AMENDED IN SENATE AUGUST 15, 2013

AMENDED IN ASSEMBLY MAY 13, 2013

AMENDED IN ASSEMBLY MAY 1, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 50

Introduced by Assembly Member Pan

December 21, 2012

An act to ~~amend Section 15926 of, to amend and repeal Sections 14016.5 and 14016.6 of, and to add Section 14011.66 to,~~ *add Section 1366.5 to the Health and Safety Code, to add Section 10112.35 to the Insurance Code, to amend Sections 14005.28, 14005.30, 14005.36, 14005.37, 14005.39, 14005.61, 14011.66, 14015.8, 14016.6, 14102, 14132.02, 14154, and 15926 of, and to add Sections 14005.22, 14148.65, and 14148.67 to,* the Welfare and Institutions Code, relating to health care coverage, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 50, as amended, Pan. Health care coverage: Medi-Cal: eligibility: ~~enrollment.~~ *pregnancy-related and postpartum services.*

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 also provides for the regulation of health insurers by the Department of Insurance. Existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that makes available qualified health plans to qualified

individuals and small employers. Existing state law establishes the California Health Benefit Exchange (Exchange) within state government, specifies the powers and duties of the board governing the Exchange, and requires the board to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and small employers by January 1, 2014.

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. Chapters 3 and 4 of the First Extraordinary Session of 2013–14, to be effective on the 91st day after adjournment of that session, implement various provisions of PPACA relating to determining eligibility for the Medi-Cal program. Commencing January 1, 2014, an individual who is 21 years of age and older, does not have minor children eligible for Medi-Cal benefits, would be eligible for Medi-Cal benefits but for a specified 5-year bar, and who is enrolled in coverage through the Exchange with an advanced premium tax credit is eligible for Medi-Cal benefits, as prescribed. Commencing January 1, 2014, the department is also required to pay the beneficiary's insurance premium costs and cost-sharing charges under these provisions.

This bill would authorize the department to implement some of those provisions by, among other things, all-county letters, until the time any necessary regulations are adopted. The bill would require the department to adopt regulations implementing those provisions by July 1, 2015. This bill would, under specified federal provisions applicable to qualified pregnant woman and children, provide that a woman shall be eligible for Medi-Cal benefits if her income is less than 100% of the federal poverty level as determined, counted, and valued in accordance with federal law.

This bill would, by April 1, 2014, or after the department determines that the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) has been programmed for implementation of these provisions, require the State Department of Health Care Services to implement a specified option for women eligible for Medi-Cal pregnancy-related and postpartum services who are enrolled or will be enrolled in individual health care coverage through the Exchange. The bill would, except as provided, require the department to pay the beneficiary's premium costs and the beneficiary's cost sharing for

benefits and services during the beneficiary's period of eligibility for pregnancy-related and postpartum services under the Medi-Cal program. The bill would require the department to make these premium or cost-sharing payments to the beneficiary's qualified health plan, as specified. This bill would require health care service plans and insurers providing individual coverage in the Exchange to cooperate with requests from the Exchange to collaborate in the development of, and participate in the implementation of, these premium and cost-sharing payments for eligible Exchange enrollees. Because a willful violation of the bill's provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.

Existing law, to be effective on the 91st day after adjournment of the First Extraordinary Session of 2013–14, would, commencing January 1, 2014, require the department to develop a program to implement provisions that would authorize individuals or their authorized representatives to select Medi-Cal managed care plans via CalHEERS, as specified. In this regard, the program is required to include training of specialized county employees to carry out the program.

This bill would, instead, require the program to include training of individuals, including county human services staff, to carry out the program.

Existing law requires the department to establish and maintain a County Administrative Cost Control Plan under which costs for county administration for the determination of eligibility for benefits are controlled, as specified. Existing law requires the department to develop and implement a new budgeting methodology for Medi-Cal county administrative costs to be used to reimburse counties for eligibility determinations for applicants and beneficiaries, and requires that the budgeting methodology include identification of the costs of eligibility determinations for applicants, and the costs of eligibility redeterminations and case maintenance activities for recipients, for different groupings of cases.

This bill would instead provide that the budgeting methodology may include identification of the costs of eligibility determinations for applicants, and the costs of eligibility redeterminations and case maintenance activities for recipients, for different groupings of cases. The bill would authorize the development of the new budgeting methodology to include, among other things, county survey of costs, time and motion studies, and in-person observations by department staff. The bill would require that the new budgeting methodology be

implemented no sooner than the 2015–16 fiscal year and that it reflect the impact of PPACA implementation on county administrative work.

Existing law requires the California Health and Human Services Agency, in consultation with specified entities, to establish a standardized single, accessible application form and related renewal procedures for state health subsidy programs, as defined, in accordance with specified requirements. Existing law authorizes the form to include questions that are voluntary for applicants to answer regarding demographic data categories, including race, ethnicity, primary language, disability status, and other categories recognized by the federal Secretary of Health and Human Services pursuant to federal law.

This bill would authorize the form to also include questions that are voluntary for applicants to answer regarding sexual orientation and gender identity or expression. The bill would, effective January 1, 2015, require the form to include questions that are voluntary for applicants to answer regarding the demographic data categories specified. This bill would make other technical changes.

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.

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

~~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 would require the department to establish a process in accordance with federal law to allow a hospital that is a participating Medi-Cal provider to elect to be a qualified entity for purposes of determining whether any individual is eligible for Medi-Cal and providing the individual with medical assistance during the presumptive eligibility period.~~

~~Existing law requires an applicant or beneficiary, as specified, who resides in an area served by a managed health care plan or pilot program in which beneficiaries may enroll, to personally attend a presentation~~

~~at which the applicant or beneficiary is informed of managed care and fee-for-service options for receiving Medi-Cal benefits. Existing law requires the applicant or beneficiary to indicate in writing his or her choice of health care options and provides that if the applicant or beneficiary does not make a choice he or she shall be assigned to and enrolled in an appropriate Medi-Cal managed care plan, pilot project, or fee-for-service case management provider providing service within the area in which the beneficiary resides. Existing law requires the department to develop a program, as specified, to implement these provisions.~~

~~This bill would repeal these provisions on January 1, 2015.~~

~~Existing law requires the California Health and Human Services Agency, in consultation with specified entities, to a establish standardized single, accessible application form and related renewal procedures for state health subsidy programs, as defined, in accordance with specified requirements. Existing law authorizes the form to include questions that are voluntary for applicants to answer regarding demographic data categories, including race, ethnicity, primary language, disability status, and other categories recognized by the federal Secretary of Health and Human Services pursuant to federal law.~~

~~This bill would authorize the form to also include questions that are voluntary for applicants to answer regarding sexual orientation and gender identity or expression. The bill would, effective January 1, 2015, require the form to include questions that are voluntary for applicants to answer regarding the demographic data categories specified.~~

~~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: ~~no~~ *yes*.

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

SECTION 1. Section 1366.5 is added to the Health and Safety Code, to read:

1366.5. (a) A health care service plan providing individual coverage in the Exchange shall cooperate with requests from the Exchange to collaborate in the development of, and participate in the implementation of, the Medi-Cal program's premium and cost-sharing payments under Sections 14102 and 14148.65 of the Welfare and Institutions Code for eligible Exchange enrollees.

(b) For purposes of this section, "Exchange" means the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code.

SEC. 2. Section 10112.35 is added to the Insurance Code, to read:

10112.35. (a) An insurer providing individual coverage in the Exchange shall cooperate with requests from the Exchange to collaborate in the development of, and participate in the implementation of, the Medi-Cal program's premium and cost-sharing payments under Sections 14102 and 14148.65 of the Welfare and Institutions Code for eligible Exchange enrollees.

(b) For purposes of this section, "Exchange" means the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code.

SEC. 3. Section 14005.22 is added to the Welfare and Institutions Code, to read:

14005.22. (a) A woman shall be eligible for Medi-Cal benefits under Section 1396a(a)(10)(A)(i)(III) of Title 42 of the United States Code if her income is less than 100 percent of the federal poverty level as determined, counted, and valued in accordance with the requirements of Section 1396a(e)(14) of Title 42 of the United States Code, as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148) and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments, and she meets all other eligibility requirements.

(b) 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 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. Beginning six months after the effective date of this section, notwithstanding Section 10321.5 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.

(c) This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

SEC. 4. Section 14005.28 of the Welfare and Institutions Code, as added by Section 5 of Chapter 4 of the First Extraordinary Session of the Statutes of 2013, is amended to read:

14005.28. (a) To the extent federal financial participation is available pursuant to an approved state plan amendment, the department shall implement Section 1902(a)(10)(A)(i)(IX) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(IX)) to provide Medi-Cal benefits to an individual who is in foster care on his or her 18th birthday until his or her 26th birthday. In addition, the department shall implement the federal option to provide Medi-Cal benefits to individuals who were in foster care and enrolled in Medicaid in any state.

