that all plan and provider processes necessary to obtain covered health care services, including prior authorization processes, are completed in a manner that assures the provision of covered health care services to an enrollee in a timely manner appropriate for the enrollee's condition and in compliance with this section.

(3) If it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice, and consistent with the objectives of Section 1367.03 and this section.

(4) Interpreter services required by Section 1367.04 of this code and Section 1300.67.04 of Title 28 of the California Code of Regulations shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. This subdivision does not modify the requirements established in Section 1300.67.04 of Title 28 of the California Code of Regulations, or approved by the department pursuant to Section 1300.67.04 of Title 28 of the California Code of Regulations for a plan's language assistance program.

(5) In addition to ensuring compliance with the clinical appropriateness standard set forth in paragraph (1), a health care service plan shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes:

(A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in subparagraph (H).

(B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in subparagraph (H).

(C) Nonurgent appointments for primary care: within 10 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(D) Nonurgent appointments with specialist physicians: within 15 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(E) Nonurgent appointments with a nonphysician mental health care or substance use disorder provider: within 10 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(F) Nonurgent followup appointments with a nonphysician mental health care or substance use disorder provider: within 10 business days of the prior appointment for those undergoing a

course of treatment for an ongoing mental health or substance use disorder condition, except as provided in subparagraph (H).

(G) Nonurgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within 15 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(H) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

(I) Preventive care services, as defined in subdivision (e), and periodic follow up care, including standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac, mental health, or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice.

(J) A plan may demonstrate compliance with the primary care time-elapsed standards established by this subdivision through implementation of standards, processes, and systems providing advanced access to primary care appointments, as defined in subdivision (e).

(6) In addition to ensuring compliance with the clinical appropriateness standard set forth at paragraph (1), each dental plan, and each full service plan offering coverage for dental services, shall ensure that contracted dental provider networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments for covered dental services in accordance with the following requirements:

(A) Urgent appointments within the dental plan network shall be offered within 72 hours of the time of request for appointment, if consistent with the enrollee’s individual needs and as required by professionally recognized standards of dental practice.

(B) Nonurgent appointments shall be offered within 36 business days of the request for appointment, except as provided in subparagraph (C).

(C) Preventive dental care appointments shall be offered within 40 business days of the request for appointment.

(7) A plan shall ensure it has sufficient numbers of contracted providers to maintain compliance with the standards established by this section.

(A) This section does not modify the requirements regarding provider-to-enrollee ratio or geographic accessibility established by Section 1300.51, 1300.67.2, or 1300.67.2.1 of Title 28 of the California Code of Regulations.

(B) A plan operating in a service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring an enrollee to, or, in the case of a preferred provider network, by assisting an enrollee to locate available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. A plan shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network if medically necessary for the enrollee's condition. Enrollee costs for medically necessary referrals to nonnetwork providers shall not exceed applicable copayments, coinsurance, and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

(8) A plan shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone, as defined in subdivision (e).

(A) A plan shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and that the triage or screening waiting time does not exceed 30 minutes.

(B) A plan may provide or arrange for the provision of telephone triage or screening services through one or more of the following means: plan-operated telephone triage or screening services, telephone medical advice services pursuant to Section 1348.8, the

plan's contracted primary care and mental health care provider network, or other method that provides triage or screening services consistent with this section.

(i) A plan that arranges for the provision of telephone triage or screening services through contracted primary care and mental health care providers shall require those providers to maintain a procedure for triaging or screening enrollee telephone calls, which, at a minimum, shall include the employment, during and after business hours, of a telephone answering machine, an answering service, or office staff, that shall inform the caller of both of the following:

(I) Regarding the length of wait for a return call from the provider.

(II) How the caller may obtain urgent or emergency care, including, if applicable, how to contact another provider who has agreed to be on call to triage or screen by phone, or if needed, deliver urgent or emergency care.

(ii) A plan that arranges for the provision of triage or screening services through contracted primary care and mental health care providers who are unable to meet the time-elapsed standards established in subparagraph (A) shall also provide or arrange for the provision of plan-contracted or operated triage or screening services, which shall, at a minimum, be made available to enrollees affected by that portion of the plan's network.

(iii) An unlicensed staff person handling enrollee calls may ask questions on behalf of a licensed staff person to help ascertain the condition of an insured so that the enrollee may be referred to licensed staff. However, an unlicensed staff person shall not, under any circumstances, use the answers to those questions in an attempt to assess, evaluate, advise, or make a decision regarding the condition of an enrollee or determine when an enrollee needs to be seen by a licensed medical professional.

(9) Dental, vision, chiropractic, and acupuncture plans shall ensure that contracted providers employ an answering service or a telephone answering machine during nonbusiness hours, which provide instructions regarding how an enrollee may obtain urgent or emergency care, including, if applicable, how to contact another provider who has agreed to be on call to triage or screen by phone, or if needed, deliver urgent or emergency care.

(10) A plan shall ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed 10 minutes.

(b) Dental, vision, chiropractic, and acupuncture plans shall comply with paragraphs (1), (3), (4), (7), (9), and (10) of subdivision (a).

(c) The obligation of a plan to comply with this section shall not be waived if the plan delegates to its medical groups, independent practice associations, or other contracting entities any services or activities that the plan is required to perform. A plan's implementation of this section shall be consistent with the Health Care Providers' Bill of Rights, and a material change in the obligations of a plan's contracting providers shall be considered a material change to the provider contract, within the meaning of subdivision (b) and paragraph (2) of subdivision (h) of Section 1375.7.

(d) This section confirms requirements for plans to provide or arrange for the provision of access to health care services in a timely manner, and establishes additional metrics for measuring and monitoring the adequacy of a plan's contracted provider network to provide enrollees with timely access to needed health care services. This section does not do any of the following:

(1) Establish professional standards of practice for health care providers.

(2) Establish requirements for the provision of emergency services.

(3) Create a new cause of action or a new defense to liability for any person.

(e) For purposes of this section:

(1) "Advanced access" means the provision, by an individual provider, or by the medical group or independent practice association to which an enrollee is assigned, of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered within the same or the next business day.

(2) "Appointment waiting time" means the time from the initial request for health care services by an enrollee or the enrollee's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting providers.

(3) "Preventive care" means health care provided for prevention and early detection of disease, illness, injury, or other health condition and, in the case of a full service plan includes all of the basic health care services required by paragraph (5) of subdivision (b) of Section 1345 of this code, and Section 1300.67(f) of Title 28 of the California Code of Regulations.

(4) "Provider group" has the meaning set forth in subdivision (g) of Section 1373.65.

(5) "Triage" or "screening" means the assessment of an enrollee's health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an enrollee who may need care for the purpose of determining the urgency of the enrollee's need for care.

(6) "Triage or screening waiting time" means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an enrollee who may need care.

(7) "Urgent care" means health care for a condition which requires prompt attention, consistent with paragraph (2) of subdivision (h) of Section 1367.01.

SEC. 4. Section 10133.53 of the Insurance Code is amended to read:

10133.53. (a) *(1)* A health insurance policy that is issued, renewed, or amended on or after July 1, 2017, that provides benefits through contracts with providers for alternative rates pursuant to Section 10133 shall provide information to an insured regarding the standards for timely access to care adopted pursuant to Section 10133.5 and the information required by this section, including information related to receipt of interpreter services in a timely manner, no less than annually.

(2) A health insurance policy that is issued, renewed, or amended on or after July 1, 2022, that provides benefits through

contracts with providers for alternative rates pursuant to Section 10133 shall provide information to an insured regarding the standards for timely access to care required by Section 10133.54, adopted pursuant to Section 10133.5, and the information required by this section, including information related to receipt of interpreter services in a timely manner, no less than annually.

(b) A health insurer that contracts with providers for alternative rates of payment pursuant to Section 10133 shall, at a minimum, provide information regarding appointment wait times for urgent care, nonurgent primary care, nonurgent specialty care, and telephone screening established *in Section 10133.54 or* pursuant to Section 10133.5 to insureds and contracting providers. The information shall also include notice of the availability of interpreter services at the time of the appointment pursuant to Section 10133.8. A health insurer may indicate that exceptions to appointment wait times may apply if the department has found exceptions to be permissible.

(c) The information required to be provided pursuant to this section shall be provided to an insured with individual coverage upon initial enrollment and annually thereafter upon renewal, and to insureds and group policyholders with group coverage upon initial enrollment and annually thereafter upon renewal. An insurer may include this information with other materials sent to the insured. The information shall also be provided in the following manner:

(1) In a separate section of the evidence of coverage titled "Timely Access to Care."

(2) At least annually, in or with newsletters, outreach, or other materials that are routinely disseminated to the policy's insureds.

(3) Commencing January 1, 2018, in a separate section of the provider directory published and maintained by the insurer pursuant to Section 10133.15. The separate section shall be titled "Timely Access to Care."

(4) On the ~~Internet Web site~~ *internet website* published and maintained by the insurer, in a manner that allows insureds and prospective insureds to easily locate the information.

(d) (1) A health insurer shall provide the information required by this section to contracting providers on no less than an annual basis.

(2) A health insurer shall also inform a contracting provider of all of the following:

(A) Information about a health insurer's obligation under California law to provide or arrange for timely access to care.

(B) How a contracting provider or insured can contact the health insurer to obtain assistance if a patient is unable to obtain a timely referral to an appropriate provider.

(C) The toll-free telephone number for the Department of Insurance where providers and insureds can file a complaint if they are unable to obtain a timely referral to an appropriate provider.

(3) A health insurer may comply with this subdivision by including the information with an existing communication with a contracting provider.

SEC. 5. Section 10133.54 is added to the Insurance Code, to read:

10133.54. (a) Notwithstanding Section 10133.5, a health insurer that provides or arranges for the provision of hospital or physician services, including a specialized mental health insurer that provides physician or hospital services, or that provides mental health services pursuant to a contract with a full service insurer, shall comply with the following timely access requirements:

(1) A health insurer shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the insured's condition, consistent with good professional practice. An insurer shall establish and maintain provider networks, policies, procedures, and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.

(2) A health insurer shall ensure that all insurer and provider processes necessary to obtain covered health care services, including prior authorization processes, are completed in a manner that assures the provision of covered health care services to an insured in a timely manner appropriate for the insured's condition and in compliance with this section.

(3) If it is necessary for a provider or an insured to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the insured's health care needs, and ensures continuity of care consistent with good professional

practice, and consistent with the objectives of Section 10133.5 and this section.

(4) Interpreter services required by Section 10133.8 of this code and Section 2538.6 of Title 10 of the California Code of Regulations shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. This subdivision does not modify the requirements established in Section 2538.6 of Title 10 of the California Code of Regulations, or approved by the department pursuant to Section 2538.6 of Title 10 of the California Code of Regulations for an insurer's language assistance program.

(5) In addition to ensuring compliance with the clinical appropriateness standard set forth in paragraph (1), a health insurer shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer insureds appointments that meet the following timeframes:

(A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in subparagraph (H).

(B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in subparagraph (H).

(C) Nonurgent appointments for primary care: within 10 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(D) Nonurgent appointments with specialist physicians: within 15 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(E) Nonurgent appointments with a nonphysician mental health care or substance use disorder provider: within 10 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(F) Nonurgent followup appointments with a nonphysician mental health care or substance use disorder provider: within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition, except as provided in subparagraph (H).

(G) Nonurgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition:

within 15 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(H) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the insured.

(I) Preventive care services, as defined in subdivision (e), and periodic follow up care, including standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac, mental health, or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice.

(J) An insurer may demonstrate compliance with the primary care time-elapsed standards established by this subdivision through implementation of standards, processes, and systems providing advanced access to primary care appointments, as defined in subdivision (e).

(6) In addition to ensuring compliance with the clinical appropriateness standard set forth at paragraph (1), each dental plan, and each full service insurer offering coverage for dental services, shall ensure that contracted dental provider networks have adequate capacity and availability of licensed health care providers to offer insureds appointments for covered dental services in accordance with the following requirements:

(A) Urgent appointments within the dental plan network shall be offered within 72 hours of the time of request for appointment, if consistent with the insured’s individual needs and as required by professionally recognized standards of dental practice.

(B) Nonurgent appointments shall be offered within 36 business days of the request for appointment, except as provided in subparagraph (C).

(C) Preventive dental care appointments shall be offered within 40 business days of the request for appointment.

(7) An insurer shall ensure it has sufficient numbers of contracted providers to maintain compliance with the standards established by this section.

(A) This section does not modify the requirements regarding provider-to-insured ratio or geographic accessibility established by Section 2240.1 of Title 10 of the California Code of Regulations.

(B) An insurer operating in a service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring an insured to, or, in the case of a preferred provider network, by assisting an insured to locate available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the insured's health needs. An insurer shall arrange for the provision of specialty services from specialists outside the insurer's contracted network if unavailable within the network if medically necessary for the insured's condition. Insured costs for medically necessary referrals to nonnetwork providers shall not exceed applicable copayments, coinsurance, and deductibles. This requirement does not prohibit an insurer or its delegated provider group from accommodating an insured's preference to wait for a later appointment from a specific contracted provider.

(8) An insurer shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone, as defined in subdivision (e).

(A) An insurer shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the insured's condition, and that the triage or screening waiting time does not exceed 30 minutes.

