Senate Bill No. 857

CHAPTER 31

An act to amend Section 56.36 of the Civil Code, to amend Sections 6254 and 100504 of the Government Code, to amend Sections 1280.15, 1341.45, 1399.861, 11833.02, 11833.04, 120955, 128200, 128205, 128210, 128215, 128225, 128230, 128235, 130200, and 136030 of, to amend and renumber Sections 130201, 130202, 130203, 130204, and 130205 of, to add Sections 1347.5, 1368.05, 1374.76, 120962, 121451, 121452, and 131058 to, and to repeal and add Section 136000 of, the Health and Safety Code, to amend Sections 10965.15, 12693.70, 12739.61, and 12739.78 of, to add Sections 10112.35, 12699.15, 12699.64, 12701, 12710.2, and 12739.79 to, and to repeal Part 6.3 (commencing with Section 12695), Part 6.4 (commencing with Section 12699.50), and Part 6.5 (commencing with Section 12700) of Division 2 of, the Insurance Code, to add Section 19548.2 to the Revenue and Taxation Code, and to amend Sections 4061, 5897, 14043.38, 14132.275, 14132.277, 14154, 14165.50, 15800, 15801, 15803, 15804, and 15805 of, to amend the heading of Chapter 2 (commencing with Section 15810) of Part 3.3 of Division 9 of, to amend, repeal, and add Sections 15810, 15811, 15826, 15832, and 15840 of, to add Sections 14005.22, 14005.225, 14104.35, 14131.11, 14132.915, 14148.65, 14148.67, 15802.5, 15806, 15814, 15818, 15827, 15833, 15835, 15839, 15841, 15847, 15847.3, 15847.5, 15847.7, 15848, and 15848.5 to, and to add Chapter 3 (commencing with Section 15850) and Chapter 4 (commencing with Section 15870) to Part 3.3 of Division 9 of, the Welfare and Institutions Code, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.

[Approved by Governor June 20, 2014. Filed with
Secretary of State June 20, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

SB 857, Committee on Budget and Fiscal Review. Health.

(1) Existing law establishes the Office of Health Information Integrity within the California Health and Human Services Agency to ensure the enforcement of state law mandating the confidentiality of medical information, as defined, and to impose administrative fines on providers of health care for the unauthorized use of medical information.

This bill would transfer the duty to impose administrative fines on providers of health care for the unauthorized use of medical information to the State Department of Public Health, and would make other conforming changes.

(2) Existing law establishes the California Health Benefit Exchange for the purpose of facilitating the enrollment of qualified individuals and small

employers in qualified health plans. Existing law authorizes the board of the California Health Benefit Exchange to adopt emergency regulations until January 1, 2016. Under existing law, emergency regulations remain in effect for no more than 180 days, except as specified, and may be readopted for 2 additional 90-day periods.

This bill would allow more than 2 readoptions of those emergency regulations until January 1, 2017, and would allow the emergency regulations adopted by the board to remain in effect for 2 years, as specified.

(3) Existing law, as of July 1, 2012, transferred the Office of Patient Advocate from the Department of Managed Health Care to the California Health and Human Services Agency, to provide assistance to, and advocate on behalf of, individuals served by health care service plans regulated by the Department of Managed Health Care, insureds covered by health insurers regulated by the Department of Insurance, and individuals who receive or are eligible for other health care coverage in California, including coverage available through the Medi-Cal program, the California Health Benefit Exchange, the Healthy Families Program, or any other county or state health care program. The duties of the office, include, but are not limited to, compiling an annual publication, to be made available on the office's Internet Web site, of a quality of care report card, rendering assistance to consumers regarding procedures, rights, and responsibilities related to the filing of complaints, grievances, and appeals, and coordinating and working with other government and nongovernment patient assistance programs and health care ombudsperson programs.

This bill would revise and recast those provisions by transferring the direct consumer assistance activities that had previously been conferred on the office to the Department of Managed Health Care to be carried out in partnership with community-based consumer assistance organizations for the purposes of serving health care consumers, as provided. The bill would instead require the office, among other things, to provide assistance to, and advocate on behalf of, health care consumers, and would instead make the goal of the office to coordinate amongst, provide assistance to, and collect data from, all of the state agency consumer assistance or patient assistance programs and call centers, to better enable health care consumers to access the health care services to which they are eligible under the law. The duties of the office would include, but not be limited to, producing a baseline review and annual report to be made publically available on the office's Internet Web site by July 1, 2015, and annually thereafter, of health care consumer or patient assistance help centers, call centers, ombudsperson, or other assistance centers operated by the Department of Managed Health Care, the State Department of Health Care Services (DHCS), the Department of Insurance, and the Exchange, and including certain minimum information, and collecting, tracking, and analyzing data on problems and complaints by, and questions from, consumers about health care coverage for the purpose of providing public information about problems faced and information needed by consumers in obtaining coverage and care. This bill would also make conforming changes.

(4) Existing federal law requires a health insurance issuer that offers group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits to establish parity in the terms and conditions applicable to medical and mental health benefits, as specified.

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 requires a health care service plan contract that provides hospital, medical, or surgical coverage to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses under the same terms and conditions applied to other medical conditions, as specified.

This bill would require large group, small group, and individual health care service plan contracts to provide covered mental health and substance use disorder benefits in compliance with the provisions of federal law governing mental health parity no later than January 1, 2015. Because a willful violation of that requirement would be a crime, the bill would impose a state-mandated local program.

(5) Under existing law, DHCS is responsible for licensing and certifying alcoholism and drug abuse recovery and treatment programs and facilities, including both residential and nonresidential programs. Existing law requires the department to charge a fee for the licensure or certification of these facilities and to establish fee scales using different capacity levels, categories based on measures other than program capacity, or any other category or classification that the department deems necessary or convenient to maintain an effective and equitable fee structure. Existing law requires the department to submit proposed new fees or fee changes to the Legislature for approval, as specified, and prohibits new fees or fee changes without legislative approval.

This bill would require the department to issue a provider bulletin setting forth the approved fee structure and, on an annual basis, to publish the fee structure on the department's Internet Web site.

Existing law authorizes the department to implement the licensing and certification provisions for alcoholism and drug abuse recovery and treatment programs and facilities through emergency regulations.

This bill would remove the authorization for emergency regulations and would require the department to adopt regulations through the Administrative Procedure Act. The bill would authorize the department to implement new fees or fee changes by means of provider bulletins or similar action and to supersede the existing licensing and certification fees until the department amends the regulations. The bill would also require the department to notify and consult with interested parties and appropriate stakeholders regarding new fees or fee changes.

(6) Existing law requires the State Public Health Officer to establish, and authorizes him or her to administer, a program to provide drug treatments to persons infected with HIV, to the extent that state and federal funds are

appropriated. Existing law requires the State Department of Public Health to determine a person whose adjusted gross income does not exceed $50,000 per year to be financially eligible to receive services under this program, as specified. Existing law authorizes the State Department of Public Health to subsidize certain cost-sharing requirements for persons otherwise eligible for the AIDS Drug Assistance Program (ADAP) with non-ADAP drug coverage by paying for prescription drugs included on the ADAP formulary, as specified.

This bill would additionally authorize the department, if the director determines that it would result in a cost savings to the state, to subsidize costs associated with a health care service plan or health insurance policy, including medical copayments and deductibles for outpatient care, and premiums to purchase or maintain health insurance coverage. The bill would authorize federal funds and moneys in the AIDS Drug Assistance Program Rebate Fund to be used for these purposes. By expanding the purposes for which moneys from the continuously appropriated AIDS Drug Assistance Program Rebate Fund may be expended, the bill would make an appropriation.

The bill would also, for purposes of determining financial eligibility for the ADAP program, require information sharing between the Franchise Tax Board and the State Department of Public Health to verify the amount of a person's adjusted gross income.

(7) Existing law establishes a program for the control of tuberculosis and requires the State Department of Public Health to maintain the program and administer funds made available by the state for the care of tuberculosis patients. Existing law authorizes the department to establish standards and procedures for the operation of local tuberculosis control programs and to distribute for the purpose of tuberculosis control an annual subvention to any local health department that maintains a tuberculosis control program consistent with the standards and procedures established by the department.

This bill would require a local entity that receives funding from the state for the purposes of tuberculosis control to first allocate the moneys received for specified purposes and activities, including submitting the written treatment plan to the local health officer and for cities, counties, and cities and counties to provide counsel to nonindigent tuberculosis patients who are subject to a civil order of detention issued by a local health officer, as specified.

(8) Existing law, the Song-Brown Health Care Workforce Training Act, establishes a state medical contract program with accredited medical schools, programs that train primary care physician's assistants, programs that train primary care nurse practitioners and registered nurses, hospitals, and other health care delivery systems.

Existing law establishes the California Healthcare Workforce Policy Commission, consisting of 15 members, to administer the state medical contract program, except as specified. Existing law requires the commission to identify specific areas of the state where unmet priority needs for primary care family physicians and registered nurses exist, establish standards for,

among other things, family practice training programs, family practice residency programs, primary care physician's assistants programs, and programs that train primary care nurse practitioners, and to make recommendations to the Director of the Office of Statewide Health Planning and Development with regard to the funding of specific programs. Existing law requires the director to select and contract on behalf of the state with the above-described entities for the purpose of, among other things, training medical students and residents in the specialty of family practice, subject to criteria established by the commission.

This bill would authorize the state medical contract program to include contracts with teaching health centers, as defined. The bill would require a teaching health center that receives funds pursuant to the state medical contract program to include within its curriculum, programs or departments that recognize family medicine as a major independent specialty.

For purposes of the provisions that implement the state medical contract program, the bill would delete references to the specialty of family practice and would refer instead to the specialties of primary care or family medicine, thereby expanding the scope of the state medical contract program to include those specialties. The bill would also require the director to select and contract on behalf of the state for the purpose of, among other things, training medical students and residents in the specialties of internal medicine, obstetrics and gynecology, pediatrics, and family medicine, subject to criteria established by the commission.

Existing law requires the commission to review and make recommendations to the Director of the Office of Statewide Health Planning and Development concerning the funding of those programs that are submitted to the Health Professions Development Program for participation in the state medical contract program established under these provisions. Existing law requires the Chief of the Health Professions Development Program, or his or her designee, to serve as executive secretary for the commission.

This bill would delete references to the Health Professions Development Program and would refer instead to the Healthcare Workforce Development Division. The bill would instead specify that the Deputy Director of the Healthcare Workforce Development Division, or his or her designee, serve as executive secretary for the commission.

(9) Existing law authorizes the State Department of Public Health to perform various activities relating to the protection, preservation, and advancement of public health, including studies and demonstrations of innovative methods, and authorizes the department to, among other things, apply for and receive grants for the performance of the activity.

This bill would authorize the State Department of Public Health to investigate, apply for, and enter into agreements to secure federal or nongovernmental funding opportunities for the purposes of advancing public health, as specified.

(10) Existing law creates the Managed Risk Medical Insurance Board (MRMIB) and requires MRMIB to administer various programs that provide

health care coverage to certain populations, including the California Major Risk Medical Insurance Program, the Access for Infants and Mothers Program, the County Health Initiative Matching Fund, and the Federal Temporary High Risk Pool.

This bill would eliminate MRMIB as of July 1, 2014, and transfer the powers, purposes, responsibilities, and jurisdiction of MRMIB to DHCS. The bill would authorize DHCS to conduct transition activities prior to July 1, 2014, to ensure the transfer of the programs administered by MRMIB to DHCS.

Existing law establishes the California Major Risk Medical Insurance Program (MRMIP), which is administered by MRMIB, to provide major risk medical coverage to persons who, among other things, have been rejected for coverage by at least one private health plan. Existing law authorizes MRMIB to take various actions with respect to MRMIP, including determining the eligibility of applicants. Existing law affords dissatisfied subscribers a right to appeal and requires hearings to be conducted pursuant to specified procedures. Existing law creates the Major Risk Medical Insurance Fund as a continuously appropriated fund for purposes of MRMIP and requires that specified amounts from the Cigarette and Tobacco Products Surtax Fund (Surtax Fund) be deposited in the fund.

This bill would authorize DHCS to establish eligibility criteria for MRMIP and would authorize DHCS to implement that authority by means of plan letters, plan or provider bulletins, or similar instructions. The bill would authorize hearings regarding subscriber grievances to be conducted pursuant to specified procedures. The bill would continue the Major Risk Medical Insurance Fund in existence to be administered by DHCS for purposes of MRMIP, would eliminate the required deposits from the Surtax Fund, and instead authorize funds to be deposited in the fund from the Surtax Fund. The bill would require DHCS to, by August 1, 2014, establish a work group to develop a plan to utilize available Major Risk Medical Insurance Program Fund moneys, in order to provide subsidized health care coverage for individuals not eligible for or receiving comprehensive health care.

Existing law establishes the Access for Infants and Mothers (AIM) Program, administered by MRMIB. Existing law transferred the infant element of AIM to the DHCS on October 1, 2013, and entitled this program the AIM-Linked Infants Program. Existing law requires that an infant be disenrolled from the program if his or her household income exceeds 300% of the federal poverty level. In order to participate in the mother element of AIM, existing law requires that the person have a household income between 200% and 250% of the federal poverty level, unless MRMIB determines that funds are adequate to serve households above 250% of the federal poverty level. Existing law authorizes MRMIB to determine subscriber contribution amount schedules and requires that the contribution not exceed 2% of the subscriber's annual gross family income.

This bill would transfer the mother element of AIM to DHCS and would rename the program, including the AIM-Linked Infants Program, the Medi-Cal Access Program. The bill would require a household income

between 208% and 317% of the federal poverty level in order to be eligible for the mother element of the program and would require that an infant be disenrolled from the program if his or her household income exceeds 317% of the federal poverty level. The bill would also require that the subscriber contribution for mothers conform with the maintenance of effort requirements under the federal Patient Protection and Affordable Care Act.

Existing law creates the County Health Initiative Matching Fund in the State Treasury, administered by MRMIB in collaboration with DHCS, for the purpose of providing matching state funds and local funds received by the fund through intergovernmental transfers to a county agency, a local initiative, or a county organized health system in order to provide health insurance coverage to certain children and adults in low-income households who do not qualify for health care benefits through the Healthy Families Program or Medi-Cal. Under existing law, a county, county agency, local initiative, or county organized health system that will provide an intergovernmental transfer may apply to MRMIB for funding to provide health care coverage to eligible children whose family income is at or below 300% or 400% of the federal poverty level, at the option of the applicant, or to eligible adults whose family income does not exceed 200% of the federal poverty level, provided that the children or adults do not qualify for the Healthy Families Program or the Medi-Cal program.

This bill would transfer the powers, purposes, responsibilities, and jurisdiction of MRMIB with respect to this fund to DHCS and would prohibit DHCS from approving any additional local entities for participation in the fund. The bill would require a local entity that was participating in the fund on March 23, 2010, to continue to participate in the fund, maintaining eligibility standards, methodologies, and procedures at least as favorable as those in effect on March 23, 2010. If a county participating in the fund on March 23, 2010, elects to cease funding the nonfederal share of program expenditures, the bill would require DHCS to administer the program within that county and would require the General Fund to provide funding amounts equal to the total nonfederal share of all expenditures incurred by DHCS in that regard. The bill would continuously appropriate money in the fund, thereby making an appropriation. The bill would eliminate the provisions authorizing funding for coverage for certain low-income adults and would authorize a county, county agency, local initiative, or county organized health system that will provide an intergovernmental transfer to apply to DHCS for funding to provide health care coverage to eligible children who are not eligible for the Medi-Cal program, the Medi-Cal Access Program, or a specified targeted low-income program and whose family income is at or below 317% or 411% of the federal poverty level, at the option of the applicant. The bill would also limit the intergovernmental transfer amount to the expenditures that would be eligible for federal financial participation. The bill would require that the state be held harmless from any federal audit disallowance and interest resulting from payments made to a participating application for a disallowed claim.

The bill would authorize DHCS to implement these MRMIB transfer provisions by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions.

(11) Existing law requires DHCS to implement mental health services relating to the care and treatment of persons with mental disorders. Existing law requires DHCS to utilize a joint state-county decisionmaking process to determine the appropriate use of state and local resources to meet the mission and goals of the state's mental health system. Existing law requires the department to use that process in, among other things, providing assistance to local mental health departments.

This bill would require DHCS to also utilize this decisionmaking process to determine the appropriate use of state and local resources to meet the mission and goals with respect to substance use disorders and to provide technical assistance to local behavioral health and substance use disorder services departments.

(12) Existing law provides that contracts awarded by various state entities, including the DHCS, for purposes of providing these services may be awarded in accordance with, or are exempt from, specified procedures governing the awarding of state contracts.

Existing law, the Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs. Existing law requires that funds be reserved, prior to making allocations from the fund, for the costs incurred by state entities, including the State Department of Public Health, in implementing the programs funded by the act, as specified. The act provides that it may be amended by the Legislature by a $\frac{2}{3}$ vote of each house as long as the amendment is consistent with and furthers the intent of the act, and that the Legislature may also clarify procedures and terms of the act by majority vote.

This bill would authorize contracts awarded by the State Department of Public Health for purposes of providing mental health services, as specified, to be awarded in accordance with, and exempt those contracts from, specified procedures governing the awarding of state contracts. The bill would also make technical changes. The bill would state the findings and declarations of the Legislature that these changes clarify procedures and terms of the act.

(13) Existing law provides for the Medi-Cal program, which is administered by the DHCS, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing federal law provides for the federal Medicare Program, which is a public health insurance program for persons 65 years of age and older and specified persons with disabilities who are under 65 years of age.

This bill would exclude from reimbursement under Medi-Cal any increase in the amount charged to the Medi-Cal program for patient care or treatment

that is directly related to an identifiable provider-preventable condition, as prescribed.

(14) Under existing law, 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 limit the premium and cost-sharing payments the department would make under those provisions to the amount necessary to pay for the 2nd lowest cost silver plan in the Exchange and would require the department to consult with various entities in the development and implementation of specified processes, procedures, and notices for purposes of those provisions. The bill would require the health care service plans and health insurers providing 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, and would also prohibit those plans and insurers from charging or requiring an enrollee or insured to make any payments for any services subject to these payments. Because a willful violation of that requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The bill would also, under specified federal provisions applicable to qualified pregnant women and children, provide that a woman shall be eligible for Medi-Cal benefits if her income is less than or equal to 109% of the federal poverty level as determined, counted, and valued in accordance with federal law. The bill would also require the department to seek any state plan amendments or federal waivers necessary to provide full scope Medi-Cal benefits to pregnant women during their pregnancy and for 60 days thereafter for women whose income is over 109% of, and is up to and including 138% of, the federal poverty level. The bill would require these women to enroll in a Medi-Cal managed care plan in the counties in which one is available, to the extent permitted by state and federal law.

The bill would, after the department determines that the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) has been programmed for implementation of these provisions, but no sooner than January 1, 2015, require the department 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 and also opt to enroll in Medi-Cal. The bill would, except as provided, require the department to provide specified benefits and pay the beneficiary's insurance 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. The bill would require the department to consult with various entities in developing specified processes, procedures, and notices for purposes of these provisions. The bill would authorize the department to contract with public and private entities to implement these provisions for purposes of these provisions and would make those contracts exempt from specified public contracting requirements. The 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 and would also prohibit those plans and insurers from charging or requiring an enrollee or insured to make any payments for any services subject to these payments. Because a willful violation of that provision by a health care service plan would be a crime, this bill would impose a state-mandated local program.

(15) Existing law authorizes the DHCS to enter into nonexclusive contracts to arrange for the administration and disbursement of funds to Medi-Cal providers or to their designated agents in consideration for services rendered and supplies furnished, as prescribed.

This bill would, except as specified, exempt any contract amendments, modifications, or change orders to a fiscal intermediary contract entered into by the department pursuant to this authorization from certain provisions of the Public Contract Code.

(16) Existing law requires the DHCS to screen Medi-Cal providers and designate each provider as "limited," "moderate," or "high" categorical risk. Existing law requires the State Department of Health Care Services to conduct a criminal background check of all providers designated as a "high" categorical risk.

This bill would require a provider or applicant designated as a "high" categorical risk to submit to the Department of Justice fingerprint images and related information for the purpose of obtaining information as to the existence of past criminal conduct, as specified. The bill would require the Department of Justice to request specified information from the Federal Bureau of Investigation with respect to a provider's past criminal conduct, and to review and provide this information to DHCS. The bill would require the Department of Justice to charge a fee, to be paid by the applicant or provider, sufficient to cover the cost of processing the criminal background check request.

(17) Existing law requires DHCS to seek federal approval pursuant to a Medicare or a Medicaid demonstration project or waiver, or a combination thereof, to establish a demonstration project that enables beneficiaries dually eligible for the Medi-Cal program and the Medicare Program to receive a continuum of services that maximizes access to, and coordination of, benefits between the programs. Existing law requires, with some exceptions, DHCS to enroll dual eligible beneficiaries into a managed care plan that is selected to participate in the demonstration project unless the beneficiary makes an affirmative choice to opt out of enrollment or is already enrolled in a

specified managed care organization on or before June 1, 2013. Existing law requires DHCS, for the 2013 and 2014 calendar years, to comply with certain requirements with respect to offering contracts to Medicare Advantage Dual Special Needs Plans (D-SNP plans) and the application of the above-mentioned enrollment provisions to beneficiaries in Medicare Advantage and D-SNP plans.

This bill would, for the 2015 calendar year and the remainder of the demonstration project, authorize DHCS to offer D-SNP contracts, as defined, in non-Coordinated Care Initiative counties to D-SNP plans. The bill would, in Coordinated Care Initiative counties, authorize DHCS to offer the contracts to D-SNP plans approved for the plans' service areas on January 1, 2013, and only for specified beneficiaries. The bill would also make related changes to the application of the above-mentioned enrollment provisions for the 2015 calendar year and the remainder of the demonstration project.

(18) Existing law requires DHCS to establish a list of performance measures to ensure dental health plans meet quality criteria required by DHCS. Existing law requires DHCS to post, on a quarterly basis, the list of performance measures and each plan's performance on the DHCS Internet Web site.

This bill would require DHCS, in consultation with stakeholders, to establish a list of performance measures to ensure the dental fee-for-service program meets quality and access criteria required by DHCS. The bill would require DHCS, commencing October 1, 2014, for the 2013 calendar year, and annually on or before October 1 for each preceding calendar year thereafter, to post the list of performance measures along with the data of the dental fee-for-service program performance on the DHCS Internet Web site. The bill would also require DHCS to annually prepare and post on its Internet Web site, as specified, a summary report of the nature and types of complaints and grievances regarding access to, and quality of, dental services, including the outcome.

(19) Existing law requires DHCS to establish and maintain a plan, known as the County Administrative Cost Control Plan, for the purpose of effectively controlling costs related to the county administration of the determination of eligibility for benefits under the Medi-Cal program within the amounts annually appropriated for that administration.

Under existing law, the Legislature 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. Existing law further provides that it is the intent of the Legislature to provide appropriate funding to the counties for the effectual administration of the Medi-Cal program, except that it is the intent of the Legislature to not appropriate money for a cost-of-doing-business adjustment for specified fiscal years.

This bill would additionally provide that it is the intent of the Legislature to not appropriate funds for the cost-of-doing-business adjustment for the 2014–15 fiscal year.

(20) Existing law requires Medi-Cal funding to be made available for a new hospital, as defined, that is a nonprofit entity that serves the population of South Los Angeles formerly served by the Los Angeles County Martin Luther King Jr.-Harbor Hospital, as prescribed.

This bill would modify those funding provisions for the new hospital as they relate to Medi-Cal payments for hospital services and certain supplemental payments.

(21) Existing federal law provides for the federal Supplemental Nutrition Assistance Program, formerly the Food Stamp Program, under which nutrition assistance benefits are allocated to each state by the federal government. Existing federal law also provides for the Supplemental Nutrition Assistance Program Education (SNAP-Ed) program for purposes of nutrition education and obesity prevention grant programs.

Existing law requires the State Department of Public Health to investigate and apply for federal funding opportunities regarding promoting healthy eating and preventing obesity, including those available under federal law, as specified. Existing law requires the department to, upon receipt of federal funding regarding healthy eating and preventing obesity, provide in-kind support and award grants to support local assistance to local governments, nonprofit organizations, and local education agencies.

Between July 1, 2014, and October 31, 2015, inclusive, this bill would require the State Department of Public Health to convene a quarterly meeting of stakeholders to solicit input and receive feedback on nutrition education and obesity prevention, and to help minimize disruption to services in the SNAP-Ed program during a specified transition period.

(22) This bill would require DHCS to, by August 1, 2014, work with stakeholders to develop a notice to be sent or made available to individuals enrolled in a state health care program administered by DHCS that does not provide minimum essential coverage who, as determined by DHCS, may be eligible for Medi-Cal or coverage through the California Health Benefit Exchange.

(23) This bill would require the State Department of Public Health to report to the fiscal and appropriate policy committees of the Legislature and post on its Internet Web site various reports, including, among others, specified workload and performance metrics and updates that relate to the State Department of Public Health's Licensing and Certification Program. The bill would require the State Department of Public Health to hold semiannual stakeholder meetings for all interested stakeholders to provide feedback on improving the program.

(24) This bill would also reappropriate the balance of a specified appropriation made in the Budget Act of 2011 to the Mental Health Services Oversight and Accountability Commission and would make those funds available for encumbrance until June 30, 2015.

(25) Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

(26) 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.

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

Appropriation: yes.

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

SECTION 1. Section 56.36 of the Civil Code is amended to read:

56.36. (a) Any violation of the provisions of this part that results in economic loss or personal injury to a patient is punishable as a misdemeanor.

(b) In addition to any other remedies available at law, any individual may bring an action against any person or entity who has negligently released confidential information or records concerning him or her in violation of this part, for either or both of the following:

(1) Except as provided in subdivision (e), nominal damages of one thousand dollars ($1,000). In order to recover under this paragraph, it shall not be necessary that the plaintiff suffered or was threatened with actual damages.

(2) The amount of actual damages, if any, sustained by the patient.

(c) (1) In addition, any person or entity that negligently discloses medical information in violation of the provisions of this part shall also be liable, irrespective of the amount of damages suffered by the patient as a result of that violation, for an administrative fine or civil penalty not to exceed two thousand five hundred dollars ($2,500) per violation.

(2) (A) Any person or entity, other than a licensed health care professional, who knowingly and willfully obtains, discloses, or uses medical information in violation of this part shall be liable for an administrative fine or civil penalty not to exceed twenty-five thousand dollars ($25,000) per violation.

(B) Any licensed health care professional, who knowingly and willfully obtains, discloses, or uses medical information in violation of this part shall be liable on a first violation, for an administrative fine or civil penalty not to exceed two thousand five hundred dollars ($2,500) per violation, or on a second violation for an administrative fine or civil penalty not to exceed ten thousand dollars ($10,000) per violation, or on a third and subsequent violation for an administrative fine or civil penalty not to exceed twenty-five thousand dollars ($25,000) per violation. Nothing in this subdivision shall

be construed to limit the liability of a health care service plan, a contractor, or a provider of health care that is not a licensed health care professional for any violation of this part.

(3) (A) Any person or entity, other than a licensed health care professional, who knowingly or willfully obtains or uses medical information in violation of this part for the purpose of financial gain shall be liable for an administrative fine or civil penalty not to exceed two hundred fifty thousand dollars ($250,000) per violation and shall also be subject to disgorgement of any proceeds or other consideration obtained as a result of the violation.

(B) Any licensed health care professional, who knowingly and willfully obtains, discloses, or uses medical information in violation of this part for financial gain shall be liable on a first violation, for an administrative fine or civil penalty not to exceed five thousand dollars ($5,000) per violation, or on a second violation for an administrative fine or civil penalty not to exceed twenty-five thousand dollars ($25,000) per violation, or on a third and subsequent violation for an administrative fine or civil penalty not to exceed two hundred fifty thousand dollars ($250,000) per violation and shall also be subject to disgorgement of any proceeds or other consideration obtained as a result of the violation. Nothing in this subdivision shall be construed to limit the liability of a health care service plan, a contractor, or a provider of health care that is not a licensed health care professional for any violation of this part.

(4) Nothing in this subdivision shall be construed as authorizing an administrative fine or civil penalty under both paragraphs (2) and (3) for the same violation.