(1) A foster care adolescent who is in foster care in this state on his or her 18th birthday shall be enrolled to receive benefits under this section without any interruption in coverage and without requiring a new application.

(2) The department shall develop procedures to identify and enroll individuals who meet the criteria for Medi-Cal eligibility in this subdivision, including, but not limited to, former foster care adolescents who were in foster care on their 18th birthday and who lost Medi-Cal coverage as a result of attaining 21 years of age. The department shall work with counties to identify and conduct outreach to former foster care adolescents who lost Medi-Cal coverage during the 2013 calendar year as a result of attaining 21 years of age, to ensure they are aware of the ability to reenroll under the coverage provided pursuant to this section.

(3) (A) The department shall develop and implement a simplified redetermination form for this program. A beneficiary qualifying for the benefits extended pursuant to this section shall fill out and return this form only if information known to the department is no longer accurate or is materially incomplete.

(B) The department shall seek federal approval to institute a renewal process that allows a beneficiary receiving benefits under this section to remain on Medi-Cal after a redetermination form is returned as undeliverable and the county is otherwise unable to establish contact. If federal approval is granted, the recipient shall remain eligible for services under the Medi-Cal fee-for-service

program until the time contact is reestablished or ineligibility is established, and to the extent federal financial participation is available.

(C) The department shall terminate eligibility only after it determines that the recipient is no longer eligible and all due process requirements are met in accordance with state and federal law.

(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 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. The department shall adopt regulations by July 1, 2015, 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 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.

~~(b)~~

(c) This section shall be implemented only if and to the extent that federal financial participation is available.

~~(c)~~

(d) This section shall become operative January 1, 2014.

SEC. 5. Section 14005.30 of the Welfare and Institutions Code, as added by Section 4 of Chapter 3 of the First Extraordinary Session of the Statutes of 2013, is amended to read:

14005.30. (a) ~~(1)~~ Medi-Cal benefits under this chapter shall be provided to individuals eligible for services under Section 1396u-1 of Title 42 of the United States Code.

(b) (1) When determining eligibility under this section, an applicant's or beneficiary's income and resources shall be determined, counted, and valued in accordance with the requirements of Section 1396a(e)(14) of Title 42 of the United States Code, as added by the ACA.

(2) When determining eligibility under this section, an applicant's or beneficiary's assets shall not be considered and deprivation shall not be a requirement for eligibility.

(c) For purposes of calculating income under this section during any calendar year, increases in social security benefit payments under Title II of the federal Social Security Act (42 U.S.C. Sec. 401 et seq.) arising from cost-of-living adjustments shall be disregarded commencing in the month that these social security benefit payments are increased by the cost-of-living adjustment through the month before the month in which a change in the federal poverty level requires the department to modify the income disregard pursuant to subdivision (c) and in which new income limits for the program established by this section are adopted by the department.

(d) The MAGI-based income eligibility standard applied under this section shall conform with the maintenance of effort requirements of Sections 1396a(e)(14) and 1396a(gg) of Title 42 of the United States Code, as added by the ACA.

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

(1) "ACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as originally enacted and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

(2) "MAGI-based income" means income calculated using the financial methodologies described in Section 1396a(e)(14) of Title 42 of the United States Code, as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148) and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 1, 2015, 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 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.

~~(f)~~

(g) This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

~~(g)~~

(h) This section shall become operative on January 1, 2014.

SEC. 6. Section 14005.36 of the Welfare and Institutions Code, as amended by Section 5 of Chapter 3 of the First Extraordinary Session of the Statutes of 2013, is amended to read:

14005.36. (a) The county shall undertake outreach efforts to beneficiaries receiving benefits under this chapter, in order to maintain the most up-to-date home addresses, telephone numbers, and other necessary contact information, and to encourage and assist with timely submission of the annual reaffirmation form, and, when applicable, transitional Medi-Cal program reporting forms and to facilitate the Medi-Cal redetermination process when one is required as provided in Section 14005.37. In implementing this subdivision, a county may collaborate with community-based organizations, provided that confidentiality is protected.

(b) The department shall encourage and facilitate efforts by managed care plans to report updated beneficiary contact information to counties.

(c) (1) The department and each county shall incorporate, in a timely manner, updated contact information received from managed care plans pursuant to subdivision (b) into the beneficiary's Medi-Cal case file and into all systems used to inform plans of their beneficiaries' enrollee status. Updated Medi-Cal beneficiary contact information shall be limited to the beneficiary's telephone number, change of address information, and change of name.

(2) When a managed care plan obtains a beneficiary's updated contact information, the managed care plan shall ask the beneficiary for approval to provide the beneficiary's updated contact information to the appropriate county. If the managed care plan does not obtain approval from the beneficiary to provide the appropriate county with the updated contact information, the county shall attempt to verify *that the information that it receives from* the plan is accurate, which may include, but is not limited to,

making contact with the beneficiary, before updating the beneficiary's case file. The contact shall first be attempted using the method of contact identified by the beneficiary as the preferred method of contact, if a method has been identified.

(d) This section shall be implemented only to the extent that federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is available.

(e) To the extent otherwise required by Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall adopt emergency regulations implementing this section no later than July 1, 2015. The department may thereafter readopt the emergency regulations pursuant to that chapter. The adoption and readoption, by the department, of regulations implementing this section shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

SEC. 7. Section 14005.37 of the Welfare and Institutions Code, as added by Section 7 of Chapter 3 of the First Extraordinary Session of the Statutes of 2013, is amended to read:

14005.37. (a) Except as provided in Section 14005.39, a county shall perform redeterminations of eligibility for Medi-Cal beneficiaries every 12 months and shall promptly redetermine eligibility whenever the county receives information about changes in a beneficiary's circumstances that may affect eligibility for Medi-Cal benefits. The procedures for redetermining Medi-Cal eligibility described in this section shall apply to all Medi-Cal beneficiaries.

(b) Loss of eligibility for cash aid under that program shall not result in a redetermination under this section unless the reason for the loss of eligibility is one that would result in the need for a redetermination for a person whose eligibility for Medi-Cal under Section 14005.30 was determined without a concurrent determination of eligibility for cash aid under the CalWORKs program.

(c) A loss of contact, as evidenced by the return of mail marked in such a way as to indicate that it could not be delivered to the

intended recipient or that there was no forwarding address, shall require a prompt redetermination according to the procedures set forth in this section.

(d) Except as otherwise provided in this section, Medi-Cal eligibility shall continue during the redetermination process described in this section and a beneficiary's Medi-Cal eligibility shall not be terminated under this section until the county makes a specific determination based on facts clearly demonstrating that the beneficiary is no longer eligible for Medi-Cal benefits under any basis and due process rights guaranteed under this division have been met. For the purposes of this subdivision, for a beneficiary who is subject to the use of MAGI-based financial methods, the determination of whether the beneficiary is eligible for Medi-Cal benefits under any basis shall include, but is not limited to, a determination of eligibility for Medi-Cal benefits on a basis that is exempt from the use of MAGI-based financial methods only if either of the following occurs:

(A) The county assesses the beneficiary as being potentially eligible under a program that is exempt from the use of MAGI-based financial methods, including, but not limited to, on the basis of age, blindness, disability, or the need for long-term care services and supports.

(B) The beneficiary requests that the county determine whether he or she is eligible for Medi-Cal benefits on a basis that is exempt from the use of MAGI-based financial methods.

(e) (1) For purposes of acquiring information necessary to conduct the eligibility redeterminations described in this section, a county shall gather information available to the county that is relevant to the beneficiary's Medi-Cal eligibility prior to contacting the beneficiary. Sources for these efforts shall include information contained in the beneficiary's file or other information, including more recent information available to the county, including, but not limited to, Medi-Cal, CalWORKs, and CalFresh case files of the beneficiary or of any of his or her immediate family members, which are open, or were closed within the last 90 days, information accessed through any databases accessed under Sections 435.948, 435.949, and 435.956 of Title 42 of the Code of Federal Regulations, and wherever feasible, other sources of relevant information reasonably available to the county or to the county via the department.

(2) In the case of an annual redetermination, if, based upon information obtained pursuant to paragraph (1), the county is able to make a determination of continued eligibility, the county shall notify the beneficiary of both of the following:

(A) The eligibility determination and the information it is based on.

(B) That the beneficiary is required to inform the county via the Internet, by telephone, by mail, in person, or through other commonly available electronic means, in counties where such electronic communication is available, if any information contained in the notice is inaccurate but that the beneficiary is not required to sign and return the notice if all information provided on the notice is accurate.

(3) The county shall make all reasonable efforts not to send multiple notices during the same time period about eligibility. The notice of eligibility renewal shall contain other related information such as if the beneficiary is in a new Medi-Cal program.

(4) In the case of a redetermination due to a change in circumstances, if a county determines that the change in circumstances does not affect the beneficiary's eligibility status, the county shall not send the beneficiary a notice unless required to do so by federal law.

