

**Department of Health Care Services
Proposed Trailer Bill Language**

Managed Care Organization Tax

Article 7.2 of Chapter 7, Part 3, Division 9 of the Welfare and Institutions Code, Sections 14199.90 through 14199.97, is added, to read:

14199.90. Legislative Findings and Declarations

14199.90 The Legislature finds and declares all of the following:

(a) The Legislature continues to recognize that an enrollment-based managed care organization provider tax is an essential and necessary source of nonfederal funding for maintaining and improving access to care and reimbursement levels under, and maximizing federal financial participation for, the Medi-Cal program.

(b) The Legislature recognizes how the previous iterations of the managed care organization provider tax, in effect nearly continuously from July 1, 2016, enabled the state to provide ongoing funding for health care and prevention, while minimizing the need for any new reductions to the Medi-Cal program during the time periods when the tax was in effect.

(c) The current managed care organization provider tax, set forth in Article 7.1 of this Chapter, expires on December 31, 2026.

(d) Article 6 of Chapter 7.5, Part 3, Division 9 of the Welfare and Institutions Code, commencing with section 14199.123, requires the department to submit an application for a continued, permanent managed care organization provider tax utilizing substantially similar models and methodologies as the managed care organization provider tax authorized in Article 7.1 of this Chapter to the federal Centers for Medicare & Medicaid Services, to be effective January 1, 2027.

(e) The federal passage of H.R. 1, 119th Congress (2025-2026), and the publication of the federal Center for Medicare & Medicaid Services' February 2, 2026, Final Rule entitled "Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole" (91 FR 4794), materially changed the standards by which the federal Centers for Medicare & Medicaid Services may approve applications for a waiver from the broad-based and uniformity requirements for health care-related taxes under Subdivision (e) of Section 433.68 of Title 42 of the Code of Federal Regulations.

(f) These new federal requirements may result in a denial of federal approval for the managed care organization provider tax authorized in Article 6 of Chapter 7.5, Part 3, Division 9 of the Welfare and Institutions Code.

(g) The federal Centers for Medicare & Medicaid Services' February 2, 2026, Final Rule provided the State with a transition period up to and including December 31, 2026, to bring its managed care organization provider tax into compliance with the new requirements under Subdivision (e) of Section 433.68 of Title 42 of the Code of Federal Regulations.

(h) Implementation of a continued federally-approvable managed care organization provider tax at the earliest possible effective date allowable under federal law, with an application for any necessary federal approvals submitted to the federal Centers for Medicare & Medicaid Services prior to the end of the state's transition period on December 31, 2026, will best position the state to maintain and improve access to care and reimbursement levels, maximize federal financial participation, and minimize the need for any new reductions to the Medi-Cal program.

(i) In furtherance of subdivisions (a) to (h), inclusive, it is the intent of the Legislature that the department implement a managed care organization provider tax effective January 1, 2027, that is not subject to Chapter 7.5, Part 3, Division 9 of the Welfare and Institutions Code, to meet all of the following goals:

(1) Generate an amount of funds for the Medi-Cal program that is sufficient to fund the purposes specified in paragraphs (1) to (3), inclusive, of subdivision (d) of Section 14199.92 in full and the purpose specified in paragraph (4) of subdivision (d) of Section 14199.92 in the amount of at least two billion dollars (\$2,000,000,000) annually.

(2) Comply with federal Medicaid requirements applicable to permissible health care-related taxes, including, but not limited to, Section 433.68 of Title 42 of the Code of Federal Regulations.

(3) Provide funding to support the Medi-Cal program.

(4) Minimize, to the extent possible, the need for any new reductions to the Medi-Cal program.

14199.91. Definitions

14199.91 The following definitions shall apply for purposes of this article:

(a) "Base data source" means the quarterly financial statement filings or annual enrollment data submitted by health plans to the Department of Managed Health Care retrieved by the department no later than June 30, 2026, and supplemented by, as necessary, Medi-Cal enrollment data for the base year as maintained by the department and retrieved no later than June 30, 2026, and as modified by the department to account for known or anticipated changes that will affect Medi-Cal enrollment on or after January 1, 2027. However, if the department elects to update the base year pursuant to subdivision (b), "base data source" means the most recently available quarterly financial statement filings or annual enrollment data submitted by health plans to the Department of Managed Health Care for that updated base year, retrieved by the department, and supplemented by, as necessary, Medi-Cal enrollment data for the updated base year as maintained by the department, and as modified by the department to account for known or anticipated changes that will affect Medi-Cal enrollment.