(B) An insurer may provide or arrange for the provision of telephone triage or screening services through one or more of the following means: insurer-operated telephone triage or screening services, telephone medical advice services pursuant to Section 10279, the insurer's contracted primary care and mental health care provider network, or other method that provides triage or screening services consistent with this section.

(i) An insurer that arranges for the provision of telephone triage or screening services through contracted primary care and mental

health care providers shall require those providers to maintain a procedure for triaging or screening insured telephone calls, which, at a minimum, shall include the employment, during and after business hours, of a telephone answering machine, an answering service, or office staff, that shall inform the caller of both of the following:

(I) Regarding the length of wait for a return call from the provider.

(II) How the caller may obtain urgent or emergency care, including, if applicable, how to contact another provider who has agreed to be on call to triage or screen by phone, or if needed, deliver urgent or emergency care.

(ii) An insurer that arranges for the provision of triage or screening services through contracted primary care and mental health care providers who are unable to meet the time-elapsed standards established in subparagraph (A) shall also provide or arrange for the provision of insurer-contracted or operated triage or screening services, which shall, at a minimum, be made available to insureds affected by that portion of the insurer's network.

(iii) An unlicensed staff person handling insured calls may ask questions on behalf of a licensed staff person to help ascertain the condition of an insured so that the insured may be referred to licensed staff. However, an unlicensed staff person shall not, under any circumstances, use the answers to those questions in an attempt to assess, evaluate, advise, or make a decision regarding the condition of an insured or determine when an insured needs to be seen by a licensed medical professional.

(9) Dental, vision, chiropractic, and acupuncture plans shall ensure that contracted providers employ an answering service or a telephone answering machine during nonbusiness hours, which provide instructions regarding how an insured may obtain urgent or emergency care, including, if applicable, how to contact another provider who has agreed to be on call to triage or screen by phone, or if needed, deliver urgent or emergency care.

(10) An insurer shall ensure that, during normal business hours, the waiting time for an insured to speak by telephone with an insurer customer service representative knowledgeable and competent regarding the insured's questions and concerns shall not exceed 10 minutes.

(b) Dental, vision, chiropractic, and acupuncture plans shall comply with paragraphs (1), (3), (4), (7), (9), and (10) of subdivision (a).

(c) The obligation of a health insurer to comply with this section shall not be waived if the insurer delegates to its medical groups, independent practice associations, or other contracting entities any services or activities that the insurer is required to perform. An insurer's implementation of this section shall be consistent with the Health Care Providers' Bill of Rights, and a material change in the obligations of an insurer's contracting providers shall be considered a material change to the provider contract, within the meaning of subdivision (b) and paragraph (3) of subdivision (h) of Section 10133.65.

(d) This section confirms requirements for insurers to provide or arrange for the provision of access to health care services in a timely manner, and establishes additional metrics for measuring and monitoring the adequacy of an insurer's contracted provider network to provide insureds with timely access to needed health care services. This section does not do any of the following:

(1) Establish professional standards of practice for health care providers.

(2) Establish requirements for the provision of emergency services.

(3) Create a new cause of action or a new defense to liability for any person.

(e) For purposes of this section:

(1) "Advanced access" means the provision, by an individual provider, or by the medical group or independent practice association to which an insured is assigned, of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the insured prefers not to accept the appointment offered within the same or the next business day.

(2) "Appointment waiting time" means the time from the initial request for health care services by an insured or the insured's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the

insurer or completing any other condition or requirement of the insurer or its contracting providers.

(3) "Preventive care" means health care provided for prevention and early detection of disease, illness, injury, or other health condition and, in the case of a full service insurer includes all of the basic health care services required by paragraph (5) of subdivision (b) of Section 1345 of the Health and Safety Code, and Section 2594.3 of Title 10 of the California Code of Regulations.

(4) "Provider group" has the meaning set forth in subdivision (v) of Section 10133.15.

(5) "Triage" or "screening" means the assessment of an insured's health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an insured who may need care for the purpose of determining the urgency of the insured's need for care.

(6) "Triage or screening waiting time" means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an insured who may need care.

(7) "Urgent care" means health care for a condition which requires prompt attention, consistent with paragraph (2) of subdivision (h) of Section 10123.135.

SEC. 6. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because 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.

O

SENATE BILL **No. 258**

Introduced by Senator Laird

January 26, 2021

An act to amend Section 9015 of the Welfare and Institutions Code, relating to aging.

LEGISLATIVE COUNSEL'S DIGEST

SB 258, as introduced, Laird. Aging.

Existing law, the Mello-Granlund Older Californians Act, establishes the California Department of Aging and sets forth its mission to provide leadership to the area agencies on aging in developing systems of home- and community-based services that maintain individuals in their own homes or least restrictive homelike environments. Existing law requires the department, in allocating specified state and federal funding to area agencies on aging, to ensure that priority consideration is given to criteria that reflect the state's intent to target services to those in greatest economic or social need. Existing law defines "greatest social need" to mean the need caused by noneconomic factors, including physical and mental disabilities, that restrict an individual's ability to perform normal daily tasks or that threaten the individual's capacity to live independently.

This bill would revise this definition to include human immunodeficiency virus (HIV) status as a specified noneconomic factor.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Section 9015 of the Welfare and Institutions Code is amended to read:

9015. "Greatest social need" means the need caused by noneconomic factors that restrict an individual's ability to perform normal daily tasks or that threaten ~~his or her~~ *the individual's* capacity to live independently. These factors include physical or mental disability, language barriers, and cultural or social isolation caused by, among other things, racial and ethnic status, sexual orientation, *human immunodeficiency virus (HIV) status,* gender identity, or gender expression.

O

SENATE BILL No. 306

Introduced by Senator Pan
(Principal coauthor: Senator Wiener)

February 4, 2021

An act to amend Section 4076 of the Business and Professions Code, to amend Sections 1367.31, 120582, 120685, and 120917 of the Health and Safety Code, to amend Section 10123.202 of the Insurance Code, and to amend Sections 14105.181, 14132, and 24007 of the Welfare and Institutions Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 306, as introduced, Pan. Sexually transmitted disease: testing.

(1) Existing law authorizes a specified health care provider who diagnoses an STD, as specified, to prescribe, dispense, furnish, or otherwise provide prescription antibiotic drugs to that patient's sexual partner or partners without examination of that patient's partner or partners. The Pharmacy Law provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy. The Pharmacy Law requires a pharmacist to dispense a prescription in a container that, among other things, is correctly labeled with the name of the patient or patients.

This bill would name the above practice "expedited partner therapy." The bill would require a health care provider to include "expedited partner therapy" or "EPT" on a prescription if the practitioner is unable to obtain the name of a patient's sexual partner, and would authorize a pharmacist to dispense an expedited partner therapy prescription and label the drug without an individual's name if the prescription includes "expedited partner therapy" or "EPT." The bill would specify that a health care provider is not liable in a medical malpractice action or professional disciplinary action, and that a pharmacist is not liable in a

civil, criminal, or administrative action, if the use of expedited partner therapy is in compliance with the law, except in cases of intentional misconduct, gross negligence, or wanton or reckless activity.

(2) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy to provide coverage for reproductive and sexual health care services.

This bill would include home test kits for sexually transmitted diseases, as defined, and the laboratory costs for processing those kits in the definition of "reproductive and sexual health care services." By expanding the definition of a crime, this bill wold impose a state-mandated local program.

(3) Existing law requires every licensed physician and surgeon or other person engaged in prenatal care of a pregnant woman, or attending the woman at the time of delivery, to obtain or cause to be obtained a blood specimen of the woman to test for syphilis at the time of the first professional visit or within 10 days thereafter.

This bill would require an additional blood test for syphilis in the 3rd trimester of pregnancy and would require a licensed health care provider who is attending a woman at the time of delivery to ensure that a blood specimen is obtained from the patient at the time of delivery for the purpose of testing for syphilis unless the patient's chart shows a negative syphilis screen in the 3rd trimester.

(4) Under existing law, the State Department of Public Health licenses, registers, and regulates clinical laboratories and various clinical laboratory personnel. Existing law authorizes an HIV counselor who receives specified training and works in specified counseling and testing sites to perform HIV, hepatitis C virus (HCV), or combined HIV/HCV tests, including performing skin punctures for purposes of withdrawing blood for purposes of these tests, as specified. Under existing law, an HIV counselor must receive training directly from the Office of AIDS or work directly with HIV counseling staff that have been trained by the Office of AIDS or its agents.

This bill would authorize an HIV counselor to also perform a rapid STI test, or any combination HIV/HCV/STI test, as specified. The bill would also allow HIV counselors to receive HIV counseling training through a training course that has been certified by the Office of AIDS.

(5) Existing law provides for the Medi-Cal program, 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 law prohibits a Medi-Cal managed care plan from restricting a beneficiary's choice of a qualified provider from whom the beneficiary may receive covered family planning services.

Under existing law, the Medi-Cal program administers the Family Planning, Access, Care, and Treatment (Family PACT) Program within the department to provide comprehensive clinical family planning services to a person with a family income at or below 200% of the federal poverty level. Existing law requires reimbursement rates for office visits billed as comprehensive clinical family planning services by Family PACT providers or Medi-Cal providers to receive a rate augmentation equal to the weighted average of at least 80% of the amount that the federal Medicare program reimburses for the same or similar office visits.

This bill would, subject to an appropriation by the Legislature and any potential draw down of federal matching funds, authorize an office visit to a Family PACT provider or Medi-Cal provider for specified STD-related services for uninsured, income-eligible patients, or patients with health care coverage who have confidentiality concerns, who are not at risk of experiencing or causing an unintended pregnancy, and who are not in need of contraceptive services, to be reimbursed at the same rate as comprehensive clinical family planning services.

The bill would include in the benefits for Medi-Cal and the Family PACT program home test kits for sexually transmitted diseases and the laboratory testing required to process those kits.

(6) 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 no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. The Legislature finds and declares the following:

(a) The COVID-19 pandemic has exacerbated rates of sexually transmitted diseases (STDs) in California and across the country that were already skyrocketing to epidemic proportions prior to the public health emergency.

(b) Although the STD epidemic has reached communities across the state, California youth, people of color, and gay, bisexual, and transgender people are disproportionately impacted.

(c) These disparities are expected to worsen during the COVID-19 crisis due to stigma, discrimination, drug use, and a reduction in testing and access to treatment.

(d) A new, antibiotic-resistant strain of gonorrhea began to spread across the country during the COVID-19 crisis, a sign that the epidemic has been neglected for a long period of time.

(e) The federal Centers for Disease Control and Prevention (CDC) estimates that there are approximately 19,000,000 new STD infections each year. Nearly 340,000 Californians were infected with syphilis, chlamydia, or gonorrhea in 2018, which is an increase of 40 percent since 2013.

(f) In 2016 alone, gonorrhea rates increased by double digits in the following counties: Los Angeles by 27 percent, San Diego by 35.5 percent, Orange by 32 percent, San Francisco by 18 percent, Kings by 41 percent, and Fresno by 13 percent. The Counties of Mendocino and Sacramento led the increase at 81 percent and 50 percent, respectively. These rates continued to increase in 2017 and 2018.

(g) Statewide data indicate that over one-half of all STDs in the state are experienced by California youth 15 to 24, inclusive, years of age.

(h) Currently, African American young women are 500 percent more likely to contract gonorrhea and chlamydia than their white counterparts.

(i) California has the second highest syphilis rate in the nation. While 90 percent of all male syphilis cases in 2013 were among bisexual and gay men, the epidemic has spread among women. Between 2008 and 2018, the syphilis rate among women of reproductive age increased by 743 percent.

(j) California ranks fifth among states in congenital syphilis rates. In 2018, approximately 329 babies were born with congenital syphilis across the state and there were 20 stillbirths associated with the disease. More than 100 babies were born with congenital

syphilis in Los Angeles County in 2020 during the COVID-19 pandemic.

(k) Approximately $1 billion is spent annually statewide on health costs associated with STDs.

(*l*) The cost of STDs to the United States health care system is estimated to be as much as $15.9 billion annually.

(m) Untreated STDs can lead to serious long-term health consequences. The CDC estimates that untreated STDs cause at least 24,000 women in the United States each year to become infertile.

(n) STDs increase both the transmission and acquisition of human immunodeficiency virus (HIV), particularly among bisexual and gay men.

(o) The human papilloma virus (HPV) can lead to increased risk of developing cancer. The number of HPV-related cancers in men dramatically increased in 2016.

(p) Untreated syphilis can also result in devastating and negative maternal child health outcomes, including infant death. The CDC estimates that of the pregnant women who acquire syphilis up to four years before delivery, 80 percent will transmit the infection to the fetus and 40 percent may result in stillbirth or death.

(q) The scope of the STD epidemic requires a bold response. California must take a comprehensive and robust approach to strengthen our public health infrastructure, ensure access to STD coverage, and care for all Californians, during the pandemic and beyond.

SEC. 2. Section 4076 of the Business and Professions Code is amended to read:

4076. (a) A pharmacist shall not dispense ~~any~~ *a* prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:

(1) Except when the prescriber or the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or

4052.6 orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.

(2) The directions for the use of the drug.

(3) The name of the patient or patients.

(4) The name of the prescriber or, if applicable, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.

(5) The date of issue.

(6) The name and address of the pharmacy, and prescription number or other means of identifying the prescription.

(7) The strength of the drug or drugs dispensed.

(8) The quantity of the drug or drugs dispensed.

(9) The expiration date of the effectiveness of the drug dispensed.

(10) The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription.