(f) (1) In the case of an annual eligibility redetermination, if the county is unable to determine continued eligibility based on the information obtained pursuant to paragraph (1) of subdivision (e), the beneficiary shall be so informed and shall be provided with an annual renewal form, at least 60 days before the beneficiary's annual redetermination date, that is prepopulated with information that the county has obtained and that identifies any additional information needed by the county to determine eligibility. The form shall include all of the following:

(A) The requirement that he or she provide any necessary information to the county within 60 days of the date that the form is sent to the beneficiary.

(B) That the beneficiary may respond to the county via the Internet, by mail, by telephone, in person, or through other commonly available electronic means if those means are available in that county.

(C) That if the beneficiary chooses to return the form to the county in person or via mail, the beneficiary shall sign the form in order for it to be considered complete.

(D) The telephone number to call in order to obtain more information.

(2) The county shall attempt to contact the beneficiary via the Internet, by telephone, or through other commonly available electronic means, if those means are available in that county, during the 60-day period after the prepopulated form is mailed to the beneficiary to collect the necessary information if the beneficiary has not responded to the request for additional information or has provided an incomplete response.

(3) If the beneficiary has not provided any response to the written request for information sent pursuant to paragraph (1) within 60 days from the date the form is sent, the county shall terminate his or her eligibility for Medi-Cal benefits following the provision of timely notice.

(4) If the beneficiary responds to the written request for information during the 60-day period pursuant to paragraph (1) but the information provided is not complete, the county shall follow the procedures set forth in paragraph (3) of subdivision (g) to work with the beneficiary to complete the information.

(5) (A) The form required by this subdivision shall be developed by the department in consultation with the counties and representatives of eligibility workers and consumers.

(B) For beneficiaries whose eligibility is not determined using MAGI-based financial methods, the county may use existing renewal forms until the state develops prepopulated renewal forms to provide to beneficiaries. The department shall develop prepopulated renewal forms for use with beneficiaries whose eligibility is not determined using MAGI-based financial methods by January 1, 2015.

(g) (1) In the case of a redetermination due to change in circumstances, if a county cannot obtain sufficient information to redetermine eligibility pursuant to subdivision (e), the county shall send to the beneficiary a form that is prepopulated with the information that the county has obtained and that states the information needed to renew eligibility. The county shall only request information related to the change in circumstances. The county shall not request information or documentation that has

been previously provided by the beneficiary, that is not absolutely necessary to complete the eligibility determination, or that is not subject to change. The county shall only request information for nonapplicants necessary to make an eligibility determination or for a purpose directly related to the administration of the state Medicaid plan. The form shall advise the individual to provide any necessary information to the county via the Internet, by telephone, by mail, in person, or through other commonly available electronic means and, if the individual will provide the form by mail or in person, to sign the form. The form shall include a telephone number to call in order to obtain more information. The form shall be developed by the department in consultation with the counties, representatives of consumers, and eligibility workers. A Medi-Cal beneficiary shall have 30 days from the date the form is mailed pursuant to this subdivision to respond. Except as provided in paragraph (2), failure to respond prior to the end of this 30-day period shall not impact his or her Medi-Cal eligibility.

(2) If the purpose for a redetermination under this section is a loss of contact with the Medi-Cal beneficiary, as evidenced by the return of mail marked in such a way as to indicate that it could not be delivered to the intended recipient or that there was no forwarding address, a return of the form described in this subdivision marked as undeliverable shall result in an immediate notice of action terminating Medi-Cal eligibility.

(3) During the 30-day period after the date of mailing of a form to the Medi-Cal beneficiary pursuant to this subdivision, the county shall attempt to contact the beneficiary by telephone, in writing, or other commonly available electronic means, in counties where such electronic communication is available, to request the necessary information if the beneficiary has not responded to the request for additional information or has provided an incomplete response. If the beneficiary does not supply the necessary information to the county within the 30-day limit, a 10-day notice of termination of Medi-Cal eligibility shall be sent.

(h) Beneficiaries shall be required to report any change in circumstances that may affect their eligibility within 10 calendar days following the date the change occurred.

(i) If within 90 days of termination of a Medi-Cal beneficiary's eligibility or a change in eligibility status pursuant to this section, the beneficiary submits to the county a signed and completed form

or otherwise provides the needed information to the county, eligibility shall be redetermined by the county and if the beneficiary is found eligible, or the beneficiary's *eligibility* status has not changed, whichever applies, the termination shall be rescinded as though the form were submitted in a timely manner.

(j) If the information available to the county pursuant to the redetermination procedures of this section does not indicate a basis of eligibility, Medi-Cal benefits may be terminated so long as due process requirements have otherwise been met.

(k) The department shall, with the counties and representatives of consumers, including those with disabilities, and Medi-Cal eligibility workers, develop a timeframe for redetermination of Medi-Cal eligibility based upon disability, including ex parte review, the redetermination forms described in subdivisions (f) and (g), timeframes for responding to county or state requests for additional information, and the forms and procedures to be used. The forms and procedures shall be as consumer-friendly as possible for people with disabilities. The timeframe shall provide a reasonable and adequate opportunity for the Medi-Cal beneficiary to obtain and submit medical records and other information needed to establish eligibility for Medi-Cal based upon disability.

(*l*) The county shall consider blindness as continuing until the reviewing physician determines that a beneficiary's vision has improved beyond the applicable definition of blindness contained in the plan.

(m) The county shall consider disability as continuing until the review team determines that a beneficiary's disability no longer meets the applicable definition of disability contained in the plan.

(n) In the case of a redetermination due to a change in circumstances, if a county determines that the beneficiary remains eligible for Medi-Cal benefits, the county shall begin a new 12-month eligibility period.

(o) For individuals determined ineligible for Medi-Cal by a county following the redetermination procedures set forth in this section, the county shall determine eligibility for other insurance affordability programs and if the individual is found to be eligible, the county shall, as appropriate, transfer the individual's electronic account to other insurance affordability programs via a secure electronic interface.

(p) Any renewal form or notice shall be accessible to persons who are limited-English proficient and persons with disabilities consistent with all federal and state requirements.

(q) The requirements to provide information in subdivisions (e) and (g), and to report changes in circumstances in subdivision (h), may be provided through any of the modes of submission allowed in Section 435.907(a) of Title 42 of the Code of Federal Regulations, including an Internet Web site identified by the department, telephone, mail, in person, and other commonly available electronic means as authorized by the department.

(r) Forms required to be signed by a beneficiary pursuant to this section shall be signed under penalty of perjury. Electronic signatures, telephonic signatures, and handwritten signatures transmitted by electronic transmission shall be accepted.

(s) For purposes of this section, "MAGI-based financial methods" means income calculated using the financial methodologies described in Section 1396a(e)(14) of Title 42 of the United States Code, and as added by 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 subsequent amendments.

(t) When contacting a beneficiary under paragraphs (2) and (4) of subdivision (f), and paragraph (3) of subdivision (g), a county shall first attempt to use the method of contact identified by the beneficiary as the preferred method of contact, if a method has been identified.

(u) The department shall seek federal approval to extend the annual redetermination date under this section for a three-month period for those Medi-Cal beneficiaries whose annual redeterminations are scheduled to occur between January 1, 2014, and March 31, 2014.

(v) 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 regulations are adopted. ~~Thereafter, the~~ *The* department shall adopt regulations *by July 1, 2015,* 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 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.

(w) This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

(x) This section shall become operative on January 1, 2014.

SEC. 8. Section 14005.39 of the Welfare and Institutions Code, as amended by Section 10 of Chapter 4 of the First Extraordinary Session of the Statutes of 2013, is amended to read:

14005.39. (a) If a county has facts clearly demonstrating that a Medi-Cal beneficiary cannot be eligible for Medi-Cal due to an event, such as death or change of state residency, Medi-Cal benefits shall be terminated without a redetermination under Section 14005.37.

(b) Whenever Medi-Cal eligibility is terminated without a redetermination, as provided in subdivision (a), the Medi-Cal eligibility worker shall record that fact or event causing the eligibility termination in the beneficiary's file, along with a certification that a full redetermination could not result in a finding of Medi-Cal eligibility. Following this certification, a notice of action specifying the basis for termination of Medi-Cal eligibility shall be sent to the beneficiary.

(c) 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. The department shall adopt regulations by July 1, 2015, 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 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.

~~(e)~~

(d) This section shall be implemented only if and to the extent that federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et. seq.) is available and necessary federal approvals have been obtained.

SEC. 9. Section 14005.61 of the Welfare and Institutions Code, as added by Section 10 of Chapter 3 of the First Extraordinary Session of the Statutes of 2013, is amended to read:

14005.61. (a) Except as provided in subdivision (e), individuals who are enrolled in a Low Income Health Program (LIHP) as of December 31, 2013, under California's Bridge to Reform Section 1115(a) Medicaid Demonstration who are at or below 133 percent of the federal poverty level shall be transitioned directly to the Medi-Cal program in accordance with the requirements of this section and pursuant to federal approval.