(5) Any person or entity who is not permitted to receive medical information pursuant to this part and who knowingly and willfully obtains, discloses, or uses medical information without written authorization from the patient shall be liable for a civil penalty not to exceed two hundred fifty thousand dollars ($250,000) per violation.

(d) In assessing the amount of an administrative fine or civil penalty pursuant to subdivision (c), the State Department of Public Health, licensing agency, or certifying board or court shall consider any one or more of the relevant circumstances presented by any of the parties to the case including, but not limited to, the following:

(1) Whether the defendant has made a reasonable, good faith attempt to comply with this part.

(2) The nature and seriousness of the misconduct.

(3) The harm to the patient, enrollee, or subscriber.

(4) The number of violations.

(5) The persistence of the misconduct.

(6) The length of time over which the misconduct occurred.

(7) The willfulness of the defendant’s misconduct.

(8) The defendant’s assets, liabilities, and net worth.

(e) (1) In an action brought by an individual pursuant to subdivision (b) on or after January 1, 2013, in which the defendant establishes the affirmative

defense in paragraph (2), the court shall award any actual damages and reasonable attorney's fees and costs, but may not award nominal damages for a violation of this part.

(2) The defendant is entitled to an affirmative defense if all of the following are established, subject to the equitable considerations in paragraph (3):

(A) The defendant is a covered entity or business associate, as defined in Section 160.103 of Title 45 of the Code of Federal Regulations, in effect as of January 1, 2012.

(B) The defendant has complied with any obligations to notify all persons entitled to receive notice regarding the release of the information or records.

(C) The release of confidential information or records was solely to another covered entity or business associate.

(D) The release of confidential information or records was not an incident of medical identity theft. For purposes of this subparagraph, "medical identity theft" means the use of an individual's personal information, as defined in Section 1798.80, without the individual's knowledge or consent, to obtain medical goods or services, or to submit false claims for medical services.

(E) The defendant took appropriate preventive actions to protect the confidential information or records against release consistent with the defendant's obligations under this part or other applicable state law and the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) (HIPAA) and all HIPAA Administrative Simplification Regulations in effect on January 1, 2012, contained in Parts 160, 162, and 164 of Title 45 of the Code of Federal Regulations and Part 2 of Title 42 of the Code of Federal Regulations, including, but not limited to:

(i) Developing and implementing security policies and procedures.

(ii) Designating a security official who is responsible for developing and implementing its security policies and procedures, including educating and training the workforce.

(iii) Encrypting the information or records, and protecting against the release or use of the encryption key and passwords, or transmitting the information or records in a manner designed to provide equal or greater protections against improper disclosures.

(F) The defendant took reasonable and appropriate corrective action after the release of the confidential information or records, and the covered entity or business associate that received the confidential information or records destroyed or returned the confidential information or records in the most expedient time possible and without unreasonable delay, consistent with any measures necessary to determine the scope of the breach and restore the reasonable integrity of the data system. A court may consider this subparagraph to be established if the defendant shows in detail that the covered entity or business associate could not destroy or return the confidential information or records because of the technology utilized.

(G) The covered entity or business associate that received the confidential information or records, or any of its agents, independent contractors, or

employees, regardless of the scope of the employee's employment, did not retain, use, or release the information or records.

(H) After the release of the confidential information or records, the defendant took reasonable and appropriate action to prevent a future similar release of confidential information or records.

(I) The defendant has not previously established an affirmative defense pursuant to this subdivision, or the court determines, in its discretion, that application of the affirmative defense is compelling and consistent with the purposes of this section to promote reasonable conduct in light of all the facts.

(3) (A) In determining whether the affirmative defense may be established pursuant to paragraph (2), the court shall consider the equity of the situation, including, but not limited to, (i) whether the defendant has previously violated this part, regardless of whether an action has previously been brought, and (ii) the nature of the prior violation.

(B) To the extent the court allows discovery to determine whether there has been any other violation of this part that the court will consider in balancing the equities, the defendant shall not provide any medical information, as defined in Section 56.05. The court, in its discretion, may enter a protective order prohibiting the further use of any personal information, as defined in Section 1798.80, about the individual whose medical information may have been disclosed in a prior violation.

(4) In an action under this subdivision in which the defendant establishes the affirmative defense pursuant to paragraph (2), a plaintiff shall be entitled to recover reasonable attorney's fees and costs without regard to an award of actual or nominal damages or the imposition of administrative fines or civil penalties.

(5) In an action brought by an individual pursuant to subdivision (b) on or after January 1, 2013, in which the defendant establishes the affirmative defense pursuant to paragraph (2), a defendant shall not be liable for more than one judgment on the merits under this subdivision for releases of confidential information or records arising out of the same event, transaction, or occurrence.

(f) (1) The civil penalty pursuant to subdivision (c) shall be assessed and recovered in a civil action brought in the name of the people of the State of California in any court of competent jurisdiction by any of the following:

(A) The Attorney General.

(B) Any district attorney.

(C) Any county counsel authorized by agreement with the district attorney in actions involving violation of a county ordinance.

(D) Any city attorney of a city.

(E) Any city attorney of a city and county having a population in excess of 750,000, with the consent of the district attorney.

(F) A city prosecutor in any city having a full-time city prosecutor or, with the consent of the district attorney, by a city attorney in any city and county.

(G) The State Public Health Officer, or his or her designee, may recommend that any person described in subparagraphs (A) to (F), inclusive, bring a civil action under this section.

(2) If the action is brought by the Attorney General, one-half of the penalty collected shall be paid to the treasurer of the county in which the judgment was entered, and one-half to the General Fund. If the action is brought by a district attorney or county counsel, the penalty collected shall be paid to the treasurer of the county in which the judgment was entered. Except as provided in paragraph (3), if the action is brought by a city attorney or city prosecutor, one-half of the penalty collected shall be paid to the treasurer of the city in which the judgment was entered and one-half to the treasurer of the county in which the judgment was entered.

(3) If the action is brought by a city attorney of a city and county, the entire amount of the penalty collected shall be paid to the treasurer of the city and county in which the judgment was entered.

(4) Nothing in this section shall be construed as authorizing both an administrative fine and civil penalty for the same violation.

(5) Imposition of a fine or penalty provided for in this section shall not preclude imposition of any other sanctions or remedies authorized by law.

(6) Administrative fines or penalties issued pursuant to Section 1280.15 of the Health and Safety Code shall offset any other administrative fine or civil penalty imposed under this section for the same violation.

(g) For purposes of this section, "knowing" and "willful" shall have the same meanings as in Section 7 of the Penal Code.

(h) No person who discloses protected medical information in accordance with the provisions of this part shall be subject to the penalty provisions of this part.

SEC. 2. Section 6254 of the Government Code is amended to read:

6254. Except as provided in Sections 6254.7 and 6254.13, this chapter does not require the disclosure of any of the following records:

(a) Preliminary drafts, notes, or interagency or intra-agency memoranda that are not retained by the public agency in the ordinary course of business, if the public interest in withholding those records clearly outweighs the public interest in disclosure.

(b) Records pertaining to pending litigation to which the public agency is a party, or to claims made pursuant to Division 3.6 (commencing with Section 810), until the pending litigation or claim has been finally adjudicated or otherwise settled.

(c) Personnel, medical, or similar files, the disclosure of which would constitute an unwarranted invasion of personal privacy.

(d) Contained in or related to any of the following:

(1) Applications filed with any state agency responsible for the regulation or supervision of the issuance of securities or of financial institutions, including, but not limited to, banks, savings and loan associations, industrial loan companies, credit unions, and insurance companies.

(2) Examination, operating, or condition reports prepared by, on behalf of, or for the use of, any state agency referred to in paragraph (1).

(3) Preliminary drafts, notes, or interagency or intra-agency communications prepared by, on behalf of, or for the use of, any state agency referred to in paragraph (1).

(4) Information received in confidence by any state agency referred to in paragraph (1).

(e) Geological and geophysical data, plant production data, and similar information relating to utility systems development, or market or crop reports, that are obtained in confidence from any person.

(f) Records of complaints to, or investigations conducted by, or records of intelligence information or security procedures of, the office of the Attorney General and the Department of Justice, the Office of Emergency Services and any state or local police agency, or any investigatory or security files compiled by any other state or local police agency, or any investigatory or security files compiled by any other state or local agency for correctional, law enforcement, or licensing purposes. However, state and local law enforcement agencies shall disclose the names and addresses of persons involved in, or witnesses other than confidential informants to, the incident, the description of any property involved, the date, time, and location of the incident, all diagrams, statements of the parties involved in the incident, the statements of all witnesses, other than confidential informants, to the victims of an incident, or an authorized representative thereof, an insurance carrier against which a claim has been or might be made, and any person suffering bodily injury or property damage or loss, as the result of the incident caused by arson, burglary, fire, explosion, larceny, robbery, carjacking, vandalism, vehicle theft, or a crime as defined by subdivision (b) of Section 13951, unless the disclosure would endanger the safety of a witness or other person involved in the investigation, or unless disclosure would endanger the successful completion of the investigation or a related investigation. However, nothing in this division shall require the disclosure of that portion of those investigative files that reflects the analysis or conclusions of the investigating officer.

Customer lists provided to a state or local police agency by an alarm or security company at the request of the agency shall be construed to be records subject to this subdivision.

Notwithstanding any other provision of this subdivision, state and local law enforcement agencies shall make public the following information, except to the extent that disclosure of a particular item of information would endanger the safety of a person involved in an investigation or would endanger the successful completion of the investigation or a related investigation:

(1) The full name and occupation of every individual arrested by the agency, the individual's physical description including date of birth, color of eyes and hair, sex, height and weight, the time and date of arrest, the time and date of booking, the location of the arrest, the factual circumstances surrounding the arrest, the amount of bail set, the time and manner of release or the location where the individual is currently being held, and all charges

the individual is being held upon, including any outstanding warrants from other jurisdictions and parole or probation holds.

(2) Subject to the restrictions imposed by Section 841.5 of the Penal Code, the time, substance, and location of all complaints or requests for assistance received by the agency and the time and nature of the response thereto, including, to the extent the information regarding crimes alleged or committed or any other incident investigated is recorded, the time, date, and location of occurrence, the time and date of the report, the name and age of the victim, the factual circumstances surrounding the crime or incident, and a general description of any injuries, property, or weapons involved. The name of a victim of any crime defined by Section 220, 236.1, 261, 261.5, 262, 264, 264.1, 265, 266, 266a, 266b, 266c, 266e, 266f, 266j, 267, 269, 273a, 273d, 273.5, 285, 286, 288, 288a, 288.2, 288.3 (as added by Chapter 337 of the Statutes of 2006), 288.3 (as added by Section 6 of Proposition 83 of the November 7, 2006, statewide general election), 288.5, 288.7, 289, 422.6, 422.7, 422.75, 646.9, or 647.6 of the Penal Code may be withheld at the victim's request, or at the request of the victim's parent or guardian if the victim is a minor. When a person is the victim of more than one crime, information disclosing that the person is a victim of a crime defined in any of the sections of the Penal Code set forth in this subdivision may be deleted at the request of the victim, or the victim's parent or guardian if the victim is a minor, in making the report of the crime, or of any crime or incident accompanying the crime, available to the public in compliance with the requirements of this paragraph.

(3) Subject to the restrictions of Section 841.5 of the Penal Code and this subdivision, the current address of every individual arrested by the agency and the current address of the victim of a crime, where the requester declares under penalty of perjury that the request is made for a scholarly, journalistic, political, or governmental purpose, or that the request is made for investigation purposes by a licensed private investigator as described in Chapter 11.3 (commencing with Section 7512) of Division 3 of the Business and Professions Code. However, the address of the victim of any crime defined by Section 220, 236.1, 261, 261.5, 262, 264, 264.1, 265, 266, 266a, 266b, 266c, 266e, 266f, 266j, 267, 269, 273a, 273d, 273.5, 285, 286, 288, 288a, 288.2, 288.3 (as added by Chapter 337 of the Statutes of 2006), 288.3 (as added by Section 6 of Proposition 83 of the November 7, 2006, statewide general election), 288.5, 288.7, 289, 422.6, 422.7, 422.75, 646.9, or 647.6 of the Penal Code shall remain confidential. Address information obtained pursuant to this paragraph may not be used directly or indirectly, or furnished to another, to sell a product or service to any individual or group of individuals, and the requester shall execute a declaration to that effect under penalty of perjury. Nothing in this paragraph shall be construed to prohibit or limit a scholarly, journalistic, political, or government use of address information obtained pursuant to this paragraph.

(g) Test questions, scoring keys, and other examination data used to administer a licensing examination, examination for employment, or academic examination, except as provided for in Chapter 3 (commencing

with Section 99150) of Part 65 of Division 14 of Title 3 of the Education Code.

(h) The contents of real estate appraisals or engineering or feasibility estimates and evaluations made for or by the state or local agency relative to the acquisition of property, or to prospective public supply and construction contracts, until all of the property has been acquired or all of the contract agreement obtained. However, the law of eminent domain shall not be affected by this provision.

(i) Information required from any taxpayer in connection with the collection of local taxes that is received in confidence and the disclosure of the information to other persons would result in unfair competitive disadvantage to the person supplying the information.

(j) Library circulation records kept for the purpose of identifying the borrower of items available in libraries, and library and museum materials made or acquired and presented solely for reference or exhibition purposes. The exemption in this subdivision shall not apply to records of fines imposed on the borrowers.

(k) Records, the disclosure of which is exempted or prohibited pursuant to federal or state law, including, but not limited to, provisions of the Evidence Code relating to privilege.

(*l*) Correspondence of and to the Governor or employees of the Governor's office or in the custody of or maintained by the Governor's Legal Affairs Secretary. However, public records shall not be transferred to the custody of the Governor's Legal Affairs Secretary to evade the disclosure provisions of this chapter.

(m) In the custody of or maintained by the Legislative Counsel, except those records in the public database maintained by the Legislative Counsel that are described in Section 10248.

(n) Statements of personal worth or personal financial data required by a licensing agency and filed by an applicant with the licensing agency to establish his or her personal qualification for the license, certificate, or permit applied for.

(o) Financial data contained in applications for financing under Division 27 (commencing with Section 44500) of the Health and Safety Code, where an authorized officer of the California Pollution Control Financing Authority determines that disclosure of the financial data would be competitively injurious to the applicant and the data is required in order to obtain guarantees from the United States Small Business Administration. The California Pollution Control Financing Authority shall adopt rules for review of individual requests for confidentiality under this section and for making available to the public those portions of an application that are subject to disclosure under this chapter.

(p) Records of state agencies related to activities governed by Chapter 10.3 (commencing with Section 3512), Chapter 10.5 (commencing with Section 3525), and Chapter 12 (commencing with Section 3560) of Division 4, that reveal a state agency's deliberative processes, impressions, evaluations, opinions, recommendations, meeting minutes, research, work

products, theories, or strategy, or that provide instruction, advice, or training to employees who do not have full collective bargaining and representation rights under these chapters. Nothing in this subdivision shall be construed to limit the disclosure duties of a state agency with respect to any other records relating to the activities governed by the employee relations acts referred to in this subdivision.

(q) (1) Records of state agencies related to activities governed by Article 2.6 (commencing with Section 14081), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, that reveal the special negotiator's deliberative processes, discussions, communications, or any other portion of the negotiations with providers of health care services, impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy, or that provide instruction, advice, or training to employees.

(2) Except for the portion of a contract containing the rates of payment, contracts for inpatient services entered into pursuant to these articles, on or after April 1, 1984, shall be open to inspection one year after they are fully executed. If a contract for inpatient services that is entered into prior to April 1, 1984, is amended on or after April 1, 1984, the amendment, except for any portion containing the rates of payment, shall be open to inspection one year after it is fully executed. If the California Medical Assistance Commission enters into contracts with health care providers for other than inpatient hospital services, those contracts shall be open to inspection one year after they are fully executed.

(3) Three years after a contract or amendment is open to inspection under this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(4) Notwithstanding any other law, the entire contract or amendment shall be open to inspection by the Joint Legislative Audit Committee and the Legislative Analyst's Office. The committee and that office shall maintain the confidentiality of the contracts and amendments until the time a contract or amendment is fully open to inspection by the public.

(r) Records of Native American graves, cemeteries, and sacred places and records of Native American places, features, and objects described in Sections 5097.9 and 5097.993 of the Public Resources Code maintained by, or in the possession of, the Native American Heritage Commission, another state agency, or a local agency.

(s) A final accreditation report of the Joint Commission on Accreditation of Hospitals that has been transmitted to the State Department of Health Care Services pursuant to subdivision (b) of Section 1282 of the Health and Safety Code.

(t) Records of a local hospital district, formed pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code, or the records of a municipal hospital, formed pursuant to Article 7 (commencing with Section 37600) or Article 8 (commencing with Section 37650) of Chapter 5 of Part 2 of Division 3 of Title 4 of this code, that relate to any

contract with an insurer or nonprofit hospital service plan for inpatient or outpatient services for alternative rates pursuant to Section 10133 of the Insurance Code. However, the record shall be open to inspection within one year after the contract is fully executed.

(u) (1) Information contained in applications for licenses to carry firearms issued pursuant to Section 26150, 26155, 26170, or 26215 of the Penal Code by the sheriff of a county or the chief or other head of a municipal police department that indicates when or where the applicant is vulnerable to attack or that concerns the applicant's medical or psychological history or that of members of his or her family.

(2) The home address and telephone number of prosecutors, public defenders, peace officers, judges, court commissioners, and magistrates that are set forth in applications for licenses to carry firearms issued pursuant to Section 26150, 26155, 26170, or 26215 of the Penal Code by the sheriff of a county or the chief or other head of a municipal police department.

(3) The home address and telephone number of prosecutors, public defenders, peace officers, judges, court commissioners, and magistrates that are set forth in licenses to carry firearms issued pursuant to Section 26150, 26155, 26170, or 26215 of the Penal Code by the sheriff of a county or the chief or other head of a municipal police department.

(v) (1) Records of the Managed Risk Medical Insurance Board and the State Department of Health Care Services related to activities governed by Part 6.3 (commencing with Section 12695), Part 6.5 (commencing with Section 12700), Part 6.6 (commencing with Section 12739.5), or Part 6.7 (commencing with Section 12739.70) of Division 2 of the Insurance Code, or Chapter 2 (commencing with Section 15810) or Chapter 4 (commencing with Section 15870) of Part 3.3 of Division 9 of the Welfare and Institutions Code, and that reveal any of the following:

(A) The deliberative processes, discussions, communications, or any other portion of the negotiations with entities contracting or seeking to contract with the board or the department, entities with which the board or the department is considering a contract, or entities with which the board or department is considering or enters into any other arrangement under which the board or the department provides, receives, or arranges services or reimbursement.

(B) The impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff or the department or its staff, or records that provide instructions, advice, or training to their employees.

(2) (A) Except for the portion of a contract that contains the rates of payment, contracts entered into pursuant to Part 6.3 (commencing with Section 12695), Part 6.5 (commencing with Section 12700), Part 6.6 (commencing with Section 12739.5), or Part 6.7 (commencing with Section 12739.70) of Division 2 of the Insurance Code, or Chapter 2 (commencing with Section 15810) or Chapter 4 (commencing with Section 15870) of Part 3.3 of Division 9 of the Welfare and Institutions Code, on or after July 1, 1991, shall be open to inspection one year after their effective dates.

(B) If a contract that is entered into prior to July 1, 1991, is amended on or after July 1, 1991, the amendment, except for any portion containing the rates of payment, shall be open to inspection one year after the effective date of the amendment.

(3) Three years after a contract or amendment is open to inspection pursuant to this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(4) Notwithstanding any other law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto, until the contracts or amendments to the contracts are open to inspection pursuant to paragraph (3).

(w) (1) Records of the Managed Risk Medical Insurance Board related to activities governed by Chapter 8 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

(2) Except for the portion of a contract that contains the rates of payment, contracts for health coverage entered into pursuant to Chapter 8 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, on or after January 1, 1993, shall be open to inspection one year after they have been fully executed.

(3) Notwithstanding any other law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto, until the contracts or amendments to the contracts are open to inspection pursuant to paragraph (2).

(x) Financial data contained in applications for registration, or registration renewal, as a service contractor filed with the Director of Consumer Affairs pursuant to Chapter 20 (commencing with Section 9800) of Division 3 of the Business and Professions Code, for the purpose of establishing the service contractor's net worth, or financial data regarding the funded accounts held in escrow for service contracts held in force in this state by a service contractor.

(y) (1) Records of the Managed Risk Medical Insurance Board and the State Department of Health Care Services related to activities governed by Part 6.2 (commencing with Section 12693) or Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code or Sections 14005.26 and 14005.27 of, or Chapter 3 (commencing with Section 15850) of Part 3.3 of Division 9 of, the Welfare and Institutions Code, if the records reveal any of the following:

(A) The deliberative processes, discussions, communications, or any other portion of the negotiations with entities contracting or seeking to contract with the board or the department, entities with which the board or

department is considering a contract, or entities with which the board or department is considering or enters into any other arrangement under which the board or department provides, receives, or arranges services or reimbursement.

(B) The impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or the department or its staff, or records that provide instructions, advice, or training to employees.

(2) (A) Except for the portion of a contract that contains the rates of payment, contracts entered into pursuant to Part 6.2 (commencing with Section 12693) or Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code, on or after January 1, 1998, or Sections 14005.26 and 14005.27 of, or Chapter 3 (commencing with Section 15850) of Part 3.3 of Division 9 of, the Welfare and Institutions Code shall be open to inspection one year after their effective dates.

(B) If a contract entered into pursuant to Part 6.2 (commencing with Section 12693) or Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code or Sections 14005.26 and 14005.27 of, or Chapter 3 (commencing with Section 15850) of Part 3.3 of Division 9 of, the Welfare and Institutions Code, is amended, the amendment shall be open to inspection one year after the effective date of the amendment.

(3) Three years after a contract or amendment is open to inspection pursuant to this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(4) Notwithstanding any other law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto until the contract or amendments to a contract are open to inspection pursuant to paragraph (2) or (3).

(5) The exemption from disclosure provided pursuant to this subdivision for the contracts, deliberative processes, discussions, communications, negotiations, impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or the department or its staff, shall also apply to the contracts, deliberative processes, discussions, communications, negotiations, impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of applicants pursuant to Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code or Chapter 3 (commencing with Section 15850) of Part 3.3 of Division 9 of the Welfare and Institutions Code.

(z) Records obtained pursuant to paragraph (2) of subdivision (f) of Section 2891.1 of the Public Utilities Code.

(aa) A document prepared by or for a state or local agency that assesses its vulnerability to terrorist attack or other criminal acts intended to disrupt the public agency’s operations and that is for distribution or consideration in a closed session.

(ab) Critical infrastructure information, as defined in Section 131(3) of Title 6 of the United States Code, that is voluntarily submitted to the California Emergency Management Agency for use by that office, including the identity of the person who or entity that voluntarily submitted the information. As used in this subdivision, "voluntarily submitted" means submitted in the absence of the office exercising any legal authority to compel access to or submission of critical infrastructure information. This subdivision shall not affect the status of information in the possession of any other state or local governmental agency.

(ac) All information provided to the Secretary of State by a person for the purpose of registration in the Advance Health Care Directive Registry, except that those records shall be released at the request of a health care provider, a public guardian, or the registrant's legal representative.

(ad) The following records of the State Compensation Insurance Fund:

(1) Records related to claims pursuant to Chapter 1 (commencing with Section 3200) of Division 4 of the Labor Code, to the extent that confidential medical information or other individually identifiable information would be disclosed.

(2) Records related to the discussions, communications, or any other portion of the negotiations with entities contracting or seeking to contract with the fund, and any related deliberations.

(3) Records related to the impressions, opinions, recommendations, meeting minutes of meetings or sessions that are lawfully closed to the public, research, work product, theories, or strategy of the fund or its staff, on the development of rates, contracting strategy, underwriting, or competitive strategy pursuant to the powers granted to the fund in Chapter 4 (commencing with Section 11770) of Part 3 of Division 2 of the Insurance Code.

(4) Records obtained to provide workers' compensation insurance under Chapter 4 (commencing with Section 11770) of Part 3 of Division 2 of the Insurance Code, including, but not limited to, any medical claims information, policyholder information provided that nothing in this paragraph shall be interpreted to prevent an insurance agent or broker from obtaining proprietary information or other information authorized by law to be obtained by the agent or broker, and information on rates, pricing, and claims handling received from brokers.

(5) (A) Records that are trade secrets pursuant to Section 6276.44, or Article 11 (commencing with Section 1060) of Chapter 4 of Division 8 of the Evidence Code, including without limitation, instructions, advice, or training provided by the State Compensation Insurance Fund to its board members, officers, and employees regarding the fund's special investigation unit, internal audit unit, and informational security, marketing, rating, pricing, underwriting, claims handling, audits, and collections.

(B) Notwithstanding subparagraph (A), the portions of records containing trade secrets shall be available for review by the Joint Legislative Audit Committee, the Bureau of State Audits, Division of Workers' Compensation, and the Department of Insurance to ensure compliance with applicable law.

(6) (A) Internal audits containing proprietary information and the following records that are related to an internal audit:

(i) Personal papers and correspondence of any person providing assistance to the fund when that person has requested in writing that his or her papers and correspondence be kept private and confidential. Those papers and correspondence shall become public records if the written request is withdrawn, or upon order of the fund.

(ii) Papers, correspondence, memoranda, or any substantive information pertaining to any audit not completed or an internal audit that contains proprietary information.

(B) Notwithstanding subparagraph (A), the portions of records containing proprietary information, or any information specified in subparagraph (A) shall be available for review by the Joint Legislative Audit Committee, the Bureau of State Audits, Division of Workers' Compensation, and the Department of Insurance to ensure compliance with applicable law.

(7) (A) Except as provided in subparagraph (C), contracts entered into pursuant to Chapter 4 (commencing with Section 11770) of Part 3 of Division 2 of the Insurance Code shall be open to inspection one year after the contract has been fully executed.

(B) If a contract entered into pursuant to Chapter 4 (commencing with Section 11770) of Part 3 of Division 2 of the Insurance Code is amended, the amendment shall be open to inspection one year after the amendment has been fully executed.

(C) Three years after a contract or amendment is open to inspection pursuant to this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(D) Notwithstanding any other law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto until the contract or amendments to a contract are open to inspection pursuant to this paragraph.

(E) This paragraph is not intended to apply to documents related to contracts with public entities that are not otherwise expressly confidential as to that public entity.

(F) For purposes of this paragraph, "fully executed" means the point in time when all of the necessary parties to the contract have signed the contract.

This section shall not prevent any agency from opening its records concerning the administration of the agency to public inspection, unless disclosure is otherwise prohibited by law.

This section shall not prevent any health facility from disclosing to a certified bargaining agent relevant financing information pursuant to Section 8 of the National Labor Relations Act (29 U.S.C. Sec. 158).

SEC. 3. Section 100504 of the Government Code is amended to read:

100504. (a) The board may do the following:

(1) With respect to individual coverage made available in the Exchange, collect premiums and assist in the administration of subsidies.

(2) Enter into contracts.

(3) Sue and be sued.

(4) Receive and accept gifts, grants, or donations of moneys from any agency of the United States, any agency of the state, and any municipality, county, or other political subdivision of the state.

(5) Receive and accept gifts, grants, or donations from individuals, associations, private foundations, and corporations, in compliance with the conflict of interest provisions to be adopted by the board at a public meeting.

(6) Adopt rules and regulations, as necessary. Until January 1, 2016, any necessary rules and regulations may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2). The adoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2, including subdivisions (e) and (h) of Section 11346.1, any emergency regulation adopted pursuant to this section shall not be repealed by the Office of Administrative Law until revised or repealed by the board, except that an emergency regulation adopted pursuant to this section shall be repealed by operation of law unless the adoption, amendment, or repeal of the regulation is promulgated by the board pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code within two years of the initial adoption of the emergency regulation. Notwithstanding subdivision (h) of Section 11346.1, until January 1, 2017, the Office of Administrative Law may approve more than two readoptions of an emergency regulation adopted pursuant to this section.