(b) "Base year" for the 2027 calendar year tax period means either the 12-month period of January 1, 2024, through December 31, 2024, or the 12-month period of January 1, 2025, through December 31, 2025, as determined by the department. For subsequent tax periods, the department may elect to update the base year to the extent that it deems such action to be consistent with the requirements of

federal law or regulations, or necessary to obtain or maintain federal approval or to ensure federal financial participation is available or is not otherwise jeopardized.

(c) "Countable enrollee" means an individual enrolled in a health plan, as defined in subdivision (f), during a month of the base year according to the base data source. "Countable enrollee" does not include an individual enrolled in a Medicare plan, a plan-to-plan enrollee, as defined in subdivision (h), or an individual enrolled in a health plan pursuant to the Federal Employees Health Benefits Act of 1959 (Public Law 86-382) to the extent the imposition of the tax under this article is preempted pursuant to Section 8909(f) of Title 5 of the United States Code.

(d) "Department" means the State Department of Health Care Services.

(e) "Director" means the Director of Health Care Services.

(f) "Enrollee" means an individual enrolled in a health plan, as defined in subdivision (g), unless otherwise specified.

(g) "Health care service plan" or "health plan" means a health care service plan, other than a plan that provides only specialized or discount services, that is licensed by the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) or a managed care plan contracted with the State Department of Health Care Services to provide full-scope Medi-Cal services.

(h) "Plan-to-plan enrollee" means an individual who receives their health care services through a health plan pursuant to a subcontract from another health plan.

(i) "Tax amount" means the amount of tax assessed per countable enrollee.

(j) "Tax period" means a period of not more than 12 months for which the tax authorized by this article is assessed, in accordance with the requirements described in Section 14199.94.

14199.92. Medi-Cal Stability Fund

14199.92 (a) The Medi-Cal Stability Fund is hereby created in the State Treasury.

(b) All revenues, less refunds, derived from the taxes provided for in this article shall be deposited in the State Treasury to the credit of the Medi-Cal Stability Fund.

(c) Notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on moneys in the Medi-Cal Stability Fund shall be retained in the fund and used solely for the purpose specified in subdivision (d).

(d) Notwithstanding Section 13340 of the Government Code or any other law, funds deposited in the Medi-Cal Stability Fund pursuant to this article are continuously appropriated, without regard to fiscal year, to the department for the purpose of funding all of the following subcomponents to support the Medi-Cal program, in the following order of priority:

(1) The department's administrative costs in an amount not to exceed four million dollars (\$4,000,000) annually.

(2) The nonfederal share of increased capitation payments to Medi-Cal managed care plans accounting for their projected tax obligation pursuant to this article for the applicable tax period or periods.

(3) The nonfederal share of the payments described in Section 14105.201.

(4) The nonfederal share of Medi-Cal managed care rates for health care services furnished to children, adults, seniors and persons with disabilities, and persons dually eligible for the Medi-Cal program and the Medicare Program, in the amount of at least two billion dollars (\$2,000,000,000) annually.

(e) Notwithstanding any other law, the Controller may use the funds in the Medi-Cal Stability Fund for cashflow loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code.

14199.93. Determination of enrollment; data corrections

14199.93 (a) The department shall determine for each health plan, using the base data source, all of the following:

(1) Total cumulative enrollment for the base year.

(2) Total Medicare cumulative enrollment for the base year.

(3) Total Medi-Cal cumulative enrollment for the base year.

(4) Total plan-to-plan cumulative enrollment for the base year.

(5) Total cumulative enrollment through the Federal Employees Health Benefits Act of 1959 (Public Law 86-382) for the base year.

(6) Total other cumulative enrollment for the base year that is not otherwise counted in paragraphs (2) to (5), inclusive.

(b) Notwithstanding any other provision in this article, the director may correct any identified material or significant error in the data, including, but not limited to, the total cumulative enrollment, Medicare cumulative enrollment, Medi-Cal cumulative enrollment, plan-to-plan cumulative enrollment, cumulative enrollment through the Federal Employees Health Benefits Act of 1959 (Public Law 86-382), and other cumulative enrollment. The director's determination as to whether to exercise discretion under this section and any determination made by the director under this section shall not be subject to judicial review, except that a health plan may bring a writ of mandate under Section 1085 of the Code of Civil Procedure to rectify an abuse of discretion by the department in correcting that health plan's data when that correction results in a greater tax amount for that health plan pursuant to Section 14199.95.