(b) Except as provided in paragraph (8) of subdivision (c), individuals who are eligible under subdivision (a) shall be required to enroll into Medi-Cal managed care health plans.

(c) Except as provided in subdivision (d), with respect to managed care health plan enrollment, a LIHP enrollee shall be notified by the department at least 60 days prior to January 1, 2014, in accordance with the department's LIHP transition plan of all of the following:

(1) Which Medi-Cal managed care health plan or plans contain his or her existing primary care provider, if the department has this information and the primary care provider is contracted with a Medi-Cal managed care health plan.

(2) That the LIHP enrollee, subject to his or her ability to change as described in paragraph (3), will be assigned to a health plan that includes his or her primary care provider and enrolled effective January 1, 2014. If the enrollee wants to keep his or her primary care provider, no additional action will be required if the primary care provider is contracted with a Medi-Cal managed care health plan.

(3) That the LIHP enrollee may choose any available Medi-Cal managed care health plan and primary care provider in his or her county of residence prior to January 1, 2014, if more than one such plan is available in the county where he or she resides, and he or she will receive all provider and health plan information required

to be sent to new enrollees and instructions on how to choose or change his or her health plan and primary care provider.

(4) That in counties with more than one Medi-Cal managed care health plan, if the LIHP enrollee does not affirmatively choose a plan within 30 days of receipt of the notice, he or she shall be enrolled into the Medi-Cal managed care health plan that contains his or her LIHP primary care provider as part of the Medi-Cal managed care contracted primary care network, if the department has this information about the primary care provider, and the primary care provider is contracted with a Medi-Cal managed care health plan. If the primary care provider is contracted with more than one Medi-Cal managed care health plan, then the LIHP enrollee will be assigned to one of the health plans containing his or her primary care provider in accordance with an assignment process established to ensure the linkage.

(5) That if the LIHP enrollee's existing primary care provider is not contracted with any Medi-Cal managed care health plan, then he or she will receive all provider and health plan information required to be sent to new enrollees. If the LIHP enrollee does not affirmatively select one of the available Medi-Cal managed care plans within 30 days of receipt of the notice, he or she will automatically be assigned a plan through the department-prescribed auto-assignment process.

(6) That the LIHP enrollee does not need to take any action to be transitioned to the Medi-Cal program or to retain his or her primary care provider, if the primary care provider is available pursuant to paragraph (2).

(7) That the LIHP enrollee may choose not to transition to the Medi-Cal program, and what this choice will mean for his or her health care coverage and access to health care services.

(8) That in counties where no Medi-Cal managed care health plans are available, the LIHP enrollee will be transitioned into fee-for-service Medi-Cal, and provided with all information that is required to be sent to new Medi-Cal enrollees including the assistance telephone number for fee-for-service beneficiaries, and that, if a Medi-Cal managed care health plan becomes available in the residence county, he or she will be enrolled in a Medi-Cal managed care health plan according to the enrollment procedures in place at that time.

(d) Individuals who qualify under subdivision (a) who apply and are determined eligible for LIHP after the date identified by the department that is not later than October 1, 2013, will be considered late enrollees. Late enrollees shall be notified in accordance with subdivision (c), except according to a different timeframe, but will transition to Medi-Cal coverage on January 1, 2014. Late enrollees after the date identified in this subdivision shall be transitioned pursuant to the department's LIHP transition plan process.

(e) Individuals who qualify under subdivision (a) and are not denoted as active LIHP enrollees according to the Medi-Cal Eligibility Data System at any point within the date range identified by the department that will start not sooner than December 20, 2013, and continue through December 31, 2013, will not be included in the LIHP transition to the Medi-Cal program. These individuals may apply for Medi-Cal eligibility separately from the LIHP transition process.

(f) In conformity with the department's transition plan, individuals who are enrolled in a LIHP at any point from September 2013 through December 2013, under California's Bridge to Reform Section 1115(a) Medicaid Demonstration and are above 133 percent of the federal poverty level will be provided information regarding how to apply for *an eligibility determination for* an insurance affordability program, including submission of an application by telephone, by mail, online, or in person.

(g) A Medi-Cal managed care health plan that receives a LIHP enrollee during this transition shall assign the LIHP primary care provider of the enrollee as the Medi-Cal managed care health plan primary care provider of the enrollee, to the extent possible, if the Medi-Cal managed care health plan contracts with that primary care provider, unless the beneficiary has chosen another primary care provider on his or her choice form. A LIHP enrollee who is enrolled into a Medi-Cal managed care plan may work through the Medi-Cal managed care plan to change his or her assigned primary care provider or other provider, after enrollment and subject to provider availability, according to the standard processes that are currently available in Medi-Cal managed care for selecting providers.

(h) The director may, with federal approval, suspend, delay, or otherwise modify the requirement for LIHP program eligibility

redeterminations in 2013 to facilitate the process of transitioning LIHP enrollees to other health coverage in 2014.

(i) The county LIHPs and their designees shall work with the department and its designees during the 2013 and 2014 calendar years to facilitate continuity of care and data sharing for the purposes of delivering Medi-Cal services in the 2014 calendar year.

(j) This section shall be implemented only if and to the extent that federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is available and all necessary federal approvals have been obtained.

SEC. 10. Section 14011.66 of the Welfare and Institutions Code, as added by Section 22 of Chapter 4 of the First Extraordinary Session of the Statutes of 2013, is amended to read:

14011.66. (a) Effective January 1, 2014, the department shall provide Medi-Cal benefits during a presumptive eligibility period to individuals who have been determined eligible on the basis of preliminary information by a qualified hospital in accordance with Section 1396a(a)(47)(B) of Title 42 of the United States Code and as set forth in this section.

(b) A hospital may only make presumptive eligibility determinations under this section if it complies with all of following:

(1) It is a participating provider under the state plan or under a federal waiver under Section 1315 of Title 42 of the United States Code.

(2) It has notified the department in writing that it has elected to be a qualified entity for the purpose of making presumptive eligibility determinations.

(3) It agrees to make presumptive eligibility determinations consistent with all applicable policies and procedures.

(4) It has not been disqualified to make presumptive eligibility determinations by the department.

(c) Qualified hospitals may only make presumptive eligibility determinations based upon income for children, pregnant women, parents and other caretaker relatives, and other adults, whose income is calculated using the applicable MAGI-based income standard.

(d) The department shall establish a process for determining whether a hospital should be disqualified from being able to make presumptive eligibility determinations under this section.

(e) For purposes of this section, "MAGI-based income" means income calculated using the financial methodologies described in Section 1396a(e)(14) of Title 42 of the United States Code, as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148) and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 1, 2015, 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 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.

~~(f)~~

(g) This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

SEC. 11. Section 14015.8 of the Welfare and Institutions Code, as added by Section 18 of Chapter 3 of the First Extraordinary Session of the Statutes of 2013, is amended to read:

14015.8. *(a)* The department, any other government agency that is determining eligibility for, or enrollment in, the Medi-Cal program or any other program administered by the department, or collecting protected health information for those purposes, and the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code, shall share information with each other as necessary to enable them to perform their respective statutory and regulatory duties under state and federal law. This information shall include, but not be

limited to, personal information, as defined in subdivision (a) of Section 1798.3 of the Civil Code, and protected health information, as defined in Parts 160 and 164 of Title 45 of the Code of Federal Regulations, regarding individual beneficiaries and applicants.

(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 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. The department shall adopt regulations by July 1, 2015, 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 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.

SEC. 12. Section 14016.6 of the Welfare and Institutions Code, as added by Section 22 of Chapter 3 of the First Extraordinary Session of the Statutes of 2013, is amended to read:

14016.6. The State Department of Health Care Services shall develop a program to implement subdivision (p) of Section 14016.5 and to provide information and assistance to enable Medi-Cal beneficiaries to understand and successfully use the services of the Medi-Cal managed care plans in which they enroll. The program shall include, but not be limited to, the following components:

(a) (1) Development of a method to inform beneficiaries and applicants of all of the following:

(A) Their choices for receiving Medi-Cal benefits including the use of fee-for-service sector managed health care plans, or pilot programs.

(B) The availability of staff and information resources to Medi-Cal managed health care plan enrollees described in subdivision (f).

(2) (A) Marketing and informational materials, including printed materials, films, and exhibits, to be provided to Medi-Cal beneficiaries and applicants when choosing methods of receiving health care benefits.

(B) The department shall not be responsible for the costs of developing material required by subparagraph (A).

(C) (i) The department may prescribe the format and edit the informational materials for factual accuracy, objectivity, and ~~comprehensibility .~~ *comprehensibility.*

(ii) The department, the California Health Benefit Exchange (Exchange), the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), and entities or persons designated pursuant to subdivision (g) shall use the edited materials in informing beneficiaries and applicants of their choices for receiving Medi-Cal benefits.