(7) Collaborate with the State Department of Health Care Services and the Managed Risk Medical Insurance Board, to the extent possible, to allow an individual the option to remain enrolled with his or her carrier and provider network in the event the individual experiences a loss of eligibility of premium tax credits and becomes eligible for the Medi-Cal program or the Healthy Families Program, or loses eligibility for the Medi-Cal program or the Healthy Families Program and becomes eligible for premium tax credits through the Exchange.

(8) Share information with relevant state departments, consistent with the confidentiality provisions in Section 1411 of the federal act, necessary for the administration of the Exchange.

(9) Require carriers participating in the Exchange to make available to the Exchange and regularly update an electronic directory of contracting health care providers so that individuals seeking coverage through the Exchange can search by health care provider name to determine which health plans in the Exchange include that health care provider in their network. The board may also require a carrier to provide regularly updated information to the Exchange as to whether a health care provider is accepting new patients for a particular health plan. The Exchange may provide an integrated and uniform consumer directory of health care providers indicating

which carriers the providers contract with and whether the providers are currently accepting new patients. The Exchange may also establish methods by which health care providers may transmit relevant information directly to the Exchange, rather than through a carrier.

(10) Make available supplemental coverage for enrollees of the Exchange to the extent permitted by the federal act, provided that no General Fund money is used to pay the cost of that coverage. Any supplemental coverage offered in the Exchange shall be subject to the charge imposed under subdivision (n) of Section 100503.

(b) The Exchange shall only collect information from individuals or designees of individuals necessary to administer the Exchange and consistent with the federal act.

(c) The board shall have the authority to standardize products to be offered through the Exchange.

SEC. 4. Section 1280.15 of the Health and Safety Code is amended to read:

1280.15. (a) A clinic, health facility, home health agency, or hospice licensed pursuant to Section 1204, 1250, 1725, or 1745 shall prevent unlawful or unauthorized access to, and use or disclosure of, patients' medical information, as defined in Section 56.05 of the Civil Code and consistent with Section 1280.18. For purposes of this section, internal paper records, electronic mail, or facsimile transmissions inadvertently misdirected within the same facility or health care system within the course of coordinating care or delivering services shall not constitute unauthorized access to, or use or disclosure of, a patient's medical information. The department, after investigation, may assess an administrative penalty for a violation of this section of up to twenty-five thousand dollars ($25,000) per patient whose medical information was unlawfully or without authorization accessed, used, or disclosed, and up to seventeen thousand five hundred dollars ($17,500) per subsequent occurrence of unlawful or unauthorized access, use, or disclosure of that patient's medical information. For purposes of the investigation, the department shall consider the clinic's, health facility's, agency's, or hospice's history of compliance with this section and other related state and federal statutes and regulations, the extent to which the facility detected violations and took preventative action to immediately correct and prevent past violations from recurring, and factors outside its control that restricted the facility's ability to comply with this section. The department shall have full discretion to consider all factors when determining the amount of an administrative penalty pursuant to this section.

(b) (1) A clinic, health facility, home health agency, or hospice to which subdivision (a) applies shall report any unlawful or unauthorized access to, or use or disclosure of, a patient's medical information to the department no later than five business days after the unlawful or unauthorized access, use, or disclosure has been detected by the clinic, health facility, home health agency, or hospice.

(2) Subject to subdivision (c), a clinic, health facility, home health agency, or hospice shall also report any unlawful or unauthorized access to, or use or disclosure of, a patient's medical information to the affected patient or the patient's representative at the last known address, no later than five business days after the unlawful or unauthorized access, use, or disclosure has been detected by the clinic, health facility, home health agency, or hospice.

(c) (1) A clinic, health facility, home health agency, or hospice shall delay the reporting, as required pursuant to paragraph (2) of subdivision (b), of any unlawful or unauthorized access to, or use or disclosure of, a patient's medical information beyond five business days if a law enforcement agency or official provides the clinic, health facility, home health agency, or hospice with a written or oral statement that compliance with the reporting requirements of paragraph (2) of subdivision (b) would likely impede the law enforcement agency's investigation that relates to the unlawful or unauthorized access to, and use or disclosure of, a patient's medical information and specifies a date upon which the delay shall end, not to exceed 60 days after a written request is made, or 30 days after an oral request is made. A law enforcement agency or official may request an extension of a delay based upon a written declaration that there exists a bona fide, ongoing, significant criminal investigation of serious wrongdoing relating to the unlawful or unauthorized access to, and use or disclosure of, a patient's medical information, that notification of patients will undermine the law enforcement agency's investigation, and that specifies a date upon which the delay shall end, not to exceed 60 days after the end of the original delay period.

(2) If the statement of the law enforcement agency or official is made orally, then the clinic, health facility, home health agency, or hospice shall do both of the following:

(A) Document the oral statement, including, but not limited to, the identity of the law enforcement agency or official making the oral statement and the date upon which the oral statement was made.

(B) Limit the delay in reporting the unlawful or unauthorized access to, or use or disclosure of, the patient's medical information to the date specified in the oral statement, not to exceed 30 calendar days from the date that the oral statement is made, unless a written statement that complies with the requirements of this subdivision is received during that time.

(3) A clinic, health facility, home health agency, or hospice shall submit a report that is delayed pursuant to this subdivision not later than five business days after the date designated as the end of the delay.

(d) If a clinic, health facility, home health agency, or hospice to which subdivision (a) applies violates subdivision (b), the department may assess the licensee a penalty in the amount of one hundred dollars ($100) for each day that the unlawful or unauthorized access, use, or disclosure is not reported to the department or the affected patient, following the initial five-day period specified in subdivision (b). However, the total combined penalty assessed by the department under subdivision (a) and this subdivision

shall not exceed two hundred fifty thousand dollars ($250,000) per reported event. For enforcement purposes, it shall be presumed that the facility did not notify the affected patient if the notification was not documented. This presumption may be rebutted by a licensee only if the licensee demonstrates, by a preponderance of the evidence, that the notification was made.

(e) In enforcing subdivisions (a) and (d), the department shall take into consideration the special circumstances of small and rural hospitals, as defined in Section 124840, and primary care clinics, as defined in subdivision (a) of Section 1204, in order to protect access to quality care in those hospitals and clinics. When assessing a penalty on a skilled nursing facility or other facility subject to Section 1423, 1424, 1424.1, or 1424.5, the department shall issue only the higher of either a penalty for the violation of this section or a penalty for violation of Section 1423, 1424, 1424.1, or 1424.5, not both.

(f) All penalties collected by the department pursuant to this section, Sections 1280.1, 1280.3, and 1280.4, shall be deposited into the Internal Departmental Quality Improvement Account, which is hereby created within the Special Deposit Fund under Section 16370 of the Government Code. Upon appropriation by the Legislature, moneys in the account shall be expended for internal quality improvement activities in the Licensing and Certification Program.

(g) If the licensee disputes a determination by the department regarding a failure to prevent or failure to timely report unlawful or unauthorized access to, or use or disclosure of, patients' medical information, or the imposition of a penalty under this section, the licensee may, within 10 days of receipt of the penalty assessment, request a hearing pursuant to Section 131071. Penalties shall be paid when appeals have been exhausted and the penalty has been upheld.

(h) In lieu of disputing the determination of the department regarding a failure to prevent or failure to timely report unlawful or unauthorized access to, or use or disclosure of, patients' medical information, transmit to the department 75 percent of the total amount of the administrative penalty, for each violation, within 30 business days of receipt of the administrative penalty.

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

(1) "Reported event" means all breaches included in any single report that is made pursuant to subdivision (b), regardless of the number of breach events contained in the report.

(2) "Unauthorized" means the inappropriate access, review, or viewing of patient medical information without a direct need for medical diagnosis, treatment, or other lawful use as permitted by the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code) or any other statute or regulation governing the lawful access, use, or disclosure of medical information.

SEC. 5. Section 1341.45 of the Health and Safety Code is amended to read:

1341.45. (a) There is hereby created in the State Treasury the Managed Care Administrative Fines and Penalties Fund.

(b) The fines and administrative penalties collected pursuant to this chapter, on and after September 30, 2008, shall be deposited into the Managed Care Administrative Fines and Penalties Fund.

(c) The fines and administrative penalties deposited into the Managed Care Administrative Fines and Penalties Fund shall be transferred by the department, beginning September 1, 2009, and annually thereafter, as follows:

(1) The first one million dollars ($1,000,000) shall be transferred to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) or Chapter 5 of Part 3 of Division 107 and, notwithstanding Section 128555, shall not be used to provide funding for the Physician Volunteer Program.

(2) Any amount over the first one million dollars ($1,000,000), including accrued interest, in the fund shall be transferred to the Major Risk Medical Insurance Fund continued pursuant to Section 15893 of the Welfare and Institutions Code and shall, upon appropriation by the Legislature, be used for the Major Risk Medical Insurance Program for the purposes specified in Section 15894 of the Welfare and Institutions Code.

(d) Notwithstanding subdivision (b) of Section 1356 and Section 1356.1, the fines and administrative penalties authorized pursuant to this chapter shall not be used to reduce the assessments imposed on health care service plans pursuant to Section 1356.

(e) The amendments made to this section by the act adding this subdivision shall become operative on July 1, 2014.

SEC. 6. Section 1347.5 is added to the Health and Safety Code, to read:

1347.5. (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) A health care service plan providing individual coverage in the Exchange shall not charge, bill, ask, or require an enrollee receiving benefits under Section 14102 or Section 14148.65 of the Welfare and Institutions Code to make any premium or cost-sharing payments for any services that are subject to premium or cost-sharing payments by the State Department of Health Care Services under Section 14102 or Section 14148.65 of the Welfare and Institutions Code.

(c) 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. 7. Section 1368.05 is added to the Health and Safety Code, to read:

1368.05. (a) (1) By enacting this section, which was originally enacted by Assembly Bill 922 (Chapter 552 of the Statutes of 2011), the Legislature recognizes that, because of the enactment of federal health care reform on March 23, 2010, and the implementation of various provisions by January 1, 2014, and the ongoing complexities of health care reform, it is appropriate to transfer the direct consumer assistance activities that were newly conferred on the Office of the Patient Advocate to the Department of Managed Health Care, and the Legislature recognizes that these new duties are necessary to be carried out by the department in partnership with community-based consumer assistance organizations for the purposes of serving California's health care consumers.

(2) In addition to maintaining the toll-free telephone number for the purpose of receiving complaints regarding health care service plans as required in Section 1368.02, the department and its contractors shall carry out these new responsibilities, which include assisting consumers in navigating private and public health care coverage and assisting consumers in determining the regulator that regulates the health care coverage of a particular consumer. In order to further assist in implementing health care reform, the department and its contractors shall also receive and respond to inquiries, complaints, and requests for assistance and education concerning health care coverage available in California.

(b) (1) The department shall annually contract with community-based organizations in furtherance of providing assistance to consumers as described in subdivision (a), as authorized by and in accordance with Section 19130 of the Government Code.

(2) These organizations shall be community-based nonprofit consumer assistance programs that shall include in their mission the assistance of, and duty to, health care consumers.

(3) Contracting consumer assistance organizations shall have experience in assisting consumers in navigating the local health care system, advising consumers regarding their health care coverage options, assisting consumers with problems in accessing health care services, and serving consumers with special needs, including, but not limited to, consumers with limited-English language proficiency, consumers requiring culturally competent services, low-income consumers, consumers with disabilities, consumers with low literacy rates, and consumers with multiple health conditions, including behavioral health. The organizations shall also have experience with, and the capacity for, collecting and reporting data regarding the consumers they assist, including demographic data, source of coverage, regulator, type of problem or issue, and resolution of complaints.

SEC. 8. Section 1374.76 is added to the Health and Safety Code, immediately following Section 1374.74, to read:

1374.76. (a) No later than January 1, 2015, a large group health care service plan contract shall provide all covered mental health and substance use disorder benefits in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) and all rules, regulations, and guidance issued pursuant to

Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(b) No later than January 1, 2015, an individual or small group health care service plan contract shall provide all covered mental health and substance use disorder benefits in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26), and Section 1367.005.

(c) Until January 1, 2016, the director may issue guidance to health care service plans regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Any guidance issued pursuant to this subdivision shall be effective only until the director adopts regulations pursuant to the Administrative Procedure Act. The department shall consult with the Department of Insurance in issuing guidance under this subdivision.

SEC. 9. Section 1399.861 of the Health and Safety Code is amended to read:

1399.861. (a) On or before October 1, 2013, and annually every October 1 thereafter, a health care service plan shall issue the following notice to all subscribers enrolled in an individual health benefit plan that is a grandfathered health plan:

New improved health insurance options are available in California. You currently have health insurance that is not required to follow many of the new laws. For example, your plan may not provide preventive health services without you having to pay any cost sharing (copayments or coinsurance). Also, your current plan may be allowed to increase your rates based on your health status while new plans and policies cannot. You have the option to remain in your current plan or switch to a new plan. Under the new rules, a health plan cannot deny your application based on any health conditions you may have. For more information about your options, please contact Covered California at ____, your plan representative or insurance agent, or an entity paid by Covered California to assist with health coverage enrollment such as a navigator or an assister.

(b) Commencing October 1, 2013, a health care service plan shall include the notice described in subdivision (a) in any renewal material of the individual grandfathered health plan and in any application for dependent coverage under the individual grandfathered health plan.

(c) A health care service plan shall not advertise or market an individual health benefit plan that is a grandfathered health plan for purposes of enrolling a dependent of a subscriber into the plan for policy years on or after January 1, 2014. Nothing in this subdivision shall be construed to prohibit an individual enrolled in an individual grandfathered health plan from adding a dependent to that plan to the extent permitted by PPACA.

SEC. 10. Section 11833.02 of the Health and Safety Code is amended to read:

11833.02. (a) The department shall charge a fee to all programs for licensure or certification by the department, regardless of the form of organization or ownership of the program.

(b) The department may establish fee scales using different capacity levels, categories based on measures other than program capacity, or any other category or classification that the department deems necessary or convenient to maintain an effective and equitable fee structure.

(c) Licensing and certification fees shall be evaluated annually, taking into consideration the overall cost of the residential and outpatient licensing and certification activities of the department, including initial issuance, renewals, complaints, enforcement activity, related litigation, and any other program activity relating to licensure and certification, plus a reasonable reserve.

(d) The department shall submit any proposed new fees or fee changes to the Legislature for approval no later than April 1 of each year as part of the spring finance letter process. No new fees or fee changes shall be implemented without legislative approval.

(e) The department shall issue a provider bulletin pursuant to subdivision (a) of Section 11833.04 setting forth the approved fee structure. The department shall, on an annual basis, publish the current fee structure on the department's Internet Web site.

(f) Unless funds are specifically appropriated from the General Fund in the annual Budget Act or other legislation to support the division, the Licensing and Certification Division, no later than the beginning of the 2010–11 fiscal year, shall be supported entirely by federal funds and special funds.

SEC. 11. Section 11833.04 of the Health and Safety Code is amended to read:

11833.04. (a) Notwithstanding the rulemaking provisions of the Administrative Procedure Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement new fees or fee changes as approved by the Legislature pursuant to subdivision (d) of Section 11833.02 by means of provider bulletins or similar instructions from the director without taking regulatory action. The department shall notify and consult with interested parties and appropriate stakeholders regarding new fees or fee changes made pursuant to this chapter.

(b) (1) The department shall adopt regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code by January 1, 2016, to amend Section 10701 of Title 9 of Division 4 of Chapter 5.5 of the California Code of Regulations to be consistent with this chapter.

(2) The authority to implement Section 11833.02 and this section shall include the authority to supersede the licensing and certification fees in effect on the operative date of the act that adds this paragraph and shall

continue until the department has amended Section 10701 of Title 9 of Division 4 of Chapter 5.5 of the California Code of Regulations pursuant to paragraph (1).

SEC. 12. Section 120955 of the Health and Safety Code is amended to read:

120955. (a) (1) To the extent that state and federal funds are appropriated in the annual Budget Act for these purposes, the director shall establish and may administer a program to provide drug treatments to persons infected with human immunodeficiency virus (HIV), the etiologic agent of acquired immunodeficiency syndrome (AIDS). If the director makes a formal determination that, in any fiscal year, funds appropriated for the program will be insufficient to provide all of those drug treatments to existing eligible persons for the fiscal year and that a suspension of the implementation of the program is necessary, the director may suspend eligibility determinations and enrollment in the program for the period of time necessary to meet the needs of existing eligible persons in the program.

(2) The director, in consultation with the AIDS Drug Assistance Program Medical Advisory Committee, shall develop, maintain, and update as necessary a list of drugs to be provided under this program. The list shall be exempt from the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and shall not be subject to the review and approval of the Office of Administrative Law.

(b) The director may grant funds to a county public health department through standard agreements to administer this program in that county. To maximize the recipients' access to drugs covered by this program, the director shall urge the county health department in counties granted these funds to decentralize distribution of the drugs to the recipients.

(c) The director shall establish a rate structure for reimbursement for the cost of each drug included in the program. Rates shall not be less than the actual cost of the drug. However, the director may purchase a listed drug directly from the manufacturer and negotiate the most favorable bulk price for that drug.

(d) Manufacturers of the drugs on the list shall pay the department a rebate equal to the rebate that would be applicable to the drug under Section 1927(c) of the federal Social Security Act (42 U.S.C. Sec. 1396r-8(c)) plus an additional rebate to be negotiated by each manufacturer with the department, except that no rebates shall be paid to the department under this section on drugs for which the department has received a rebate under Section 1927(c) of the federal Social Security Act (42 U.S.C. Sec. 1396r-8(c)) or that have been purchased on behalf of county health departments or other eligible entities at discount prices made available under Section 256b of Title 42 of the United States Code.

(e) The department shall submit an invoice, not less than two times per year, to each manufacturer for the amount of the rebate required by subdivision (d).

(f) Drugs may be removed from the list for failure to pay the rebate required by subdivision (d), unless the department determines that removal of the drug from the list would cause substantial medical hardship to beneficiaries.

(g) The department may adopt emergency regulations to implement amendments to this chapter made during the 1997–98 Regular Session, in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The initial adoption of emergency regulations shall be deemed to be an emergency and considered by the Office of Administrative Law as necessary for the immediate preservation of the public peace, health and safety, or general welfare. Emergency regulations adopted pursuant to this section shall remain in effect for no more than 180 days.

(h) Reimbursement under this chapter shall not be made for any drugs that are available to the recipient under any other private, state, or federal programs, or under any other contractual or legal entitlements, except that the director may authorize an exemption from this subdivision where exemption would represent a cost savings to the state.

(i) The department may also subsidize certain cost-sharing requirements for persons otherwise eligible for the AIDS Drug Assistance Program (ADAP) with existing non-ADAP drug coverage by paying for prescription drugs included on the ADAP formulary within the existing ADAP operational structure up to, but not exceeding, the amount of that cost-sharing obligation. This cost sharing may only be applied in circumstances in which the other payer recognizes the ADAP payment as counting toward the individual's cost-sharing obligation. If the director determines that it would result in a cost savings to the state, the department may subsidize, using available federal funds and moneys from the AIDS Drug Assistance Program Rebate Fund, costs associated with a health care service plan or health insurance policy, including medical copayments and deductibles for outpatient care, and premiums to purchase or maintain health insurance coverage.

SEC. 13. Section 120962 is added to the Health and Safety Code, to read:

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

(2) Notwithstanding any other law, the department shall disclose the name and individual taxpayer identification number (ITIN) or social security number of an applicant for, or recipient of, services under this chapter to the Franchise Tax Board for the purpose of verifying the adjusted gross income of an applicant or recipient pursuant to subdivision (b) of Section 120960.

(b) The Franchise Tax Board, upon receipt of this information, shall inform the department of the amount of the federal adjusted gross income as reported by the taxpayer to the Franchise Tax Board, and the California adjusted gross income as reported by the taxpayer to the Franchise Tax Board or as adjusted by the Franchise Tax Board. The Franchise Tax Board shall provide the information to the department for the most recent taxable year that the Franchise Tax Board has information available, and shall include the first and last name, date of birth, and the ITIN or social security number of the taxpayer.

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

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

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

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

SEC. 14. Section 121451 is added to the Health and Safety Code, to read:

121451. A local entity that receives funding from the state for the purposes of this part, including, but not limited to, funding from the state for tuberculosis control pursuant to Item 4265-111-0001 of Section 2.00 of the annual Budget Act, shall first allocate the moneys received for the following purposes and activities before allocating the moneys for any other purposes or activities described in this part:

(a) Either of the following activities if those activities are carried out by a local detention facility:

(1) When a person who has active tuberculosis or is reasonably believed to have active tuberculosis is discharged or released from a detention facility, doing both of the following:

(A) Drafting and submitting notification to the local health officer.

(B) Submitting the written treatment plan that includes the information required by Section 121362 to the local health officer. This activity does not include drafting the written treatment plan.

(2) When a person who has active tuberculosis or is reasonably believed to have active tuberculosis is transferred to a local detention facility in another jurisdiction, doing both of the following:

(A) Drafting and submitting notification to the local health officer and the medical officer of the local detention facility receiving the person.

(B) Submitting the written treatment plan that includes the information required by Section 121362 to the local health officer and the medical officer of the local detention facility receiving the person. This activity does not include drafting the written treatment plan.

(b) Either of the following activities if those activities are carried out by a local health officer or his or her designee:

(1) Receiving and reviewing for approval within 24 hours of receipt only those treatment plans submitted by a health facility. This activity includes all of the following:

(A) Receiving the health facility's treatment plan.

(B) Sending a request to a health facility for medical records and information on tuberculosis medications, dosages, and diagnostic workup and reviewing records and information.

(C) Coordinating with the health facility on any adjustments to the treatment plan.

(D) Sending approval to the health facility.

(2) Drafting and sending a notice to the medical officer of a parole region, or a physician or surgeon designated by the Department of Corrections and Rehabilitation, if there are reasonable grounds to believe that a parolee has active tuberculosis and ceases treatment for the disease.

(c) For cities, counties, and cities and counties to provide counsel to nonindigent tuberculosis patients who are subject to a civil order of detention issued by a local health officer pursuant to Section 121365 upon request of the patient. Services provided by counsel include representation of the tuberculosis patient at any court review of the order of detention required by Section 121366.

SEC. 15. Section 121452 is added to the Health and Safety Code, to read:

121452. A local health department or local health officer that receives funding from the state for tuberculosis control pursuant to Item 4265-111-0001 of Section 2.00 of the annual Budget Act for purposes of this part may use those funds to reimburse the actual costs of carrying out the activities described in Section 121451.

SEC. 16. Section 128200 of the Health and Safety Code is amended to read:

128200. (a) This article shall be known and may be cited as the Song-Brown Health Care Workforce Training Act.

(b) (1) The Legislature hereby finds and declares that physicians engaged in family medicine are in very short supply in California. The current emphasis placed on specialization in medical education has resulted in a shortage of physicians trained to provide comprehensive primary health care to families. The Legislature hereby declares that it regards the furtherance of a greater supply of competent family physicians to be a public purpose of great importance and further declares the establishment of the program pursuant to this article to be a desirable, necessary, and economical

method of increasing the number of family physicians to provide needed medical services to the people of California. The Legislature further declares that it is to the benefit of the state to assist in increasing the number of competent family physicians graduated by colleges and universities of this state to provide primary health care services to families within the state.

(2) The Legislature finds that the shortage of family physicians can be improved by the placing of a higher priority by public and private medical schools, hospitals, and other health care delivery systems in this state, on the recruitment and improved training of medical students and residents to meet the need for family physicians. To help accomplish this goal, each medical school in California is encouraged to organize a strong family medicine program or department. It is the intent of the Legislature that the programs or departments be headed by a physician who possesses specialty certification in the field of family medicine, and has broad clinical experience in the field of family medicine.

(3) The Legislature further finds that encouraging the training of primary care physician's assistants and primary care nurse practitioners will assist in making primary health care services more accessible to the citizenry, and will, in conjunction with the training of family physicians, lead to an improved health care delivery system in California.

(4) Community hospitals in general and rural community hospitals in particular, as well as other health care delivery systems, are encouraged to develop family medicine residencies in affiliation or association with accredited medical schools, to help meet the need for family physicians in geographical areas of the state with recognized family primary health care needs. Utilization of expanded resources beyond university-based teaching hospitals should be emphasized, including facilities in rural areas wherever possible.

(5) The Legislature also finds and declares that nurses are in very short supply in California. The Legislature hereby declares that it regards the furtherance of a greater supply of nurses to be a public purpose of great importance and further declares the expansion of the program pursuant to this article to include nurses to be a desirable, necessary, and economical method of increasing the number of nurses to provide needed nursing services to the people of California.

(6) It is the intent of the Legislature to provide for a program designed primarily to increase the number of students and residents receiving quality education and training in the primary care specialties of family medicine, internal medicine, obstetrics and gynecology, and pediatrics and as primary care physician's assistants, primary care nurse practitioners, and registered nurses and to maximize the delivery of primary care family physician services to specific areas of California where there is a recognized unmet priority need. This program is intended to be implemented through contracts with accredited medical schools, teaching health centers, programs that train primary care physician's assistants, programs that train primary care nurse practitioners, programs that train registered nurses, hospitals, and other health care delivery systems based on per-student or per-resident capitation

formulas. It is further intended by the Legislature that the programs will be professionally and administratively accountable so that the maximum cost-effectiveness will be achieved in meeting the professional training standards and criteria set forth in this article and Article 2 (commencing with Section 128250).

SEC. 17. Section 128205 of the Health and Safety Code is amended to read:

128205. As used in this article, and Article 2 (commencing with Section 128250), the following terms mean:

(a) "Family physician" means a primary care physician who is prepared to and renders continued comprehensive and preventative health care services to families and who has received specialized training in an approved family medicine residency for three years after graduation from an accredited medical school.

(b) "Primary care physician" means a physician who is prepared to and renders continued comprehensive and preventative health care services, and has received specialized training in the areas of internal medicine, obstetrics and gynecology, or pediatrics.

(c) "Associated" and "affiliated" mean that relationship that exists by virtue of a formal written agreement between a hospital or other health care delivery system and an approved medical school that pertains to the primary care or family medicine training program for which state contract funds are sought.

(d) "Commission" means the California Healthcare Workforce Policy Commission.

(e) "Programs that train primary care physician's assistants" means a program that has been approved for the training of primary care physician assistants pursuant to Section 3513 of the Business and Professions Code.

(f) "Programs that train primary care nurse practitioners" means a program that is operated by a California school of medicine or nursing, or that is authorized by the Regents of the University of California or by the Trustees of the California State University, or that is approved by the Board of Registered Nursing.

(g) "Programs that train registered nurses" means a program that is operated by a California school of nursing and approved by the Board of Registered Nursing, or that is authorized by the Regents of the University of California, the Trustees of the California State University, or the Board of Governors of the California Community Colleges, and that is approved by the Board of Registered Nursing.

(h) "Teaching health center" means a community-based ambulatory patient care center that operates a primary care residency program. Community-based ambulatory patient care settings include, but are not limited to, federally qualified health centers, community mental health centers, rural health clinics, health centers operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization, and entities receiving funds under Title X of the federal Public Health Service Act (Public Law 91-572).

SEC. 18. Section 128210 of the Health and Safety Code is amended to read:

128210. There is hereby created a state medical contract program with accredited medical schools, teaching health centers, programs that train primary care physician's assistants, programs that train primary care nurse practitioners, programs that train registered nurses, hospitals, and other health care delivery systems to increase the number of students and residents receiving quality education and training in the primary care specialties of family medicine, internal medicine, obstetrics and gynecology, and pediatrics, or in nursing and to maximize the delivery of primary care and family physician services to specific areas of California where there is a recognized unmet priority need for those services.

SEC. 19. Section 128215 of the Health and Safety Code is amended to read:

128215. There is hereby created a California Healthcare Workforce Policy Commission. The commission shall be composed of 15 members who shall serve at the pleasure of their appointing authorities:

(a) Nine members appointed by the Governor, as follows:

(1) One representative of the University of California medical schools, from a nominee or nominees submitted by the University of California.

(2) One representative of the private medical or osteopathic schools accredited in California from individuals nominated by each of these schools.

(3) One representative of practicing family medicine physicians.

(4) One representative who is a practicing osteopathic physician or surgeon and who is board certified in either general or family medicine.

(5) One representative of undergraduate medical students in a family medicine program or residence in family medicine training.