(11) (A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules, except as follows:

(i) Prescriptions dispensed by a veterinarian.

(ii) An exemption from the requirements of this paragraph shall be granted to a new drug for the first 120 days that the drug is on the market and for the 90 days during which the national reference file has no description on file.

(iii) Dispensed medications for which no physical description exists in ~~any~~ *a* commercially available database.

(B) This paragraph applies to outpatient pharmacies only.

(C) The information required by this paragraph may be printed on an auxiliary label that is affixed to the prescription container.

(D) This paragraph shall not become operative if the board, prior to January 1, 2006, adopts regulations that mandate the same labeling requirements set forth in this paragraph.

(b) If a pharmacist dispenses a prescribed drug by means of a unit dose medication system, as defined by administrative regulation, for a patient in a skilled nursing, intermediate care, or other health care facility, the requirements of this section will be satisfied if the unit dose medication system contains the aforementioned information or the information is otherwise readily available at the time of drug administration.

(c) If a pharmacist dispenses a dangerous drug or device in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include on individual unit dose containers for a specific patient, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.

(d) If a pharmacist dispenses a prescription drug for use in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include the information required in paragraph (11) of subdivision (a) when the prescription drug is administered to a patient by a person licensed under the Medical Practice Act (Chapter 5 (commencing with Section 2000)), the Nursing Practice Act (Chapter 6 (commencing with Section 2700)), or the Vocational Nursing Practice Act (Chapter 6.5 (commencing with Section 2840)), who is acting within ~~his or her~~ *the* scope of practice.

(e) A pharmacist shall use professional judgment to provide a patient with directions for use that enhance the patient's understanding of those directions, consistent with the prescriber's instructions.

(f) Notwithstanding subdivision (a) or any other law, a pharmacist may dispense a drug prescribed pursuant to Section 120582 of the Health and Safety Code and label the drug without the name of an individual for whom the drug is intended if the prescription includes the words "expedited partner therapy" or the letters "EPT."

(g) A pharmacist who prescribes, dispenses, furnishes, or otherwise renders EPT, as authorized in subdivision (f), shall not be liable in, and shall not be subject to, a civil, criminal, or administrative action, sanction, or penalty for rendering EPT, if the use of EPT is in compliance with this section, except in cases of intentional misconduct, gross negligence, or wanton or reckless activity.

SEC. 3. Section 1367.31 of the Health and Safety Code is amended to read:

1367.31. (a) Every health care service plan contract issued, amended, renewed, or delivered on or after January 1, 2017, shall be prohibited from requiring an enrollee to receive a referral prior to receiving coverage or services for reproductive and sexual health care.

(b) (1) For the purposes of this section, "reproductive and sexual health care services" are all reproductive and sexual health services described in Sections 6925, 6926, 6927, and 6928 of the Family Code, or Section 121020 of ~~the Health and Safety Code,~~ *this code,* obtained by a patient.

(2) For the purposes of this section, "reproductive and sexual health care services" include home test kits for sexually transmitted diseases, including the laboratory costs of processing the kit. For purposes of this paragraph, "home test kit" means a product intended to be administered by the patient and collected remotely.

~~(2)~~

(3) For the purposes of this section, "reproductive and sexual health care services" do not include the services subject to a health care service plan's referral procedures as required by subdivisions (a) and (b) of Section 1374.16.

~~(3)~~

(4) This section applies whether or not the patient is a minor.

(c) In implementing this section, a health care service plan may establish reasonable provisions governing utilization protocols for obtaining reproductive and sexual health care services, as provided

for in subdivision (a), from health care providers participating in, or contracting with, the plan network, medical group, or independent practice association, provided that these provisions shall be consistent with the intent of this section and shall be those customarily applied to other health care providers, such as primary care physicians and surgeons, to whom the enrollee has direct access, and shall not be more restrictive for the provision of reproductive and sexual health care services. An enrollee shall not be required to obtain prior approval from another physician, another provider, or the health care service plan prior to obtaining direct access to reproductive and sexual health care services. A health care service plan may establish reasonable provisions governing communication with the enrollee's primary care physician and surgeon regarding the enrollee's condition, treatment, and any need for followup care.

(d) This section ~~shall~~ *does* not apply to a health care service plan contract that does not require enrollees to obtain a referral from their primary care physician prior to seeking covered health care services from a specialist.

(e) A health care service plan shall not impose utilization protocols related to contraceptive drugs, supplies, and devices beyond the provisions outlined in Section 1367.25 of this code or Section 14132 of the Welfare and Institutions Code.

(f) This section ~~shall~~ *does* not apply to specialized health care service plan contracts or any health care service plan that is governed by Section 14131 of the Welfare and Institutions Code.

SEC. 4. Section 120582 of the Health and Safety Code is amended to read:

120582. (a) Notwithstanding any other ~~provision of~~ law, a physician and surgeon who diagnoses a sexually transmitted chlamydia, gonorrhea, or other sexually transmitted infection, as determined by the department, in an individual patient may prescribe, dispense, furnish, or otherwise provide prescription antibiotic drugs to that patient's sexual partner or partners without examination of that patient's partner or partners. *This practice shall be known as expedited partner therapy (EPT).* The department may adopt regulations to implement this section.

(b) Notwithstanding any other ~~provision of~~ law, a nurse practitioner pursuant to Section 2836.1 of the Business and Professions Code, a certified nurse-midwife pursuant to Section

2746.51 of the Business and Professions Code, and a physician assistant pursuant to Section 3502.1 of the Business and Professions Code may ~~dispense, furnish, or otherwise provide~~ *include EPT in their practice by dispensing, furnishing, or otherwise providing* prescription antibiotic drugs to the sexual partner or partners of a patient with a diagnosed sexually transmitted chlamydia, gonorrhea, or other sexually transmitted infection, as determined by the department, without examination of the patient's sexual partner or partners.

(c) If a health care provider is unable to obtain the name of a patient's sexual partner for a drug prescribed pursuant to subdivision (a) or (b), the prescription shall include the words "expedited partner therapy" or the letters "EPT."

(d) A health care provider shall not be liable in a medical malpractice action or professional disciplinary action if the use of EPT is in compliance with this section, except in cases of intentional misconduct, gross negligence, or wanton or reckless activity.

SEC. 5. Section 120685 of the Health and Safety Code is amended to read:

120685. *(a)* Every licensed physician and surgeon or other person engaged in prenatal care of a pregnant woman, or attending the woman at the time of delivery, shall obtain or cause to be obtained a blood specimen of the woman at ~~the time of the first professional visit or within 10 days thereafter.~~ *both of the following times:*

(1) A the time of the first professional visit or within 10 days thereafter.

(2) During the third trimester of pregnancy.

(b) A licensed health care provider who is attending a woman at the time of delivery shall ensure that a blood specimen is obtained from the patient at the time of delivery for the purpose of conducting a standard laboratory blood test unless the patient's chart shows a negative syphilis screen in the third trimester.

SEC. 6. Section 120917 of the Health and Safety Code is amended to read:

120917. (a) An HIV counselor who meets the requirements of subdivision (e) may do all of the following:

(1) Perform any HIV, hepatitis C virus (HCV), *or other sexually transmitted infection (STI) test*, or *any* combination ~~HIV/HCV~~

HIV/HCV/STI test that is classified as waived under the federal Clinical Laboratory Improvement Act (CLIA) (42 U.S.C. Sec. 263a and following) if all of the following conditions exist:

(A) The performance of the HIV, HCV, *or STI test,* or *any* combination ~~HIV/HCV~~ *HIV/HCV/STI* test meets the requirements of CLIA and, subject to subparagraph (B), Chapter 3 (commencing with Section 1200) of Division 2 of the Business and Professions Code.

(B) Notwithstanding Section 1246 of the Business and Professions Code, an HIV counselor may perform skin punctures for the purpose of withdrawing blood for *an* HIV, HCV, *STI test,* or *any* combination ~~HIV/HCV~~ *HIV/HCV/STI* testing, upon specific authorization from a licensed physician and surgeon, provided that the person meets both of the following requirements:

(i) ~~He or she~~ *The HIV counselor* works under the direction of a licensed physician and surgeon.

(ii) ~~He or she~~ *The HIV counselor* has been ~~trained in both~~ *trained, and is proficient, in administering* rapid HIV, HCV, *or STI tests,* or combination ~~HIV/HCV test proficiency for skin puncture blood tests and oral swab tests~~ *HIV/HCV/STI test,* and in universal infection control precautions, consistent with best infection control practices established by the Division of Occupational Safety and Health in the Department of Industrial Relations and the federal Centers for Disease Control and Prevention.

(C) The person performing the HIV, HCV, *or STI test,* or *any* combination ~~HIV/HCV~~ *HIV/HCV/STI* test meets the requirements for the performance of waived laboratory testing pursuant to subdivision (a) of Section 1206.5 of the Business and Professions Code. For purposes of this subdivision and subdivision (a) of Section 1206.5 of the Business and Professions Code, an HIV counselor who meets the requirements of subdivision (e) shall be "other health care personnel providing direct patient care" as referred to in paragraph (13) of subdivision (a) of Section 1206.5 of the Business and Professions Code.

(D) The patient is informed that the preliminary result of the test is indicative of the likelihood of HIV ~~infection or HCV exposure~~ *infection, HCV exposure, or other STI exposure* and that the result ~~must~~ *may need to* be confirmed by an additional more specific test, or, if approved by the federal Centers for Disease

Control and Prevention for that purpose, a second different rapid HIV, HCV, *or STI test,* or *any* combination ~~HIV/HCV~~ *HIV/HCV/STI* test. ~~Nothing in this~~ *This* subdivision ~~shall be construed to~~ *does not* allow an HIV counselor to perform ~~any HIV, HCV, or combination HIV/HCV~~ *an HIV, HCV, or STI test, or any combination HIV/HCV/STI* test that is not classified as waived under the CLIA.

(2) Notwithstanding Section 1246.5 of the Business and Professions Code, order and report HIV, HCV, *or STI tests,* or *any* combination ~~HIV/HCV~~ *HIV/HCV/STI* test results from tests performed pursuant to paragraph (1) to patients without authorization from a licensed health care professional or ~~his or her~~ *the health care professional's* authorized representative. Patients with indeterminate or positive test results from tests performed pursuant to paragraph (1) shall be referred to a licensed health care provider whose scope of practice includes the authority to refer patients for laboratory testing for further evaluation.

(b) An HIV counselor who has been certified pursuant to subdivision (b) of Section 120871 prior to September 1, 2009, and who will administer rapid HIV, HCV, *or STI tests,* or *any* combination ~~HIV/HCV~~ *HIV/HCV/STI* skin puncture tests shall obtain training required by clause (ii) of subparagraph (B) of paragraph (1) of subdivision (a) prior to September 1, 2011. The HIV counselor shall not, unless also certified as a limited phlebotomist technician, perform a skin puncture pursuant to this section until ~~he or she has completed~~ *after completing* the training required by that clause.

(c) An HIV counselor who meets the requirements of this section with respect to performing any HIV, HCV, *or STI test,* or *any* combination ~~HIV/HCV~~ *HIV/HCV/STI* test that is classified as waived under the CLIA may not perform any other test unless that person meets the statutory and regulatory requirements for performing that other test.

(d) This section ~~shall not be construed to~~ *does not* certify an HIV counselor as a phlebotomy technician or a limited phlebotomy technician, or ~~to~~ fulfill any requirements for certification as a phlebotomy technician or a limited phlebotomy technician, unless the HIV counselor has otherwise satisfied the certification requirements imposed pursuant to Section 1246 of the Business and Professions Code.

(e) (1) An HIV counselor shall meet one of the following criteria:

(A) Is trained by the Office of AIDS and working in an HIV counseling and testing site funded by the department through a local health jurisdiction, or its agents.

(B) Is working in an HIV counseling and testing site that meets both of the following criteria:

(i) Utilizes HIV counseling staff who are trained by the Office of AIDS or its agents.

(ii) Has a quality assurance plan approved by the local health department in the jurisdiction where the site is located and has HIV counseling and testing staff who comply with the quality assurance requirements specified in Section 1230 of Article 1 of Group 9 of Subchapter 1 of Chapter 2 of Division 1 of Title 17 of the California Code of Regulations.

(C) Has completed HIV counseling training course that has been approved by the Office of AIDS.

(2) (A) The Office of AIDS or its agents may charge a fee for training HIV counseling staff.

(B) The local health department may charge a fee for the quality assurance plan approval.

SEC. 7. Section 10123.202 of the Insurance Code is amended to read:

10123.202. (a) A health insurance policy issued, amended, renewed, or delivered on or after January 1, 2017, excluding specialized health insurance policies, shall be prohibited from requiring an insured to receive a referral before receiving coverage or services for reproductive and sexual health care.

(b) (1) For the purposes of this section, "reproductive and sexual health care services" are all reproductive and sexual health services described in Sections 6925, 6926, 6927, and 6928 of the Family Code, or Section 121020 of the Health and Safety Code, obtained by a patient.

(2) For the purposes of this section, "reproductive and sexual health care services" include home test kits for sexually transmitted diseases, including the laboratory costs of processing the kit. For purposes of this paragraph, "home test kit" means a product intended to be administered by the patient and collected remotely.

~~(2)~~

(3) This section applies whether or not the patient is a minor.