(b) Provision of information that is necessary to implement this program in a manner that fairly and objectively explains to beneficiaries and applicants their choices for methods of receiving Medi-Cal benefits, including information prepared by the department.

(c) Provision of information about providers who will provide services to Medi-Cal beneficiaries. This may be information about provider referral services of a local provider professional organization. The information shall be made available to Medi-Cal beneficiaries and applicants at the same time the beneficiary or applicant is being informed of the options available for receiving care.

(d) Training of ~~specialized county employees~~ *individuals, including county human services staff,* to carry out the program.

(e) Monitoring the implementation of the program at any location, including online at the Exchange or at counties, where choices are made available in order to assure that beneficiaries and applicants may make a well-informed choice, without duress.

(f) Staff and information resources dedicated to directly assist Medi-Cal managed health care plan enrollees to understand how to effectively use the services of, and resolve problems or complaints involving, their managed health care plans.

(g) Notwithstanding any other ~~provision of state~~ law, the department, in consultation with the Exchange, may authorize specific persons or entities, including counties, to provide information to beneficiaries concerning their health care options for receiving Medi-Cal benefits and assistance with enrollment. This subdivision shall apply in all geographic areas designated by

the director. This subdivision shall be implemented in a manner consistent with federal law.

(h) To the extent otherwise required by Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall adopt emergency regulations implementing this section no later than July 1, 2015. The department may thereafter readopt the emergency regulations pursuant to that chapter. The adoption and readoption, by the department, of regulations implementing this section shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

(i) This section shall become operative on January 1, 2014.

SEC. 13. Section 14102 of the Welfare and Institutions Code, as added by Section 25 of Chapter 4 of the First Extraordinary Session of the Statutes of 2013, is amended to read:

14102. (a) Notwithstanding any other ~~provision of~~ law and except as otherwise provided in this section, any individual who is 21 years of age or older, who does not have minor children eligible for Medi-Cal benefits and would be eligible for Medi-Cal benefits pursuant to Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)) but for the five-year eligibility limitation under Section 1613 of Title 8 of the United States Code, and who is enrolled in coverage through the Exchange with an advanced premium tax credit shall be eligible for the following:

(1) Those Medi-Cal benefits for which he or she would have been eligible but for the five-year eligibility limitation only to the extent that they are not available through his or her individual health plan.

(2) The department shall pay on behalf of the beneficiary:

(A) The beneficiary's insurance premium costs for an individual health plan, minus the beneficiary's premium tax credit authorized by Section 36B of Title 26 of the United States Code and its implementing regulations.

(B) The beneficiary's cost-sharing charges so that the individual has the same cost-sharing charges as he or she would have in the Medi-Cal program.

(b) (1) If an individual is eligible for benefits under subdivision (a) and he or she is otherwise eligible for state-only funded full-scope benefits, but (A) he or she is barred from enrolling in an Exchange qualified health plan because he or she is outside of an available enrollment period for coverage or (B) the Exchange and the department do not have the operational capability to implement the benefits under subdivision (a), he or she shall remain eligible for those state-only funded benefits subject to paragraph (2).

(2) On the first date that an individual referenced in paragraph (1) is eligible for and can enroll in coverage under a qualified health plan offered through the Exchange, he or she shall be ineligible for the state-only funded full-scope benefits referenced in paragraph (1) unless the Exchange and the department do not have the operational capability to implement the benefits under subdivision (a).

(c) The department shall inform and assist individuals eligible under this section on enrolling in coverage through the Exchange with the premium assistance, cost sharing, and benefits described in subdivision (a), including, but not limited to, developing processes to coordinate with the county entities that administer eligibility for coverage in Medi-Cal and the Exchange.

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

(1) "Cost-sharing charges" means any expenditure required by or on behalf of an enrollee by his or her individual health plan with respect to essential health benefits and includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, and spending for noncovered services.

(2) "Exchange" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(e) Benefits for services under this section shall be provided with state-only funds only if federal financial participation is not available for those services. The department shall maximize federal financial participation in implementing this section to the extent allowable.

(f) 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 regulations are adopted. ~~Thereafter, the~~ *The* department shall adopt regulations *by July 1, 2015,* 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 this section, *and notwithstanding Section 10321.5 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.

(g) This section shall become operative on January 1, 2014.

SEC. 14. Section 14132.02 of the Welfare and Institutions Code, as added by Section 28 of Chapter 4 of the First Extraordinary Session of the Statutes of 2013, is amended to read:

14132.02. (a) The department shall seek approval from the United States Secretary of Health and Human Services to provide individuals made eligible pursuant to Section 14005.60 with the alternative benefit package option authorized by Section 1396u-7(b)(1)(D) of Title 42 of the United States Code. Effective January 1, 2014, the alternative benefit package shall provide the same schedule of benefits provided to full-scope Medi-Cal beneficiaries qualifying under the modified adjusted gross income standard pursuant to Section 1396a(e)(14) of Title 42 of the United States Code, except coverage of long-term services and supports shall be excluded unless otherwise required by Section 1396u-7(a)(2) of Title 42 of the United States Code or made available pursuant to subdivision (b). The alternative benefit package shall also include any benefits otherwise required by Section 1396u-7 of Title 42 of the United States Code and any regulations or guidance issued pursuant to that section.

(b) Notwithstanding Section 14005.64, and only to the extent federal approval is obtained, the department shall provide coverage for long-term services and supports to only those individuals who meet the asset requirements imposed under the Medi-Cal program for receipt of ~~such~~ *the* services.

(c) For purposes of this section, long-term services and supports include nursing facility services, a level of care in any institution equivalent to nursing facility services, home- and community-based services furnished under the state plan or a waiver under Section 1315 or 1396n of Title 42 of the United States Code, home health services as described in Section 1396d(a)(7) of Title 42 of the United States Code, and personal care services described in Section 1396d(a)(24) of Title 42 of the United States Code.

(d) The department may seek approval of any necessary state plan amendments or waivers to implement this section.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 1, 2015, 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 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.

~~(e)~~

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

SEC. 15. Section 14148.65 is added to the Welfare and Institutions Code, to read:

14148.65. (a) (1) It is the intent of the Legislature in adding this section and Sections 14005.22 and 14148.67, to help prevent premature delivery and low birth weights, the leading cause of infant and maternal morbidity and mortality, and to promote women's overall health, well-being, and financial security, while maximizing federal funds.

(2) It is therefore the intent of the Legislature that all Medi-Cal eligible pregnant women with incomes up to 100 percent of the federal poverty level are eligible for full-scope benefits through the Medi-Cal program. In addition, the intent of the Legislature

is to maintain and not to alter, restrict, or limit Medi-Cal comprehensive pregnancy-related benefits and services currently available to eligible pregnant women with incomes between 100 percent and 200 percent of the federal poverty level through the Medi-Cal program.

(3) It is further the intent of the Legislature to maximize federal funding while making no cost health care coverage available to pregnant women with incomes between 100 percent and 200 percent of the federal poverty level who are enrolled in a qualified health plan through the Exchange. To this end, it is the intent of the Legislature to enact an affordability and benefit wrap for pregnant women within this income range within the Exchange. The intent of the Legislature is to enact a wrap within the Exchange that would provide pregnant women with no share of cost and supplemental benefits so that pregnant women may receive a benefit package equal to full-scope, comprehensive benefits that are provided for Medi-Cal beneficiaries who are pregnant. It is also the intent of the Legislature that no cost health coverage for pregnant women between 100 percent and 200 percent of the federal poverty level means providers and plans are prohibited from requiring the women to pay any of the costs or charges of any services, premiums, cost sharing, copayments, or any other costs at any time. It is further the intent of the Legislature that providers are prohibited from refusing to provide these supplemental services to an eligible pregnant woman.

(b) By April 1, 2014, or after the department determines that CalHEERS has been programmed for implementation of this section, whichever is later, the department, in coordination with the Exchange, shall implement the following option for women eligible for Medi-Cal pregnancy-related and postpartum services who are or will be enrolled in individual health care coverage through the Exchange. To promote continuity of care, at the beneficiary's option, the department shall allow the beneficiary to remain enrolled in her Exchange individual qualified health plan while at the same time ensuring she receives the services and benefits to which she is entitled as a result of her eligibility for and enrollment in the Medi-Cal program as provided in this section.

(c) If a beneficiary is only eligible for pregnancy-related and postpartum services under this chapter and the beneficiary is also

enrolled in coverage under a qualified health plan offered under the Exchange, the department shall pay both of the following on behalf of the beneficiary without the beneficiary being billed or paying any costs for the qualified health plan:

(1) The beneficiary's premium costs for Exchange coverage, minus the beneficiary's premium tax credit authorized by Section 36B of Title 26 of the United States Code and its implementing regulations, during the beneficiary's period of eligibility for pregnancy-related and postpartum services under this chapter.