14199.94. Managed care organization provider tax; tax periods; collection; interest and penalties

14199.94 (a) A managed care organization provider tax shall be imposed on each health plan. The tax shall be imposed for the 2027, 2028, and 2029 calendar years. The tax shall be imposed for all periods within a calendar year that the tax is effective and operative as set forth in Section 14199.96.

(b) The department shall compute the annual tax for each health plan subject to the tax during each applicable calendar year pursuant to Section 14199.95.

(c) The department shall collect the tax for each health plan in quarterly installments and shall determine the amount due for each installment in the applicable tax period by dividing the total tax for a tax period by the number of calendar quarters in the respective tax period.

(d) The department shall not collect the tax imposed pursuant to this article until one of the following conditions is met:

(1) The director certifies in writing that the tax imposed pursuant to this article is a federally-permissible health care-related tax that meets the broad-based and uniformity requirements under Subdivisions (b) through (d) of Section 433.68 of Title 42 of the Code of Federal Regulations and complies with federal hold harmless requirements under Subdivision (w)(4) of Section 1396b of Title 42 of the United States Code and Subdivision (f) of Section 433.68 of Title 42 of the Code of Federal Regulations. The department shall post the certification on its internet website and send a copy of the certification to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(2) The department receives written approval from the federal Centers for Medicare & Medicaid Services that this tax is a permissible health care-related tax in accordance with Section 433.68 of Title 42 of the Code of Federal Regulations.

(A) Within 10 business days following the date the department receives all necessary federal approvals for the tax pursuant to this article, the director shall certify in writing that federal approval has been received, and the department shall post the certification on its internet website and send a copy of the certification to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(e) Within 30 business days following the date the director issues a certification as set forth in paragraph (1) of subdivision (d) or the date the department receives all necessary federal approvals for the tax pursuant to this article as set forth in paragraph (2) of subdivision (d), the department shall send a notice to each health plan subject to the tax that shall contain the following information:

(1) The tax due for the 2027 calendar year tax period and the estimated tax due for subsequent tax periods.

(2) The dates on which the installment tax payments are due for the 2027 calendar year tax period and the estimated dates on which the installment tax payments are due for subsequent tax periods.

(f) A health plan shall pay the tax for each tax period in installments as calculated pursuant to Section 14199.95, based on a schedule developed by the department. The department shall establish the date that each tax payment is due, provided that the first tax payment shall be due no earlier than 20 calendar days following the date the department sends the notice pursuant to paragraph (2), and the tax payments shall be paid at least one month apart.

(4) A health plan shall pay the taxes that are due, if any, in the amounts and at the times set forth in the notice unless superseded by a subsequent notice issued by the department.

(g) The tax assessed pursuant to this article shall be paid by each health plan subject to the tax to the department for deposit in the Medi-Cal Stability Fund created pursuant to Section 14199.92.

(h)(1) Interest shall be assessed on an applicable health plan for any amount of the managed care organization provider taxes that are not paid on the date due at a rate of 10 percent per annum. Interest shall begin to accrue the day after the date the tax payment was due and shall be deposited in the Medi-Cal Stability Fund created pursuant to Section 14199.92.

(2) If a tax payment is more than 60 days overdue, a penalty equal to the total accrued interest charge described in paragraph (1) shall also be assessed on the applicable health plan and due for each month for which the tax payment is not received after 60 days.

(i)(1) Subject to paragraph (2), the director may waive a portion or all of either the interest or penalties, or both, assessed under this article if the director determines, in their sole discretion, that the health plan has demonstrated that imposition of the full amount of the tax pursuant to the timelines applicable under this article has a high likelihood of creating an undue financial hardship for the health plan or creates a significant financial difficulty in providing needed services to Medi-Cal members.

(2) Waiver of some or all of the interest or penalties pursuant to this subdivision shall be conditioned on the health plan's agreement to make tax payments on an alternative schedule developed by the department that takes into account the financial situation of the health plan and the potential impact on the delivery of services to Medi-Cal members.