(6) One representative of trainees in a primary care physician's assistant program or a practicing physician's assistant.

(7) One representative of trainees in a primary care nurse practitioners program or a practicing nurse practitioner.

(8) One representative of the Office of Statewide Health Planning and Development, from nominees submitted by the office director.

(9) One representative of practicing registered nurses.

(b) Two consumer representatives of the public who are not elected or appointed public officials, one appointed by the Speaker of the Assembly and one appointed by the Chairperson of the Senate Committee on Rules.

(c) Two representatives of practicing registered nurses, one appointed by the Speaker of the Assembly and one appointed by the Chairperson of the Senate Committee on Rules.

(d) Two representatives of students in a registered nurse training program, one appointed by the Speaker of the Assembly and one appointed by the Chairperson of the Senate Committee on Rules.

(e) The Deputy Director of the Healthcare Workforce Development Division in the Office of Statewide Health Planning and Development, or the deputy director's designee, shall serve as executive secretary for the commission.

SEC. 20. Section 128225 of the Health and Safety Code is amended to read:

128225. The commission shall do all of the following:

(a) Identify specific areas of the state where unmet priority needs for primary care family physicians and registered nurses exist.

(b) (1) Establish standards for primary care and family medicine training programs, primary care and family medicine residency programs, postgraduate osteopathic medical programs in primary care or family medicine, and primary care physician assistants programs and programs that train primary care nurse practitioners, including appropriate provisions to encourage primary care physicians, family physicians, osteopathic family physicians, primary care physician's assistants, and primary care nurse practitioners who receive training in accordance with this article and Article 2 (commencing with Section 128250) to provide needed services in areas of unmet need within the state. Standards for primary care and family medicine residency programs shall provide that all of the residency programs contracted for pursuant to this article and Article 2 (commencing with Section 128250) shall be approved by the Accreditation Council for Graduate Medical Education's Residency Review Committee for Family Medicine, Internal Medicine, Pediatrics, or Obstetrics and Gynecology. Standards for postgraduate osteopathic medical programs in primary care and family medicine, as approved by the American Osteopathic Association Committee on Postdoctoral Training for interns and residents, shall be established to meet the requirements of this subdivision in order to ensure that those programs are comparable to the other programs specified in this subdivision. Every program shall include a component of training designed for medically underserved multicultural communities, lower socioeconomic neighborhoods, or rural communities, and shall be organized to prepare program graduates for service in those neighborhoods and communities. Medical schools receiving funds under this article and Article 2 (commencing with Section 128250) shall have programs or departments that recognize family medicine as a major independent specialty. Existence of a written agreement of affiliation or association between a hospital and an accredited medical school shall be regarded by the commission as a favorable factor in considering recommendations to the director for allocation of funds appropriated to the state medical contract program established under this article and Article 2 (commencing with Section 128250). Teaching health centers receiving funds under this article shall have programs or departments that recognize family medicine as a major independent specialty.

(2) For purposes of this subdivision, "primary care" and "family medicine" includes the general practice of medicine by osteopathic physicians.

(c) Establish standards for registered nurse training programs. The commission may accept those standards established by the Board of Registered Nursing.

(d) Review and make recommendations to the Director of the Office of Statewide Health Planning and Development concerning the funding of

primary care and family medicine programs or departments and primary care and family medicine residencies and programs for the training of primary care physician assistants and primary care nurse practitioners that are submitted to the Healthcare Workforce Development Division for participation in the contract program established by this article and Article 2 (commencing with Section 128250). If the commission determines that a program proposal that has been approved for funding or that is the recipient of funds under this article and Article 2 (commencing with Section 128250) does not meet the standards established by the commission, it shall submit to the Director of the Office of Statewide Health Planning and Development and the Legislature a report detailing its objections. The commission may request the Office of Statewide Health Planning and Development to make advance allocations for program development costs from amounts appropriated for the purposes of this article and Article 2 (commencing with Section 128250).

(e) Review and make recommendations to the Director of the Office of Statewide Health Planning and Development concerning the funding of registered nurse training programs that are submitted to the Healthcare Workforce Development Division for participation in the contract program established by this article. If the commission determines that a program proposal that has been approved for funding or that is the recipient of funds under this article does not meet the standards established by the commission, it shall submit to the Director of the Office of Statewide Health Planning and Development and the Legislature a report detailing its objections. The commission may request the Office of Statewide Health Planning and Development to make advance allocations for program development costs from amounts appropriated for the purposes of this article.

(f) Establish contract criteria and single per-student and per-resident capitation formulas that shall determine the amounts to be transferred to institutions receiving contracts for the training of primary care and family medicine students and residents and primary care physician's assistants and primary care nurse practitioners and registered nurses pursuant to this article and Article 2 (commencing with Section 128250), except as otherwise provided in subdivision (d). Institutions applying for or in receipt of contracts pursuant to this article and Article 2 (commencing with Section 128250) may appeal to the director for waiver of these single capitation formulas. The director may grant the waiver in exceptional cases upon a clear showing by the institution that a waiver is essential to the institution's ability to provide a program of a quality comparable to those provided by institutions that have not received waivers, taking into account the public interest in program cost-effectiveness. Recipients of funds appropriated by this article and Article 2 (commencing with Section 128250) shall, as a minimum, maintain the level of expenditure for family medicine or primary care physician's assistant or family care nurse practitioner training that was provided by the recipients during the 1973–74 fiscal year. Recipients of funds appropriated for registered nurse training pursuant to this article shall, as a minimum, maintain the level of expenditure for registered nurse training

that was provided by recipients during the 2004–05 fiscal year. Funds appropriated under this article and Article 2 (commencing with Section 128250) shall be used to develop new programs or to expand existing programs, and shall not replace funds supporting current family medicine or registered nurse training programs. Institutions applying for or in receipt of contracts pursuant to this article and Article 2 (commencing with Section 128250) may appeal to the director for waiver of this maintenance of effort provision. The director may grant the waiver if he or she determines that there is reasonable and proper cause to grant the waiver.

(g) (1) Review and make recommendations to the Director of the Office of Statewide Health Planning and Development concerning the funding of special programs that may be funded on other than a capitation rate basis. These special programs may include the development and funding of the training of primary health care teams of primary care and family medicine residents or primary care or family physicians and primary care physician assistants or primary care nurse practitioners or registered nurses, undergraduate medical education programs in primary care or family medicine, and programs that link training programs and medically underserved communities in California that appear likely to result in the location and retention of training program graduates in those communities. These special programs also may include the development phase of new primary care or family medicine residency, primary care physician assistant programs, primary care nurse practitioner programs, or registered nurse programs.

(2) The commission shall establish standards and contract criteria for special programs recommended under this subdivision.

(h) Review and evaluate these programs regarding compliance with this article and Article 2 (commencing with Section 128250). One standard for evaluation shall be the number of recipients who, after completing the program, actually go on to serve in areas of unmet priority for primary care or family physicians in California or registered nurses who go on to serve in areas of unmet priority for registered nurses.

(i) Review and make recommendations to the Director of the Office of Statewide Health Planning and Development on the awarding of funds for the purpose of making loan assumption payments for medical students who contractually agree to enter a primary care specialty and practice primary care medicine for a minimum of three consecutive years following completion of a primary care residency training program pursuant to Article 2 (commencing with Section 128250).

SEC. 21. Section 128230 of the Health and Safety Code is amended to read:

128230. When making recommendations to the Director of the Office of Statewide Health Planning and Development concerning the funding of primary care and family medicine programs or departments, primary care and family medicine residencies, and programs for the training of primary care physician assistants, primary care nurse practitioners, or registered

nurses, the commission shall give priority to programs that have demonstrated success in the following areas:

(a) Actual placement of individuals in medically underserved areas.

(b) Success in attracting and admitting members of minority groups to the program.

(c) Success in attracting and admitting individuals who were former residents of medically underserved areas.

(d) Location of the program in a medically underserved area.

(e) The degree to which the program has agreed to accept individuals with an obligation to repay loans awarded pursuant to the Health Professions Education Fund.

SEC. 22. Section 128235 of the Health and Safety Code is amended to read:

128235. Pursuant to this article and Article 2 (commencing with Section 128250), the Director of the Office of Statewide Health Planning and Development shall do all of the following:

(a) Determine whether primary care and family medicine, primary care physician's assistant training program proposals, primary care nurse practitioner training program proposals, and registered nurse training program proposals submitted to the California Healthcare Workforce Policy Commission for participation in the state medical contract program established by this article and Article 2 (commencing with Section 128250) meet the standards established by the commission.

(b) Select and contract on behalf of the state with accredited medical schools, teaching health centers, programs that train primary care physician's assistants, programs that train primary care nurse practitioners, hospitals, and other health care delivery systems for the purpose of training undergraduate medical students and residents in the specialties of internal medicine, obstetrics and gynecology, pediatrics, and family medicine. Contracts shall be awarded to those institutions that best demonstrate the ability to provide quality education and training and to retain students and residents in specific areas of California where there is a recognized unmet priority need for primary care family physicians. Contracts shall be based upon the recommendations of the commission and in conformity with the contract criteria and program standards established by the commission.

(c) Select and contract on behalf of the state with programs that train registered nurses. Contracts shall be awarded to those institutions that best demonstrate the ability to provide quality education and training and to retain students and residents in specific areas of California where there is a recognized unmet priority need for registered nurses. Contracts shall be based upon the recommendations of the commission and in conformity with the contract criteria and program standards established by the commission.

(d) Terminate, upon 30 days' written notice, the contract of any institution whose program does not meet the standards established by the commission or that otherwise does not maintain proper compliance with this part, except as otherwise provided in contracts entered into by the director pursuant to this article and Article 2 (commencing with Section 128250).

SEC. 23. Section 130200 of the Health and Safety Code is amended to read:

130200. There is hereby established within the California Health and Human Services Agency the Office of Health Information Integrity to ensure the enforcement of state law mandating the confidentiality of medical information. The Office of Health Information Integrity shall be administered by a director who shall be appointed by the Secretary of California Health and Human Services.

SEC. 24. Section 130201 of the Health and Safety Code is amended and renumbered to read:

1280.16. For purposes of Sections 1280.17, 1280.18, 1280.19, and 1280.20, the following definitions apply:

(a) "Department" means the State Department of Public Health.

(b) "Director" means the State Public Health Officer.

(c) "Medical information" means the term as defined in Section 56.05 of the Civil Code.

(d) "Provider of health care" means the term as defined in Sections 56.05 and 56.06 of the Civil Code.

(e) "Unauthorized access" means the inappropriate review or viewing of patient medical information without a direct need for diagnosis, treatment, or other lawful use as permitted by the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code) or by other statutes or regulations governing the lawful access, use, or disclosure of medical information.

SEC. 25. Section 130202 of the Health and Safety Code is amended and renumbered to read:

1280.17. (a) (1) The department may assess an administrative fine against any person or any provider of health care, whether licensed or unlicensed, for any violation of Section 1280.18 of this code or Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code in an amount as provided in Section 56.36 of the Civil Code. Proceedings against any person or entity for a violation of this section shall be held in accordance with administrative adjudication provisions of Chapter 4.5 (commencing with Section 11400) and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(2) Paragraph (1) shall not apply to a clinic, health facility, agency, or hospice licensed pursuant to Section 1204, 1250, 1725, or 1745.

(b) The department shall adopt, amend, or repeal, in accordance with the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, rules and regulations as may be reasonable and proper to carry out the purposes and intent of Sections 1280.18, 1280.19, and 1280.20, and to enable the authority to exercise the powers and perform the duties conferred upon it by those sections not inconsistent with any other provision of law.

SEC. 26. Section 130203 of the Health and Safety Code is amended and renumbered to read:

1280.18. (a) Every provider of health care shall establish and implement appropriate administrative, technical, and physical safeguards to protect the privacy of a patient's medical information. Every provider of health care shall reasonably safeguard confidential medical information from any unauthorized access or unlawful access, use, or disclosure.

(b) In exercising its duties pursuant to Section 1280.17, the department shall consider the provider's capability, complexity, size, and history of compliance with this section and other related state and federal statutes and regulations, the extent to which the provider detected violations and took steps to immediately correct and prevent past violations from reoccurring, and factors beyond the provider's immediate control that restricted the facility's ability to comply with this section.

(c) The department may conduct joint investigations of individuals and health facilities for violations of this section and Section 1280.15, respectively.

SEC. 27. Section 130204 of the Health and Safety Code is amended and renumbered to read:

1280.19. The Internal Health Information Integrity Quality Improvement Account is hereby created in the State Treasury. All administrative fines assessed by the department pursuant to Section 56.36 of the Civil Code shall be deposited in the Internal Health Information Integrity Quality Improvement Account. Notwithstanding Section 16305.7 of the Government Code, all interest earned on the moneys deposited in the account shall be retained in the account. Upon appropriation by the Legislature, money in the account shall be used for the purpose of supporting quality improvement activities in the department.

SEC. 28. Section 130205 of the Health and Safety Code is amended and renumbered to read:

1280.20. Notwithstanding any other law, the director may send a recommendation for further investigation of, or discipline for, a potential violation of the licensee's relevant licensing authority. The recommendation shall include all documentary evidence collected by the director in evaluating whether or not to make that recommendation. The recommendation and accompanying evidence shall be deemed in the nature of an investigative communication and be protected by Section 6254 of the Government Code. The licensing authority of the provider of health care shall review all evidence submitted by the director and may take action for further investigation or discipline of the licensee.

SEC. 29. Section 131058 is added to the Health and Safety Code, to read:

131058. The State Department of Public Health may investigate, apply for, and enter into agreements to secure federal or nongovernmental funding opportunities for the purposes of advancing public health, subject to the provisions of Section 13326 of the Government Code for federal funding or applicable administrative review and approval for nongovernmental funding opportunities.

SEC. 30. Section 136000 of the Health and Safety Code is repealed.

SEC. 31. Section 136000 is added to the Health and Safety Code, to read:

136000. (a) (1) The Office of Patient Advocate is hereby established within the California Health and Human Services Agency, to provide assistance to, and advocate on behalf of, health care consumers. The goal of the office shall be to coordinate amongst, provide assistance to, and collect data from, all of the state agency consumer assistance or patient assistance programs and call centers, to better enable health care consumers to access the health care services to which they are eligible under the law, including, but not limited to, commercial and Exchange coverage, Medi-Cal, Medicare, and federal veterans health benefits. Notwithstanding any provision of this division, each regulator and health coverage program shall retain its respective authority, including its authority to resolve complaints, grievances, and appeals.

(2) The office shall be headed by a patient advocate appointed by the Governor. The patient advocate shall serve at the pleasure of the Governor.

(b) (1) The duties of the office shall include, but not be limited to, all of the following:

(A) Coordinate and work in consultation with state agency and local, nongovernment health care consumer or patient assistance programs and health care ombudsperson programs.

(B) Produce a baseline review and annual report to be made publically available on the office's Internet Web site by July 1, 2015, and annually thereafter, of health care consumer or patient assistance help centers, call centers, ombudsperson, or other assistance centers operated by the Department of Managed Health Care, the Department of Health Care Services, the Department of Insurance, and the Exchange, that includes, at a minimum, all of the following:

(i) The types of calls received and the number of calls.

(ii) The call center's role with regard to each type of call, question, complaint, or grievance.

(iii) The call center's protocol for responding to requests for assistance from health care consumers, including any performance standards.

(iv) The protocol for referring or transferring calls outside the jurisdiction of the call center.

(v) The call center's methodology of tracking calls, complaints, grievances, or inquiries.

(C) (i) Collect, track, and analyze data on problems and complaints by, and questions from, consumers about health care coverage for the purpose of providing public information about problems faced and information needed by consumers in obtaining coverage and care. The data collected shall include demographic data, source of coverage, regulator, type of problem or issue or comparable types of problems or issues, and resolution of complaints, including timeliness of resolution. Notwithstanding Section 10231.5 of the Government Code, the office shall submit a report by July 1, 2015, and annually thereafter to the Legislature. The report shall be submitted in compliance with Section 9795 of the Government Code. The

format may be modified annually as needed based upon comments from the Legislature and stakeholders.

(ii) For the purpose of publically reporting information as required in subparagraph (B) and this subparagraph about the problems faced by consumers in obtaining care and coverage, the office shall analyze data on consumer complaints and grievances resolved by the agencies listed in subdivision (c), including demographic data, source of coverage, insurer or plan, resolution of complaints, and other information intended to improve health care and coverage for consumers.

(D) Make recommendations, in consultation with stakeholders, for improvement or standardization of the health consumer assistance functions, referral process, and data collection and analysis.

(E) Develop model protocols, in consultation with consumer assistance call centers and stakeholders, that may be used by call centers for responding to and referring calls that are outside the jurisdiction of the call center, program, or regulator.

(F) Compile an annual publication, to be made publically available on the office's Internet Web site, of a quality of care report card, including, but not limited, to health care service plans, preferred provider organizations, and medical groups.

(G) Make referrals to the appropriate state agency, whether further or additional actions may be appropriate, to protect the interests of consumers or patients.

(H) Assist in the development of educational and informational guides for consumers and patients describing their rights and responsibilities and informing them on effective ways to exercise their rights to secure and access health care coverage, produced by the Department of Managed Health Care, the Department of Health Care Services, the Exchange, and the California Department of Insurance, and to endeavor to make those materials easy to read and understand and available in all threshold languages, using an appropriate literacy level and in a culturally competent manner.

(I) Coordinate with other state and federal agencies engaged in outreach and education regarding the implementation of federal health care reform, and to assist in these duties, may provide or assist in the provision of grants to community-based consumer assistance organizations for these purposes.

(J) If appropriate, refer consumers to the appropriate regulator of their health coverage programs for filing complaints or grievances.

(2) The office shall employ necessary staff. The office may employ or contract with experts when necessary to carry out the functions of the office. The patient advocate shall make an annual budget request for the office that shall be identified in the annual Budget Act.

(3) The patient advocate shall annually issue a public report on the activities of the office, and shall appear before the appropriate policy and fiscal committees of the Senate and Assembly, if requested, to report and make recommendations on the activities of the office.

(4) The office shall adopt standards for the organizations with which it contracts pursuant to this section to ensure compliance with the privacy and

confidentiality laws of this state, including, but not limited to, the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code). The office shall conduct privacy trainings as necessary, and regularly verify that the organizations have measures in place to ensure compliance with this provision.

(c) The Department of Managed Health Care, the Department of Health Care Services, the Department of Insurance, the Exchange, and any other public health coverage programs shall provide to the office data concerning call centers to meet the reporting requirements in subparagraph (B) of paragraph (1) of subdivision (b) and consumer complaints and grievances to meet the reporting requirements in clause (i) of subparagraph (C) of paragraph (1) of subdivision (b).

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

(1) "Consumer" or "individual" includes the individual or his or her parent, guardian, conservator, or authorized representative.

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

(3) "Health care" includes services provided by any of the health care coverage programs.

(4) "Health care service plan" has the same meaning as that set forth in subdivision (f) of Section 1345. Health care service plan includes "specialized health care service plans," including behavioral health plans.

(5) "Health coverage program" includes the Medi-Cal program, Healthy Families Program, tax subsidies and premium credits under the Exchange, the Basic Health Program, if enacted, county health coverage programs, and the Access for Infants and Mothers Program.

(6) "Health insurance" has the same meaning as set forth in Section 106 of the Insurance Code.

(7) "Health insurer" means an insurer that issues policies of health insurance.

(8) "Office" means the Office of Patient Advocate.

(9) "Threshold languages" has the same meaning as for Medi-Cal managed care.

SEC. 32. Section 136030 of the Health and Safety Code is amended to read:

136030. (a) In addition to the moneys received pursuant to subdivision (d), funding for the actual and necessary expenses of the office in implementing this division shall be provided, subject to appropriation by the Legislature, from transfers of moneys from the Managed Care Fund and the Insurance Fund.

(b) The share of funding from the Managed Care Fund shall be based on the number of covered lives in the state that are covered under plans regulated by the Department of Managed Health Care, including covered lives under Medi-Cal managed care, as determined by the Department of

Managed Health Care, in proportion to the total number of all covered lives in the state.

(c) The share of funding to be provided from the Insurance Fund shall be based on the number of covered lives in the state that are covered under health insurance policies and benefit plans regulated by the Department of Insurance, including covered lives under Medicare supplement plans, as determined by the Department of Insurance, in proportion to the total number of all covered lives in the state.

(d) In addition to moneys received pursuant to subdivision (a), the office may receive funding as follows:

(1) The office may apply to the United States Secretary of Health and Human Services for federal grants.

(2) The office may seek private grant funding from foundations or other sources.

(3) To the extent permitted by federal law, the office may seek federal financial participation for assisting beneficiaries of the Medi-Cal program.

(e) All moneys received by the Office of Patient Advocate shall be deposited into the fund specified in Section 136020.

SEC. 33. 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 insureds.

(b) An insurer providing individual coverage in the Exchange shall not charge, bill, ask, or require an insured receiving benefits under Section 14102 or Section 14148.65 of the Welfare and Institutions Code to make any premium or cost-sharing payments for any services that are subject to premium or cost-sharing payments by the State Department of Health Care Services under Section 14102 or Section 14148.65 of the Welfare and Institutions Code.

(c) 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. 34. Section 10965.15 of the Insurance Code is amended to read:

10965.15. (a) On or before October 1, 2013, and annually every October 1 thereafter, a health insurer shall issue the following notice to all policyholders enrolled in an individual health benefit plan that is a grandfathered health plan:

New improved health insurance options are available in California. You currently have health insurance that is not required to follow many of the new laws. For example, your policy may not provide preventive health services without you having to pay any cost sharing (copayments or coinsurance). Also your current policy may be allowed to increase your rates based on your health status while new policies cannot. You have the

option to remain in your current policy or switch to a new policy. Under the new rules, a health insurance company cannot deny your application based on any health conditions you may have. For more information about your options, please contact Covered California at ____, your policy representative or insurance agent, or an entity paid by Covered California to assist with health coverage enrollment, such as a navigator or an assister.

(b) Commencing October 1, 2013, a health insurer shall include the notice described in subdivision (a) in any renewal material of the individual grandfathered health plan and in any application for dependent coverage under the individual grandfathered health plan.

(c) A health insurer shall not advertise or market an individual health benefit plan that is a grandfathered health plan for purposes of enrolling a dependent of a policyholder into the plan for policy years on or after January 1, 2014. Nothing in this subdivision shall be construed to prohibit an individual enrolled in an individual grandfathered health plan from adding a dependent to that plan to the extent permitted by PPACA.

SEC. 35. Section 12693.70 of the Insurance Code is amended to read:

12693.70. To be eligible to participate in the program, an applicant shall meet all of the following requirements:

(a) Be an applicant applying on behalf of an eligible child, which means a child who is all of the following:

(1) Less than 19 years of age. An application may be made on behalf of a child not yet born up to three months prior to the expected date of delivery. Coverage shall begin as soon as administratively feasible, as determined by the board, after the board receives notification of the birth. However, no child less than 12 months of age shall be eligible for coverage until 90 days after the enactment of the Budget Act of 1999.

(2) Not eligible for no-cost full-scope Medi-Cal or Medicare coverage at the time of application.

(3) In compliance with Sections 12693.71 and 12693.72.

(4) A child who meets citizenship and immigration status requirements that are applicable to persons participating in the program established by Title XXI of the Social Security Act, except as specified in Section 12693.76.

(5) A resident of the State of California pursuant to Section 244 of the Government Code; or, if not a resident pursuant to Section 244 of the Government Code, is physically present in California and entered the state with a job commitment or to seek employment, whether or not employed at the time of application to or after acceptance in, the program.

(6) (A) In either of the following:

(i) In a family with an annual or monthly household income equal to or less than 200 percent of the federal poverty level.

(ii) (I) When implemented by the board, subject to subdivision (b) of Section 12693.765 and pursuant to this section, a child under the age of two years who was delivered by a mother enrolled in the Access for Infants and Mothers Program as described in Part 6.3 (commencing with Section 12695). Commencing July 1, 2007, eligibility under this subparagraph shall not

include infants during any time they are enrolled in employer-sponsored health insurance or are subject to an exclusion pursuant to Section 12693.71 or 12693.72, or are enrolled in the full scope of benefits under the Medi-Cal program at no share of cost. For purposes of this clause, any infant born to a woman whose enrollment in the Access for Infants and Mothers Program begins after June 30, 2004, shall be automatically enrolled in the Healthy Families Program, except during any time on or after July 1, 2007, that the infant is enrolled in employer-sponsored health insurance or is subject to an exclusion pursuant to Section 12693.71 or 12693.72, or is enrolled in the full scope of benefits under the Medi-Cal program at no share of cost. Except as otherwise specified in this section, this enrollment shall cover the first 12 months of the infant's life. At the end of the 12 months, as a condition of continued eligibility, the applicant shall provide income information. The infant shall be disenrolled if the gross annual household income exceeds the income eligibility standard that was in effect in the Access for Infants and Mothers Program at the time the infant's mother became eligible, or following the two-month period established in Section 12693.981 if the infant is eligible for Medi-Cal with no share of cost. At the end of the second year, infants shall again be screened for program eligibility pursuant to this section, with income eligibility evaluated pursuant to clause (i), subparagraphs (B) and (C), and paragraph (2) of subdivision (a).

(II) Effective on October 1, 2013, or when the State Department of Health Care Services has implemented Chapter 2 (commencing with Section 15810) of Part 3.3 of Division 9 of the Welfare and Institutions Code, whichever is later, eligibility for coverage in the program pursuant to this clause shall terminate. The board shall coordinate with the State Department of Health Care Services to implement Chapter 2 (commencing with Section 15810) of Part 3.3 of Division 9 of the Welfare and Institutions Code, including transition of subscribers to the AIM-Linked Infants Program. The State Department of Health Care Services shall administer the AIM-Linked Infants Program, pursuant to Chapter 2 (commencing with Section 15810) of Part 3.3 of Division 9 of the Welfare and Institutions Code, to address the health care needs of children formerly covered pursuant to this clause.

(B) All income over 200 percent of the federal poverty level but less than or equal to 250 percent of the federal poverty level shall be disregarded in calculating annual or monthly household income.

(C) In a family with an annual or monthly household income greater than 250 percent of the federal poverty level, any income deduction that is applicable to a child under Medi-Cal shall be applied in determining the annual or monthly household income. If the income deductions reduce the annual or monthly household income to 250 percent or less of the federal poverty level, subparagraph (B) shall be applied.

(b) The applicant shall agree to remain in the program for six months, unless other coverage is obtained and proof of the coverage is provided to the program.

(c) An applicant shall enroll all of the applicant's eligible children in the program.

(d) In filing documentation to meet program eligibility requirements, if the applicant's income documentation cannot be provided, as defined in regulations promulgated by the board, the applicant's signed statement as to the value or amount of income shall be deemed to constitute verification.

(e) An applicant shall pay in full any family contributions owed in arrears for any health, dental, or vision coverage provided by the program within the prior 12 months.

(f) By January 2008, the board, in consultation with stakeholders, shall implement processes by which applicants for subscribers may certify income at the time of annual eligibility review, including rules concerning which applicants shall be permitted to certify income and the circumstances in which supplemental information or documentation may be required. The board may terminate using these processes not sooner than 90 days after providing notification to the Chair of the Joint Legislative Budget Committee. This notification shall articulate the specific reasons for the termination and shall include all relevant data elements that are applicable to document the reasons for the termination. Upon the request of the Chair of the Joint Legislative Budget Committee, the board shall promptly provide any additional clarifying information regarding implementation of the processes required by this subdivision.

SEC. 36. Section 12699.15 is added to the Insurance Code, immediately following Section 12699.05, to read:

12699.15. This part shall become inoperative on July 1, 2014, except to the extent its operation is necessary to allow the State Department of Health Care Services and other affected parties to complete all transactions started under this part, and, as of January 1, 2016, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2016, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 37. Section 12699.64 is added to the Insurance Code, immediately following Section 12699.63, to read:

12699.64. This part shall become inoperative on July 1, 2014, except to the extent its operation is necessary to allow the State Department of Health Care Services and other affected parties to complete all transactions started under this part, and, as of January 1, 2016, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2016, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 38. Section 12701 is added to the Insurance Code, to read:

12701. This part shall become inoperative on July 1, 2014, except to the extent its operation is necessary to allow the State Department of Health Care Services and other affected parties to complete all transactions started under this part, and, as of January 1, 2016, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2016, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 39. Section 12710.2 is added to the Insurance Code, to read:

12710.2. Notwithstanding any other law, the board created pursuant to Section 12710 and renamed pursuant to Section 12710.1 shall continue until July 1, 2014, on which date it is dissolved and the term of any board member serving at that time ends.