(2) The beneficiary's cost sharing for benefits and services under the Exchange qualified health plan during the beneficiary's period of eligibility for pregnancy-related and postpartum services under this chapter.

(d) The department shall provide beneficiaries who are receiving benefits under subdivision (c) with only those Medi-Cal benefits for pregnancy-related and postpartum services that are covered under the State Plan and that are not available through the beneficiary's qualified health plan.

(e) Beneficiaries shall have the right to access Medi-Cal providers through the Medi-Cal program that are not contracting with the Exchange qualified health plan as required under state and federal laws for services that are not available through the beneficiary's qualified health plan including, but not limited to, the right to access Comprehensive Perinatal Services Program (CPSP) Medi-Cal providers and perinatal specialists, to the extent services provided by the CPSP providers and perinatal specialists are not covered by the beneficiary's qualified health plan.

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

(1) "Beneficiary" means a woman eligible for Medi-Cal pregnancy-related and postpartum services.

(2) "CalHEERS" means the California Healthcare Eligibility, Enrollment, and Retention System developed under Section 15926.

(3) "Cost sharing" means the expenditures required by or on behalf of the beneficiary by her qualified health plan with respect to essential health benefits and includes deductibles, coinsurance, copayments, and similar charges, but excludes premiums, and spending by an eligible beneficiary for benefits or services not covered by the qualified health plan.

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

(5) "Postpartum services" means those services and benefits provided during a postpartum period under Section 14005.18.

(g) The department shall consult with the Exchange, Exchange contracting qualified health plans, and stakeholders, including consumer advocates and counties, in the implementation of all of the following:

(1) The development of processes and procedures to inform beneficiaries and applicants how they can receive the benefits and services covered through the Exchange coverage and how they can receive benefits and services under this section.

(2) The development of a simple process for a woman eligible for the Medi-Cal program based on pregnancy to exercise the option to remain in or enroll in Exchange coverage and receive Medi-Cal coverage for pregnancy-related and postpartum services not covered by the beneficiary's Exchange qualified health plan and related assistance for premiums and cost sharing as outlined in subdivision (c). The process and all options shall be made known and available to women at the time of applying to the Medi-Cal program and the Exchange and during their enrollment in Medi-Cal or Exchange coverage, as applicable.

(3) The development of standardized notices and procedures that are designed to inform women applying for the Medi-Cal program and individuals applying for or enrolled in the Exchange of the option and the process for eligible women to remain enrolled in Exchange coverage and receive Medi-Cal pregnancy-related and postpartum coverage under this section.

(4) The development of provider notices to ensure that Medi-Cal providers are aware of the Medi-Cal pregnancy program for women enrolled in the Exchange and that providers comply with state and federal laws applicable to Medi-Cal pregnancy coverage for women who exercise the option to remain in Exchange coverage.

(h) In addition, the department shall consult with the Exchange and Exchange contracting qualified health plans in the implementation of both of the following:

(1) The department shall pay qualified health plans the portion of the premium for Exchange coverage that would be owed by

beneficiaries under this section if they were enrolled in a qualified health plan and not Medi-Cal.

(2) The department shall pay qualified health plans for reductions in beneficiary cost sharing under this section. The department shall, to the extent feasible, establish processes and procedures for qualified health plans to report, claim, and receive reimbursement for the cost-sharing reductions consistent with the federal process for qualified health plans to report, claim, and receive federal reimbursement for cost-sharing reductions provided to Exchange enrollees under 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 subsequent amendments.

(i) 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 regulations are adopted. The department shall adopt regulations codifying any previous guidance issued by July 1, 2015, 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 this section, notwithstanding Section 10321.5 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.

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

SEC. 16. Section 14148.67 is added to the Welfare and Institutions Code, to read:

14148.67. (a) When implementing the premium and cost-sharing payments required under Sections 14102 and 14148.65, the department shall make the premium and cost-sharing payments required under those sections to the beneficiary's qualified health plan in conformity with the requirements of this section and the requirements of subdivision (h) of Section 14148.65.

(b) (1) The beneficiary shall not be required to make any premium or cost-sharing payments to his or her qualified health plan or service provider for any services that are subject to premium or cost-sharing payments under Section 14102 or 14148.65.

(2) If the beneficiary makes any premium or cost-sharing payments to his or her plan for services that are subject to premium or cost-sharing payments under Section 14102 or 14148.65 the department shall reimburse the beneficiary for those payments.

(3) If as a result of reconciliation in a tax year where the beneficiary was eligible for covered premium payments under Section 14102 or 14148.65 the beneficiary owes and makes a tax payment to the federal government to return a portion of the advanced premium tax credit to which the beneficiary was not entitled and the beneficiary notifies the department, the department shall reimburse the beneficiary for the amount of the tax payment related to the tax credits for covered premium payments under Section 14102 or 14148.65.

(c) (1) Except as provided in paragraph (2), beneficiaries who are eligible for benefits under Section 14102 or 14148.65 shall be eligible for the premium and cost-sharing payments required under those sections only up to the amount necessary to pay for the second lowest silver level plan in his or her qualified health plan pricing region, as modified by cost-sharing reductions.

(2) If a beneficiary wants to select or remain in a metal level plan that is more expensive than the metal level plan amount limit required under paragraph (1), the beneficiary may select or remain in that plan only if he or she agrees to be responsible for paying all applicable premium and cost-sharing charges that are in excess of what is covered by the department. The department shall not be responsible for paying for any premium or cost sharing that is in excess of the metal level plan amount limit required under paragraph (1).

(d) 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 regulations are adopted. The department shall adopt regulations by July 1, 2015, 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 this section, notwithstanding Section 10321.5 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.

(e) This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

SEC. 17. Section 14154 of the Welfare and Institutions Code is amended to read:

14154. (a) (1) The department shall establish and maintain a plan whereby costs for county administration of the determination of eligibility for benefits under this chapter will be effectively controlled within the amounts annually appropriated for that administration. The plan, to be known as the County Administrative Cost Control Plan, shall establish standards and performance criteria, including workload, productivity, and support services standards, to which counties shall adhere. The plan shall include standards for controlling eligibility determination costs that are incurred by performing eligibility determinations at county hospitals, or that are incurred due to the outstationing of any other eligibility function. Except as provided in Section 14154.15, reimbursement to a county for outstationed eligibility functions shall be based solely on productivity standards applied to that county's welfare department office.

(2) (A) The plan shall delineate both of the following:

(i) The process for determining county administration base costs, which include salaries and benefits, support costs, and staff development.

(ii) The process for determining funding for caseload changes, cost-of-living adjustments, and program and other changes.

(B) The annual county budget survey document utilized under the plan shall be constructed to enable the counties to provide sufficient detail to the department to support their budget requests.

(3) The plan shall be part of a single state plan, jointly developed by the department and the State Department of Social Services, in conjunction with the counties, for administrative cost control for the California Work Opportunity and Responsibility to Kids

(CalWORKs), CalFresh, and Medical Assistance (Medi-Cal) programs. Allocations shall be made to each county and shall be limited by and determined based upon the County Administrative Cost Control Plan. In administering the plan to control county administrative costs, the department shall not allocate state funds to cover county cost overruns that result from county failure to meet requirements of the plan. The department and the State Department of Social Services shall budget, administer, and allocate state funds for county administration in a uniform and consistent manner.

(4) The department and county welfare departments shall develop procedures to ensure the data clarity, consistency, and reliability of information contained in the county budget survey document submitted by counties to the department. These procedures shall include the format of the county budget survey document and process, data submittal and its documentation, and the use of the county budget survey documents for the development of determining county administration costs. Communication between the department and the county welfare departments shall be ongoing as needed regarding the content of the county budget surveys and any potential issues to ensure the information is complete and well understood by involved parties. Any changes developed pursuant to this section shall be incorporated within the state's annual budget process by no later than the 2011–12 fiscal year.

(5) The department shall provide a clear narrative description along with fiscal detail in the Medi-Cal estimate package, submitted to the Legislature in January and May of each year, of each component of the county administrative funding for the Medi-Cal program. This shall describe how the information obtained from the county budget survey documents was utilized and, where applicable, modified and the rationale for the changes.

(6) Notwithstanding any other ~~provision of~~ law, the department shall develop and implement, in consultation with county program and fiscal representatives, a new budgeting methodology for Medi-Cal county administrative costs *that reflects the impact of PPACA implementation on county administrative work*. The new budgeting methodology shall be used to reimburse counties for eligibility ~~determinations~~ *processing and case maintenance* for

applicants and beneficiaries~~, including one-time eligibility processing and ongoing case maintenance~~.