(c) In implementing this section, a health insurer may establish reasonable provisions governing utilization protocols for obtaining reproductive and sexual health care services, as provided for in subdivision (a), if these provisions are consistent with the intent of this section and are those customarily applied to other health care providers, such as primary care physicians and surgeons, to whom the insured has direct access, and are not more restrictive for reproductive and sexual health care services. An insured shall not be required to obtain prior approval from another physician, another provider, or the insurer before obtaining direct access to reproductive and sexual health care services. An insurer may establish reasonable provisions governing communication with the insured's primary care physician and surgeon regarding the insured's condition, treatment, and a need for followup care.

(d) This section ~~shall~~ *does* not apply to a health insurance policy that does not require insureds to obtain a referral from their primary care physician before seeking covered health care services from a specialist.

(e) A health insurer shall not impose utilization protocols related to contraceptive drugs, supplies, and devices beyond those in Section 10123.196.

(f) This section ~~shall~~ *does* not apply to specialized health insurance, Medicare supplement insurance, CHAMPUS supplement insurance, or TRICARE supplement insurance, or to hospital indemnity, accident-only, or specified disease insurance.

SEC. 8. Section 14105.181 of the Welfare and Institutions Code is amended to read:

14105.181. (a) For purposes of this section, the following definitions shall apply:

(1) "The Family Planning, Access, Care, and Treatment (Family ~~PACT) waiver"~~ *PACT)"* or "Family ~~PACT waiver"~~ *PACT"* means the program described in subdivision (aa) of Section ~~14132, as approved by a federal demonstration waiver.~~ *14132*.

(2) "Comprehensive clinical family planning services" means those services described in paragraph (8) of subdivision (aa) of Section 14132.

(3) "Office visits" means those procedures billed under Common Procedure Terminology codes 99201, 99202, 99203, 99204, 99211, 99212, 99213, and 99214.

(b) Reimbursement rates for office visits billed as comprehensive clinical family planning services by Family PACT ~~waiver~~ providers and for office visits billed as family planning services by Medi-Cal providers shall receive a rate augmentation equal to the weighted average of at least 80 percent of the amount that the federal Medicare program reimburses for these same or similar office visits. The rate augmentation shall be based upon Medicare rates in effect on December 31, 2007.

(c) Subject to an appropriation by the Legislature and any potential draw down of federal matching funds, reimbursement may be provided for sexually transmitted disease-related services outlined as reimbursable in the Family PACT Policies, Procedures, and Billing Instructions manual, in accordance with the "Treatment and Dispensing Guidelines for Clinicians" heading in the Benefits Grid section of that manual, to uninsured, income-eligible patients or patients with health care coverage who have confidentiality concerns, who are not at risk for experiencing or causing an unintended pregnancy, and who are not in need of contraceptive services. These office visits shall be reimbursed at the same rate as those office visits specified in subdivision (b).

~~(c)~~

(d) The augmentation of reimbursement rates described in subdivision (b) shall be made for office visits rendered on or after January 1, 2008.

~~(d)~~

(e) (1) The director may adopt regulations as necessary to implement this section. These regulations may be adopted as emergency regulations in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For purposes of this section, the adoption of the regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or the general welfare.

(2) As an alternative to paragraph (1), and notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the director may administer this section, in whole or in part, by means of a provider

bulletin, or other similar instructions, without taking regulatory action.

SEC. 9. Section 14132 of the Welfare and Institutions Code is amended to read:

14132. The following is the schedule of benefits under this chapter:

(a) Outpatient services are covered as follows:

Physician, hospital or clinic outpatient, surgical center, respiratory care, optometric, chiropractic, psychology, podiatric, occupational therapy, physical therapy, speech therapy, audiology, acupuncture to the extent federal matching funds are provided for acupuncture, and services of persons rendering treatment by prayer or healing by spiritual means in the practice of any church or religious denomination insofar as these can be encompassed by federal participation under an approved plan, subject to utilization controls.

(b) (1) Inpatient hospital services, including, but not limited to, physician and podiatric services, physical therapy and occupational therapy, are covered subject to utilization controls.

(2) For Medi-Cal fee-for-service beneficiaries, emergency services and care that are necessary for the treatment of an emergency medical condition and medical care directly related to the emergency medical condition. This paragraph shall not be construed to change the obligation of Medi-Cal managed care plans to provide emergency services and care. For the purposes of this paragraph, "emergency services and care" and "emergency medical condition" shall have the same meanings as those terms are defined in Section 1317.1 of the Health and Safety Code.

(c) Nursing facility services, subacute care services, and services provided by any category of intermediate care facility for the developmentally disabled, including podiatry, physician, nurse practitioner services, and prescribed drugs, as described in subdivision (d), are covered subject to utilization controls. Respiratory care, physical therapy, occupational therapy, speech therapy, and audiology services for patients in nursing facilities and any category of intermediate care facility for ~~the developmentally disabled~~ *persons with developmental disabilities* are covered subject to utilization controls.

(d) (1) Purchase of prescribed drugs is covered subject to the Medi-Cal List of Contract Drugs and utilization controls.

(2) Purchase of drugs used to treat erectile dysfunction or any off-label uses of those drugs are covered only to the extent that federal financial participation is available.

(3) (A) To the extent required by federal law, the purchase of outpatient prescribed drugs, for which the prescription is executed by a prescriber in written, nonelectronic form on or after April 1, 2008, is covered only when executed on a tamper resistant prescription form. The implementation of this paragraph shall conform to the guidance issued by the federal Centers for Medicare and Medicaid ~~Services~~ *Services,* but shall not conflict with state statutes on the characteristics of tamper resistant prescriptions for controlled substances, including Section 11162.1 of the Health and Safety Code. The department shall provide providers and beneficiaries with as much flexibility in implementing these rules as allowed by the federal government. The department shall notify and consult with appropriate stakeholders in implementing, interpreting, or making specific this paragraph.

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instructions without taking regulatory action.

(4) (A) (i) For the purposes of this paragraph, nonlegend has the same meaning as defined in subdivision (a) of Section 14105.45.

(ii) Nonlegend acetaminophen-containing products, with the exception of children's acetaminophen-containing products, selected by the department are not covered benefits.

(iii) Nonlegend cough and cold products selected by the department are not covered benefits. This clause shall be implemented on the first day of the first calendar month following 90 days after the effective date of the act that added this clause, or on the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later.

(iv) Beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment Program shall be exempt from clauses (ii) and (iii).

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code,

the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instruction without taking regulatory action.

(e) Outpatient dialysis services and home hemodialysis services, including physician services, medical supplies, drugs, and equipment required for dialysis, are covered, subject to utilization controls.

(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetist services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and X-ray services are covered, subject to utilization controls. ~~Nothing in this~~ *This* subdivision shall *not* be construed to require prior authorization for anesthesiologist services provided as part of an outpatient medical procedure or for portable X-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses that are lost or destroyed due to circumstances beyond the beneficiary's control. Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions that preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children Services Program.

(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:

(A) Periodontal treatment is not a benefit.

(B) Endodontic therapy is not a benefit except for vital pulpotomy.

(C) Laboratory processed crowns are not a benefit.

(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.

(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

(F) Notwithstanding the conditions specified in subparagraphs (A) to (E), inclusive, the department may approve services for persons with special medical disorders subject to utilization review.

(3) Paragraph (2) shall become inoperative July 1, 1995.

(i) Medical transportation is covered, subject to utilization controls.

(j) Home health care services are covered, subject to utilization controls.

(k) *(1)* Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

~~Orthopedic~~

(2) Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated, is covered subject to utilization controls. When there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.

~~Therapeutic~~

(3) Therapeutic shoes and inserts are covered when provided to beneficiaries with a diagnosis of diabetes, subject to utilization controls, to the extent that federal financial participation is available.

(*l*) Hearing aids are covered, subject to utilization controls. Utilization controls shall allow replacement of hearing aids necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls shall allow the replacement of durable medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary's control. The utilization controls shall allow authorization of durable medical equipment needed to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian, subject to the availability of federal financial participation. The department shall adopt emergency regulations to define and establish criteria for assistive durable medical equipment in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(n) Family planning services are covered, subject to utilization controls. However, for Medi-Cal managed care plans, any utilization controls shall be subject to Section 1367.25 of the Health and Safety Code.

(o) Inpatient intensive rehabilitation hospital services, including respiratory rehabilitation services, in a general acute care hospital are covered, subject to utilization controls, when either of the following criteria are met:

(1) A patient with a permanent disability or severe impairment requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to develop function beyond the limited amount that would occur in the normal course of recovery.

(2) A patient with a chronic or progressive disease requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to maintain the patient's present functional level as long as possible.

(p) (1) Adult day health care is covered in accordance with Chapter 8.7 (commencing with Section 14520).

(2) Commencing 30 days after the effective date of the act that added this paragraph, and notwithstanding the number of days previously approved through a treatment authorization request, adult day health care is covered for a maximum of three days per week.

(3) As provided in accordance with paragraph (4), adult day health care is covered for a maximum of five days per week.

(4) As of the date that the director makes the declaration described in subdivision (g) of Section 14525.1, paragraph (2) shall become inoperative and paragraph (3) shall become operative.

(q) (1) Application of fluoride, or other appropriate fluoride treatment as defined by the department, and other prophylaxis treatment for children 17 years of age and under are covered.

(2) All dental hygiene services provided by a registered dental hygienist, registered dental hygienist in extended functions, and registered dental hygienist in alternative practice licensed pursuant to Sections 1753, 1917, 1918, and 1922 of the Business and Professions Code may be covered as long as they are within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental hygienist, registered dental hygienist in extended functions, or registered dental hygienist in alternative practice.

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under former Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of former Section 1482 of the article.

(2) All providers enrolled under this subdivision shall satisfy all applicable statutory and regulatory requirements for becoming a Medi-Cal provider.

(3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.

(s) In-home medical care services are covered when medically appropriate and subject to utilization controls, for beneficiaries who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be provided to patients placed in shared or congregate living arrangements, if a home setting is not medically appropriate or available to the beneficiary. As used in this section, “in-home medical care service” includes utility bills directly attributable to

continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

As used in this subdivision, in-home medical care services include, but are not limited to:

(1) Level-of-care and cost-of-care evaluations.

(2) Expenses, directly attributable to home care activities, for materials.

(3) Physician fees for home visits.

(4) Expenses directly attributable to home care activities for shelter and modification to shelter.

(5) Expenses directly attributable to additional costs of special diets, including tube feeding.

(6) Medically related personal services.

(7) Home nursing education.

(8) Emergency maintenance repair.

(9) Home health agency personnel benefits that permit coverage of care during periods when regular personnel are on vacation or using sick leave.

(10) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.

(11) Emergency and nonemergency medical transportation.

(12) Medical supplies.

(13) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.

(14) Utility use directly attributable to the requirements of home care activities that are in addition to normal utility use.

(15) Special drugs and medications.

(16) Home health agency supervision of visiting staff that is medically necessary, but not included in the home health agency rate.

(17) Therapy services.

(18) Household appliances and household utensil costs directly attributable to home care activities.

(19) Modification of medical equipment for home use.

(20) Training and orientation for use of life-support systems, including, but not limited to, support of respiratory functions.

(21) Respiratory care practitioner services as defined in Sections 3702 and 3703 of the Business and Professions Code, subject to prescription by a physician and surgeon.

Beneficiaries receiving in-home medical care services are entitled to the full range of services within the Medi-Cal scope of benefits as defined by this section, subject to medical necessity and applicable utilization control. Services provided pursuant to this subdivision, which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with a home- and community-based services waiver.

(t) Home- and community-based services approved by the United States Department of Health and Human Services are covered to the extent that federal financial participation is available for those services under the state plan or waivers granted in accordance with Section 1315 or 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and community-based services approvable under Section 1315 or 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers.

(u) Comprehensive perinatal services, as provided through an agreement with a health care provider designated in Section 14134.5 and meeting the standards developed by the department pursuant to Section 14134.5, subject to utilization controls.

The department shall seek any federal waivers necessary to implement the provisions of this subdivision. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained or for which waivers are not required shall be implemented notwithstanding any inability to obtain federal waivers for the other provisions. No provision of this subdivision shall be implemented unless matching funds from Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are available.

(v) Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(w) Hospice service ~~which~~ *that* is Medicare-certified hospice service is covered, subject to utilization controls. Coverage shall be available only to the extent that no additional net program costs are incurred.

(x) When a claim for treatment provided to a beneficiary includes both services that are authorized and reimbursable under this ~~chapter,~~ *chapter* and services that are not reimbursable under this ~~chapter~~ *chapter,* that portion of the claim for the treatment and services authorized and reimbursable under this chapter shall be payable.

(y) Home- and community-based services approved by the United States Department of Health and Human Services for beneficiaries with a diagnosis of AIDS or ARC, who require intermediate care or a higher level of care.

Services provided pursuant to a waiver obtained from the Secretary of the United States Department of Health and Human Services pursuant to this subdivision, and which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with the waiver, and subject to the terms, conditions, and duration of the waiver. These services shall be provided to individual beneficiaries in accordance with the client's needs as identified in the plan of care, and subject to medical necessity and applicable utilization control.

The director ~~may~~ *may,* under this ~~section~~ *section,* contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to eligible beneficiaries. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract Code.

(z) Respiratory care when provided in organized health care systems as defined in Section 3701 of the Business and Professions Code, and as an in-home medical service as outlined in subdivision (s).