SEC. 40. Section 12739.61 of the Insurance Code is amended to read:

12739.61. (a) Subject to subdivision (c), the board shall cease to provide coverage through the program on July 1, 2013, except as required by the contract between the board and the United States Department of Health and Human Services, and at that time shall cease to operate the program except as required to complete payments to, or payment reconciliations with, participating health plans or other contractors, process appeals, or conduct other necessary termination activities.

(b) Any permanent or probationary civil service employee who is employed by the board and assigned to the program and whose function ceases due to this section shall immediately be transferred to the California Health Benefit Exchange and shall retain his or her status, position, and rights pursuant to Section 19050.9 of the Government Code and the State Civil Service Act (Part 2 (commencing with Section 18500) and Part 2.6 (commencing with Section 19815) of Division 5 of Title 2 of the Government Code).

(c) Commencing on July 1, 2014, the State Department of Health Care Services shall complete payments to, or payment reconciliations with, participating health plans or other contractors, process appeals, or conduct other necessary program termination activities.

SEC. 41. Section 12739.78 of the Insurance Code is amended to read:

12739.78. (a) (1) If any statute dissolves or terminates the board, any employee of the board who, immediately prior to the effective date of the dissolution or termination of the board, was assigned to the Healthy Families Program (Part 6.2 (commencing with Section 12693)), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695)), the County Health Initiative Matching Fund (Part 6.4 (commencing with Section 12699.50)), or the Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)) shall be transferred to the State Department of Health Care Services and shall retain his or her status, position, and rights pursuant to Section 19050.9 of the Government Code and the State Civil Service Act (Part 2 (commencing with Section 18500) and Part 2.6 (commencing with Section 19815) of Division 5 of Title 2 of the Government Code).

(2) If employees are transferred to the State Department of Health Care Services pursuant to this subdivision, the department shall prepare a report on the transfer of employees, and, if applicable, any functions transferred to the department upon dissolution or termination of the board. The report shall, at a minimum, describe any assignment of new activities to transferred employees and provide workload justification for the position authority transferred pursuant to this subdivision. The department shall submit the report to the fiscal and relevant policy committees of the Legislature by February 1 of the year following the year in which employees are transferred,

and shall update the report, if necessary, by February 1 of each of the two years following submission of the report. The report may be included with any budget information submitted by the department to those committees.

(b) (1) If any statute dissolves or terminates the board, any employee of the board who, immediately prior to the effective date of the dissolution or termination of the board, was assigned to the Federal Temporary High Risk Pool (Part 6.6 (commencing with Section 12739.5) and Part 6.7 (commencing with Section 12739.70)) shall be transferred to the California Health Benefit Exchange and shall retain his or her status, position, and rights pursuant to Section 19050.9 of the Government Code and the State Civil Service Act (Part 2 (commencing with Section 18500) and Part 2.6 (commencing with Section 19815) of Division 5 of Title 2 of the Government Code).

(2) This subdivision shall not apply to any employee who has transferred to the California Health Benefit Exchange pursuant to subdivision (b) of Section 12739.61 or Section 12739.79.

(c) If any statute dissolves or terminates the board, an employee's applicable reinstatement rights that would have applied to the board shall instead apply to the State Department of Health Care Services.

SEC. 42. Section 12739.79 is added to the Insurance Code, to read:

12739.79. Any permanent or probationary civil service employee who is employed by the board and assigned to the Federal Temporary High Risk Pool (Part 6.6 (commencing with Section 12739.5) and Part 6.7 (commencing with Section 12739.70)) and whose function ceases due to Section 12739.61 shall immediately be transferred to the California Health Benefit Exchange and shall retain his or her status, position, and rights pursuant to Section 19050.9 of the Government Code and the State Civil Service Act (Part 2 (commencing with Section 18500) and Part 2.6 (commencing with Section 19815) of Division 5 of Title 2 of the Government Code).

SEC. 43. Section 19548.2 is added to the Revenue and Taxation Code, to read:

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

(b) The Franchise Tax Board, upon receipt of this information, shall inform the State Department of Public Health of the amounts of the federal adjusted gross income as reported by the taxpayer to the Franchise Tax Board, and the California adjusted gross income as reported by the taxpayer to the Franchise Tax Board or as adjusted by the Franchise Tax Board. The Franchise Tax Board shall provide the information to the State Department of Public Health for the most recent taxable year that the Franchise Tax Board has information available, and shall include the first and last name, date of birth, and the ITIN or social security number of the taxpayer.

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

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

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

SEC. 44. Section 4061 of the Welfare and Institutions Code is amended to read:

4061. (a) The State Department of Health Care Services shall utilize a joint state-county decisionmaking process to determine the appropriate use of state and local training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health and substance use disorder services system. The department shall use the decisionmaking collaborative process required by this section in all of the following areas:

(1) Providing technical assistance to personnel of the State Department of Health Care Services and local behavioral health, mental health, and substance use disorder services departments through direction of existing state and local mental health and substance use disorder services staff and other resources.

(2) Analyzing mental health and substance use disorder programs, policies, and procedures.

(3) Providing forums on specific topics as they relate to the following:

(A) Identifying current level of services.

(B) Evaluating existing needs and gaps in current services.

(C) Developing strategies for achieving statewide goals and objectives in the provision of services for the specific area.

(D) Developing plans to accomplish the identified goals and objectives.

(4) Providing forums on policy development and direction with respect to mental health and substance use disorder program operations and clinical issues.

(5) Identifying and funding a statewide training and technical assistance entity jointly governed by local behavioral health, mental health, and substance use disorder services directors and mental health and substance use disorder constituency representation, which can do all of the following:

(A) Coordinate state and local resources to support training and technical assistance to promote quality mental health and substance use disorder programs.

(B) Coordinate training and technical assistance to ensure efficient and effective program development.

(C) Provide essential training and technical assistance, as determined by the state-county decisionmaking process.

(b) Local behavioral health, mental health, and substance use disorder services board members shall be included in discussions pursuant to Section 4060 when the following areas are discussed:

(1) Training and education program recommendations.

(2) Establishment of statewide forums for all organizations and individuals involved in mental health and substance use disorder matters to meet and discuss program and policy issues.

(3) Distribution of information between the state, local mental health and substance use disorder programs, local mental health and substance use disorder services boards, and other organizations as appropriate.

(c) The State Department of Health Care Services and local mental health and substance use disorder services departments may provide staff or other resources, including travel reimbursement, for consultant and advisory services; for the training of personnel, board members, or consumers and families in state and local programs and in educational institutions and field training centers approved by the department; and for the establishment and maintenance of field training centers.

SEC. 45. Section 5897 of the Welfare and Institutions Code is amended to read:

5897. (a) Notwithstanding any other provision of state law, the State Department of Health Care Services shall implement the mental health services provided by Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) through contracts with county mental health programs or counties acting jointly. A contract may be exclusive and may be awarded on a geographic basis. For purposes of this section, a county mental health program includes a city receiving funds pursuant to Section 5701.5.

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of those mental health services. The agreement may encompass all or any part of the mental health services provided pursuant to these parts. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.

(c) The department shall implement the provisions of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) through the annual county mental health services performance contract, as specified in Chapter 2 (commencing with Section 5650) of Part 2.

(d) When a county mental health program is not in compliance with its performance contract, the department may request a plan of correction with a specific timeline to achieve improvements.

(e) Contracts awarded by the State Department of Health Care Services, the State Department of Public Health, the California Mental Health Planning

Council, the Office of Statewide Health Planning and Development, and the Mental Health Services Oversight and Accountability Commission pursuant to Part 3 (commencing with Section 5800), Part 3.1 (commencing with Section 5820), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.7 (commencing with Section 5845), Part 4 (commencing with Section 5850), and Part 4.5 (commencing with Section 5890), may be awarded in the same manner in which contracts are awarded pursuant to Section 5814 and the provisions of subdivisions (g) and (h) of Section 5814 shall apply to those contracts.

(f) For purposes of Section 14712, the allocation of funds pursuant to Section 5892 which are used to provide services to Medi-Cal beneficiaries shall be included in calculating anticipated county matching funds and the transfer to the State Department of Health Care Services of the anticipated county matching funds needed for community mental health programs.

SEC. 46. Section 14005.22 is added to the Welfare and Institutions Code, to read:

14005.22. (a) A woman is 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 or equal to 109 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) To the extent permitted by state and federal law, a woman eligible under this section shall be required to enroll in a Medi-Cal managed care health plan in those counties in which a Medi-Cal managed care health plan is available.

(c) 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, 2017, 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. Notwithstanding Section 10231.5 of the Government Code, beginning six months after the effective date of this section, 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.

(d) 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. 47. Section 14005.225 is added to the Welfare and Institutions Code, to read:

14005.225. (a) The department shall seek any state plan amendments or federal waivers necessary to provide pregnant women whose income is over 109 percent of, and is up to and including 138 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, with full scope Medi-Cal benefits without a share of cost during their pregnancy and through the end of the calendar month in which the 60th day after the end of their pregnancy falls.

(b) To the extent permitted by state and federal law, a woman eligible under this section shall be required to enroll in a Medi-Cal managed care health plan in those counties in which a Medi-Cal managed care health plan is available.

(c) 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, 2017, 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. Notwithstanding Section 10231.5 of the Government Code, beginning six months after the effective date of this section, 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.

(d) 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. 48. Section 14043.38 of the Welfare and Institutions Code is amended to read:

14043.38. (a) Provider types are designated as “limited,” “moderate,” or “high” categorical risk by the federal government in Section 424.518 of Title 42 of the Code of Federal Regulations. The department shall, at minimum, utilize the federal regulations in determining a provider’s or applicant’s categorical risk.

(b) In accordance with Section 455.450 of Title 42 of the Code of Federal Regulations, the department shall designate a provider or applicant as a “high” categorical risk if any of the following occur:

(1) The department imposes a payment suspension based on a credible allegation of fraud, waste, or abuse.

(2) The provider or applicant has an existing Medicaid overpayment based on fraud, waste, or abuse.

(3) The provider or applicant has been excluded by the federal Office of the Inspector General or another state’s Medicaid program within the previous 10 years.

(4) The federal Centers for Medicare and Medicaid Services lifted a temporary moratorium within the previous six months for the particular provider type submitting the application, the applicant would have been prevented from enrolling based on that previous moratorium, and the applicant applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

(c) If the department designates a provider or applicant as a "high" categorical risk, the department or its designee shall do both of the following:

(1) Conduct a criminal background check of the provider or applicant, and any person with a 5-percent or greater direct or indirect ownership interest in the provider or applicant.

(2) Require the provider or applicant, and any person with a 5-percent or greater direct or indirect ownership interest in the provider or applicant, to submit a set of fingerprints within 30 days of the department's request, in a manner determined by the department.

(d) (1) The department shall submit to the Department of Justice fingerprint images and related information required by the Department of Justice of Medi-Cal providers or applicants determined to be a "high" categorical risk pursuant to subdivision (a), and any person with a 5-percent or greater direct or indirect ownership interest in those providers and applicants, for the purposes of obtaining information as to the existence and content of a record of state or federal convictions and state or federal arrests and also information as to the existence and content of a record of state or federal arrests for which the Department of Justice establishes that the person is free on bail or on his or her recognizance pending trial or appeal.

(2) When received, the Department of Justice shall forward to the Federal Bureau of Investigation requests for federal summary criminal history information received pursuant to this section. The Department of Justice shall review the information returned from the Federal Bureau of Investigation and compile and disseminate a response to the department.

(3) The Department of Justice shall provide a state or federal level response to the department pursuant to paragraph (1) of subdivision (p) of Section 11105 of the Penal Code.

(4) The department shall request from the Department of Justice subsequent notification service, as provided pursuant to Section 11105.2 of the Penal Code, for persons described in paragraph (1).

(5) The Department of Justice shall charge a fee sufficient to cover the cost of processing the request described in this section. That fee shall be paid by the subject of the criminal background check.

(e) For persons subject to the requirements of subdivision (a) of Section 15660, the procedure for obtaining and submitting fingerprints and notification by the Department of Justice of criminal record information set forth in subdivision (c) of Section 15660 shall apply instead of the procedure set forth in subdivision (d).

SEC. 49. Section 14104.35 is added to the Welfare and Institutions Code, to read:

14104.35. (a) Any contract amendments, modifications, or change orders to a fiscal intermediary contract entered into by the department for the purposes of implementing Section 14104.3 shall be exempt, except as provided in subdivision (b), from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part.

(b) Subdivision (a) shall not exempt the department from establishing a competitive bid process for awarding new contracts pursuant to Section 14104.3.

SEC. 50. Section 14131.11 is added to the Welfare and Institutions Code, to read:

14131.11. (a) Notwithstanding any other provision of this chapter or Chapter 8 (commencing with Section 14200), any increase in the amount charged to the Medi-Cal program for patient care or treatment that is directly related to an identifiable provider-preventable condition is excluded from reimbursement under Medi-Cal, in accordance with criteria set forth in federal and state law and the state's Medi-Cal State Plan, except when the provider-preventable condition existed prior to the initiation of treatment for that patient by that provider.

(b) The exclusion from reimbursement specified in subdivision (a) applies to the amounts charged for the care and treatment of individuals eligible under the Medi-Cal program, both in fee-for-service and managed care delivery systems, including individuals dually eligible for both the Medicare and Medi-Cal programs, individuals eligible under the California Children's Services Program, and individuals eligible under the Genetically Handicapped Persons Program.

(c) Exclusion from reimbursement under Medi-Cal pursuant to this section for increased amounts charged to Medi-Cal related to a provider-preventable condition shall be limited to the extent the identified provider-preventable condition would otherwise result in an increase in payment and the state can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable condition.

(d) For health care-acquired conditions, the department may limit application of the exclusion from reimbursement as appropriate for specific populations, including, but not limited to, the pediatric population, after consultation with the federal government and stakeholders.

(e) For health care-acquired conditions, the exclusion of reimbursement is initially limited to only those services provided by inpatient hospitals. For other provider-preventable conditions, the exclusion from reimbursement applies to health care services provided by any provider. This subdivision shall not limit the department from excluding from reimbursement those services provided in additional care settings as determined by the department. The department shall notify and consult with appropriate stakeholders prior to implementing, interpreting, or making specific this subdivision.

(f) Medi-Cal providers, in both fee-for-service and managed care delivery systems, shall report the occurrence of any provider-preventable condition in any individual identified in subdivision (b) that did not exist prior to

initiation of treatment by that provider. The report shall be made to the department as specified by the department, regardless of whether or not the provider seeks Medi-Cal reimbursement for services to treat the provider-preventable condition.

(g) If a provider in either a fee-for-service or managed care delivery system receives a Medi-Cal payment or reimbursement for any increase in costs for patient care or treatment directly related to an identifiable provider-preventable condition that was not present when the individual initiated treatment with that provider, the provider shall reimburse those costs to the department or plan.

(h) For purposes of this section, "provider-preventable condition," "health care-acquired condition," and "other provider-preventable condition" are defined as set forth in Section 447.26(b) of Title 42 of the Code of Federal Regulations.

(i) A provider is prohibited from pursuing payment or reimbursement from a beneficiary for any increased amounts directly related to treatment for, and related to, the provider-preventable condition.

(j) (1) 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 plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action, until the time regulations are adopted. Prior to issuing any letter, bulletin, or similar instruction authorized pursuant to this section, the department shall notify and consult with stakeholders, including advocates, providers, and beneficiaries. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance. It is the intent of the Legislature that the department be provided temporary authority as necessary to implement program changes until completion of the regulatory process, which shall further address and take into account the input of stakeholders.

(2) The department shall adopt emergency regulations pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code no later than January 1, 2017. The department may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted under this section. The initial adoption of emergency regulations and one readoption of emergency regulations implementing this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare.

(3) Initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the one readoption of emergency regulations shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(k) The department shall seek any necessary federal approvals for the implementation of this section.

(*l*) This section shall be implemented only to the extent that federal financial participation is not jeopardized.

(m) This section shall be implemented in accordance with the methodology set forth in the state plan in effect on July 1, 2012, and subsequently in accordance with any future methodologies approved by the federal Centers for Medicare and Medicaid Services.

SEC. 51. Section 14132.275 of the Welfare and Institutions Code, as amended by Section 13 of Chapter 37 of the Statutes of 2013, is amended to read:

14132.275. (a) The department shall seek federal approval to establish the demonstration project described in this section pursuant to a Medicare or a Medicaid demonstration project or waiver, or a combination thereof. Under a Medicare demonstration, the department may contract with the federal Centers for Medicare and Medicaid Services (CMS) and demonstration sites to operate the Medicare and Medicaid benefits in a demonstration project that is overseen by the state as a delegated Medicare benefit administrator, and may enter into financing arrangements with CMS to share in any Medicare program savings generated by the demonstration project.

(b) After federal approval is obtained, the department shall establish the demonstration project that enables dual eligible beneficiaries to receive a continuum of services that maximizes access to, and coordination of, benefits between the Medi-Cal and Medicare programs and access to the continuum of long-term services and supports and behavioral health services, including mental health and substance use disorder treatment services. The purpose of the demonstration project is to integrate services authorized under the federal Medicaid Program (Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.)) and the federal Medicare Program (Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.)). The demonstration project may also include additional services as approved through a demonstration project or waiver, or a combination thereof.

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

(1) "Behavioral health" means Medi-Cal services provided pursuant to Section 51341 of Title 22 of the California Code of Regulations and Drug Medi-Cal substance abuse services provided pursuant to Section 51341.1 of Title 22 of the California Code of Regulations, and any mental health benefits available under the Medicare Program.

(2) "Capitated payment model" means an agreement entered into between CMS, the state, and a managed care health plan, in which the managed care health plan receives a capitation payment for the comprehensive, coordinated provision of Medi-Cal services and benefits under Medicare Part C (42 U.S.C. Sec. 1395w-21 et seq.) and Medicare Part D (42 U.S.C. Sec. 1395w-101 et seq.), and CMS shares the savings with the state from improved provision of Medi-Cal and Medicare services that reduces the cost of those services. Medi-Cal services include long-term services and

supports as defined in Section 14186.1, behavioral health services, and any additional services offered by the demonstration site.

(3) "Demonstration site" means a managed care health plan that is selected to participate in the demonstration project under the capitated payment model.

(4) "Dual eligible beneficiary" means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) and Medicare Part B (42 U.S.C. Sec. 1395j et seq.) and is eligible for medical assistance under the Medi-Cal State Plan.

(d) No sooner than March 1, 2011, the department shall identify health care models that may be included in the demonstration project, shall develop a timeline and process for selecting, financing, monitoring, and evaluating the demonstration sites, and shall provide this timeline and process to the appropriate fiscal and policy committees of the Legislature. The department may implement these demonstration sites in phases.

(e) The department shall provide the fiscal and appropriate policy committees of the Legislature with a copy of any report submitted to CMS to meet the requirements under the demonstration project.

(f) Goals for the demonstration project shall include all of the following:

(1) Coordinate Medi-Cal and Medicare benefits across health care settings and improve the continuity of care across acute care, long-term care, behavioral health, including mental health and substance use disorder services, and home- and community-based services settings using a person-centered approach.

(2) Coordinate access to acute and long-term care services for dual eligible beneficiaries.

(3) Maximize the ability of dual eligible beneficiaries to remain in their homes and communities with appropriate services and supports in lieu of institutional care.

(4) Increase the availability of and access to home- and community-based services.

(5) Coordinate access to necessary and appropriate behavioral health services, including mental health and substance use disorder services.

(6) Improve the quality of care for dual eligible beneficiaries.

(7) Promote a system that is both sustainable and person and family centered by providing dual eligible beneficiaries with timely access to appropriate, coordinated health care services and community resources that enable them to attain or maintain personal health goals.

(g) No sooner than March 1, 2013, demonstration sites shall be established in up to eight counties, and shall include at least one county that provides Medi-Cal services via a two-plan model pursuant to Article 2.7 (commencing with Section 14087.3) and at least one county that provides Medi-Cal services under a county organized health system pursuant to Article 2.8 (commencing with Section 14087.5). The director shall consult with the Legislature, CMS, and stakeholders when determining the implementation date for this section. In determining the counties in which to establish a demonstration site, the director shall consider the following:

(1) Local support for integrating medical care, long-term care, and home- and community-based services networks.

(2) A local stakeholder process that includes health plans, providers, mental health representatives, community programs, consumers, designated representatives of in-home supportive services personnel, and other interested stakeholders in the development, implementation, and continued operation of the demonstration site.

(h) In developing the process for selecting, financing, monitoring, and evaluating the health care models for the demonstration project, the department shall enter into a memorandum of understanding with CMS. Upon completion, the memorandum of understanding shall be provided to the fiscal and appropriate policy committees of the Legislature and posted on the department's Internet Web site.

(i) The department shall negotiate the terms and conditions of the memorandum of understanding, which shall address, but are not limited to, the following:

(1) Reimbursement methods for a capitated payment model. Under the capitated payment model, the demonstration sites shall meet all of the following requirements:

(A) Have Medi-Cal managed care health plan and Medicare dual eligible-special needs plan contract experience, or evidence of the ability to meet these contracting requirements.

(B) Be in good financial standing and meet licensure requirements under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), except for county organized health system plans that are exempt from licensure pursuant to Section 14087.95.

(C) Meet quality measures, which may include Medi-Cal and Medicare Healthcare Effectiveness Data and Information Set measures and other quality measures determined or developed by the department or CMS.

(D) Demonstrate a local stakeholder process that includes dual eligible beneficiaries, managed care health plans, providers, mental health representatives, county health and human services agencies, designated representatives of in-home supportive services personnel, and other interested stakeholders that advise and consult with the demonstration site in the development, implementation, and continued operation of the demonstration project.

(E) Pay providers reimbursement rates sufficient to maintain an adequate provider network and ensure access to care for beneficiaries.

(F) Follow final policy guidance determined by CMS and the department with regard to reimbursement rates for providers pursuant to paragraphs (4) to (7), inclusive, of subdivision (o).

(G) To the extent permitted under the demonstration, pay noncontracted hospitals prevailing Medicare fee-for-service rates for traditionally Medicare covered benefits and prevailing Medi-Cal fee-for-service rates for traditionally Medi-Cal covered benefits.

(2) Encounter data reporting requirements for both Medi-Cal and Medicare services provided to beneficiaries enrolling in the demonstration project.

(3) Quality assurance withholding from the demonstration site payment, to be paid only if quality measures developed as part of the memorandum of understanding and plan contracts are met.

(4) Provider network adequacy standards developed by the department and CMS, in consultation with the Department of Managed Health Care, the demonstration site, and stakeholders.

(5) Medicare and Medi-Cal appeals and hearing process.

(6) Unified marketing requirements and combined review process by the department and CMS.

(7) Combined quality management and consolidated reporting process by the department and CMS.

(8) Procedures related to combined federal and state contract management to ensure access, quality, program integrity, and financial solvency of the demonstration site.

(9) To the extent permissible under federal requirements, implementation of the provisions of Sections 14182.16 and 14182.17 that are applicable to beneficiaries simultaneously eligible for full-scope benefits under Medi-Cal and the Medicare Program.

(10) (A) In consultation with the hospital industry, CMS approval to ensure that Medicare supplemental payments for direct graduate medical education and Medicare add-on payments, including indirect medical education and disproportionate share hospital adjustments continue to be made available to hospitals for services provided under the demonstration.

(B) The department shall seek CMS approval for CMS to continue these payments either outside the capitation rates or, if contained within the capitation rates, and to the extent permitted under the demonstration project, shall require demonstration sites to provide this reimbursement to hospitals.

(11) To the extent permitted under the demonstration project, the default rate for noncontracting providers of physician services shall be the prevailing Medicare fee schedule for services covered by the Medicare program and the prevailing Medi-Cal fee schedule for services covered by the Medi-Cal program.

(j) (1) The department shall comply with and enforce the terms and conditions of the memorandum of understanding with CMS, as specified in subdivision (i). To the extent that the terms and conditions do not address the specific selection, financing, monitoring, and evaluation criteria listed in subdivision (i), the department:

(A) Shall require the demonstration site to do all of the following:

(i) Comply with additional site readiness criteria specified by the department.

(ii) Comply with long-term services and supports requirements in accordance with Article 5.7 (commencing with Section 14186).

(iii) To the extent permissible under federal requirements, comply with the provisions of Sections 14182.16 and 14182.17 that are applicable to

beneficiaries simultaneously eligible for full-scope benefits under both Medi-Cal and the Medicare Program.

(iv) Comply with all transition of care requirements for Medicare Part D benefits as described in Chapters 6 and 14 of the Medicare Managed Care Manual, published by CMS, including transition timeframes, notices, and emergency supplies.

(B) May require the demonstration site to forgo charging premiums, coinsurance, copayments, and deductibles for Medicare Part C and Medicare Part D services.

(2) The department shall notify the Legislature within 30 days of the implementation of each provision in paragraph (1).

(k) The director may enter into exclusive or nonexclusive contracts on a bid or negotiated basis and may amend existing managed care contracts to provide or arrange for services provided under this section. Contracts entered into or amended pursuant to this section shall be exempt from the provisions of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code.

(*l*) (1) (A) Except for the exemptions provided for in this section and in Section 14132.277, the department shall enroll dual eligible beneficiaries into a demonstration site unless the beneficiary makes an affirmative choice to opt out of enrollment or is already enrolled on or before June 1, 2013, in a managed care organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has previously contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS or in any entity with a contract with the department pursuant to Chapter 8.75 (commencing with Section 14591).

(B) Dual eligible beneficiaries who opt out of enrollment into a demonstration site may choose to remain enrolled in fee-for-service Medicare or a Medicare Advantage plan for their Medicare benefits, but shall be mandatorily enrolled into a Medi-Cal managed care health plan pursuant to Section 14182.16, except as exempted under subdivision (c) of Section 14182.16.

(C) (i) Persons meeting requirements for the Program of All-Inclusive Care for the Elderly (PACE) pursuant to Chapter 8.75 (commencing with Section 14591) or a managed care organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has previously contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) of Chapter 7 to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS may select either of these managed care health plans for their Medicare and Medi-Cal benefits if one is available in that county.

(ii) In areas where a PACE plan is available, the PACE plan shall be presented as an enrollment option, included in all enrollment materials, enrollment assistance programs, and outreach programs related to the demonstration project, and made available to beneficiaries whenever enrollment choices and options are presented. Persons meeting the age qualifications for PACE and who choose PACE shall remain in the fee-for-service Medi-Cal and Medicare programs, and shall not be assigned to a managed care health plan for the lesser of 60 days or until they are assessed for eligibility for PACE and determined not to be eligible for a PACE plan. Persons enrolled in a PACE plan shall receive all Medicare and Medi-Cal services from the PACE program pursuant to the three-way agreement between the PACE program, the department, and the Centers for Medicare and Medicaid Services.

(2) To the extent that federal approval is obtained, the department may require that any beneficiary, upon enrollment in a demonstration site, remain enrolled in the Medicare portion of the demonstration project on a mandatory basis for six months from the date of initial enrollment. After the sixth month, a dual eligible beneficiary may elect to enroll in a different demonstration site, a different Medicare Advantage plan, fee-for-service Medicare, PACE, or a managed care organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has previously contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS, for his or her Medicare benefits.

(A) During the six-month mandatory enrollment in a demonstration site, a beneficiary may continue receiving services from an out-of-network Medicare provider for primary and specialty care services only if all of the following criteria are met:

(i) The dual eligible beneficiary demonstrates an existing relationship with the provider prior to enrollment in a demonstration site.

(ii) The provider is willing to accept payment from the demonstration site based on the current Medicare fee schedule.

(iii) The demonstration site would not otherwise exclude the provider from its provider network due to documented quality of care concerns.

(B) The department shall develop a process to inform providers and beneficiaries of the availability of continuity of services from an existing provider and ensure that the beneficiary continues to receive services without interruption.