(A) The budgeting methodology ~~shall~~ *may* include, but is not limited to, identification of the costs of eligibility determinations for applicants, and the costs of eligibility redeterminations and case maintenance activities for recipients, for different groupings of cases~~. The groupings of cases shall be~~, based on variations in time and resources needed to conduct eligibility determinations. The calculation of time and resources shall be based on the following factors: complexity of eligibility rules, ongoing eligibility requirements, and other factors as determined appropriate by the department. *The development of the new budgeting methodology may include, but is not limited to, county survey of costs, time and motion studies, in-person observations by department staff, data reporting, and other factors deemed appropriate by the department.*

(B) The new budgeting methodology shall be clearly described, state the necessary data elements to be collected from the counties, and establish the timeframes for counties to provide the data to the state.

(C) *The new budgeting methodology developed pursuant to this paragraph shall be implemented no sooner than the 2015–16 fiscal year.* The department may develop a process for counties to phase in the requirements of the new budgeting methodology.

~~(D) To the extent a county does not submit the requested data pursuant to subparagraph (B), the new budgeting methodology may include a process to use peer-based proxy costs in developing the county budget.~~

~~(E)~~

(D) The department shall provide the new budgeting methodology to the legislative fiscal committees by March 1~~, 2012, and may include the methodology in the May Medi-Cal Local Assistance Estimate, beginning with the May 2012 estimate, for the 2012–13 fiscal year and each fiscal year thereafter~~ *of the fiscal year immediately preceding the first fiscal year of implementation of the new budgeting methodology*.

~~(F)~~

(E) To the extent that the funding for the county budgets developed pursuant to the new budget methodology is not fully appropriated in any given fiscal year, the department, with input

from the counties, shall identify and consider options to align funding and workload responsibilities.

(F) For purposes of this paragraph, "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 subsequent amendments.

(G) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this paragraph by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 1, 2015, 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 implementation of the new budgeting methodology pursuant to this paragraph, 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.

(b) Nothing in this section, Section 15204.5, or Section 18906 shall be construed so as to limit the administrative or budgetary responsibilities of the department in a manner that would violate Section 14100.1, and thereby jeopardize federal financial participation under the Medi-Cal program.

(c) (1) The Legislature finds and declares that in order for counties to do the work that is expected of them, it is necessary that they receive adequate funding, including adjustments for reasonable annual cost-of-doing-business increases. The Legislature further finds and declares that linking appropriate funding for county Medi-Cal administrative operations, including annual cost-of-doing-business adjustments, with performance standards will give counties the incentive to meet the performance standards and enable them to continue to do the work they do on behalf of the state. It is therefore the Legislature's intent to provide appropriate funding to the counties for the effective administration of the Medi-Cal program at the local level to ensure that counties

can reasonably meet the purposes of the performance measures as contained in this section.

(2) It is the intent of the Legislature to not appropriate funds for the cost-of-doing-business adjustment for the 2008–09, 2009–10, 2010–11, 2011–12, and 2012–13 fiscal years.

(d) The department is responsible for the Medi-Cal program in accordance with state and federal law. A county shall determine Medi-Cal eligibility in accordance with state and federal law. If in the course of its duties the department becomes aware of accuracy problems in any county, the department shall, within available resources, provide training and technical assistance as appropriate. Nothing in this section shall be interpreted to eliminate any remedy otherwise available to the department to enforce accurate county administration of the program. In administering the Medi-Cal eligibility process, each county shall meet the following performance standards each fiscal year:

(1) Complete eligibility determinations as follows:

(A) Ninety percent of the general applications without applicant errors and are complete shall be completed within 45 days.

(B) Ninety percent of the applications for Medi-Cal based on disability shall be completed within 90 days, excluding delays by the state.

(2) (A) The department shall establish best-practice guidelines for expedited enrollment of newborns into the Medi-Cal program, preferably with the goal of enrolling newborns within 10 days after the county is informed of the birth. The department, in consultation with counties and other stakeholders, shall work to develop a process for expediting enrollment for all newborns, including those born to mothers receiving CalWORKs assistance.

(B) Upon the development and implementation of the best-practice guidelines and expedited processes, the department and the counties may develop an expedited enrollment timeframe for newborns that is separate from the standards for all other applications, to the extent that the timeframe is consistent with these guidelines and processes.

(3) Perform timely annual redeterminations, as follows:

(A) Ninety percent of the annual redetermination forms shall be mailed to the recipient by the anniversary date.

(B) Ninety percent of the annual redeterminations shall be completed within 60 days of the recipient’s annual redetermination

date for those redeterminations based on forms that are complete and have been returned to the county by the recipient in a timely manner.

(C) Ninety percent of those annual redeterminations where the redetermination form has not been returned to the county by the recipient shall be completed by sending a notice of action to the recipient within 45 days after the date the form was due to the county.

(D) When a child is determined by the county to change from no share of cost to a share of cost and the child meets the eligibility criteria for the Healthy Families Program established under Section 12693.98 of the Insurance Code, the child shall be placed in the Medi-Cal-to-Healthy Families Bridge Benefits Program, and these cases shall be processed as follows:

(i) Ninety percent of the families of these children shall be sent a notice informing them of the Healthy Families Program within five working days from the determination of a share of cost.

(ii) Ninety percent of all annual redetermination forms for these children shall be sent to the Healthy Families Program within five working days from the determination of a share of cost if the parent has given consent to send this information to the Healthy Families Program.

(iii) Ninety percent of the families of these children placed in the Medi-Cal-to-Healthy Families Bridge Benefits Program who have not consented to sending the child's annual redetermination form to the Healthy Families Program shall be sent a request, within five working days of the determination of a share of cost, to consent to send the information to the Healthy Families Program.

(E) Subparagraph (D) shall not be implemented until 60 days after the Medi-Cal and Joint Medi-Cal and Healthy Families applications and the Medi-Cal redetermination forms are revised to allow the parent of a child to consent to forward the child's information to the Healthy Families Program.

(e) The department shall develop procedures in collaboration with the counties and stakeholder groups for determining county review cycles, sampling methodology and procedures, and data reporting.

(f) On January 1 of each year, each applicable county, as determined by the department, shall report to the department on the county's results in meeting the performance standards specified

in this section. The report shall be subject to verification by the department. County reports shall be provided to the public upon written request.

(g) If the department finds that a county is not in compliance with one or more of the standards set forth in this section, the county shall, within 60 days, submit a corrective action plan to the department for approval. The corrective action plan shall, at a minimum, include steps that the county shall take to improve its performance on the standard or standards with which the county is out of compliance. The plan shall establish interim benchmarks for improvement that shall be expected to be met by the county in order to avoid a sanction.

(h) (1) If a county does not meet the performance standards for completing eligibility determinations and redeterminations as specified in this section, the department may, at its sole discretion, reduce the allocation of funds to that county in the following year by 2 percent. Any funds so reduced may be restored by the department if, in the determination of the department, sufficient improvement has been made by the county in meeting the performance standards during the year for which the funds were reduced. If the county continues not to meet the performance standards, the department may reduce the allocation by an additional 2 percent for each year thereafter in which sufficient improvement has not been made to meet the performance standards.

(2) No reduction of the allocation of funds to a county shall be imposed pursuant to this subdivision for failure to meet performance standards during any period of time in which the cost-of-doing-business increase is suspended.

(i) The department shall develop procedures, in collaboration with the counties and stakeholders, for developing instructions for the performance standards established under subparagraph (D) of paragraph (3) of subdivision (d), no later than September 1, 2005.

(j) No later than September 1, 2005, the department shall issue a revised annual redetermination form to allow a parent to indicate parental consent to forward the annual redetermination form to the Healthy Families Program if the child is determined to have a share of cost.

(k) The department, in coordination with the Managed Risk Medical Insurance Board, shall streamline the method of providing the Healthy Families Program with information necessary to

determine Healthy Families eligibility for a child who is receiving services under the Medi-Cal-to-Healthy Families Bridge Benefits Program.

(*l*) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, *and except as provided in subparagraph (G) of paragraph (6) of subdivision (a),* the department shall, without taking any further regulatory action, implement, interpret, or make specific this section and any applicable federal waivers and state plan amendments by means of all-county letters or similar instructions.

SEC. 18. Section 15926 of the Welfare and Institutions Code, as amended by Section 26 of Chapter 3 of the First Extraordinary Session of the Statutes of 2013, is amended to read:

15926. (a) The following definitions apply for purposes of this part:

(1) "Accessible" means in compliance with Section 11135 of the Government Code, Section 1557 of the PPACA, and regulations or guidance adopted pursuant to these statutes.

(2) "Limited-English-proficient" means not speaking English as one's primary language and having a limited ability to read, speak, write, or understand English.

(3) "Insurance affordability program" means a program that is one of the following:

(A) The Medi-Cal program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(B) The state's children's health insurance program (CHIP) under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(C) A program that makes available to qualified individuals coverage in a qualified health plan through the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code with advance payment of the premium tax credit established under Section 36B of the Internal Revenue Code.