(aa) (1) There is hereby established in the department, a program to provide comprehensive clinical family planning services to any person who has a family income at or below 200 percent of the federal poverty level, as revised annually, and who is eligible to receive these services pursuant to the waiver identified in paragraph (2). This program shall be known as the Family Planning, Access, Care, and Treatment (Family PACT) Program.

(2) The department shall seek a waiver in accordance with Section 1315 of Title 42 of the United States Code, or a state plan amendment adopted in accordance with Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code,

which was added to Section 1396a of Title 42 of the United States Code by Section 2303(a)(2) of the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), for a program to provide comprehensive clinical family planning services as described in paragraph (8). Under the waiver, the program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. Under the state plan amendment, which shall replace the waiver and shall be known as the Family PACT successor state plan amendment, the program shall be operated only in accordance with this subdivision and the statutes and regulations in paragraph (4). The state shall use the standards and processes imposed by the state on January 1, 2007, including the application of an eligibility discount factor to the extent required by the federal Centers for Medicare and Medicaid Services, for purposes of determining eligibility as permitted under Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code. To the extent that federal financial participation is available, the program shall continue to conduct education, outreach, enrollment, service delivery, and evaluation services as specified under the waiver. The services shall be provided under the program only if the waiver and, when applicable, the successor state plan amendment are approved by the federal Centers for Medicare and Medicaid Services and only to the extent that federal financial participation is available for the services. ~~Nothing in this section shall~~ *This section does not* prohibit the department from seeking the Family PACT successor state plan amendment during the operation of the waiver.

(3) Solely for the purposes of the waiver or Family PACT successor state plan amendment and notwithstanding any other law, the collection and use of an individual's social security number shall be necessary only to the extent required by federal law.

(4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005, and 24013, and any regulations adopted under these statutes shall apply to the program provided for under this subdivision. No other provision of law under the Medi-Cal program or the State-Only Family Planning Program shall apply to the program provided for under this subdivision.

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code,

the department may implement, without taking regulatory action, the provisions of the waiver after its approval by the federal Centers for Medicare and Medicaid Services and the provisions of this section by means of an all-county letter or similar instruction to providers. Thereafter, the department shall adopt regulations to implement this section and the approved waiver in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of the act adding this subdivision, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(6) In the event that the Department of Finance determines that the program operated under the authority of the waiver described in paragraph (2) or the Family PACT successor state plan amendment is no longer cost effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no share of cost, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a share of cost or if they are otherwise eligible under Section 24003.

(8) For purposes of this subdivision, “comprehensive clinical family planning services” means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, federal Food and Drug Administration approved

contraceptive drugs, devices, and supplies, natural family planning, abstinence methods, and basic, limited fertility management. Comprehensive clinical family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Comprehensive clinical family planning services shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that is not incident to the diagnosis of pregnancy. Comprehensive clinical family planning services shall be subject to utilization control and include all of the following:

(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

(B) All United States Department of Agriculture, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.

(C) Culturally and linguistically appropriate health education and counseling services, including informed consent, that include all of the following:

(i) Psychosocial and medical aspects of contraception.

(ii) Sexuality.

(iii) Fertility.

(iv) Pregnancy.

(v) Parenthood.

(vi) Infertility.

(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

(x) Use of contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies.

(xi) Possible contraceptive consequences and followup.

(xii) Interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(D) A comprehensive health history, updated at the next periodic visit (between 11 and 24 months after initial examination) that includes a complete obstetrical history, gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.

(E) A complete physical examination on initial and subsequent periodic visits.

(F) Services, drugs, devices, and supplies deemed by the federal Centers for Medicare and Medicaid Services to be appropriate for inclusion in the program.

(G) (i) Home STD test kits for sexually transmitted diseases, including the laboratory costs of processing the kit.

(ii) For purposes of this subparagraph, "home STD test kit" means a product approved by the Food and Drug Administration for the purpose of an individual collecting specimens for STD testing in a location outside of a clinical setting and ordered directly by a clinician or furnished under a standing order based on clinical guidelines and individual patient health needs.

(9) In order to maximize the availability of federal financial participation under this subdivision, the director shall have the discretion to implement the Family PACT successor state plan amendment retroactively to July 1, 2010.

(ab) (1) Purchase of prescribed enteral nutrition products is covered, subject to the Medi-Cal list of enteral nutrition products and utilization controls.

(2) Purchase of enteral nutrition products is limited to those products to be administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube. Beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment Program shall be exempt from this paragraph.

(3) Notwithstanding paragraph (2), the department may deem an enteral nutrition product, not administered through a feeding

tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube, a benefit for patients with diagnoses, including, but not limited to, malabsorption and inborn errors of metabolism, if the product has been shown to be neither investigational nor experimental when used as part of a therapeutic regimen to prevent serious disability or death.

(4) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement the amendments to this subdivision made by the act that added this paragraph by means of all-county letters, provider bulletins, or similar instructions, without taking regulatory action.

(5) The amendments made to this subdivision by the act that added this paragraph shall be implemented June 1, 2011, or on the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later.

(ac) Diabetic testing supplies are covered when provided by a pharmacy, subject to utilization controls.

(ad) (1) Nonmedical transportation is covered, subject to utilization controls and permissible time and distance standards, for a beneficiary to obtain covered Medi-Cal services.

(2) (A) (i) Nonmedical transportation includes, at a minimum, round trip transportation for a beneficiary to obtain covered Medi-Cal services by passenger car, taxicab, or any other form of public or private conveyance, and mileage reimbursement when conveyance is in a private vehicle arranged by the beneficiary and not through a transportation broker, bus passes, taxi vouchers, or train tickets.

(ii) Nonmedical transportation does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated beneficiaries by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations.

(B) Nonmedical transportation shall be provided for a beneficiary who can attest in a manner to be specified by the department that other currently available resources have been reasonably exhausted. For beneficiaries enrolled in a managed care plan, nonmedical transportation shall be provided by the beneficiary's managed care plan. For Medi-Cal fee-for-service

beneficiaries, the department shall provide nonmedical transportation when those services are not available to the beneficiary under Sections 14132.44 and 14132.47.

(3) Nonmedical transportation shall be provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the beneficiary and consistent with applicable state and federal disability rights laws.

(4) It is the intent of the Legislature in enacting this subdivision to affirm the requirement under Section 431.53 of Title 42 of the Code of Federal Regulations, in which the department is required to provide necessary transportation, including nonmedical transportation, for recipients to and from covered services. This subdivision shall not be interpreted to add a new benefit to the Medi-Cal program.

(5) The department shall seek any federal approvals that may be required to implement this subdivision, including, but not limited to, approval of revisions to the existing state plan that the department determines are necessary to implement this subdivision.

(6) This subdivision shall be implemented only to the extent that federal financial participation is available and not otherwise jeopardized, and any necessary federal approvals have been obtained.

(7) Prior to the effective date of any necessary federal approvals, nonmedical transportation was not a Medi-Cal managed care benefit with the exception of when provided as an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service.

(8) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. By July 1, 2018, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Commencing January 1, 2018, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(9) This subdivision shall not be implemented until July 1, 2017.

SEC. 10. Section 24007 of the Welfare and Institutions Code is amended to read:

24007. (a) The department shall determine the scope of benefits for the program, which shall include, but is not limited to, the following:

(1) Family planning related services and male and female sterilization. Family planning services for men and women include emergency and complication services directly related to the contraceptive method and followup, consultation and referral services, as indicated, ~~which~~ *that* may require treatment authorization requests.

(2) All United States Department of Health and Human Services, Federal Drug Administration-approved birth control methods, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.

(3) Culturally and linguistically appropriate health education and counseling services, including informed consent; psychosocial and medical aspects of contraception, sexuality, fertility, pregnancy, and parenthood; infertility; reproductive health care; preconceptual and nutrition counseling; prevention and treatment of sexually transmitted infection; use of contraceptive methods, devices, and supplies; possible contraceptive consequences and followup; interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(4) A comprehensive health history, updated at next periodic visit (between 11 and 24 months after initial examination) that includes a complete obstetrical history, gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.

(5) A complete physical examination on initial and subsequent periodic visits.

(6) (A) Home STD test kits for sexually transmitted diseases, including the laboratory costs of processing the kit.

(B) For purposes of this paragraph, "home STD test kit" means a product approved by the United States Food and Drug Administration for the purpose of an individual collecting specimens for STD testing in a location outside of a clinical setting

and ordered directly by a clinician or furnished under a standing order based on clinical guidelines and individual patient health needs.

(b) Benefits under this program shall be effective in 30 days after notice to providers, but not sooner than January 1, 1997.

SEC. 11. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because 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.

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SENATE BILL No. 316

Introduced by Senators Eggman and McGuire
(Principal coauthor: Assembly Member Aguiar-Curry)
(Coauthors: Senators Dahle, Hertzberg, Jones, Nielsen, and Wiener)
(Coauthors: Assembly Members Frazier, Cristina Garcia, Eduardo Garcia, Lorena Gonzalez, Mathis, Patterson, Robert Rivas, and Stone)

February 4, 2021

An act to amend Section 14132.100 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 316, as introduced, Eggman. Medi-Cal: federally qualified health centers and rural health clinics.

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, including federally qualified health center (FQHC) services and rural health clinic (RHC) services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides that FQHC and RHC services are to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. "Visit" is defined as a face-to-face encounter between a patient of an FQHC or RHC and specified health care professionals, including a physician and marriage and family therapist. Under existing law, "physician," for these purposes, includes, but is not limited to, a physician and surgeon, an osteopath, and a podiatrist.

This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or

treatment, or if the patient has a medical visit and a mental health visit or a dental visit, as defined. The bill would authorize an FQHC or RHC that currently includes the cost of a medical visit and a mental health visit that take place on the same day at a single location as a single visit for purposes of establishing the FQHC's or RHC's rate to apply for an adjustment to its per-visit rate, and after the department has approved that rate adjustment, to bill a medical visit and a mental health visit that take place on the same day at a single location as separate visits, in accordance with the bill.

This bill would also include a licensed acupuncturist within those health professionals covered under the definition of a "visit." The bill would require the department, by July 1, 2022, to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services to reflect certain changes described in the bill, and to seek necessary federal approvals. The bill would also make conforming and technical changes.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Section 14132.100 of the Welfare and Institutions Code is amended to read:

14132.100. (a) The federally qualified health center services described in Section 1396d(a)(2)(C) of Title 42 of the United States Code are covered benefits.

(b) The rural health clinic services described in Section 1396d(a)(2)(B) of Title 42 of the United States Code are covered benefits.

(c) Federally qualified health center services and rural health clinic services shall be reimbursed on a per-visit basis in accordance with the definition of "visit" set forth in subdivision (g).

(d) Effective October 1, 2004, and on each October 1 thereafter, until no longer required by federal law, federally qualified health center (FQHC) and rural health clinic (RHC) per-visit rates shall be increased by the Medicare Economic Index applicable to primary care services in the manner provided for in Section 1396a(bb)(3)(A) of Title 42 of the United States Code. ~~Prior to~~ *Before* January 1, 2004, FQHC and RHC per-visit rates shall be

adjusted by the Medicare Economic Index in accordance with the methodology set forth in the state plan in effect on October 1, 2001.

(e) (1) An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope of ~~services~~ *service* provided by the FQHC or RHC. Rate changes based on a change in the scope of ~~services~~ *service* provided by an FQHC or RHC shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(2) Subject to the conditions set forth in subparagraphs (A) to (D), inclusive, of paragraph (3), a change in scope of service means any of the following:

(A) The addition of a new FQHC or RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate.

(B) A change in service due to amended regulatory requirements or rules.

(C) A change in service resulting from relocating or remodeling an FQHC or RHC.

(D) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.

(E) An increase in service intensity attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

(F) Any changes in any of the services described in subdivision (a) or (b), or in the provider mix of an FQHC or RHC or one of its sites.

(G) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in subdivision (a) or (b), including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(H) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.

(I) Any changes in the scope of a project approved by the federal Health Resources and Services Administration (HRSA).

(3) A change in costs is not, in and of itself, a scope-of-service change, unless all of the following apply:

(A) The increase or decrease in cost is attributable to an increase or decrease in the scope of ~~services~~ *service* defined in subdivisions (a) and (b), as applicable.

(B) The cost is allowable under Medicare reasonable cost principles set forth in Part 413 (commencing with Section ~~413) of Subchapter B of Chapter 4~~ *413.1)* of Title 42 of the Code of Federal Regulations, or its successor.

(C) The change in the scope of ~~services~~ *service* is a change in the type, intensity, duration, or amount of services, or any combination thereof.

(D) The net change in the FQHC's or RHC's rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75-percent threshold shall be applied to the average per-visit rate of all sites for the purposes of calculating the cost associated with a ~~scope-of-service~~ *scope of service* change. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

(4) An FQHC or RHC may submit requests for ~~scope-of-service~~ *scope of service* changes once per fiscal year, only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(5) An FQHC or RHC shall submit a ~~scope-of-service~~ *scope of service* rate change request within 90 days of the beginning of any FQHC or RHC fiscal year occurring after the effective date of this section, if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope of ~~services~~ *service* provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If an FQHC or RHC discontinues providing onsite pharmacy or dental services, it shall submit a ~~scope-of-service~~ *scope of service* rate change request within 90 days of the beginning of the

following fiscal year. The rate change shall be effective as provided for in paragraph (4). As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent.