(3) (A) Notwithstanding subparagraph (A) of paragraph (1), a dual eligible beneficiary shall be excluded from enrollment in the demonstration project if the beneficiary meets any of the following:

(i) The beneficiary has a prior diagnosis of end-stage renal disease. This clause shall not apply to beneficiaries diagnosed with end-stage renal disease subsequent to enrollment in the demonstration project. The director may, with stakeholder input and federal approval, authorize beneficiaries with a

prior diagnosis of end-stage renal disease in specified counties to voluntarily enroll in the demonstration project.

(ii) The beneficiary has other health coverage, as defined in paragraph (5) of subdivision (b) of Section 14182.16.

(iii) The beneficiary is enrolled in a home- and community-based waiver that is a Medi-Cal benefit under Section 1915(c) of the federal Social Security Act (42 U.S.C. Sec. 1396n et seq.), except for persons enrolled in Multipurpose Senior Services Program services.

(iv) The beneficiary is receiving services through a regional center or state developmental center.

(v) The beneficiary resides in a geographic area or ZIP Code not included in managed care, as determined by the department and CMS.

(vi) The beneficiary resides in one of the Veterans' Homes of California, as described in Chapter 1 (commencing with Section 1010) of Division 5 of the Military and Veterans Code.

(B) (i) Beneficiaries who have been diagnosed with HIV/AIDS may opt out of the demonstration project at the beginning of any month. The State Department of Public Health may share relevant data relating to a beneficiary's enrollment in the AIDS Drug Assistance Program with the department, and the department may share relevant data relating to HIV-positive beneficiaries with the State Department of Public Health.

(ii) The information provided by the State Department of Public Health pursuant to this subparagraph shall not be further disclosed by the State Department of Health Care Services, and shall be subject to the confidentiality protections of subdivisions (d) and (e) of Section 121025 of the Health and Safety Code, except this information may be further disclosed as follows:

(I) To the person to whom the information pertains or the designated representative of that person.

(II) To the Office of AIDS within the State Department of Public Health.

(C) Beneficiaries who are Indians receiving Medi-Cal services in accordance with Section 55110 of Title 22 of the California Code of Regulations may opt out of the demonstration project at the beginning of any month.

(D) The department, with stakeholder input, may exempt specific categories of dual eligible beneficiaries from enrollment requirements in this section based on extraordinary medical needs of specific patient groups or to meet federal requirements.

(4) For the 2013 calendar year, the department shall offer federal Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275) compliant contracts to existing Medicare Advantage Dual Special Needs Plans (D-SNP plans) to continue to provide Medicare benefits to their enrollees in their service areas as approved on January 1, 2012. In the 2013 calendar year, beneficiaries in Medicare Advantage and D-SNP plans shall be exempt from the enrollment provisions of subparagraph (A) of paragraph (1), but may voluntarily choose to enroll in the demonstration project. Enrollment into the demonstration project's managed care health

plans shall be reassessed in 2014 depending on federal reauthorization of the D-SNP model and the department's assessment of the demonstration plans.

(5) For the 2013 calendar year, demonstration sites shall not offer to enroll dual eligible beneficiaries eligible for the demonstration project into the demonstration site's D-SNP.

(6) The department shall not terminate contracts in a demonstration site with a managed care organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has previously contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) to provide services to beneficiaries who are HIV positive beneficiaries or who have been diagnosed with AIDS and with any entity with a contract pursuant to Chapter 8.75 (commencing with Section 14591), except as provided in the contract or pursuant to state or federal law.

(m) Notwithstanding Section 10231.5 of the Government Code, the department shall conduct an evaluation, in partnership with CMS, to assess outcomes and the experience of dual eligibles in these demonstration sites and shall provide a report to the Legislature after the first full year of demonstration operation, and annually thereafter. A report submitted to the Legislature pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code. The department shall consult with stakeholders regarding the scope and structure of the evaluation.

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

(o) It is the intent of the Legislature that:

(1) In order to maintain adequate provider networks, demonstration sites shall reimburse providers at rates sufficient to ensure access to care for beneficiaries.

(2) Savings under the demonstration project are intended to be achieved through shifts in utilization, and not through reduced reimbursement rates to providers.

(3) Reimbursement policies shall not prevent demonstration sites and providers from entering into payment arrangements that allow for the alignment of financial incentives and provide opportunities for shared risk and shared savings in order to promote appropriate utilization shifts, which encourage the use of home- and community-based services and quality of care for dual eligible beneficiaries enrolled in the demonstration sites.

(4) To the extent permitted under the demonstration project, and to the extent that a public entity voluntarily provides an intergovernmental transfer for this purpose, both of the following shall apply:

(A) The department shall work with CMS in ensuring that the capitation rates under the demonstration project are inclusive of funding currently provided through certified public expenditures supplemental payment programs that would otherwise be impacted by the demonstration project.

(B) Demonstration sites shall pay to a public entity voluntarily providing intergovernmental transfers that previously received reimbursement under a certified public expenditures supplemental payment program, rates that include the additional funding under the capitation rates that are funded by the public entity's intergovernmental transfer.

(5) The department shall work with CMS in developing other reimbursement policies and shall inform demonstration sites, providers, and the Legislature of the final policy guidance.

(6) The department shall seek approval from CMS to permit the provider payment requirements contained in subparagraph (G) of paragraph (1) and paragraphs (10) and (11) of subdivision (i), and Section 14132.276.

(7) Demonstration sites that contract with hospitals for hospital services on a fee-for-service basis that otherwise would have been traditionally Medicare services will achieve savings through utilization changes and not by paying hospitals at rates lower than prevailing Medicare fee-for-service rates.

(p) The department shall enter into an interagency agreement with the Department of Managed Health Care to perform some or all of the department's oversight and readiness review activities specified in this section. These activities may include providing consumer assistance to beneficiaries affected by this section and conducting financial audits, medical surveys, and a review of the adequacy of provider networks of the managed care health plans participating in this section. The interagency agreement shall be updated, as necessary, on an annual basis in order to maintain functional clarity regarding the roles and responsibilities of the Department of Managed Health Care and the department. The department shall not delegate its authority under this section as the single state Medicaid agency to the Department of Managed Health Care.

(q) (1) Beginning with the May Revision to the 2013–14 Governor's Budget, and annually thereafter, the department shall report to the Legislature on the enrollment status, quality measures, and state costs of the actions taken pursuant to this section.

(2) (A) By January 1, 2013, or as soon thereafter as practicable, the department shall develop, in consultation with CMS and stakeholders, quality and fiscal measures for health plans to reflect the short- and long-term results of the implementation of this section. The department shall also develop quality thresholds and milestones for these measures. The department shall update these measures periodically to reflect changes in this program due to implementation factors and the structure and design of the benefits and services being coordinated by managed care health plans.

(B) The department shall require health plans to submit Medicare and Medi-Cal data to determine the results of these measures. If the department finds that a health plan is not in compliance with one or more of the measures set forth in this section, the health plan 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 health plan shall take to improve its performance based on the standard or standards with which the

health plan is out of compliance. The plan shall establish interim benchmarks for improvement that shall be expected to be met by the health plan in order to avoid a sanction pursuant to Section 14304. Nothing in this subparagraph is intended to limit Section 14304.

(C) The department shall publish the results of these measures, including via posting on the department's Internet Web site, on a quarterly basis.

(r) 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 and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. Prior to issuing any letter or similar instrument authorized pursuant to this section, the department shall notify and consult with stakeholders, including advocates, providers, and beneficiaries. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

(s) This section shall be inoperative if the Coordinated Care Initiative becomes inoperative pursuant to Section 34 of the act that added this subdivision.

SEC. 52. Section 14132.277 of the Welfare and Institutions Code is amended to read:

14132.277. (a) For purposes of this section, the following definitions shall apply:

(1) "Alternate health care service plan" means a prepaid health plan that is a nonprofit health care service plan with at least 3.5 million enrollees statewide, that owns or operates its own pharmacies, and that provides medical services to enrollees in specific geographic regions through an exclusive contract with a single medical group in each specific geographic region in which it operates to provide services to enrollees.

(2) "Cal MediConnect plan" means a health plan or other qualified entity jointly selected by the state and CMS for participation in the demonstration project.

(3) "CMS" means the federal Centers for Medicare and Medicaid Services.

(4) "Coordinated Care Initiative county" means the Counties of Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara, and any other county identified in Appendix 3 of the Memorandum of Understanding Between the Centers for Medicare and Medicaid Services and the State of California, Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees, inclusive of all amendments, as authorized by Section 14132.275.

(5) "D-SNP plan" means a Medicare Advantage Dual Special Needs Plan.

(6) "D-SNP contract" means a federal Medicare Improvements for Patients and Provider Act of 2008 (Public Law 110-275) compliant contract between the department and a D-SNP plan.

(7) "Demonstration project" means the demonstration project authorized by Section 14132.275.

(8) "Excluded beneficiaries" means those beneficiaries who are not eligible to participate in the demonstration project pursuant to subdivision (*l*) of Section 14132.275.

(9) "FIDE-SNP plan" means a Medicare Advantage Fully-Integrated Dual Eligible Special Needs Plan.

(10) "Non-Coordinated Care Initiative counties" means counties not participating in the demonstration project.

(b) For the 2014 calendar year, the department shall offer D-SNP contracts to existing D-SNP plans to continue to provide benefits to their enrollees in their service areas as approved on January 1, 2013. The director may include in any D-SNP contract provisions requiring that the D-SNP plan do the following:

(1) Submit to the department a complete and accurate copy of the bid submitted by the plan to CMS for its D-SNP contract.

(2) Submit to the department copies of all utilization and quality management reports submitted to CMS.

(c) In Coordinated Care Initiative counties, Medicare Advantage plans and D-SNP plans may continue to enroll beneficiaries in 2014. In the 2014 calendar year, beneficiaries enrolled in a Medicare Advantage or D-SNP plan operating in a Coordinated Care Initiative county shall be exempt from the enrollment provisions of subparagraph (A) of paragraph (1) of subdivision (*l*) of Section 14132.275. Those beneficiaries may at any time voluntarily choose to disenroll from their Medicare Advantage or D-SNP plan and enroll in a demonstration site operating pursuant to subdivision (g) of Section 14132.275. If a beneficiary chooses to do so, that beneficiary may subsequently disenroll from the demonstration site and return to fee-for-service Medicare or to a D-SNP plan or Medicare Advantage plan.

(d) For the 2015 calendar year and the remainder of the demonstration project, in Coordinated Care Initiative counties, the department shall offer D-SNP contracts to D-SNP plans that were approved for the D-SNP plan's service areas as of January 1, 2013. In Coordinated Care Initiative counties, the department shall enter into D-SNP contracts with D-SNP plans only for excluded beneficiaries and for those beneficiaries identified in paragraphs (2) and (5) of subdivision (g).

(e) For the 2015 calendar year and the remainder of the demonstration project, in non-Coordinated Care Initiative counties, the department shall offer D-SNP contracts to D-SNP plans.

(f) The director may include in a D-SNP contract offered pursuant to subdivision (d) or (e) provisions requiring that the D-SNP plan do the following:

(1) Submit to the department a complete and accurate copy of the bid submitted by the plan to CMS for its D-SNP contract.

(2) Submit to the department copies of all utilization and quality management reports submitted to CMS.

(g) For the 2015 calendar year and the remainder of the demonstration project, in Coordinated Care Initiative counties, the enrollment provisions of subdivision (*l*) of Section 14132.275 shall apply subject to the following:

(1) Beneficiaries enrolled in a FIDE-SNP plan or a Medicare Advantage plan, other than a D-SNP plan, shall be exempt from the enrollment provisions of subparagraph (A) of paragraph (1) of subdivision (*l*) of Section 14132.275.

(2) Where the D-SNP plan is not a Cal MediConnect plan, beneficiaries enrolled as of December 31, 2014, in a D-SNP plan shall be exempt from the enrollment provisions of subparagraph (A) of paragraph (1) of subdivision (*l*) of Section 14132.275. Those beneficiaries may at any time voluntarily choose to disenroll from their D-SNP plan and enroll in a demonstration site operating pursuant to subdivision (g) of Section 14132.275. A dual eligible beneficiary who is enrolled as of December 31, 2014, in a D-SNP plan that is not a Cal MediConnect plan and who opts out of a demonstration site during the course of the demonstration project may choose to reenroll in that D-SNP plan.

(3) Where the D-SNP is a Cal MediConnect plan, beneficiaries enrolled in a D-SNP plan who are eligible for the demonstration project shall be subject to the enrollment provisions of subparagraph (A) of paragraph (1) of subdivision (*l*) of Section 14132.275.

(4) For FIDE-SNP plans serving beneficiaries in Coordinated Care Initiative counties, the department shall require the following provisions:

(A) After December 31, 2014, enrollment in Los Angeles County shall not exceed 6,000 additional beneficiaries at any point during the term of the demonstration project. After December 31, 2014, enrollment in the combined Riverside and San Bernardino counties shall not exceed 1,500 additional beneficiaries at any point during the term of the demonstration project.

(B) Any necessary data or information requirements provided by the FIDE-SNP to ensure contract compliance.

(5) Beneficiaries enrolled in an alternate health care service plan (AHCSP) who become dually eligible for Medicare and Medicaid benefits while enrolled in that AHCSP may elect to enroll in the AHCSP's D-SNP plan subject to the following requirements:

(A) The beneficiary was a member of the AHCSP immediately prior to becoming dually eligible for Medicare and Medicaid benefits.

(B) Upon mutual agreement between a Cal MediConnect Plan operated by a health authority or commission contracting with the department and the AHCSP, the AHCSP shall take full financial and programmatic responsibility for the long-term supports and services of the D-SNP enrollee, including, but not limited to, in-home supportive services, long term skilled nursing care, community based adult services, multipurpose senior services program services, and other Medi-Cal benefits offered in the demonstration project.

(6) Prior to assigning a beneficiary in a Medi-Cal managed care health plan pursuant to Section 14182.16, the department shall determine whether the beneficiary is already a member of the AHCSP. If so, the beneficiary shall be assigned to a Medi-Cal managed care health plan operated by a health authority or commission contracting with the department and subcontracting with the AHCSP.

SEC. 53. Section 14132.915 is added to the Welfare and Institutions Code, to read:

14132.915. (a) (1) The department shall establish a list of performance measures to ensure the dental fee-for-service program meets quality and access criteria required by the department. The performance measures shall be designed to evaluate utilization, access, availability, and effectiveness of preventive care and treatment.

(2) Prior to establishing the quality and access criteria described in paragraph (1), the department shall consult with stakeholders, including representatives from counties, local dental societies, nonprofit entities, legal aid entities, and other interested parties.

(3) The performance measures established by the department to monitor the dental fee-for-service program for children shall include, but not be limited to, all of the following:

(A) Overall utilization of dental services.

(B) Number of annual dental visits, preventive dental services, dental treatment services, and examinations and oral health evaluations.

(C) Number of applications of dental sealants.

(D) Continuity of care and overall utilization over an extended period of time.

(E) All of the following ratios:

(i) Sealant to restoration.

(ii) Filling to preventive services.

(iii) Treatment to caries prevention.

(4) The performance measures established by the department to monitor the dental fee-for-service program for adults shall include, but not be limited to, all of the following:

(A) Number of annual dental visits and preventive dental services.

(B) Treatment to caries prevention ratio.

(5) The performance measures shall be reported as aggregate numbers and as percentages, if appropriate, using standards that are as equivalent to those used by managed care entities as feasible. Performance measures for the dental fee-for-service program for children shall be reported by age groupings if appropriate.

(b) The department shall include the initial list of performance measures in any dental contract entered into between the department and a fee-for-service contractor on or after enactment of this section.

(c) To ensure that the dental health needs of Medi-Cal beneficiaries are met, the department shall, when evaluating performance measures for retention on, addition to, or deletion from, the list of performance measures, consider all of the following criteria:

(1) Annual and multiyear Medi-Cal dental fee-for-service trended data.

(2) Other state and national dental program performance and quality measures.

(3) Other state and national performance ratings.

(d) Commencing October 1, 2014, for the 2013 calendar year, and annually on or before October 1 for each preceding calendar year thereafter, the list of performance measures established by the department along with the data of the dental fee-for-service program performance shall be posted on the department's Internet Web site.

(e) The department may amend or remove performance measures and establish additional performance measures in accordance with all of the following:

(1) The department shall consider performance measures established by other states, the federal government, and national organizations developing dental program performance and quality measures.

(2) The department shall notify a fee-for-service contractor, at least 30 days prior to the implementation date, of any updates or changes to performance measures. The department shall also post these updates or changes on its Internet Web site at least 30 days prior to implementation in order to maintain transparency to the public.

(3) In establishing the performance measures, the department shall consult with stakeholders, including representatives from counties, local dental societies, nonprofit entities, legal aid entities, and other interested parties.

(f) The department shall annually prepare a summary report of the nature and types of complaints and grievances regarding access to, and quality of, dental services, including the outcome. Commencing no sooner than October 1, 2015, for the prior calendar year, and annually thereafter, for each preceding calendar year, this report shall be posted on the department's Internet Web site.

SEC. 54. 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 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 to maintain and not to alter, reduce, suspend, restrict, or otherwise limit any Medi-Cal benefits or services currently available to eligible pregnant women receiving only pregnancy-related and postpartum services through the Medi-Cal program to the extent those services and benefits are not available through the beneficiary's qualified health plan through the Exchange.

(3) It is further the intent of the Legislature to maximize federal funding while making no-cost health care coverage available to pregnant women receiving only pregnancy-related and postpartum services who opt to enroll or remain 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

program for pregnant women within the applicable income range within the Exchange. The intent of the Legislature is to enact a program within the Exchange that would provide pregnant women with no-share of cost health 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 receiving only pregnancy-related and postpartum services means Exchange qualified health plans and providers serving beneficiaries pursuant to those plans are prohibited from charging, billing, requesting, or requiring the women to pay any of the costs or charges for any services covered by the Exchange qualified health plan, or any premiums or cost sharing during their pregnancy and postpartum coverage as provided in paragraph (1) of subdivision (b) of Section 14148.67. The Legislature reaffirms that Medi-Cal providers are prohibited from charging, billing, requesting, or requiring beneficiaries to pay for or refusing to provide Medi-Cal covered services that are not available through an eligible woman's Exchange qualified health plan.

(b) After the director determines in writing that CalHEERS has been programmed for implementation of this section, but no sooner than January 1, 2015, the department, in coordination with the Exchange, shall implement this section 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. At the applicant's or beneficiary's option, the department shall allow the individual to enroll or remain enrolled in an Exchange qualified health plan while at the same time enrolling or remaining enrolled in the Medi-Cal program, and shall ensure that the beneficiary 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 follows:

(1) If a beneficiary is only eligible for pregnancy-related and postpartum services under this chapter and the beneficiary has opted to enroll or remain enrolled in both Medi-Cal and coverage under a qualified health plan offered under the Exchange, the department shall pay both of the following on behalf of the beneficiary in accordance with Section 14148.67:

(A) 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.

(B) 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.

(2) The department shall provide beneficiaries who are receiving benefits under this section with only those Medi-Cal benefits for pregnancy-related and postpartum services that are covered under the Medi-Cal program and, except when otherwise required by state or federal law, that are not available through the beneficiary's qualified health plan. These beneficiaries shall retain all rights and responsibilities to which they are legally entitled under

the Medi-Cal program. The beneficiaries shall have the right to access Medi-Cal providers' services through the Medi-Cal program that are not contracting with the Exchange qualified health plan as required under state or federal law, including, but not limited to, the right to access family planning services, services provided by Comprehensive Perinatal Services Program (CPSP) Medi-Cal providers, perinatal specialists, certified nurse-midwife services, and alternative and freestanding birth center services, to the extent those services are not available through the beneficiary's Exchange qualified health plan, except when state or federal law requires the right to access the service without regard to its availability through the beneficiary's Exchange qualified health plan. The department shall implement its policies and procedures on other health care coverage in a manner consistent with this subdivision.

(3) Nothing in this section shall preclude a beneficiary from opting to enroll or remain enrolled in Medi-Cal for pregnancy-related and postpartum services without enrolling or remaining enrolled in an Exchange qualified health plan or from enrolling or remaining enrolled in an Exchange qualified health plan without enrolling or remaining enrolled in Medi-Cal for pregnancy-related and postpartum services.

(c) The department shall consult with the Exchange, Exchange contracting health care service plans and health insurers, and stakeholders, including consumer advocates, Medi-Cal providers, counties, the State Department of Public Health, county maternal, child, and adolescent health directors, and county CPSP coordinators, in the development and implementation of all of the following:

(1) Processes and procedures to inform affected applicants and beneficiaries in a clear, consumer-friendly manner of all of their enrollment options under the Medi-Cal program and the Exchange, of the manner in which they may receive the benefits and services covered through the Exchange coverage, and of the manner in which they may receive benefits and services under this section. This information shall be provided at the time of application and renewal and when a beneficiary who is enrolled in the Medi-Cal program or in an Exchange qualified health plan informs Medi-Cal or the Exchange qualified health plan that she is pregnant.

(2) A process and procedure for applicants and beneficiaries who are 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 (b) or to remain in or enroll in Medi-Cal and not enroll in Exchange coverage. The process and all options shall be made available to women at the time of applying to the Medi-Cal program or the Exchange and during their enrollment in Medi-Cal or Exchange coverage, as applicable.

(3) The process for implementing other health coverage policy and the right to access Medi-Cal providers' services through the Medi-Cal program that are not contracting with the Exchange qualified health plan, including,

but not limited to, family planning services, services provided by CPSP Medi-Cal providers, perinatal specialists, certified nurse-midwife services, and alternative and freestanding birth center services, to the extent those services are not available through the beneficiary's Exchange qualified health plan, except when state or federal law requires the right to access the service without regard to its availability through the beneficiary's Exchange qualified health plan.

(4) Standardized notices and procedures to inform affected Medi-Cal applicants and beneficiaries and affected individuals applying for or enrolled in the Exchange of the option and the process for eligible women to enroll or remain enrolled in Exchange coverage and receive Medi-Cal pregnancy-related and postpartum coverage under this section or to remain in or enroll in Medi-Cal and not enroll in Exchange coverage.

(5) Standardized notices and procedures to inform Medi-Cal beneficiaries receiving benefits under this section that infants born to pregnant women receiving Medi-Cal benefits at the time of birth are automatically eligible for the Medi-Cal program throughout the infant's first year of life and of the processes for enrolling their newborns in the Medi-Cal program without an application.

(6) Provider notices to ensure that Medi-Cal providers are aware of the Medi-Cal pregnancy program under this section 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.

(7) Monitoring and data reporting required by subdivision (e).

(d) All notices developed under subdivision (c) shall be accessible to persons who have limited English language proficiency and persons with disabilities consistent with all federal and state requirements.

(e) (1) In addition, the department shall consult with the Exchange and Exchange contracting qualified health plans in the development of a process for the department to make the payment of premiums and cost sharing under this section and in the development of a process for the department to evaluate the birth outcomes of women who are receiving benefits under this section.

(2) (A) The department shall consult with the Exchange regarding the inclusion of certified CPSP Medi-Cal providers in qualified health plan provider networks. Additionally, the department shall encourage certified CPSP Medi-Cal providers to contract with Exchange qualified health plans in order to serve the beneficiaries who are receiving services under this section.

(B) The department shall monitor the birth outcomes of women who are receiving benefits under this section and the birth outcomes of women receiving full scope and limited scope pregnancy services under the Medi-Cal program, shall monitor access to and the utilization of CPSP services from Medi-Cal providers by beneficiaries receiving benefits under this section, and shall assess if there are any differences in birth outcomes between

pregnant women receiving full scope and limited scope services under the Medi-Cal program and women receiving benefits under this section.

(C) To the extent possible, the department shall assess CPSP Medi-Cal provider participation as contracted providers with Exchange qualified health plans.

(f) (1) The department may contract with public or private entities, or both, including the Exchange, to implement this section and Section 14148.67. Contracts entered into under these sections may be on a noncompetitive bid basis and are exempt from the following:

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

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

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

(2) For contracts entered into under this subdivision, the department shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on the projected or actual beneficiary enrollments to a total amount not to exceed the amount appropriated for the program.

(g) 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, 2017, 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. Notwithstanding Section 10231.5 of the Government Code, beginning six months after the effective date of this section, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(h) 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.

(i) 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.

SEC. 55. 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.

(b) (1) The beneficiary shall not be charged, billed, asked, or 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 by the department under Section 14102 or 14148.65.

(2) If the beneficiary makes any premium or cost-sharing payments to his or her plan or provider for services that are subject to premium or cost-sharing payments by the department under Section 14102 or 14148.65, the department shall reimburse the beneficiary for those payments. The department shall make every reasonable effort to do both of the following:

(A) Make the reimbursement process simple and easy for beneficiaries to use.

(B) Promptly reimburse beneficiaries under this paragraph.

(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.

(4) 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 federal government owes and makes a tax refund to the beneficiary based upon the beneficiary's advanced premium tax credit, the beneficiary shall reimburse the department for the portion of the refund that is related to the tax credits that were applied to the premium payments made by the department.

(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 selects or remains 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) The department shall consult with the Exchange, Exchange contracting health care service plans and health insurers, and stakeholders, including consumer advocates, Medi-Cal providers, and the counties, in the development and implementation of the following:

(1) Processes and procedures to inform affected applicants and beneficiaries in a clear, consumer-friendly manner of all of their enrollment options under the Medi-Cal program and the Exchange, of the manner in which they may receive the benefits and services covered through the Exchange coverage, and of the manner in which they may receive benefits and services under Section 14102.

(2) Provider notices to ensure that Medi-Cal providers are aware of the Medi-Cal program under Section 14102 and that providers comply with state laws applicable to Medi-Cal coverage for individuals eligible under Section 14102.

(e) All notices developed under subdivision (d) shall be accessible to persons with limited English language proficiency and persons with disabilities consistent with all federal and state requirements.

(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. The department shall adopt regulations by July 1, 2017, 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. Notwithstanding Section 10231.5 of the Government Code, beginning six months after the effective date of this section, 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 be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

SEC. 56. 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, if applicable, modified and the rationale for the changes.

(6) Notwithstanding any other 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 processing and case maintenance for applicants and beneficiaries.

(A) The budgeting methodology 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, 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) The department shall provide the new budgeting methodology to the legislative fiscal committees by March 1 of the fiscal year immediately preceding the first fiscal year of implementation of the new budgeting methodology.

(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, 2017, 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 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, 2012–13, and 2014–15 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) If 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. 57. Section 14165.50 of the Welfare and Institutions Code is amended to read:

14165.50. (a) To facilitate the financial viability of a new private nonprofit hospital that will serve the population of South Los Angeles that was formerly served by the Los Angeles County Martin Luther King, Jr.-Harbor Hospital, Medi-Cal funding shall, at a minimum, be made available, as specified in this section, or pursuant to mechanisms that provide equivalent funding under successor or modified Medi-Cal payment systems.

(b) Medi-Cal payment for hospital services provided by the new hospital, exclusive of any payments under the Medi-Cal Hospital Reimbursement

Improvement Act of 2013 (Article 5.230 (commencing with Section 14169.50)) or funded by another statewide hospital fee program, and exclusive of the supplemental payments specified in subdivision (d), shall include consideration of the new hospital's projected Medi-Cal costs for providing the services as set forth in this section.

(1) (A) Subject to paragraph (2) of subdivision (c), and notwithstanding any other law, Medi-Cal payments made to the new hospital on a fee-for-service basis, including payments made pursuant to the methodology authorized under Section 14105.28 or successor or modified methodologies, shall provide compensation that is, at a minimum, equal to 100 percent of the new hospital's projected Medi-Cal costs for each fiscal year.

(B) To the extent supplemental payments are necessary for any fiscal year to meet the applicable minimum reimbursement level as described in subparagraph (A), the department shall seek federal approval, as necessary, to enable the new hospital to receive the Medi-Cal supplemental payments.

(2) (A) To the extent permitted under federal law, the department shall require Medi-Cal managed care plans serving Medi-Cal beneficiaries in the County of Los Angeles to pay the new hospital amounts determined necessary to meet compensation levels for services provided to managed care enrollees that are no less than the amount to which the new hospital would have received on a fee-for-service basis pursuant to paragraph (1). The amounts shall be determined in consultation with the new hospital, the County of Los Angeles, and the Medi-Cal managed care plan, and shall be subject to paragraph (2) of subdivision (c).