(4) A program that makes available coverage in a qualified health plan through the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code with cost-sharing reductions established under Section 1402 of PPACA and any subsequent amendments to that act.

(b) An individual shall have the option to apply for insurance affordability programs in person, by mail, online, by telephone, or by other commonly available electronic means.

(c) (1) A single, accessible, standardized paper, electronic, and telephone application for insurance affordability programs shall be developed by the department in consultation with MRMIB and the board governing the Exchange as part of the stakeholder process described in subdivision (b) of Section 15925. The application shall be used by all entities authorized to make an eligibility determination for any of the insurance affordability programs and by their agents.

(2) The department may develop and require the use of supplemental forms to collect additional information needed to determine eligibility on a basis other than the financial methodologies described in Section 1396a(e)(14) of Title 42 of the United States Code, as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148), and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments, as provided under Section 435.907(c) of Title 42 of the Code of Federal Regulations.

(3) The application shall be tested and operational by the date as required by the federal Secretary of Health and Human Services.

(4) The application form shall, to the extent not inconsistent with federal statutes, regulations, and guidance, satisfy all of the following criteria:

(A) The form shall include simple, user-friendly language and instructions.

(B) The form may not ask for information related to a nonapplicant that is not necessary to determine eligibility in the applicant's particular circumstances.

(C) The form may require only information necessary to support the eligibility and enrollment processes for insurance affordability programs.

(D) The form may be used for, but shall not be limited to, screening.

(E) The form may ask, or be used otherwise to identify, if the mother of an infant applicant under one year of age had coverage through an insurance affordability program for the infant's birth, for the purpose of automatically enrolling the infant into the

applicable program without the family having to complete the application process for the infant.

(F) (i) Except as specified in clause (ii), the form may include questions that are voluntary for applicants to answer regarding demographic data categories, including race, ethnicity, primary language, disability status, sexual orientation, gender identity or expression, and other categories recognized by the federal Secretary of Health and Human Services under Section 4302 of the PPACA.

~~(F) The form may~~

(ii) Effective January 1, 2015, the form shall include questions that are voluntary for applicants to answer regarding demographic data categories, including race, ethnicity, primary language, disability status, *sexual orientation, gender identity or expression,* and other categories recognized by the federal Secretary of Health and Human Services under Section 4302 of the PPACA.

(G) Until January 1, 2016, the department shall instruct counties to not reject an application that was in existence prior to January 1, 2014, but to accept the application and request any additional information needed from the applicant in order to complete the eligibility determination process. The department shall work with counties and consumer advocates to develop the supplemental questions.

(d) Nothing in this section shall preclude the use of a provider-based application form or enrollment procedures for insurance affordability programs or other health programs that differs from the application form described in subdivision (c), and related enrollment procedures. Nothing in this section shall preclude the use of a joint application, developed by the department and the State Department of Social Services, that allows for an application to be made for multiple programs, including, but not limited to, CalWORKs, CalFresh, and insurance affordability programs.

(e) The entity making the eligibility determination shall grant eligibility immediately whenever possible and with the consent of the applicant in accordance with the state and federal rules governing insurance affordability programs.

(f) (1) If the eligibility, enrollment, and retention system has the ability to prepopulate an application form for insurance affordability programs with personal information from available

electronic databases, an applicant shall be given the option, with his or her informed consent, to have the application form prepopulated. Before a prepopulated application is submitted to the entity authorized to make eligibility determinations, the individual shall be given the opportunity to provide additional eligibility information and to correct any information retrieved from a database.

(2) All insurance affordability programs may accept self-attestation, instead of requiring an individual to produce a document, for age, date of birth, family size, household income, state residence, pregnancy, and any other applicable criteria needed to determine the eligibility of an applicant or recipient, to the extent permitted by state and federal law.

(3) An applicant or recipient shall have his or her information electronically verified in the manner required by the PPACA and implementing federal regulations and guidance and state law.

(4) Before an eligibility determination is made, the individual shall be given the opportunity to provide additional eligibility information and to correct information.

(5) The eligibility of an applicant shall not be delayed beyond the timeliness standards as provided in Section 435.912 of Title 42 of the Code of Federal Regulations or denied for any insurance affordability program unless the applicant is given a reasonable opportunity, of at least the kind provided for under the Medi-Cal program pursuant to Section 14007.5 and paragraph (7) of subdivision (e) of Section 14011.2, to resolve discrepancies concerning any information provided by a verifying entity.

(6) To the extent federal financial participation is available, an applicant shall be provided benefits in accordance with the rules of the insurance affordability program, as implemented in federal regulations and guidance, for which he or she otherwise qualifies until a determination is made that he or she is not eligible and all applicable notices have been provided. Nothing in this section shall be interpreted to grant presumptive eligibility if it is not otherwise required by state law, and, if so required, then only to the extent permitted by federal law.

(g) The eligibility, enrollment, and retention system shall offer an applicant and recipient assistance with his or her application or renewal for an insurance affordability program in person, over the telephone, by mail, online, or through other commonly available

electronic means and in a manner that is accessible to individuals with disabilities and those who are limited-English proficient.

(h) (1) During the processing of an application, renewal, or a transition due to a change in circumstances, an entity making eligibility determinations for an insurance affordability program shall ensure that an eligible applicant and recipient of insurance affordability programs that meets all program eligibility requirements and complies with all necessary requests for information moves between programs without any breaks in coverage and without being required to provide any forms, documents, or other information or undergo verification that is duplicative or otherwise unnecessary. The individual shall be informed about how to obtain information about the status of his or her application, renewal, or transfer to another program at any time, and the information shall be promptly provided when requested.

(2) The application or case of an individual screened as not eligible for Medi-Cal on the basis of Modified Adjusted Gross Income (MAGI) household income but who may be eligible on the basis of being 65 years of age or older, or on the basis of blindness or disability, shall be forwarded to the Medi-Cal program for an eligibility determination. During the period this application or case is processed for a non-MAGI Medi-Cal eligibility determination, if the applicant or recipient is otherwise eligible for an insurance affordability program, he or she shall be determined eligible for that program.

(3) Renewal procedures shall include all available methods for reporting renewal information, including, but not limited to, face-to-face, telephone, mail, and online renewal or renewal through other commonly available electronic means.

(4) An applicant who is not eligible for an insurance affordability program for a reason other than income eligibility, or for any reason in the case of applicants and recipients residing in a county that offers a health coverage program for individuals with income above the maximum allowed for the Exchange premium tax credits, shall be referred to the county health coverage program in his or her county of residence.

(i) Notwithstanding subdivisions (e), (f), and (j), before an online applicant who appears to be eligible for the Exchange with a

premium tax credit or reduction in cost sharing, or both, may be enrolled in the Exchange, both of the following shall occur:

(1) The applicant shall be informed of the overpayment penalties under the federal Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (Public Law 112-9), if the individual's annual family income increases by a specified amount or more, calculated on the basis of the individual's current family size and current income, and that penalties are avoided by prompt reporting of income increases throughout the year.

(2) The applicant shall be informed of the penalty for failure to have minimum essential health coverage.

(j) The department shall, in coordination with MRMIB and the Exchange board, streamline and coordinate all eligibility rules and requirements among insurance affordability programs using the least restrictive rules and requirements permitted by federal and state law. This process shall include the consideration of methodologies for determining income levels, assets, rules for household size, citizenship and immigration status, and self-attestation and verification requirements.

(k) (1) Forms and notices developed pursuant to this section shall be accessible and standardized, as appropriate, and shall comply with federal and state laws, regulations, and guidance prohibiting discrimination.

(2) Forms and notices developed pursuant to this section shall be developed using plain language and shall be provided in a manner that affords meaningful access to limited-English-proficient individuals, in accordance with applicable state and federal law, and at a minimum, provided in the same threshold languages as required for Medi-Cal managed care plans.

(*l*) The department, the California Health and Human Services Agency, MRMIB, and the Exchange board shall establish a process for receiving and acting on stakeholder suggestions regarding the functionality of the eligibility systems supporting the Exchange, including the activities of all entities providing eligibility screening to ensure the correct eligibility rules and requirements are being used. This process shall include consumers and their advocates, be conducted no less than quarterly, and include the recording, review, and analysis of potential defects or enhancements of the eligibility systems. The process shall also include regular updates

on the work to analyze, prioritize, and implement corrections to confirmed defects and proposed enhancements, and to monitor screening.

(m) In designing and implementing the eligibility, enrollment, and retention system, the department, MRMIB, and the Exchange board shall ensure that all privacy and confidentiality rights under the PPACA and other federal and state laws are incorporated and followed, including responses to security breaches.

(n) Except as otherwise specified, this section shall be operative on January 1, 2014.

SEC. 19. 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. 20. 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 Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to implement provisions of 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), it is necessary that this act take effect immediately.

All matter omitted in this version of the bill appears in the bill as amended in the Assembly May 13, 2013. (JR11)

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