(6) Notwithstanding paragraph (4), if the approved ~~scope-of-service~~ *scope of service* change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a ~~scope-of-service~~ *scope of service* change, the adjusted reimbursement rate for that ~~scope-of-service~~ *scope of service* change shall be made retroactive to the date the ~~scope-of-service~~ *scope of service* change was initially implemented. ~~Scope-of-service~~ *Scope of service* changes under this paragraph shall be required to be submitted within the later of 150 days after the adoption and issuance of the written instructions by the department, or 150 days after the end of the FQHC's or RHC's fiscal year ending in 2003.

(7) All references in this subdivision to "fiscal year" shall be construed to be references to the fiscal year of the individual FQHC or RHC, as the case may be.

(f) (1) An FQHC or RHC may request a supplemental payment if extraordinary circumstances beyond the control of the FQHC or RHC occur after December 31, 2001, and PPS payments are insufficient due to these extraordinary circumstances. Supplemental payments arising from extraordinary circumstances under this subdivision shall be solely and exclusively within the discretion of the department and shall not be subject to subdivision ~~*(l).*~~ *(m).* These supplemental payments shall be determined separately from the ~~scope-of-service~~ *scope of service* adjustments described in subdivision (e). Extraordinary circumstances include, but are not limited to, acts of nature, changes in applicable requirements in the Health and Safety Code, changes in applicable licensure requirements, and changes in applicable rules or regulations. Mere inflation of costs alone, absent extraordinary circumstances, shall not be grounds for supplemental payment. If an FQHC's or RHC's PPS rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, then a supplemental payment is not warranted.

(2) The department shall accept requests for supplemental payment at any time throughout the prospective payment rate year.

(3) Requests for supplemental payments shall be submitted in writing to the department and shall set forth the reasons for the request. Each request shall be accompanied by sufficient documentation to enable the department to act upon the request. Documentation shall include the data necessary to demonstrate that the circumstances for which supplemental payment is requested meet the requirements set forth in this section. Documentation shall include both of the following:

(A) A presentation of data to demonstrate reasons for the FQHC's or RHC's request for a supplemental payment.

(B) Documentation showing the cost implications. The cost impact shall be material and significant, two hundred thousand dollars ($200,000) or 1 percent of a facility's total costs, whichever is less.

(4) A request shall be submitted for each affected year.

(5) Amounts granted for supplemental payment requests shall be paid as lump-sum amounts for those years and not as revised PPS rates, and shall be repaid by the FQHC or RHC to the extent that it is not expended for the specified purposes.

(6) The department shall notify the provider of the department's discretionary decision in writing.

(g) (1) An FQHC or RHC "visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse. For purposes of this section, "physician" shall be interpreted in a manner consistent with the federal Centers for Medicare and Medicaid Services' Medicare Rural Health Clinic and Federally Qualified Health Center Manual (Publication 27), or its successor, only to the extent that it defines the professionals whose services are reimbursable on a per-visit basis and not as to the types of services that these professionals may render during these visits and shall include a ~~physician and surgeon,~~ *medical doctor,* osteopath, podiatrist, dentist, optometrist, and chiropractor. A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a comprehensive perinatal practitioner, as defined in Section 51179.7 of Title 22 of the California Code of Regulations, providing comprehensive perinatal services, a

four-hour day of attendance at an adult day health care center, and any other provider identified in the state plan's definition of an FQHC or RHC visit.

(2) (A) A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a dental hygienist, a dental hygienist in alternative practice, ~~or~~ a marriage and family ~~therapist.~~ *therapist, or a licensed acupuncturist.*

(B) Notwithstanding subdivision (e), if an FQHC or RHC that currently includes the cost of the services of a dental hygienist in alternative practice, or a marriage and family therapist for the purposes of establishing its FQHC or RHC rate chooses to bill these services as a separate visit, the FQHC or RHC shall apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, shall bill these services as a separate visit. However, multiple encounters with dental professionals or marriage and family therapists that take place on the same day shall constitute a single visit. The department shall develop the appropriate forms to determine which FQHC's or RHC's rates shall be adjusted and to facilitate the calculation of the adjusted rates. An FQHC's or RHC's application for, or the department's approval of, a rate adjustment pursuant to this subparagraph shall not constitute a change in scope of service within the meaning of subdivision (e). An FQHC or RHC that applies for an adjustment to its rate pursuant to this subparagraph may continue to bill for all other FQHC or RHC visits at its existing per-visit rate, subject to reconciliation, until the rate adjustment for visits between an FQHC or RHC patient and a dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist has been approved. Any approved increase or decrease in the provider's rate shall be made within six months after the date of receipt of the department's rate adjustment forms pursuant to this subparagraph and shall be retroactive to the beginning of the fiscal year in which the FQHC or RHC submits the request, but in no case shall the effective date be earlier than January 1, 2008.

(C) An FQHC or RHC that does not provide dental hygienist, dental hygienist in alternative practice, or marriage and family therapist services, and later elects to add these services and bill these services as a separate visit, shall process the addition of these

services as a change in scope of service pursuant to subdivision (e).

(3) Notwithstanding ~~any other provision of~~ this section, ~~no later than~~ *by* July 1, 2018, a visit shall include a marriage and family therapist.

(h) If FQHC or RHC services are partially reimbursed by a third-party payer, such as a managed care entity, as defined in Section 1396u-2(a)(1)(B) of Title 42 of the United States Code, the Medicare Program, or the Child Health and Disability Prevention (CHDP) Program, the department shall reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate, and may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

(i) (1) Provided that the following entities are not operating as intermittent clinics, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, each entity shall have its reimbursement rate established in accordance with one of the methods outlined in paragraph (2) or (3), as selected by the FQHC or RHC:

(A) An entity that first qualifies as an FQHC or RHC in 2001 or later.

(B) A newly licensed facility at a new location added to an existing FQHC or RHC.

(C) An entity that is an existing FQHC or RHC that is relocated to a new site.

(2) (A) An FQHC or RHC that adds a new licensed location to its existing primary care license under paragraph (1) of subdivision (b) of Section 1212 of the Health and Safety Code may elect to have the reimbursement rate for the new location established in accordance with paragraph (3), or notwithstanding subdivision (e), an FQHC or RHC may choose to have one PPS rate for all locations that appear on its primary care license determined by submitting a change in ~~scope of service~~ *scope-of-service* request if both of the following requirements are met:

(i) The change in ~~scope of service~~ *scope-of-service* request includes the costs and visits for those locations for the first full fiscal year immediately following the date the new location is added to the FQHC's or RHC's existing licensee.

(ii) The FQHC or RHC submits the change in ~~scope of service~~ *scope-of-service* request within 90 days after the FQHC's or RHC's first full fiscal year.

(B) The FQHC's or RHC's single PPS rate for those locations shall be calculated based on the total costs and total visits of those locations and shall be determined based on the following:

(i) An audit in accordance with Section 14170.

(ii) Rate changes based on a change in ~~scope of service~~ *scope-of-service* request shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successors.

(iii) Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(C) Except as specified in subdivision (j), this paragraph does not apply to a location that was added to an existing primary care clinic license by the State Department of Public Health, whether by a regional district office or the centralized application unit, ~~prior to~~ *before* January 1, 2017.

(3) If an FQHC or RHC does not elect to have the PPS rate determined by a change in ~~scope of service~~ *scope-of-service* request, the FQHC or RHC shall have the reimbursement rate established for any of the entities identified in paragraph (1) or (2) in accordance with one of the following methods at the election of the FQHC or RHC:

(A) The rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or adjacent area with a similar caseload.

(B) In the absence of three comparable FQHCs or RHCs with a similar caseload, the rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or an adjacent service area, or in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics.

(C) At a new entity's one-time election, the department shall establish a reimbursement rate, calculated on a per-visit basis, that is equal to 100 percent of the projected allowable costs to the

FQHC or RHC of furnishing FQHC or RHC services during the first 12 months of operation as an FQHC or RHC. After the first 12-month period, the projected per-visit rate shall be increased by the Medicare Economic Index then in effect. The projected allowable costs for the first 12 months shall be cost settled and the prospective payment reimbursement rate shall be adjusted based on actual and allowable cost per visit.

(D) The department may adopt any further and additional methods of setting reimbursement rates for newly qualified FQHCs or RHCs as are consistent with Section 1396a(bb)(4) of Title 42 of the United States Code.

(4) In order for an FQHC or RHC to establish the comparability of its caseload for purposes of subparagraph (A) or (B) of paragraph (1), the department shall require that the FQHC or RHC submit its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report. FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit to the department a completed report in the format applicable to the prior calendar year. FQHCs or RHCs that have not previously submitted an annual utilization report shall submit to the department a completed report in the format applicable to the prior calendar year. The FQHC or RHC shall not be required to submit the annual utilization report for the comparable FQHCs or RHCs to the department, but shall be required to identify the comparable FQHCs or RHCs.

(5) The rate for any newly qualified entity set forth under this subdivision shall be effective retroactively to the later of the date that the entity was first qualified by the applicable federal agency as an FQHC or RHC, the date a new facility at a new location was added to an existing FQHC or RHC, or the date on which an existing FQHC or RHC was relocated to a new site. The FQHC or RHC shall be permitted to continue billing for Medi-Cal covered benefits on a fee-for-service basis under its existing provider number until it is informed of its *new* FQHC or RHC ~~enrollment approval,~~ *provider number,* and the department shall reconcile the difference between the fee-for-service payments and the FQHC's or RHC's prospective payment rate at that time.

(j) (1) Visits occurring at an intermittent clinic site, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, of an existing FQHC or RHC, in a mobile unit as defined by ~~paragraph (2) of~~ subdivision (b) of Section 1765.105 of the Health and Safety Code, or at the election of the FQHC or RHC and subject to paragraph (2), a location added to an existing primary care clinic license by the State Department of Public Health ~~prior to~~ *before* January 1, 2017, shall be billed by and reimbursed at the same rate as the FQHC or RHC that either established the intermittent clinic site or mobile unit, or that held the clinic license to which the location was added ~~prior to~~ *before* January 1, 2017.

(2) If an FQHC or RHC with at least one additional location on its primary care clinic license that was added by the State Department of Public Health ~~prior to~~ *before* January 1, 2017, applies for an adjustment to its per-visit rate based on a change in the scope of ~~services~~ *service* provided by the FQHC or RHC as described in subdivision (e), all locations on the FQHC's or RHC's primary care clinic license shall be subject to a ~~scope-of-service~~ *scope of service* adjustment in accordance with either paragraph (2) or (3) of subdivision (i), as selected by the FQHC or RHC.

(3) This subdivision does not preclude ~~or~~ *nor* otherwise limit the right of the FQHC or RHC to request a ~~scope-of-service~~ *scope of service* adjustment to the rate.

(k) An FQHC or RHC may elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. These costs shall be adjusted out of the FQHC's or RHC's clinic base rate as ~~scope-of-service~~ *scope of service* changes. An FQHC or RHC that reverses its election under this subdivision shall revert to its prior rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with applicable ~~scope-of-service~~ *scope of service* adjustments as provided in subdivision (e).

(l) (1) For purposes of this subdivision, the following definitions apply:

(A) "Mental health visit" means a face-to-face encounter between an FQHC or RHC patient and a psychiatrist, clinical psychologist, licensed clinical social worker, or marriage and family therapist.

(B) "Dental visit" means a face-to-face encounter between an FQHC or RHC patient and a dentist, dental hygienist, or registered dental hygienist in alternative practice.

(C) "Medical visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, visiting nurse, or a comprehensive perinatal practitioner, as defined in Section 51179.7 of Title 22 of the California Code of Regulations, providing comprehensive perinatal services.

(2) A maximum of two visits, as defined in subdivision (g), that take place on the same day at a single location shall be reimbursed when one or both of the following conditions exists:

(A) Following the first visit, the patient suffers illness or injury that requires additional diagnosis or treatment.

(B) The patient has a medical visit and a mental health visit or a dental visit.

(3) (A) Notwithstanding subdivision (e), for purposes of establishing an FQHC or RHC rate, if an FQHC or RHC includes the cost of a medical visit and a mental health visit that take place on the same day at a single location as a single visit, then the FQHC or RHC may elect to apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, the FQHC or RHC shall bill a medical visit and a mental health visit that take place on the same day at a single location as separate visits.

(B) The department shall develop and adjust all appropriate forms to determine which FQHC's or RHC's rates shall be adjusted and shall facilitate the calculation of the adjusted rates.

(C) An FQHC's or RHC's application for, or the department's approval of, a rate adjustment pursuant to this paragraph shall not constitute a change in scope of service within the meaning of subdivision (e).

(D) An FQHC or RHC that applies for an adjustment to its rate pursuant to this paragraph may continue to bill for all other FQHC or RHC visits at its existing per-visit rate, subject to reconciliation, until the rate adjustment has been approved.

(4) The department, by July 1, 2022, shall submit a state plan amendment to the federal Centers for Medicare and Medicaid Services reflecting the changes described in this subdivision.

~~(l)~~

(m) Reimbursement for Drug Medi-Cal services shall be provided pursuant to this subdivision.

(1) An FQHC or RHC may elect to have Drug Medi-Cal services reimbursed directly from a county or the department under contract with the FQHC or RHC pursuant to paragraph (4).