(B) Consistent with federal law, the capitation rates paid to Medi-Cal managed care plans serving Medi-Cal beneficiaries in the County of Los Angeles shall be determined to reflect the obligations described in subparagraph (A). The increased payments to Medi-Cal managed care plans that would be paid consistent with actuarial certification and enrollment in the absence of this paragraph shall not be reduced as a consequence of this paragraph.

(C) A Medi-Cal managed care plan receiving the increased payments described in subparagraph (B) shall not impose a fee or retention amount, or reduce other payments to the new hospital that would result in a direct or indirect reduction to the amounts required to be paid under subparagraph (A).

(3) This subdivision shall not be construed to result in payments that are less than the rates of compensation that would be payable to the new hospital for Medi-Cal services without regard to the requirements of paragraphs (1) and (2).

(c) If the applicable minimum reimbursement levels required in subdivision (b) result in payments to the new hospital that are above the levels of compensation that would have been payable absent that requirement, and to the extent a nonfederal share is necessary with respect to the additional compensation, the following provisions shall apply:

(1) (A) For each fiscal year through the 2016–17 fiscal year, General Fund amounts appropriated in the annual Budget Act for the Medi-Cal

program shall fund the nonfederal share of the additional payments to the extent that the rates of compensation for inpatient hospital services provided by the new hospital that would have been payable in the absence of the requirements of subdivision (b) are less than 77 percent of the new hospital's projected Medi-Cal costs. With respect to the nonfederal share of the additional payments described in paragraph (2) of subdivision (b), however, this subparagraph shall be applicable only for inpatient services provided in conjunction with the implementation of Section 14182, and other mandatory managed care enrollment provisions implemented subsequent to January 1, 2011.

(B) For the 2017–18 fiscal year and each subsequent fiscal year, General Fund amounts appropriated in the annual Budget Act for the Medi-Cal program shall fund the nonfederal share of the additional payments to the extent that the rates of compensation for inpatient hospital services provided by the new hospital that would have been payable in the absence of the requirements of subdivision (b) are less than 72 percent of the new hospital's projected Medi-Cal costs. With respect to the nonfederal share of the additional payments described in paragraph (2) of subdivision (b), however, this subparagraph shall be applicable only for inpatient services provided in conjunction with the implementation of Section 14182, and other mandatory managed care enrollment provisions implemented subsequent to January 1, 2011.

(2) (A) The remaining necessary nonfederal share of the additional payments, after taking into account the General Fund amounts described in paragraph (1), may be funded with public funds that are transferred to the state from the County of Los Angeles, at the county's election, pursuant to Section 14164. To the extent the county elects not to fund any portion of the remaining necessary nonfederal share, the applicable minimum reimbursement levels required in subdivision (b) shall be reduced accordingly.

(B) Any public funds transferred to the state for payments to the new hospital as described in this paragraph with respect to a fiscal period shall be expended solely for the nonfederal share of the payments. Notwithstanding any other law, except as provided in subdivision (m), the department shall not impose any fee or assessment in connection with the transferred funds or the payments provided for under this section, including, but not limited to, reimbursement for state staffing or administrative costs.

(C) If any portion of the funds transferred pursuant to this paragraph is not expended, or not expected to be expended, for the specified rate amounts required in subdivision (b), the unexpended funds shall be returned promptly to the transferring county.

(3) This subdivision shall not be construed to reduce the nonfederal share of payments funded by General Fund amounts below the amounts that would be funded without regard to the minimum payment levels required under this section.

(d) (1) In addition to payments meeting the applicable minimum reimbursement levels described in subdivision (b), the new hospital shall

be eligible to receive supplemental payments. The supplemental payments shall be provided annually in amounts determined in consultation with the new hospital and the County of Los Angeles, and subject to paragraph (3).

(2) The department shall seek federal approval, as necessary, to enable the new hospital to receive supplemental payments that are in addition to the applicable minimum reimbursement levels required in subdivision (b). The supplemental payments may be provided for under the mechanisms described in Sections 14166.12 and 14301.4 or successor or modified mechanisms, or any other federally permissible payment mechanism. Supplemental payments that are payable through a Medi-Cal managed care plan shall be subject to the same requirements described in subparagraph (C) of paragraph (2) of subdivision (b).

(3) If a nonfederal share is necessary to fund the supplemental payments, the County of Los Angeles may voluntarily provide public funds that are transferred to the state pursuant to Section 14164. The county may specify the type of supplemental payment for which it is transferring funds, and any other category relevant to the payment, including, but not limited to, fee-for-service supplemental payment, managed care rate range payment, and payment for services rendered to newly eligible beneficiaries as defined in subdivision (s) of Section 17612.2.

(4) Any public funds transferred to the state for supplemental payments to the new hospital as described in this subdivision with respect to a fiscal period shall be expended solely for the nonfederal share of the supplemental payments as specified pursuant to paragraph (3). Notwithstanding any other law, subdivision (o) of Section 14166.12 shall not apply, and the department shall not assess the fee described in subdivision (d) of Section 14301.4, or any other similar fee, except as provided in subdivision (m). If any portion of the funds transferred pursuant to this subdivision is not expended, or not expected to be expended, for the specified supplemental payments, the unexpended funds shall be returned promptly to the transferring county.

(e) Notwithstanding any other law, all payments provided for under this section shall be treated as having been paid for purposes of any determination of available room under the federal upper payment limit, as specified in Part 447 of Title 42 of the Code of Federal Regulations, with respect to the applicable class of services and class of health care provider.

(f) (1) For purposes of this article, "new hospital" means a health facility that is certified under Title XVIII and Title XIX of the federal Social Security Act, and is licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code to provide acute inpatient hospital services, and includes all components of the facility, with an inpatient hospital service location on the campus of the former Los Angeles County Martin Luther King, Jr.-Harbor Hospital.

(2) "Medi-Cal managed care plan" shall have the meaning provided in paragraph (5) of subdivision (b) of Section 14199.1.

(g) For purposes of this article, the new hospital's projected Medi-Cal costs shall be based on the cost finding principles applied under subdivision (b) of Section 14166.4, except that the projected costs shall not be multiplied

by the federal medical assistance percentage and are not subject to the reimbursement limitations set forth in Article 7.5 (commencing with Section 51536) of Chapter 3 of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations. The projected Medi-Cal costs shall be determined prior to the start of each fiscal year in consultation with the new hospital, using the best available and reasonable current estimates or projections made with respect to the new hospital for an annual period, and shall be considered final as of the start of the fiscal year for purposes of the minimum payment levels described in subdivision (b).

(h) Notwithstanding any other law, the new hospital shall not be eligible to receive payments pursuant to Section 14166.11. This subdivision, however, shall not be construed to preclude the hospital from eligibility for disproportionate share status, or from receipt of any federal Medicaid disproportionate share hospital payments to which it would be entitled, pursuant to the Medi-Cal State Plan.

(i) Except as specified in subdivision (h), this section shall not be construed to preclude the new hospital from receiving any other payment for which it is eligible in addition to the payments provided for by this section.

(j) Notwithstanding any other law, for purposes of Article 12 (commencing with Section 17612.1) of Chapter 6 of Part 5, the intergovernmental transfers described in this section as reflected in the actual net expenditures for all operating budget units of the County of Los Angeles Department of Health Services shall not be reduced in any manner in the determination of total costs under paragraph (6) of subdivision (b) of Section 17612.5, by application of the imputed other entity intergovernmental transfer amounts or otherwise.

(k) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of all-facility letters, all-county letters, or similar instructions, without taking further regulatory action. This section shall not be construed to preclude the department from adopting regulations.

(*l*) (1) The department shall obtain federal approvals or waivers as necessary to implement this section and to obtain federal matching funds to the maximum extent permitted by federal law. This section shall be implemented only if, and to the extent that, federal financial participation is available and this section does not jeopardize the federal financial participation available for any other state program.

(2) This section shall be implemented only if, and to the extent that, any necessary federal approvals are obtained.

(m) As part of its voluntary participation to provide the nonfederal share of payments under this section, the County of Los Angeles shall agree to reimburse the state for the nonfederal share of state staffing and administrative costs directly attributable to the cost of administrating the payments and associated intergovernmental transfers. The costs shall be documented and subject to review by the county.

SEC. 58. Section 15800 of the Welfare and Institutions Code is amended to read:

15800. (a) (1) Commencing October 1, 2013, the State Department of Health Care Services shall administer the AIM-Linked Infants Program to address the health care needs of children formerly covered pursuant to clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 of the Insurance Code. The department is vested with the same powers, purposes, responsibilities, and jurisdiction exercised by the Managed Risk Medical Insurance Board as they relate to those children. Nothing in this paragraph shall be construed to alter, diminish, or supersede the authority of the Managed Risk Medical Insurance Board to exercise the same powers, purposes, responsibilities, and jurisdiction within the Healthy Families Program established under Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.

(2) (A) Commencing on July 1, 2014, the State Department of Health Care Services shall administer any other programs under, and succeeds to and is vested with the same powers, purposes, responsibilities, and jurisdiction exercised by, the Managed Risk Medical Insurance Board.

(B) Commencing on July 1, 2014, any reference in any statute, except for this chapter, Chapter 3 (commencing with Section 15850), and Section 12739.61 of, and Part 6.8 (commencing with Section 12739.77) of Division 2 of, the Insurance Code, and in any regulation, contract, or any other document, to the Managed Risk Medical Insurance Board is deemed to instead refer to the State Department of Health Care Services.

(3) The department may, before October 1, 2013, conduct transition activities necessary to ensure the efficient transfer of the program identified in paragraph (1) and populations served by that program.

(4) The department may, before July 1, 2014, conduct transition activities necessary to ensure the efficient transfer of the programs identified in paragraph (2) and populations served by these programs.

(b) The department shall seek any federal waivers, approvals, and state plan amendments necessary to implement this part. This part shall only be implemented to the extent that necessary federal approvals are obtained and federal financial participation is available for eligible programs and services.

SEC. 59. Section 15801 of the Welfare and Institutions Code is amended to read:

15801. (a) The terms of all regulations and orders adopted by the Managed Risk Medical Insurance Board in effect preceding July 1, 2014, that relate to the operation of the program and to the children transferred by the act that added this section and are not rendered legally unenforceable by the act that added this section shall be fully enforceable by the State Department of Health Care Services within the AIM-Linked Infants Program and the Medi-Cal Access Program unless and until the department adopts regulations for the Medi-Cal Access Program. Nothing in this subdivision shall be construed to alter, diminish, or supersede the authority of the Managed Risk Medical Insurance Board to interpret, enforce, maintain, or amend the same regulations for purposes of the Healthy Families Program

established under Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.

(b) All regulations and orders adopted by the Managed Risk Medical Insurance Board that relate to the programs transferred pursuant to paragraph (2) of subdivision (a) of Section 15800 in effect on July 1, 2014, and not rendered legally unenforceable by the act adding this subdivision shall remain in effect and shall be fully enforceable unless and until readopted, amended, or repealed by the State Department of Health Care Services, or until they expire by their own terms.

SEC. 60. Section 15802.5 is added to the Welfare and Institutions Code, to read:

15802.5. Effective on July 1, 2014, all permanent or probationary civil service employees who are employed by the Managed Risk Medical Insurance Board shall be transferred to the State Department of Health Care Services or the California Health Benefits Exchange as described in Section 12739.78 of the Insurance Code, and their civil service status, position, and rights, including return rights, shall be determined pursuant to Section 12739.78 of the Insurance Code.

SEC. 61. Section 15803 of the Welfare and Institutions Code is amended to read:

15803. (a) To implement this part and clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 of the Insurance Code, the State Department of Health Care Services may contract with public or private entities. Contracts entered into under this part may be on a noncompetitive bid basis and are exempt from the following:

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

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

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

(b) During the transition of the programs to the department, the department shall also be exempt from the review or approval of feasibility study reports and the requirements of Sections 4819.35 to 4819.37, inclusive, and 4920 to 4928, inclusive, of the State Administrative Manual.

(c) For contracts entered into under this part, the State Department of Health Care Services shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on the projected or actual subscriber enrollments to a total amount not to exceed the amount appropriated for the program including family contributions.

SEC. 62. Section 15804 of the Welfare and Institutions Code is amended to read:

15804. On October 1, 2013, or when the State Department of Health Care Services has implemented Chapter 2 (commencing with Section 15810), whichever occurs later, the Managed Risk Medical Insurance Board shall

cease to provide coverage to the children transferred to the AIM-Linked Infants Program, pursuant to Section 15800.

SEC. 63. Section 15805 of the Welfare and Institutions Code is amended to read:

15805. (a) (1) The Managed Risk Medical Insurance Board shall provide the State Department of Health Care Services any data, information, or record concerning the Healthy Families Program or the Access for Infants and Mothers Program as are necessary to implement this part and clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 of the Insurance Code.

(2) All books, documents, files, property, data, information, or record in possession of the Managed Risk Medical Insurance Board, except for personnel records related to staff transferred to the California Health Benefits Exchange pursuant to Section 12739.61 or 12739.78 of the Insurance Code, shall be transferred to the State Department of Health Care Services on July 1, 2014.

(3) Until the transition of duties from the Managed Risk Medical Insurance Board to the State Department of Health Care Services required under subdivision (a) of Section 15800 is complete, any book, document, file, property, data, information, or record in the possession of the Managed Risk Medical Insurance Board pertaining to functions, programs, and subscribers to be transferred to the State Department of Health Care Services pursuant to subdivision (a) of Section 15800 shall immediately be made available to the State Department of Health Care Services upon request for review, inspection, and copying, including electronic transmittal, including records otherwise not subject to disclosure under Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code.

(b) Notwithstanding any other law, all of the following shall apply:

(1) The term "book, document, file, property, data, information, or record" shall include, but is not limited to, personal information as defined in Section 1798.3 of the Civil Code.

(2) Any book, document, file, property, data, information, or record shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of the Government Code) and any other law, to the same extent that it was exempt from disclosure or privileged prior to the provision of the book, document, file, property, data, information, or record to the department.

(3) The provision of any book, document, file, property, data, information, or record to the department shall not constitute a waiver of any evidentiary privilege or exemption from disclosure.

(4) The department shall keep all books, documents, files, property, data, information, or records provided by the Managed Risk Medical Insurance Board confidential to the full extent permitted by law, including, but not limited to, the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of the Government Code), and consistent with the Managed Risk Medical Insurance Board's contractual obligations

to keep books, documents, files, property, data, information, or records confidential.

SEC. 64. Section 15806 is added to the Welfare and Institutions Code, to read:

15806. (a) A contract, lease, license, bond, or any other agreement to which the Managed Risk Medical Insurance Board is a party is not void or voidable by reason of the act that added this section, but shall continue in full force and effect, with the State Department of Health Care Services assuming all of the rights, obligations, liabilities, and duties of the Managed Risk Medical Insurance Board and any of its predecessors that relate to the duties, powers, purposes, responsibilities, and jurisdiction vested by the act that added this section in the State Department of Health Care Services. The assumption by the State Department of Health Care Services does not in any way affect the rights of the parties to the contract, lease, license, or agreement.

(b) This section shall become operative on July 1, 2014.

SEC. 65. The heading of Chapter 2 (commencing with Section 15810) of Part 3.3 of Division 9 of the Welfare and Institutions Code is amended to read:

CHAPTER 2. MEDI-CAL ACCESS PROGRAM

SEC. 66. Section 15810 of the Welfare and Institutions Code is amended to read:

15810. (a) This chapter shall be known, and may be cited, as the AIM-Linked Infants Program.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2015, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 67. Section 15810 is added to the Welfare and Institutions Code, to read:

15810. (a) This chapter, formerly known as the AIM-Linked Infants Program, shall be known, and may be cited, as the Medi-Cal Access Program.

(b) This section shall become operative on July 1, 2014.

SEC. 68. Section 15811 of the Welfare and Institutions Code is amended to read:

15811. (a) The definitions contained in this section govern the construction of this chapter, unless the context requires otherwise.

(b) "AIM-linked infant" means any infant born to a woman whose enrollment in the Access for Infants and Mothers Program under Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code begins after June 30, 2004.

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

(d) "Program" means the AIM-Linked Infants Program.

(e) "Subscriber" means an individual who is eligible for and enrolled in the program.

(f) "Subscriber contribution" means the cost to the subscriber to participate in the program.

(g) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2015, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 69. Section 15811 is added to the Welfare and Institutions Code, to read:

15811. (a) The definitions contained in this section govern the construction of this chapter, unless the context requires otherwise.

(b) "Access-linked infant" means any infant born to a woman enrolled in either the program under this chapter or the Access for Infants and Mothers Program under Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code.

(c) "Applicant" means an individual who applies for coverage through the program.

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

(e) "Fund" means the Perinatal Insurance Fund.

(f) "Health education services relating to tobacco use" means tobacco use prevention and education services, including, when appropriate, tobacco use cessation services, in accordance with protocols established by the department in coordination with the California Tobacco Control Program of the State Department of Public Health.

(g) "Participating health plan" means a health plan with which the department contracts to provide health care services to individuals eligible pursuant to Section 15832.

(h) "Program" means the Medi-Cal Access Program.

(i) "Subscriber" means an individual who is eligible for and enrolled in the program.

(j) "Subscriber contribution" means the cost to the subscriber to participate in the program.

(k) This section shall become operative on July 1, 2014.

SEC. 70. Section 15814 is added to the Welfare and Institutions Code, to read:

15814. (a) The department, in coordination with the California Tobacco Control Program of the State Department of Public Health, shall develop protocols relating to health education for tobacco use to the extent necessary to comply with paragraph (1) of subdivision (b) of Section 30122 of the Revenue and Taxation Code. These protocols shall include, but not be limited to, all of the following:

(1) Referral to perinatal and related support services.

(2) Outreach services and assessment of smoking status.

(3) Individualized counseling and advocacy services.

(4) Motivational messages.

(5) Cessation services, if appropriate.

(6) Incentives to maintain a healthy lifestyle.

(7) Followup assessment.

(8) Maintenance and relapse prevention services.

(b) This section shall become operative on July 1, 2014.

SEC. 71. Section 15818 is added to the Welfare and Institutions Code, to read:

15818. (a) Each participating health plan contracting with the department pursuant to this chapter shall provide health education services related to tobacco use to all program participants to the extent necessary to comply with paragraph (1) of subdivision (b) of Section 30122 of the Revenue and Taxation Code.

(b) The education activities required by subdivision (a) shall include all of the following:

(1) Dissuading persons from beginning to smoke.

(2) Encouraging smoking cessation.

(3) Providing information on the health effects of tobacco use on the user, children, and nonsmokers.

(c) This section shall become operative on July 1, 2014.

SEC. 72. Section 15826 of the Welfare and Institutions Code is amended to read:

15826. (a) The department shall administer the program and may do all of the following:

(1) Determine eligibility criteria for the program. These criteria shall include the requirements set forth in Section 15832.

(2) Determine the eligibility of AIM-linked infants.

(3) Determine when subscribers are covered and the extent and scope of coverage.

(4) Determine subscriber contribution amounts schedules. Subscriber contributions shall not be greater than those applicable on March 23, 2010, for infants enrolled pursuant to clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 of the Insurance Code.

(5) Provide coverage through Medi-Cal delivery systems and contract for the administration of the program and the enrollment of subscribers. Any contract entered into pursuant to this chapter shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of General Services. The department shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on projected and actual subscriber enrollments in a total amount not to exceed the amount appropriated for the program.

(6) Authorize expenditures to pay program expenses that exceed subscriber contributions, and to administer the program as necessary.

(7) Develop a promotional component of the program to make Californians aware of the program and the opportunity that it presents.

(8) (A) Issue rules and regulations as necessary to administer the program.

(B) During the 2011–12 to 2014–15 fiscal years, inclusive, the adoption and readoption of regulations pursuant to this chapter shall be deemed to be an emergency that calls for immediate action 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 the department describe facts showing the need for immediate action.

(9) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this chapter.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2015, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 73. Section 15826 is added to the Welfare and Institutions Code, to read:

15826. (a) The department shall administer the program and may do all of the following:

(1) Determine eligibility criteria for the program. These criteria shall include the requirements set forth in Section 15832.

(2) Determine the eligibility of applicants.

(3) Determine when subscribers are covered and the extent and scope of coverage.

(4) Determine subscriber contribution amounts schedules, subject to the following:

(A) Subscriber contributions for Access-linked infants shall not be greater than those applicable on March 23, 2010, for infants enrolled pursuant to clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 of the Insurance Code.

(B) Subscriber contributions for mothers shall conform with the maintenance of effort requirements under the federal Patient Protection and Affordable Care Act (Public Law 111-148), or any amendment or extension of that act.

(5) Provide coverage through Medi-Cal delivery systems and contract for the administration of the program and the enrollment of subscribers. Any contract entered into pursuant to this chapter shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of General Services. The department shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on projected and actual subscriber enrollments in a total amount not to exceed the amount appropriated for the program.

(6) Authorize expenditures to pay program expenses that exceed subscriber contributions, and to administer the program as necessary.

(7) Develop a promotional component of the program to make Californians aware of the program and the opportunity that it presents.

(8) (A) Issue rules and regulations as necessary to administer the program.

(B) During the 2011–12 to 2014–15 fiscal years, inclusive, the adoption and readoption of regulations pursuant to this chapter shall be deemed to be an emergency that calls for immediate action 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 the department describe facts showing the need for immediate action and from review by the Office of Administrative Law.

(9) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this chapter.

(b) This section shall become operative on July 1, 2014.

SEC. 74. Section 15827 is added to the Welfare and Institutions Code, to read:

15827. (a) The department shall administer the program in a manner that ensures that program expenditures do not exceed amounts available in the fund.

(b) This section shall be implemented only if and to the extent that it does not jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), or any amendment or extension of that act.

(c) This section shall become operative on July 1, 2014.

SEC. 75. Section 15832 of the Welfare and Institutions Code is amended to read:

15832. To be eligible to participate in the program, a person shall meet all of the following requirements:

(a) (1) Be a child under two years of age who is delivered by a mother enrolled in the program under Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code. Except as stated in this section, these infants shall be automatically enrolled in the program.

(2) For the applicable month, not be enrolled in employer-sponsored health care coverage, or have been enrolled in that health care coverage in the prior three months or enrolled in full-scope Medi-Cal without a share of cost. Exceptions may be identified in regulations or other guidance and shall, at minimum, include all exceptions applicable to the Healthy Families Program on and after March 23, 2010.

(3) Be subject to subscriber contributions as determined by the department. The subscriber contributions shall not be greater than those applicable on March 23, 2010, for infants enrolled in the Healthy Families Program pursuant to clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 of the Insurance Code.

(b) For AIM-linked infants identified in subdivision (a), all of the following shall apply:

(1) Enrollment shall cover the first 12 months of the infant's life unless he or she is eligible for Medi-Cal benefits under Section 14005.26. If the infant is eligible under Section 14005.26, he or she shall be automatically enrolled in the Medi-Cal program on that basis.

(2) (A) At the end of the 12 months, as a condition of continued eligibility, the subscriber shall provide income information. The infant shall be disenrolled from the program if the annual household income exceeds 300 percent of the federal poverty level, or if the infant is eligible for full-scope Medi-Cal with no share of cost.

(B) Effective January 1, 2014, when determining eligibility for benefits under the program, income shall be determined, counted, and valued in accordance with the requirements of Section 1397bb(b)(1)(B) 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.

(3) At the end of their first and second year in the program, infants shall be screened for eligibility for the Medi-Cal program.

(c) If at any time the director determines that the eligibility criteria established under this chapter for the program may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), or any amendment or extension of that act, the director may alter the eligibility criteria to the extent necessary for the state to receive that federal financial participation.

(d) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2015, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 76. Section 15832 is added to the Welfare and Institutions Code, to read:

15832. (a) To be eligible to participate in the program, a person shall meet all of the requirements in either paragraph (1) or (2):

(1) (A) Be a woman who is pregnant or in her postpartum period as specified in Section 15840 and who is a resident of the state. A person who is a member of a federally recognized California Indian tribe is a resident of the state for these purposes.

(B) Have a household income that is above 208 percent of the official federal poverty level but does not exceed 317 percent of the official federal poverty level.

(C) Agree to the payment of the complete subscriber contribution. A federally recognized California Indian tribal government may make the subscriber contributions on behalf of a member of the tribe only if a contribution on behalf of members of federally recognized California Indian tribes does not limit or preclude federal financial participation under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.). If a federally recognized California Indian tribal government makes a contribution on behalf of a member of the tribe, the tribal government shall ensure that the subscriber is made aware of all the health care delivery options available in the county where the member resides.

(2) (A) Be a child under two years of age who is delivered by a mother enrolled in the program under this chapter or Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code. Except as stated in this section, these infants shall be automatically enrolled in the program.

(B) For the applicable month, not be enrolled in employer-sponsored health care coverage, or have been enrolled in that health care coverage in the prior three months or enrolled in full-scope Medi-Cal without a share of cost. Exceptions may be identified in regulations or other guidance and shall, at minimum, include all exceptions applicable to the Healthy Families Program on and after March 23, 2010.

(C) Be subject to subscriber contributions as determined by the department.

(3) For AIM-linked infants identified in paragraph (2), all of the following shall apply:

(A) Enrollment in the program shall cover the first 12 months of the infant's life unless he or she is determined eligible for Medi-Cal benefits under Section 14005.26. An infant shall be screened for eligibility under Section 14005.26 immediately after he or she is born. If the infant is eligible under Section 14005.26, he or she shall be automatically enrolled in the Medi-Cal program on that basis.

(B) (i) At the end of the 12 months, as a condition of continued eligibility, the subscriber shall provide income information. The infant shall be disenrolled from the program if the annual household income exceeds 317 percent of the federal poverty level, or if the infant is eligible for full-scope Medi-Cal with no share of cost.

(ii) Effective January 1, 2014, when determining eligibility for benefits under the program, income shall be determined, counted, and valued in accordance with the requirements of Section 1397bb(b)(1)(B) 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.

(C) At the end of their first and second year in the program, infants shall be screened for eligibility for the Medi-Cal program.

(4) If at any time the director determines that the eligibility criteria established under this chapter for the program may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), or any amendment or extension of that act, the director may alter the eligibility criteria to the extent necessary for the state to receive that federal financial participation.

(b) This section shall become operative on July 1, 2014.

SEC. 77. Section 15833 is added to the Welfare and Institutions Code, to read:

15833. (a) A person eligible pursuant to paragraph (1) of subdivision (a) of Section 15832 shall not be eligible to participate in the program if, at

the time of application, she is eligible for Medi-Cal without a share of cost or for Medicare.

(b) This section shall become operative on July 1, 2014.

SEC. 78. Section 15835 is added to the Welfare and Institutions Code, to read:

15835. (a) Subscribers enrolled pursuant to paragraph (1) of subdivision (a) of Section 15832 shall not be disenrolled for failure to pay subscriber contributions. The department may impose or contract for collection actions to collect unpaid subscriber contributions.

(b) This section shall become operative on July 1, 2014.

SEC. 79. Section 15839 is added to the Welfare and Institutions Code, to read:

15839. (a) Services that would be covered under the program that are provided to pregnant women who, after receiving those services, are subsequently determined to be eligible for coverage under this chapter may be reimbursed as determined by the department. In no case shall services received prior to 40 days before a woman's date of application be eligible for reimbursement.

(b) This section shall become operative on July 1, 2014.

SEC. 80. Section 15840 of the Welfare and Institutions Code is amended to read:

15840. (a) At a minimum, coverage provided pursuant to this chapter shall be provided to eligible AIM-linked infants less than two years of age.

(b) Coverage provided pursuant to this chapter shall include, at a minimum, those services required to be provided by health care service plans approved by the Secretary of Health and Human Services as a federally qualified health care service plan pursuant to Section 417.101 of Title 42 of the Code of Federal Regulations.

(c) Medically necessary prescription drugs shall be a required benefit in the coverage provided pursuant to this chapter.