(j) In the event of a merger, acquisition, establishment, or any other similar transaction that results in the transfer of health plan responsibility for all countable enrollees under this article from a health plan to another health plan or similar entity, and that occurs at any time during which this article is operative, the resultant health plan or similar entity shall be responsible for paying the full tax amount as provided in this article that would have been the responsibility of the health plan to which that full tax amount was assessed upon the effective date of any such transaction. If a merger, acquisition, establishment, or any other similar transaction results in the transfer of health plan responsibility for only some of a health plan's countable enrollees under this article but not all countable enrollees, the full tax amount as provided in this article shall remain the responsibility of that health plan to which that full tax amount was assessed.

14199.95. Tax amounts; modifications or adjustments; federal approval

14199.95 (a)(1) For each calendar year in which the managed care organization provider tax authorized by this article is in effect, the tax amount for each health plan shall be \$8.85 per countable enrollee per month, unless modified in accordance with paragraphs (2) or (3) or subdivision (b).

(2)(A) The department may calculate and impose an alternative tax amount upon a determination by the department, in its sole discretion, that the tax amount in paragraph (1) is projected to generate revenues that are lower or materially higher

than is needed to meet the goal described in paragraph (1) of subdivision (i) of Section 14199.90.

(B) The alternative tax amount pursuant to subparagraph (A) must not be higher or lower than the tax amount in paragraph (1) by more than 10 percent for the 2027 calendar year tax period and by more than 25 percent for subsequent tax periods.

(3)(A) The department may establish taxing tiers consisting of discrete ranges of countable enrollees and may calculate and impose alternative tax amounts for these taxing tiers, but only to the extent consistent with the purposes of this article and necessary to achieve legitimate public policy goals.

(B)(i) The average of the alternative tax amounts pursuant to subparagraph (A), weighted according to the applicable number of countable enrollees, must not exceed the limits specified in subparagraph (B) of paragraph (2).

(ii) The alternative tax amounts pursuant to subparagraph (A) must not result in an increase in the aggregate tax amounts projected to be collected from any health plan under this article that the department, in its sole discretion, determines is significant.

(b) The department may modify or make adjustments to any methodology, tax amount, taxing tier, or other provision specified in this article to the extent that it deems necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure federal financial participation is available or is not otherwise jeopardized, provided the modification or adjustment does not otherwise conflict with the purposes of this article, or result in an increase in the aggregate tax amounts projected to be collected under this article that the department, in its sole discretion, determines is significant.

(c)(1) If the department calculates and imposes an alternative tax amount or amounts in accordance with paragraphs (2) or (3) of subdivision (a) or identifies that modification or adjustment is necessary in accordance with subdivision (b), the department shall consult with affected health plans, to the extent practicable, to implement that alternative tax amount or amounts or modification or adjustment, as applicable.

(2) In the event of imposition of an alternative tax amount or amounts in accordance with paragraphs (2) or (3) of subdivision (a) or a modification or adjustment made pursuant to subdivision (b), the department shall notify affected health plans, the Department of Finance, the Joint Legislative Budget Committee, the Senate Committees on Appropriations, Budget and Fiscal Review, and Health, and the Assembly Committees on Appropriations, Budget, and Health within 10 business days of taking the applicable action.

(d) The department shall request approval from the federal Centers for Medicare & Medicaid Services as is necessary to implement this article. In making that request, the department may seek, as it deems necessary, a request for waiver of the broad-based requirement, waiver of the uniformity requirement, or both, pursuant to Subdivision (e) of Section 433.68 of Title 42 of the Code of Federal Regulations, or a request for waiver of any other federal law or regulation necessary to implement this article.

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

14199.96. Effective date of tax; operative effect of article

14199.96 (a) The tax assessed under this article shall become effective and operative on January 1, 2027, or the effective date, certified in writing by the director, of federal approval if such approval is necessary, whichever occurs later. When such federal approval is necessary and is secured, the director shall post the certification of federal approval on the department's internet website and send a copy of the certification to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, the Legislative Counsel, the State Board of Equalization, the Department of Insurance, and the Executive Officer of the Franchise Tax Board.