(2) (A) For an FQHC or RHC to receive reimbursement for Drug Medi-Cal services directly from the county or the department under contract with the FQHC or RHC pursuant to paragraph (4), costs associated with providing Drug Medi-Cal services shall not be included in the FQHC's or RHC's per-visit PPS rate. For purposes of this subdivision, the costs associated with providing Drug Medi-Cal services shall not be considered to be within the FQHC's or RHC's clinic base PPS rate if in delivering Drug Medi-Cal services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver Drug Medi-Cal services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering Drug Medi-Cal services, including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing Drug Medi-Cal services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the Drug Medi-Cal services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a ~~scope-of-service~~ *scope of service* change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering Drug Medi-Cal services outside of the PPS rate. Notwithstanding subdivision (e), the ~~scope-of-service~~ *scope of service* change request shall include a full fiscal year of activity that does not include Drug Medi-Cal services costs.

(B) An FQHC or RHC may submit requests for ~~scope-of-service~~ *scope of service* change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. ~~Any scope-of-service~~ *A scope of service* change request under this subdivision approved by the department shall be retroactive to the

first day that Drug Medi-Cal services were rendered and reimbursement for Drug Medi-Cal services was received outside of the PPS rate, but in no case shall the effective date be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for Drug Medi-Cal services outside of the PPS rate when the FQHC or RHC obtains approval as a Drug Medi-Cal provider and enters into a contract with a county or the department to provide these services pursuant to paragraph (4).

(D) Within 90 days of receipt of the request for a ~~scope-of-service~~ *scope of service* change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for ~~scope-of-service~~ *scope of service* change under this subdivision shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(F) For purposes of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and Drug Medi-Cal services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate and the FQHC or RHC is approved as a Drug Medi-Cal provider, an FQHC or RHC shall not bill the PPS rate for any Drug Medi-Cal services provided pursuant to a contract entered into with a county or the department pursuant to paragraph (4).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with the applicable ~~scope-of-service~~ *scope of service* adjustments as provided for in subdivision (e).

(4) Reimbursement for Drug Medi-Cal services shall be determined according to subparagraph (A) or (B), depending on

whether the services are provided in a county that participates in the Drug Medi-Cal organized delivery system (DMC-ODS).

(A) In a county that participates in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon contract entered into between the county or county designee and the FQHC or RHC. If the county or county designee refuses to contract with the FQHC or RHC, the FQHC or RHC may follow the contract denial process set forth in the Special Terms and Conditions.

(B) In a county that does not participate in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon contract entered into between the county and the FQHC or RHC. If the county refuses to contract with the FQHC or RHC, the FQHC or RHC may request to contract directly with the department and shall be reimbursed for those services at the Drug Medi-Cal fee-for-service rate.

(5) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments for Drug Medi-Cal services made pursuant to this subdivision.

(6) For purposes of this subdivision, the following definitions apply:

(A) "Drug Medi-Cal organized delivery system" or "DMC-ODS" means the Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services and described in the Special Terms and Conditions.

(B) "Special Terms and Conditions" has the same meaning as set forth in subdivision (o) of Section 14184.10.

~~(m)~~

(n) Reimbursement for specialty mental health services shall be provided pursuant to this subdivision.

(1) An FQHC or RHC and one or more mental health plans that contract with the department pursuant to Section 14712 may mutually elect to enter into a contract to have the FQHC or RHC provide specialty mental health services to Medi-Cal beneficiaries as part of the mental health plan's network.

(2) (A) For an FQHC or RHC to receive reimbursement for specialty mental health services pursuant to a contract entered into

with the mental health plan under paragraph (1), the costs associated with providing specialty mental health services shall not be included in the FQHC's or RHC's per-visit PPS rate. For purposes of this subdivision, the costs associated with providing specialty mental health services shall not be considered to be within the FQHC's or RHC's clinic base PPS rate if in delivering specialty mental health services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver specialty mental health services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering specialty mental health services, including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing specialty mental health services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the specialty mental health services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a ~~scope-of-service~~ *scope of service* change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering specialty mental health services outside of the PPS rate. Notwithstanding subdivision (e), the ~~scope-of-service~~ *scope of service* change request shall include a full fiscal year of activity that does not include specialty mental health costs.

(B) An FQHC or RHC may submit requests for a ~~scope-of-service~~ *scope of service* change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. ~~Any scope-of-service~~ *A scope of service* change request under this subdivision approved by the department is retroactive to the first day that specialty mental health services were rendered and reimbursement for specialty mental health services was received outside of the PPS rate, but *in no case shall* the effective date ~~shall not~~ be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for specialty mental health services outside of the PPS rate when the FQHC or RHC contracts

with a mental health plan to provide these services pursuant to paragraph (1).

(D) Within 90 days of receipt of the request for a scope-of-service change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for ~~scope-of-service~~ *scope of service* change under this subdivision shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(F) For the purpose of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and specialty mental health services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate, an FQHC or RHC shall not bill the PPS rate for any specialty mental health services that are provided pursuant to a contract entered into with a mental health plan pursuant to paragraph (1).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with the applicable ~~scope-of-service~~ *scope of service* adjustments as provided for in subdivision (e).

(4) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments made for specialty mental health services under this subdivision.

~~(n)~~

(o) FQHCs and RHCs may appeal a grievance or complaint concerning ratesetting, ~~scope-of-service~~ *scope of service* changes, and settlement of cost report audits, in the manner prescribed by Section 14171. The rights and remedies provided under this subdivision are cumulative to the rights and remedies available under ~~all other provisions of law~~ *the laws* of this state.

~~(o)~~

(p) The department shall promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for Medicare and Medicaid Services for any waivers that would be necessary to implement this section.

~~(p)~~

(q) The department shall implement this section only to the extent that federal financial participation is available.

~~(q)~~

(r) Notwithstanding any other law, the director may, without taking regulatory action pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, implement, interpret, or make specific subdivisions ~~*(l)* and (m)~~ *(m) and (n)* by means of a provider bulletin or similar instruction. The department shall notify and consult with interested parties and appropriate stakeholders in implementing, interpreting, or making specific the ~~provisions of subdivisions *(l)* and (m),~~ *requirements of subdivisions (m) and (n),* including all of the following:

(1) Notifying provider representatives in writing of the proposed action or change. The notice shall occur, and the applicable draft provider bulletin or similar instruction, shall be made available at least 10 business days ~~prior to~~ *before* the meeting described in paragraph (2).

(2) Scheduling at least one meeting with interested parties and appropriate stakeholders to discuss the proposed action or change.

(3) Allowing for written input regarding the proposed action or change, to which the department shall provide summary written responses in conjunction with the issuance of the applicable final written provider bulletin or similar instruction.

(4) Providing at least 60 days advance notice of the effective date of the proposed action or change.

O

SENATE BILL No. 464

Introduced by Senator Hurtado

February 16, 2021

An act to amend, repeal, and add Section 18930 of the Welfare and Institutions Code, relating to public social services.

LEGISLATIVE COUNSEL'S DIGEST

SB 464, as introduced, Hurtado. California Food Assistance Program: eligibility.

Existing federal law provides for the Supplemental Nutrition Assistance Program (SNAP), known in California as CalFresh, under which supplemental nutrition assistance benefits allocated to the state by the federal government are distributed to eligible individuals by each county.

Existing law requires the State Department of Social Services to establish the California Food Assistance Program for a noncitizen of the United States if the person's immigration status meets the eligibility criteria of SNAP in effect on August 21, 1996, but the person is not eligible for SNAP benefits solely due to their immigration status, as specified. Existing law also makes eligible for the program an applicant who is otherwise eligible for the program, but who entered the United States on or after August 22, 1996, if the applicant is sponsored and the applicant meets one of a list of criteria, including that the applicant, after entry into the United States, is a victim of the sponsor or the spouse of the sponsor if the spouse is living with the sponsor.

This bill, commencing January 1, 2023, would instead make a noncitizen applicant eligible for the California Food Assistance Program if the noncitizen satisfies all eligibility criteria for participation in the CalFresh program except any requirements related to immigration status. The bill would, commencing January 1, 2023, eliminate the distinctions

based on when the noncitizen applicant entered the country and would eliminate the sponsorship and other listed criteria requirements for eligibility on a noncitizen who entered the country on or after August 22, 1996. To the extent this bill would expand eligibility for the California Food Assistance Program, which is administered by the counties, this bill would impose a state-mandated local program.

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, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. (a) The Legislature finds and declares all of the following:

(1) The Supplemental Nutrition Assistance Program (SNAP) is a federal entitlement program. The federal government funds the nutrition benefits, and establishes most program rules, sets the benefit levels, and funds all program food benefits. The state determines certain conditions of eligibility and oversees county administration of the program.

(2) In California, SNAP is known as CalFresh, and is the largest and most impactful antihunger program in the state.

(3) CalFresh is also an effective antipoverty program, lifting more than 700,000 Californians out of poverty.

(4) Federal SNAP law prohibits participation in CalFresh for many low-income Californians, solely due to their immigration status.

(5) The California Food Assistance Program (CFAP) is a state-funded program created in response to the 1996 federal welfare reform that removed SNAP eligibility from many lawfully present immigrants.

(6) Federal laws exclude noncitizen immigrants without lawful status, Deferred Action for Childhood Arrivals (DACA) recipients,

Temporary Protected Status (TPS) holders, and other certain other visa holders from CalFresh and CFAP eligibility.

(7) Immigrant Californians experience food insecurity at higher rates compared to their United States-born counterparts.

(8) The COVID-19 pandemic has greatly increased food insecurity among low-income Californians, and disproportionately impacted noncitizen immigrants.

(9) Access to food assistance means greater opportunity to reduce hunger, improve health, and lift people out of poverty.

(10) In order to end the inequitable provision of vital food assistance based solely on immigration status and meet the current needs of all California immigrants impacted by the COVID-19 pandemic, CFAP needs to be modernized.

(b) It is the intent of the Legislature that all Californians, regardless of immigration status, have access to food assistance to maximize the impact of federal safety net funding to reduce poverty, fight hunger, and improve health for all low-income Californians.

SEC. 2. Section 18930 of the Welfare and Institutions Code is amended to read:

18930. (a) The State Department of Social Services shall establish a Food Assistance Program to provide assistance for those persons described in subdivision (b). The department shall enter into an agreement with the United States Department of Agriculture to use the existing federal Supplemental Nutrition Assistance Program coupons for the purposes of administering this program. Persons who are members of a household receiving CalFresh benefits under this chapter or under Chapter 10 (commencing with Section 18900), and are receiving CalWORKs benefits under Chapter 2 (commencing with Section 11200) of Part 3 on September 1, 1998, shall have eligibility determined under this chapter without need for a new application no later than November 1, 1998, and the beginning date of assistance under this chapter for those persons shall be September 1, 1998.

(b) (1) Except as provided in paragraphs (2), (3), and (4) and Section 18930.5, noncitizens of the United States shall be eligible for the program established pursuant to subdivision (a) if the person's immigration status meets the eligibility criteria of the federal Supplemental Nutrition Assistance Program in effect on August 21, 1996, but ~~he or she~~ *the person* is not eligible for federal

Supplemental Nutrition Assistance Program benefits solely due to ~~his or her~~ *the person's* immigration status under Public Law 104-193 and any subsequent amendments thereto.

(2) Noncitizens of the United States shall be eligible for the program established pursuant to subdivision (a) if the person is a battered immigrant spouse or child or the parent or child of the battered immigrant, as described in Section 1641(c) of Title 8 of the United States Code, as amended by Section 5571 of Public Law 105-33, or if the person is a Cuban or Haitian entrant as described in Section 501(e) of the federal Refugee Education Assistance Act of 1980 (Public Law 96-122).

(3) An applicant who is otherwise eligible for the program but who entered the United States on or after August 22, 1996, shall be eligible for aid under this chapter only if ~~he or she~~ *the applicant* is sponsored and one of the following apply:

(A) The sponsor has died.

(B) The sponsor is disabled as defined in subparagraph (A) of paragraph (3) of subdivision (b) of Section 11320.3.

(C) The applicant, after entry into the United States, is a victim of abuse by the sponsor or the spouse of the sponsor if the spouse is living with the sponsor.

(4) An applicant who is otherwise eligible for the program but who entered the United States on or after August 22, 1996, who does not meet one of the conditions of paragraph (3), shall be eligible for aid under this chapter beginning on October 1, 1999.

(5) The applicant shall be required to provide verification that one of the conditions of subparagraph (A), (B), or (C) *of paragraph (3)* has been met.

(6) For purposes of subparagraph (C) of paragraph (2), abuse shall be defined in the same manner as provided in Section 11495.1 and Section 11495.12. A sworn statement of abuse by a victim, or the representative of the victim if the victim is not able to competently swear, shall be sufficient to establish abuse if one or more additional items of evidence of abuse is also provided. Additional evidence may include, but is not limited to, the following:

(A) Police, government agency, or court records or files.

(B) Documentation from a domestic violence program, legal, clinical, medical, or other professional from whom the applicant or recipient has sought assistance in dealing with abuse.

(C) A statement from any other individual with knowledge of the circumstances that provided the basis for the claim.

(D) Physical evidence of abuse.

(7) If the victim cannot provide additional evidence of abuse, then the sworn statement shall be sufficient if the county makes a determination documented in writing in the case file that the applicant is credible.

(c) In counties approved for alternate benefit issuance systems, that same alternate benefit issuance system shall be approved for the program established by this chapter.

(d) (1) To the extent allowed by federal law, the income, resources, and deductible expenses of those persons described in subdivision (b) shall be excluded when calculating CalFresh benefits under Chapter 10 (commencing with Section 18900).

(2) No household shall receive more CalFresh benefits under this section than it would if no household member was rendered ineligible pursuant to Title IV of Public Law 104-193 and any subsequent amendments thereto.

~~(e) This section shall become operative on September 1, 1998.~~

(e) This section shall remain in effect only until January 1, 2023, and as of that date is repealed.

SEC. 3. Section 18930 is added to the Welfare and Institutions Code, to read:

18930. (a) The State Department of Social Services shall establish a Food Assistance Program to provide assistance for those persons described in subdivision (b). The department shall enter into an agreement with the United States Department of Agriculture to use the existing federal Supplemental Nutrition Assistance Program coupons for the purposes of administering this program. Persons who are members of a household receiving CalFresh benefits under this chapter or under Chapter 10 (commencing with Section 18900), and are receiving CalWORKs benefits under Chapter 2 (commencing with Section 11200) of Part 3 on September 1, 1998, shall have eligibility determined under this chapter without need for a new application no later than November 1, 1998, and the beginning date of assistance under this chapter for those persons shall be September 1, 1998.

(b) Noncitizens of the United States shall be eligible for the program established pursuant to subdivision (a) if the person

satisfies all eligibility criteria for participation in the CalFresh program except any requirements related to immigration status.

(c) In counties approved for alternate benefit issuance systems, that same alternate benefit issuance system shall be approved for the program established by this chapter.

(d) (1) To the extent allowed by federal law, the income, resources, and deductible expenses of those persons described in subdivision (b) shall be excluded when calculating CalFresh benefits under Chapter 10 (commencing with Section 18900).

(2) No household shall receive more CalFresh benefits under this section than it would if no household member was rendered ineligible pursuant to Title IV of Public Law 104-193 and any subsequent amendments thereto.

(e) This section shall become operative on January 1, 2023.

SEC. 4. If the Commission on State Mandates determines that this act contains 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.

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Senate Bill No. 803

CHAPTER 150

An act to add Article 1.4 (commencing with Section 14045.10) to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor September 25, 2020. Filed with Secretary of State September 25, 2020.]

LEGISLATIVE COUNSEL'S DIGEST

SB 803, Beall. Mental health services: peer support specialist certification.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a schedule of benefits under the Medi-Cal program and provides for various services, including behavioral and mental health services that are rendered by Medi-Cal enrolled providers.

This bill would require the department, by July 1, 2022, subject to any necessary federal waivers or approvals, to establish statewide requirements for counties or their representatives to use in developing certification programs for the certification of peer support specialists, who are individuals who self-identify as having lived experience with the process of recovery from mental illness, substance use disorder, or both. The bill would authorize a county, or an agency that represents a county, to develop a peer support specialist certification program and certification fee schedule, both of which would be subject to department approval. The bill would require the department to seek any federal waivers it deems necessary to establish a demonstration or pilot project for the provision of peer support services in a county that agrees to participate in and fund the project, as specified.

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

SECTION 1. This act shall be known, and may be cited, as the Peer Support Specialist Certification Program Act of 2020.

SEC. 2. Article 1.4 (commencing with Section 14045.10) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 1.4. Peer Support Specialist Certification Program

14045.10. The Legislature finds and declares all of the following:

(a) Peer providers in California provide individualized support, coaching, facilitation, and education to clients with mental health care needs and substance use disorders in a variety of settings. Yet, no statewide scope of practice, standardized curriculum, training standards, supervision standards, or certification protocol is available.

(b) The United States Department of Veterans Affairs and at least 48 states utilize standardized curricula and certification protocols for peer support services.

(c) The federal Centers for Medicare and Medicaid Services (CMS) recognizes that the experiences of peer support specialists, as part of an evidence-based model of care, can be an important component in a state's delivery of effective mental health and substance use disorder treatment. The CMS encourages states to offer comprehensive programs.

(d) A substantial number of research studies demonstrate that peer supports improve client functioning, increase client satisfaction, reduce family burden, alleviate depression and other symptoms, reduce homelessness, reduce hospitalizations and hospital days, increase client activation, and enhance client self-advocacy.

(e) Certification can increase the diversity and effectiveness of the behavioral health workforce through the use of peers with lived experience.

14045.11. It is the intent of the Legislature that the peer support specialist certification program, established under this article, achieve all of the following:

(a) Support the ongoing provision of services for individuals experiencing mental health care needs, substance use disorder needs, or both, by certified peer support specialists.

(b) Support coaching, linkage, and skill building of individuals with mental health needs, substance use disorder needs, or both, and to families or significant support persons.

(c) Increase family support by building on the strengths of families and helping them achieve a better understanding of mental illness in order to help individuals achieve desired outcomes.

(d) Support collaboration with others providing care or support to the individual or family.

(e) Assist parents, families, and individuals in developing coping mechanisms and problem-solving skills in order to help individuals achieve desired outcomes.

(f) Promote skill building for individuals in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

(g) Encourage employment under the peer support specialist certification to reflect the culture, ethnicity, sexual orientation, gender identity, mental health service experiences, and substance use disorder experiences of the individuals the peer support specialists serve.

14045.12. For purposes of this article, the following definitions apply:

(a) "Certification" means the activities related to the verification that an individual has met all of the requirements under this article and that the

individual may provide peer support specialist services pursuant to this article.

(b) "Certified" means all federal and state requirements have been satisfied by an individual who is seeking designation under this article, including completion of curriculum and training requirements, testing, and agreement to uphold and abide by the code of ethics.

(c) "Code of ethics" means the standards to which a peer support specialist is required to adhere.

(d) "Core competencies" means the foundational and essential knowledge, skills, and abilities required for peer specialists.

(e) "Cultural competence" means a set of congruent behaviors, attitudes, and policies that come together in a system or agency that enables that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates, at all levels, the importance of language and culture, intersecting identities, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs to provide services in a culturally competent manner.

(f) "Department" means the State Department of Health Care Services.

(g) "Peer support specialist" means an individual who is 18 years of age or older, who has self-identified as having lived experience with the process of recovery from mental illness, substance use disorder, or both, either as a consumer of these services or as the parent or family member of the consumer, and who has been granted certification under a county peer support specialist certification program.

(h) "Peer support specialist services" means culturally competent services that promote engagement, socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths. Peer support specialist services include, but are not limited to, prevention services, support, coaching, facilitation, or education that is individualized and is conducted by a certified peer support specialist.

(i) "Recovery" means a process of change through which an individual improves their health and wellness, lives a self-directed life, and strives to reach their full potential. This process of change recognizes cultural diversity and inclusion, and honors the different routes to resilience and recovery based on the individual and their cultural community.

14045.13. By July 1, 2022, subject to Section 14045.19, the department shall do all of the following:

(a) Establish statewide requirements for counties, or an agency representing counties, to use in developing certification programs for the certification of peer support specialists.

(b) Define the qualifications, range of responsibilities, practice guidelines, and supervision standards for peer support specialists. The department may utilize best practice materials published by the federal Substance Abuse and Mental Health Services Administration, the United States Department of

Veterans Affairs, and related notable experts in the field as a basis for development of these definitions.

(c) Determine curriculum and core competencies required for certification of an individual as a peer support specialist, including curriculum that may be offered in areas of specialization, including, but not limited to, transition-age youth, veterans, gender identity, sexual orientation, and any other areas of specialization identified by the department. Core-competencies-based curriculum shall include, at a minimum, training related to all of the following elements:

(1) The concepts of hope, recovery, and wellness.

(2) The role of advocacy.

(3) The role of consumers and family members.

(4) Psychiatric rehabilitation skills and service delivery, and addiction recovery principles, including defined practices.

(5) Cultural competence training.

(6) Trauma-informed care.

(7) Group facilitation skills.

(8) Self-awareness and self-care.

(9) Cooccurring disorders of mental health and substance use.

(10) Conflict resolution.

(11) Professional boundaries and ethics.

(12) Preparation for employment opportunities, including study and test-taking skills, application and résumé preparation, interviewing, and other potential requirements for employment.

(13) Safety and crisis planning.

(14) Navigation of, and referral to, other services.

(15) Documentation skills and standards.

(16) Confidentiality.

(d) Specify peer support specialist employment training requirements, including core-competencies-based training and specialized training necessary to become certified under this article, and require training to include people with lived experience as consumers and family members.

(e) Establish a code of ethics.

(f) Determine continuing education requirements for biennial certification renewal.

(g) Determine the process for initial certification issuance and biennial certification renewal.

(h) Determine a process for investigation of complaints and corrective action, including suspension and revocation of certification and appeals.

(i) Determine a process for an individual employed as a peer support specialist on January 1, 2022, to obtain certification under this article.

(j) Determine requirements for peer support specialist certification reciprocity between counties, and for peer support specialists from out of state.

(k) Seek any federal approvals, related to the statewide certification standards, that it deems necessary to implement this article. For any federal approvals that the department deems necessary related to the statewide

certification standards, this article shall be implemented only if and to the extent that the department obtains those federal approvals.

14045.14. (a) Subject to department approval, a county, or an agency representing the county, may develop a peer support specialist certification program in accordance with this article and any standards established by the department. That county, or an agency representing that county, shall oversee and enforce the certification requirements developed pursuant to this article. To request department approval of the county peer support specialist program, a county, or an agency representing the county, shall do all of the following:

(1) Submit to the department a peer support specialist program plan describing how the peer support specialist program will meet all of the federal and state requirements for the certification and oversight of peer support specialists.

(2) Submit to periodic reviews conducted by the department to ensure adherence to all federal and state requirements.

(3) Submit annual peer support specialist program reports to the department.

(b) If a county chooses not to develop peer support specialist certification programs in accordance with this article, the county may fund peer programs to the extent those programs meet all requirements of the applicable funding source.

(c) The Legislature finds that peer support specialist certification is conducted at the state level in other states, but this section passes this responsibility to counties. Subject to an appropriation by the Legislature, the state shall fund the startup costs to implement this section.

14045.15. (a) To receive a certification under this article, an applicant shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Possess a high school diploma or equivalent degree.

(3) Be self-identified as having experience with the process of recovery from mental illness or substance use disorder either as a consumer of these services or as the parent or family member of the consumer.

(4) Be willing to share their experience.

(5) Have a strong dedication to recovery.

(6) Agree, in writing, to adhere to a code of ethics.

(7) Successfully complete the curriculum and training requirements for a peer support specialist.

(8) Pass a certification examination approved by the department for a peer support specialist.

(b) To maintain certification under this article, a certified peer support specialist shall meet both of the following requirements:

(1) Adhere to the code of ethics and biennially sign an affirmation.

(2) Complete any required continuing education, training, and recertification requirements.

14045.16. This article does not authorize an individual who is certified pursuant to this article to diagnose an illness, prescribe medication, or provide clinical services.

14045.17. The department shall solicit stakeholder input that may include input from the Office of Statewide Health Planning and Development, peer support and family organizations, mental health services and substance use disorder treatment providers and organizations, the County Behavioral Health Directors Association of California, and the California Behavioral Health Planning Council in implementing this article. Consultation shall include regular stakeholder meetings. The department may additionally conduct technical workgroups upon the request of stakeholders.

14045.18. A participating county, or an agency representing a participating county, is authorized to establish a certification fee schedule for the purpose of supporting the activities associated with the ongoing administration of the peer support specialist certification program. Before the fee schedule may be implemented, the department shall review and either approve or disapprove the fee schedule of the participating county or an agency representing the participating county.

14045.19. (a) The department shall seek any federal waivers it deems necessary to establish a demonstration or pilot project for the provision of peer support services in counties that agree to participate and provide the necessary nonfederal share funding for the demonstration or pilot project. The demonstration or pilot project shall do all of the following:

(1) Include a peer support specialist certified pursuant to this article as a Medi-Cal provider type for purposes of the demonstration or pilot project.

(2) Include peer support specialist services as a distinct service type in counties that opt in to the demonstration or pilot project.

(3) Develop and implement one or more billing codes, reimbursement rates, and claiming requirements for peer support specialist services.

(b) (1) This section does not require a county to participate in a demonstration or pilot project pursuant to this section. A county that opts to participate in a demonstration or pilot project and provide the necessary nonfederal share funding shall be considered to do so voluntarily for purposes of all state and federal laws.

(2) A county that opts to participate in a demonstration or pilot project pursuant to this section agrees to fund the nonfederal share of any applicable expenditures through certified public expenditures or intergovernmental transfers in accordance with Section 433.51 of Title 42 of the Code of Federal Regulations. Each participating county shall certify that the local funds it uses to fund the nonfederal share of expenditures pursuant to this section qualify for federal financial participation pursuant to applicable federal Medicaid laws and any terms of federal approval, in the form and manner as required by the department.

(3) Demonstration or pilot projects developed and implemented pursuant to this section shall not constitute a mandate of a new program or higher level of service that has an overall effect of increasing the costs mandated

by the 2011 realignment legislation for the counties that opt in to a demonstration or pilot project.

(4) General Fund moneys shall not be used to fund the nonfederal share of any expenditures made pursuant to a demonstration or pilot project under this section.

(c) This section shall be implemented only if and to the extent that the department obtains any necessary federal approvals, and federal financial participation is available and is not otherwise jeopardized.

14045.20. For the purpose of implementing this article, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis, including contracts for the purpose of obtaining subject matter expertise or other technical assistance. 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 or the Department of Technology.

14045.21. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this article, in whole or in part, by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions, without taking any further regulatory action.

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