(b) This article, except for Section 14199.92 to the extent not in conflict with federal law, shall cease to be operative the first day of the calendar year beginning on or after the date the director, in consultation with the Director of Finance, determines that the tax has not met the intent as outlined in Section 14199.90 or that the tax was rejected where federal approval was necessary or found out of compliance with federal law by the federal Centers for Medicare & Medicaid Services and the director determines that it is not feasible to modify the tax to achieve such federal approval or compliance. The director shall post the determination on the department's internet website and send a copy of the determination to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, the Legislative Counsel, the State Board of Equalization, the Department of Insurance, the Department of Finance, and the Executive Officer of the Franchise Tax Board.

(c) This article, except for Section 14199.92 to the extent not in conflict with federal law, shall cease to be operative for any affected tax period or periods upon a final judicial determination made by any court of appellate jurisdiction, or a final determination by the United States Department of Health and Human Services or the federal Centers for Medicare & Medicaid Services, that the tax assessed pursuant to this article cannot be implemented for the affected tax period or periods, and any amount of the tax paid under this article with respect to the affected tax period or periods shall be refunded. The director shall post a notification of that final judicial or federal administrative determination on the department's internet website and provide this notification to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, the Legislative Counsel, the State Board of Equalization, the Department of Insurance, the Department of Finance, and the Executive Officer of the Franchise Tax Board.

(d) Notwithstanding this section, any tax and any applicable interest and penalties imposed under this article shall continue to be due and payable to the department until the tax and any applicable interest and penalties are fully paid.

(e) Upon execution of the declaration described in subdivision (b) or (c), the director shall implement a plan, in consultation with the Department of Finance, to end the program consistent with the purpose of the article, including the recoupment of payments made under this article if required by a final judicial determination made by any court of appellate jurisdiction or a final determination made by the United States Department of Health and Human Services or the federal Centers for Medicare & Medicaid Services.

14199.97. Operative date of article; duration of article

14199.97 (a) This article shall become operative on July 1, 2026, or the date on which the act that added this article is chaptered, whichever is later.

(b)(1) All sections in this Article, except for Section 14199.92 to the extent not in conflict with federal law, shall become inoperative on January 1, 2031, or on a date as specified in subdivisions (b) or (c) of Section 14199.96, whichever occurs first. All sections in this article, except for Section 14199.92, are repealed on January 1, 2032.

(2) Notwithstanding paragraph (1), any tax and any applicable interest and penalties imposed under this article shall continue to be due and payable to the department until the tax and any applicable interest and penalties are fully paid.

Section 14105.201 of the Welfare and Institutions Code is amended to read:

14105.201 (a)(1) Notwithstanding any other law, for dates of service no sooner than January 1, 2024, or on the effective date of any necessary federal approvals as required by subdivision (e), whichever is later, the reimbursement rates for the following services, as determined in accordance with subdivision (g), shall be the greater of 87.5 percent of the lowest maximum allowance established by the federal Medicare Program for the same or similar services or the level of reimbursement, which shall account for, and be inclusive of, the exemption of these services from payment reductions pursuant to Section 14105.192, and supplemental payments or rate increases, or both, as applicable, under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56, an initiative measure approved at the November 8, 2016, statewide general election) that were implemented with funds from the Healthcare Treatment Fund, as established pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code, in effect as of December 31, 2023, as determined by the department:

(A) Primary care services, including those provided by physicians or nonphysician health professionals, as defined in Section 51170.5 of Title 22 of the California Code of Regulations.

(B) Obstetric care services, and doula services as described in Section 14132.24.

(C) Outpatient mental health services that are not the financial responsibility of county mental health plans operating pursuant to Chapter 8.9 (commencing with Section 14700).

(2) The department shall annually review and revise the reimbursement rates in accordance with paragraph (1) based on changes to the lowest maximum allowance

established by the federal Medicare Program for the same or similar services. Any revisions to the reimbursement rates determined in accordance with paragraph (1) shall be considered as part of the annual budget development process and take effect beginning on January 1, 2025, and each subsequent January 1 thereafter, of the calendar year following the department's annual review.

(3) The department shall develop and implement a methodology for establishing reimbursement rates or payments for the services described in paragraph (1) where there is no specified maximum allowable rate established by the federal Medicare Program. The department shall review this methodology annually and may, in its sole discretion, modify the methodology on a prospective basis.

(b)(1)(A) For contract periods during which subdivision (a) is implemented, each Medi-Cal managed care plan shall reimburse a network provider furnishing the services subject to subdivision (a) at least the amount the network provider would be paid for those services in the Medi-Cal fee-for-service delivery system, as set forth by the department in the approved Medi-Cal State Plan and guidance issued pursuant to subdivision (f).

(B) Medi-Cal managed care plans that reimburse a network provider furnishing the services identified in subparagraphs (A) to (C), inclusive, of paragraph (1) of subdivision (a) on a capitated basis shall ensure that the network provider receives reimbursement that is equal to, or projected to be equal to, the level of reimbursement required in subparagraph (A) for the applicable services and, as applicable, shall increase reimbursement to the network provider to comply with this subparagraph.

(2)(A) The department shall direct Medi-Cal managed care plans to reimburse eligible providers furnishing the services subject to subdivision (a) in accordance with paragraph (1) using one or more methodologies pursuant to subsection (c) of Section 438.6 of Title 42 of the Code of Federal Regulations, and by the department in guidance issued pursuant to subdivision (f).

(B) Commencing with the first managed care rating period for which the department documents in the annual rate certification that the base period data submitted and attested to by Medi-Cal managed care plans that is used by the department for the development of capitation rates for the Medi-Cal managed care delivery system reflects the increased reimbursement levels for services subject to subdivision (a), the department may elect to discontinue some or all directed payment methodologies implemented pursuant to subparagraph (A) following consultation with affected stakeholders and the department's determination that the methodologies are administratively burdensome and likely to be no longer necessary to achieve, in aggregate, the reimbursement levels described in paragraph (1).

(32) The department may require Medi-Cal managed care plans and network providers of the applicable services to submit information the department deems necessary to implement and monitor compliance with this subdivision, at the times and in the form and manner specified by the department.

(c)(1) The payments implemented pursuant to subdivisions (a) and (b) shall be supported by the managed care organization provider tax revenue, pursuant to Article 7.4**7.2** (commencing with Section 14199.80**90**), or other state funds appropriated to the department as the state share for this purpose, including, but not limited to, funds

transferred to the Medi-Cal Provider Payment Reserve Fund in accordance with Sections 14105.200 and 14199.82 and to the Healthcare Treatment Fund in accordance with subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

(2) Notwithstanding any other law, increases to fee-for-service reimbursement rates and managed care directed payments that are made pursuant to subdivisions (a) and (b) constitute increases in accordance with subdivision (a) of Section 30130.55 of the Revenue and Taxation Code, and all other fee-for-service supplemental payments and managed care directed payments for the services identified in subparagraphs (A) to (C), inclusive, of paragraph (1) of subdivision (a) that are made pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code shall be discontinued on the date the payments implemented pursuant to subdivisions (a) and (b) are effective.

~~<Subdivision (d) inoperative Jan. 1, 2025.>~~

~~(d)(1) Effective for dates of service on or after January 1, 2025, community health workers shall be an eligible provider type for the rate increases effective pursuant to this section.~~

~~(2) In establishing the reimbursement rate for community health workers pursuant to subdivision (a), the department shall set rates equal to 100 percent of the lowest maximum allowance established by the federal Medicare Program for the same or similar services.~~

~~(3) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to this part at the November 5, 2024, statewide general election, 1 this subdivision shall be inoperative as of January 1, 2025.~~

(ed) In implementing this section, the department shall seek any federal approvals that it deems necessary. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(fe) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section, in whole or in part, by means of all-county letters, plan letters, provider bulletins, information notices, or other similar instructions, without taking any further regulatory action.

(gf) The department shall develop the methodologies and parameters for the payments implemented pursuant to subdivisions (a), (b), and (d), and may revise the methodologies and parameters, for purposes including, but not limited to, obtaining or maintaining any necessary federal approvals as required by subdivision (e).

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

(1) ~~“Community health workers” has the same meaning as set forth in the Medi-Cal State Plan.~~

(2) “Medi-Cal managed care plan” has the same meaning as that term is defined in subdivision (j) of Section 14184.101.

(32) “Network provider” has the same meaning as that term is defined in Section 438.2 of Title 42 of the Code of Federal Regulations.

(ih) The Legislature finds and declares that this section, as it pertains to funding made available for expenditure pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code, is consistent and in accordance with the California

Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56, an initiative measure approved at the November 8, 2016, statewide general election).