(d) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2015, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 81. Section 15840 is added to the Welfare and Institutions Code, to read:

15840. (a) At a minimum, coverage provided pursuant to this chapter shall be provided to subscribers during one pregnancy, and until the end of the month in which the 60th day after pregnancy occurs, and to eligible children less than two years of age who were born of a pregnancy covered under this program or the Access for Infants and Mothers program under Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code to a woman enrolled in the Access for Infants and Mothers program.

(b) Coverage provided pursuant to this chapter shall include, at a minimum, those services required to be provided by health care service plans approved by the Secretary of Health and Human Services as a federally

qualified health care service plan pursuant to Section 417.101 of Title 42 of the Code of Federal Regulations.

(c) Medically necessary prescription drugs shall be a required benefit in the coverage provided pursuant to this chapter.

(d) To the extent required pursuant to Section 15818 to comply with paragraph (1) of subdivision (b) of Section 30122 of the Revenue and Taxation Code, health education services related to tobacco use shall be a benefit in the coverage provided under this chapter.

(e) This section shall become operative on July 1, 2014.

SEC. 82. Section 15841 is added to the Welfare and Institutions Code, to read:

15841. (a) Through its courts, statutes, and under its Constitution, California protects a woman's right to reproductive privacy. California reaffirms these protections and specifically its Supreme Court decision in People v. Belous (1969) 71 Cal.2d 954, 966-68.

(b) The State Department of Health Care Services may accept or use moneys under Title XXI of the Social Security Act (known as the Children's Health Insurance Program or CHIP), as interpreted in Section 457.10 of Title 42 of the Code of Federal Regulations, to fund services for women pursuant to Section 14007.7 and this chapter only when, during the period of coverage, the woman is the beneficiary. The scope of services covered under Medi-Cal and this chapter, as defined in statutes, regulations, and state plans, is not altered by this section or the state plan amendment submitted pursuant to this section.

(c) California's CHIP plan and any amendments submitted and implemented pursuant to this section shall be consistent with subdivisions (a) and (b).

(d) This section is a declaration of existing law.

(e) This section shall become operative on July 1, 2014.

SEC. 83. Section 15847 is added to the Welfare and Institutions Code, to read:

15847. (a) It shall constitute unfair competition for purposes of Chapter 5 (commencing with Section 17200) of Part 2 of Division 7 of the Business and Professions Code for an insurer, an insurance agent or broker, or an administrator, as defined in Section 1759 of the Insurance Code, to refer an individual employee or employee's dependent to the program, or arrange for an individual employee or employee's dependent to apply to the program, for the purpose of separating that employee or employee's dependent from group health coverage provided in connection with the employee's employment.

(b) Any employee described in subdivision (a) shall have a personal right of action to enforce subdivision (a).

(c) This section shall become operative on July 1, 2014.

SEC. 84. Section 15847.3 is added to the Welfare and Institutions Code, to read:

15847.3. (a) It shall constitute an unfair labor practice contrary to public policy, and enforceable under Section 95 of the Labor Code, for any

employer to refer an individual employee or employee's dependent to the program, or to arrange for an individual employee or employee's dependent to apply to the program, for the purpose of separating that employee or employee's dependent from group health coverage provided in connection with the employee's employment.

(b) This section shall become operative on July 1, 2014.

SEC. 85. Section 15847.5 is added to the Welfare and Institutions Code, to read:

15847.5. (a) It shall constitute an unfair labor practice contrary to public policy and enforceable under Section 95 of the Labor Code for any employer to change the employee-employer share-of-cost ratio or to make any other modification of maternity care coverage for employees or employees' dependents that results in the enrollment of the employees or employees' dependents in the program established pursuant to this chapter.

(b) This section shall become operative on July 1, 2014.

SEC. 86. Section 15847.7 is added to the Welfare and Institutions Code, to read:

15847.7. (a) For purposes of Sections 15847, 15847.3, and 15847.5, "group health coverage" includes any nonprofit hospital service plan, health care service plan, self-insured employee welfare benefit plan, or disability insurance providing medical or hospital benefits.

(b) This section shall become operative on July 1, 2014.

SEC. 87. Section 15848 is added to the Welfare and Institutions Code, to read:

15848. (a) The Perinatal Insurance Fund is continued in existence in the State Treasury under the administration of the department.

(b) Amounts deposited in the fund shall only be used for the purposes specified by this chapter.

(c) Notwithstanding Section 13340 of the Government Code, the fund is hereby continuously appropriated, without regard to fiscal years, to the department, for the purposes specified in this chapter.

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

SEC. 88. Section 15848.5 is added to the Welfare and Institutions Code, to read:

15848.5. (a) The department shall authorize the expenditure of money in the fund to cover program expenses, including program expenses that exceed subscriber contributions.

(b) From money appropriated by the Legislature to the fund, the department may expend sufficient funds for operating expenses incurred in carrying out this chapter.

(c) The department shall develop and utilize all appropriate cost containment measures to maximize the coverage offered under the program.

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

SEC. 89. Chapter 3 (commencing with Section 15850) is added to Part 3.3 of Division 9 of the Welfare and Institutions Code, to read:

Chapter 3. County Health Initiative Matching Fund

15850. This chapter shall be known and may be cited as the County Health Initiative Matching Fund.

15850.1. For purposes of this chapter, the following definitions shall apply:

(a) "Administrative costs" means those expenses that are described in Section 1397ee(a)(1)(D) of Title 42 of the United States Code.

(b) "Applicant" means a county, county agency, a local initiative, or a county organized health system.

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

(d) "Child" means a person under 19 years of age.

(e) "Comprehensive health insurance coverage" means the coverage provided in Section 2103 of the Social Security Act (42 U.S.C. Sec. 1397cc) and shall be equivalent to the coverage provided to state employees through the Public Employees' Retirement System for the most recent plan year preceding the applicable program plan year, except that the plans may provide a mechanism for inpatient hospital care provided under the mental health benefit through which applicants may agree to a treatment plan in which each inpatient day may be substituted for two residential treatment days or three day treatment program days.

(f) "County organized health system" means a health system implemented pursuant to Article 2.8 (commencing with Section 14087.5) of Chapter 7 of Part 3 of this division and Article 1 (commencing with Section 101675) of Chapter 3 of Part 4 of Division 101 of the Health and Safety Code.

(g) "Fund" means the County Health Initiative Matching Fund.

(h) "Local initiative" means a prepaid health plan that is organized by, or designated by, a county government or county governments, or organized by stakeholders, of a region designated by the department to provide comprehensive health care to eligible Medi-Cal beneficiaries. The entities established pursuant to Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.96 are local initiatives.

(i) "Optional targeted low-income children group" means the population described in Section 1905(u)(2)(B) of the Society Security Act (42 U.S.C. Sec. 1396d(u)(2)(B)) and in Section 14005.26.

(j) "Access program" means the Medi-Cal Access Program under Chapter 2 (commencing with Section 15810).

(k) "Health care service plan" includes Medi-Cal managed care plans contracting with the department under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3.

15850.5. (a) Notwithstanding any other law, except as provided in subdivision (b), each applicant who was participating in the County Health Initiative Matching Fund on March 23, 2010, pursuant to Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code, shall participate in the program established by this chapter, maintaining eligibility standards, methodologies, and procedures at least as favorable to eligible individuals as those in effect on March 23, 2010, and in a manner

that satisfies the maintenance of effort obligation established in Section 2105(d)(3) of the Social Security Act (42 U.S.C. Sec. 1397ee(d)(3)).

(b) (1) If an applicant county participating in the County Health Initiative Matching Fund on March 23, 2010, elects to cease funding the nonfederal share of program expenditures made pursuant to Section 15852, the department shall administer the program within that applicant county consistent with subdivision (a).

(2) Notwithstanding any other law, the state general fund shall provide funding amounts equal to the total nonfederal share of all expenditures incurred by the department pursuant to paragraph (1).

(3) The nonfederal share amounts described in paragraph (2) shall be deposited in the County Health Initiative Matching Fund created pursuant to Section 15852, and those funds shall be used by the department for purposes otherwise consistent with that section.

(c) Notwithstanding any other law, as of the enactment of this section, the department shall not approve any additional applicant for participation under this chapter other than those applicants participating as of March 23, 2010.

(d) This section shall only be operative to extent that federal financial participation is not jeopardized and any necessary federal approvals are secured.

(e) This section shall become inoperative on the date that the maintenance of effort obligation pursuant to Section 2105(d)(3) of the Social Security Act (42 U.S.C. Sec. 1397ee(d)(3)) is no longer applicable to the state for purposes of this chapter.

15852. (a) The County Health Initiative Matching Fund is hereby continued in existence within the State Treasury. The fund shall accept funding, including but not limited to, funding from intergovernmental transfers as follows:

(1) The nonfederal matching fund requirement for federal financial participation through the State Children's Health Insurance Program (Subchapter 21 (commencing with Section 1397aa) of Chapter 7 of Title 42 of the United States Code).

(2) Funding associated with a proposal approved pursuant to subdivision (e) Section 15853.

(3) State general fund amounts pursuant to subdivision (b) of Section 15850.5.

(b) Notwithstanding Section 13340 of the Government Code, amounts deposited in the fund shall be continuously appropriated to the department without regard to fiscal year, and shall be used only for the purposes specified by this section.

(c) The department shall administer this fund and the provisions of this chapter for the express purpose of allowing local or state funds to be used to facilitate increasing the state's ability to utilize federal funds available to California and for costs associated with a proposal pursuant to subdivision (e) of Section 15853 or for costs incurred by the department pursuant to paragraph (1) of subdivision (b) of Section 15850.5. Federal funds shall be

used prior to the expiration of their authority for programs designed to improve and expand access for uninsured persons.

(d) The department shall be reimbursed from the fund to cover the cost to administer the program.

15853. (a) (1) An applicant that will provide an intergovernmental transfer may submit a proposal to the department for funding for the purpose of providing comprehensive health insurance coverage to any child who meets citizenship and immigration status requirements that are applicable to persons participating in the program established by Title XXI of the Social Security Act, and whose family income is at or below 317 percent of the federal poverty level or, at the option of the applicant, at or below 411 percent of the federal poverty level, in specific geographic areas, as published quarterly in the Federal Register by the United States Department of Health and Human Services, 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 which child meets both of the following requirements:

(A) Does not qualify for the optional targeted low-income children group or the Access program.

(B) Does not qualify for Medi-Cal with no share of cost pursuant to Chapter 7 (commencing with Section 14000) of Part 3.

(2) In its application, the applicant shall specify the income level at or below 411 percent of the federal poverty level for which it will provide coverage.

(3) The intergovernmental transfer amount is limited to the expenditures which would be eligible for federal financial participation.

(b) The proposal shall guarantee at least one year of intergovernmental transfer funding by the applicant at a level that ensures compliance with the requirements of any applicable approved federal waiver or state plan amendment as well as the department's requirements for the sound operation of the proposed project, and shall, on an annual basis, either commit to fully funding the necessary intergovernmental amount or withdraw from the program. The department may identify specific geographical areas that, compared to the national level, have a higher cost of living or housing or a greater need for additional health services, using data obtained from the most recent federal census, the federal Consumer Expenditure Survey, or from other sources. The proposal may include an administrative mechanism for outreach and eligibility.

(c) The applicant may include in its proposal reimbursement of medical, dental, vision, or mental health services delivered to children who are eligible under the Access program or under the Medi-Cal program as an optional targeted low-income children group beneficiary, if these services are part of an overall program with the measurable goal of enrolling served children in the Access program or the optional targeted low-income children group.

(d) If a child is determined to be eligible for benefits for the treatment of an eligible medical condition under the California Children's Services Program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, the health, dental, or vision plan providing services to the child pursuant to this chapter shall not be responsible for the provision of, or payment for, those authorized services for that child. The proposal from an applicant shall contain provisions to ensure that a child whom the health, dental, or vision plan reasonably believes would be eligible for services under the California Children's Services Program is referred to that program. The California Children's Services Program shall provide case management and authorization of services if the child is found to be eligible for the California Children's Services Program. Diagnosis and treatment services that are authorized by the California Children's Services Program shall be performed by paneled providers for that program and approved special care centers of that program and approved by the California Children's Services Program. All other services provided under the proposal from the applicant shall be made available pursuant to this chapter to a child who is eligible for services under the California Children's Services Program.

(e) Notwithstanding any other provision of this section, an applicant may submit a proposal to the department for the purposes of providing comprehensive health insurance coverage to children whose coverage is not eligible for funding under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa, et seq.), or to a combination of children whose coverage is eligible for funding under Title XXI of the Social Security Act and children whose coverage is not eligible for that funding. To be approved by the department, these proposals shall comply with both of the following requirements:

(1) Meet all applicable requirements for funding under this chapter, except for availability of funding through Title XXI of the Social Security Act.

(2) Provide for the administration of children's coverage by the department through the administrative infrastructure serving the Medi-Cal program, and through health care service plans serving the Medi-Cal program.

(f) Implementation of this section is conditioned on the department obtaining necessary federal approval of these provisions.

(g) Notwithstanding any other provision of this part, the status of any application previously submitted to, and approved by, the Managed Risk Medical Insurance Board pursuant to Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code shall not be altered as a result of the assumption by the department, pursuant to this chapter, of the responsibilities previously exercised by the Managed Risk Medical Insurance Board.

15854. (a) The department, in consultation with other appropriate parties, shall establish the criteria for evaluating an applicant's proposal, which shall include, but not be limited to, the following:

(1) The extent to which the program described in the proposal provides comprehensive coverage including health, dental, and vision benefits.

(2) Whether the proposal includes a promotional component to notify the public of its provision of health insurance to eligible children.

(3) The simplicity of the proposal's procedures for applying to participate and for determining eligibility for participation in its program.

(4) The extent to which the proposal provides for coordination and conformity with benefits provided through the Medi-Cal program.

(5) The extent to which the proposal provides for coordination and conformity with existing Medi-Cal administrative entities in order to prevent administrative duplication and fragmentation.

(6) The ability of the health care providers designated in the proposal to serve the eligible population and the extent to which the proposal includes traditional and safety net providers, as defined by the department.

(7) The extent to which the proposal intends to work with the school districts and county offices of education.

(8) The total amount of funds available to the applicant to implement the program described in its proposal, and the percentage of this amount proposed for administrative costs as well as the cost to the state to administer the proposal.

(9) The extent to which the proposal seeks to minimize the substitution of private employer health insurance coverage for health benefits provided through a governmental source.

(10) The extent to which local resources may be available after the depletion of federal funds to continue any current program expansions for persons covered under local health care financing programs or for expanded benefits.

(11) For the purposes of defining an applicant's eligibility for funding under this chapter, the following shall apply:

(A) The same income methodology shall be used for the proposed program that is currently used for the Medi-Cal program.

(B) Only participating Medi-Cal managed care plans may be used. However, the department may permit exceptions to this requirement consistent with the purpose, of this chapter.

(b) The department may, in its sole discretion, approve or disapprove projects for funding pursuant to this chapter on an annual basis.

(c) To the extent that an applicant's proposal pursuant to this chapter provides for health plan or administrative services under a contract entered into by the department or at rates negotiated for the applicant by the department, a contract entered into by the department or by an applicant shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of General Services to the same extent as contracts entered into pursuant to subdivision (p) of Section 14005.26. The department and the applicant shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on the projected or

actual subscriber enrollments to a total amount not to exceed the amount appropriated for the project including family contributions.

15855. The department shall review each funding proposal submitted by an applicant in accordance with the criteria described in Section 15854 and based on that criteria, approve or reject the proposal.

15856. (a) Upon its approval of a proposal that shall include any allowable amount of federal funds under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.), the department may provide the applicant reimbursement in an amount equal to the amount that the applicant will contribute to implement the program described in its proposal, plus the appropriate and allowable amount of federal funds. Not more than 10 percent of the County Health Initiative Matching Fund and matching federal funds shall be expended in any one fiscal year for administrative costs, including the costs to the state to administer the proposal, unless the department permits the expenditure consistent with the availability of federal matching funds not needed for the purposes described in paragraph (3) of subdivision (a) of Section 15862, or unless the department determines that an expenditure for administrative costs has no impact on available federal funding. The department may audit the expenses incurred by the applicant in implementing its program to ensure that the expenditures comply with the provisions of this chapter. No reimbursement may be made to an applicant that fails to meet its financial participation obligation under this chapter. The state's reasonable startup costs and ongoing costs for administering the program shall be reimbursed by those entities applying for funding.

(b) Any program approved pursuant to subdivision (e) of Section 15853 that requires any funding not allowable for a federal match under Title XXI of the Social Security Act shall provide the department with the total amount of funds needed to provide that portion of coverage not eligible for federal matching funds, including reasonable startup costs and ongoing costs for administering the program.

(c) Each applicant that is provided funds under this chapter shall submit to the department a plan to limit initial and continuing enrollment in its program in the event the amount of moneys for its program is insufficient to maintain health insurance coverage for those participating in the program.

(d) (1) Notwithstanding any other provision of this chapter, the state shall be held harmless, in accordance with paragraphs (2) and (3), from any federal audit disallowance and interest resulting from payments made to a participating applicant pursuant to this section, for the disallowed claim.

(2) To the extent that a federal audit disallowance and interest results from a claim or claims for which any participating applicant has received reimbursement for services rendered or other activities performed, the department shall recoup from the participating applicant that submitted the disallowed claim, through offsets or by a direct billing, amounts equal to the amount of the disallowance and interest for the disallowed claim. All subsequent claims submitted to the department applicable to any previously disallowed service, activity, or claim may be held in abeyance, with no payment made, until the federal disallowance issue is resolved.

(3) Notwithstanding paragraph (2), to the extent that a federal audit disallowance and interest results from a claim or claims for which the participating applicant has received reimbursement for services rendered or activities performed by an entity under contract with, and on behalf of, the participating applicant, the department shall be held harmless by that particular participating applicant for 100 percent of the amount of the federal audit disallowance and interest for the disallowed claim.

15857. Each health care service plan, specialized health care service plan, and health insurer that contracts to provide health care benefits under this chapter shall be licensed by the Department of Managed Health Care or the Department of Insurance, or be a Medi-Cal managed care plan.

15858. (a) The department shall administer the provisions of this chapter and may do all of the following:

(1) Administer the expenditure of moneys from the fund.

(2) (A) Issue rules and regulations as necessary.

(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 chapter and any applicable federal waivers and state plan amendments 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, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature pursuant to Section 9795 of the Government Code on a semiannual basis until regulations have been adopted.

(3) Enter into contracts.

(4) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this chapter.

15859. All expenses incurred by the department in administering this chapter, including, but not limited to, expenses for developing standards and processes to implement any of the provisions of this chapter, evaluating applications, or processing or granting appeals growing out of any of the provisions of this chapter, shall be paid from the fund or directly by applicants, except that the department may accept funding from a not-for-profit group or foundation, or from a governmental entity providing grants for health-related activities, to administer this chapter.

15860. Nothing in this chapter creates a right or an entitlement to the provision of health insurance coverage or health care benefits. Except as provided in Section 15850.5, no costs shall accrue to the state for the provision of these services. The state shall not be liable beyond the assets of the fund for any obligation incurred or liabilities sustained by applicants in the operation of the fund or of the projects authorized by this chapter.

15861. To the extent necessary to obtain federal financial participation for projects approved pursuant to this chapter, the department shall apply

for one or more waivers or shall file state plan amendments pursuant to the federal State Children's Health Insurance Program (Subchapter 21 (commencing with Section 1397aa) of Chapter 7 of Title 42 of the United States Code) to allow a county agency, local initiative, or county organized health system to apply for matching funds through the federal State Children's Health Insurance Program (Subchapter 21 (commencing with Section 1397aa) of Chapter 7 of Title 42 of the United States Code) using local funds for the state matching funds.

15862. (a) The provisions of this chapter shall be implemented only if all of the following conditions are met:

(1) Federal financial participation is available for this purpose.

(2) Federal participation is approved.

(3) The department determines that federal funds under Title XXI of the Social Security Act remain available after providing funds for all current enrollees and eligible children that are likely to enroll in the optional targeted low-income children group and, to the extent funded through the federal Children's Health Insurance Program (Subchapter 21 (commencing with Section 1397aa) of Chapter 7 of Title 42 of the United States Code), the Medi-Cal Access program and Medi-Cal program, as determined by a Department of Finance estimate.

(4) Funds are appropriated specifically for this purpose.

(b) The department may accept funding necessary for the preparation of the federal waiver applications or state plan amendments described in Section 15861 from a not-for-profit group or foundation but only to the extent that such funding may be eligible for federal financial participation.

15863. The state shall be held harmless for any federal disallowance resulting from this chapter and any other expenses or liabilities, including, but not limited to, the cost of processing or granting appeals, unless the department is acting pursuant to Section 15850.5. An applicant receiving supplemental reimbursement pursuant to this chapter shall be liable for any reduced federal financial participation, and any other expenses or liabilities, including, but not limited to, the costs of processing or granting appeals, resulting from the implementation of this chapter with respect to that applicant. The state may recoup any federal disallowance from the applicant for which it can be held harmless.

15864. This chapter shall become operative on July 1, 2014.

SEC. 90. Chapter 4 (commencing with Section 15870) is added to Part 3.3 of Division 9 of the Welfare and Institutions Code, to read:

Chapter 4. California Major Risk Medical Insurance Program

Article 1. General

15870. For the purposes of this chapter, the following terms have the following meanings:

(a) "Applicant" means an individual who applies for major risk medical coverage through the program.

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

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

(d) "Fund" means the Major Risk Medical Insurance Fund, from which the department may authorize expenditures to pay for medically necessary services which exceed subscribers' contributions, and for administration of the program.

(e) "Major risk medical coverage" means the payment for medically necessary services provided by institutional and professional providers.

(f) "Participating health plan" means either of the following entities that contracts with the department to administer major risk medical coverage to program subscribers:

(1) A private insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(2) A health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code.

(g) "Plan rates" means the total monthly amount charged by a participating health plan for a category of risk.

(h) "Program" means the California Major Risk Medical Insurance Program.

(i) "Subscriber" means an individual who is eligible for and receives major risk medical coverage through the program, and includes a member of a federally recognized California Indian tribe.

(j) "Subscriber contribution" means the portion of participating health plan rates paid by the subscriber, or paid on behalf of the subscriber by a federally recognized California Indian tribal government. If a federally recognized California Indian tribal government makes a contribution on behalf of a member of the tribe, the tribal government shall ensure that the subscriber is made aware of all the health plan options available in the county where the member resides.

15872. The California Major Risk Medical Insurance Program is hereby established within, and shall be administered by, the department.

15872.5. This chapter shall become operative on July 1, 2014.

Article 2. Powers and Duties

15873. The department shall have the authority:

(a) To establish eligibility criteria, notwithstanding Section 15884, and determine the eligibility of applicants.

(b) To determine the major risk medical coverage to be provided to program subscribers.

(c) To research and assess the needs of persons not adequately covered by existing private and public health care delivery systems and promote means of assuring the availability of adequate health care services.

(d) To approve subscriber contributions, and plan rates, and establish program contribution amounts.

(e) To provide major risk medical coverage for subscribers or to contract with a participating health plan or plans or other vendor to provide or administer major risk medical coverage for subscribers.

(f) To authorize expenditures from the fund to pay program expenses which exceed subscriber contributions.

(g) To contract for administration of the program or any portion thereof with any public agency, including any agency of state government, or with any private entity.

(h) (1) To issue rules and regulations to carry out the purposes of this chapter.

(2) 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 and any applicable federal waivers and state plan amendments by means of 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, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature pursuant to Section 9795 of the Government Code on a semiannual basis until regulations have been adopted.

(i) To authorize expenditures from the fund or from other moneys appropriated in the annual Budget Act for purposes relating to Section 10127.16 of the Insurance Code, and Section 1373.622 of the Health and Safety Code.

(j) To exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed upon it under this chapter.

15876. Plan rates for major risk medical benefits approved for the program shall not be excessive, inadequate, or unfairly discriminatory, but shall be adequate to pay anticipated costs of claims or services and administration.

Article 3. Policies Issued by the Department

15878. The department may place a lien on compensation or benefits recovered or recoverable by a subscriber from any party or parties responsible for the compensation or benefits for which benefits have been provided under a policy issued under this article or Article 4 (commencing with Section 15881).

15879. Except as provided in Article 3.5 (commencing with Section 14124.70) of Chapter 7 of Part 3, benefits received under this article or

Article 4 (commencing with Section 15881) are in excess of and secondary to, any other form of health benefits coverage.

15880. Benefits under this article or Article 4 (commencing with Section 15881) shall be subject to required subscriber copayments and deductibles as the department may authorize. Any authorized copayments shall not exceed 25 percent and any authorized deductible shall not exceed an annual household deductible amount of five hundred dollars ($500). However, health plans not utilizing a deductible may be authorized to charge an office visit copayment of up to twenty-five dollars ($25). If the department contracts with participating health plans pursuant to Article 4 (commencing with Section 15881), copayments or deductibles shall be authorized in a manner consistent with the basic method of operation of the participating health plans. The aggregate amount of deductible and copayments payable annually under this section shall not exceed two thousand five hundred dollars ($2,500) for an individual and four thousand dollars ($4,000) for a family.

Article 4. Participating Health Plans

15881. The department shall provide coverage through participating health plans and may contract for the processing of applications, the enrollment of subscribers, and activities necessary to administer the program. A contract entered into pursuant to this chapter shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of General Services. The department shall not be required to specify the amounts encumbered for each contract but may allocate funds to each contract based on projected and actual subscriber enrollments in a total amount not to exceed revenue available for the program.

15882. The department may provide or purchase stop-loss coverage under which the program and participating health plans share the risk for health plan expenses which exceed plan rates.

15883. The department shall withdraw its approval of any participating health benefits plan for noncompliance with program standards, nonpayment of claims, or other good cause shown. Approval shall not be withdrawn except after reasonable notice to the health plan, program subscribers enrolled in the plan, physicians or organizations of physicians offering services through the plan, and all interested parties.

Article 5. Subscriber Eligibility and Enrollment

15884. (a) Each resident of the state meeting the eligibility criteria of this section and who is unable to secure adequate private health coverage is eligible to apply for major risk medical coverage through the program. For these purposes, “resident” includes a member of a federally recognized California Indian tribe.

(b) To be eligible for enrollment in the program, an applicant shall have been rejected for health care coverage by at least one private health plan. An applicant shall be deemed to have been rejected if the only private health coverage that the applicant could secure would do one of the following:

(1) Impose substantial waivers that the department determines would leave a subscriber without adequate coverage for medically necessary services.

(2) Afford limited coverage that the department determines would leave the subscriber without adequate coverage for medically necessary services.

(3) Afford coverage only at an excessive price, which the department determines is significantly above standard average individual coverage rates.

(c) Rejection for policies or certificates of specified disease or policies or certificates of hospital confinement indemnity, as described in Section 10198.61 of the Insurance Code, shall not be deemed to be rejection for the purposes of eligibility for enrollment.

(d) The department may permit dependents of eligible subscribers to enroll in major risk medical coverage through the program if the department determines the enrollment can be carried out in an actuarially and administratively sound manner.

(e) Notwithstanding the provisions of this section, the department shall prescribe a period of time during which a resident is ineligible to apply for major risk medical coverage through the program if the resident either voluntarily disenrolls from, or was terminated for nonpayment of the premium from, a private health plan after enrolling in that private health plan pursuant to either Section 10127.16 of the Insurance Code, and Section 1373.622 of the Health and Safety Code.

15884.5. (a) It shall constitute unfair competition for purposes of Chapter 5 (commencing with Section 17200) of Part 2 of Division 7 of the Business and Professions Code for an insurer, an insurance agent or broker, or an administrator, as defined in Section 1759 of the Insurance Code, to refer an individual employee, or his or her dependents, to the program, or arrange for an individual employee, or his or her dependents, to apply to the program, for the purpose of separating that employee, or his or her dependents, from group health coverage provided in connection with the employees employment.

(b) It shall constitute an unfair labor practice contrary to public policy and enforceable under Section 95 of the Labor Code for any employer to refer an individual employee, or his or her dependents, to the program, or to arrange for an individual employee, or his or her dependents, to apply to the program, for the purpose of separating that employee, or his or her dependents, from group health coverage provided in connection with the employee's employment.

(c) As used in this section, "group health coverage" includes any nonprofit hospital service plan, health care service plan, self-insured employee welfare benefit plan, or disability insurance providing medical or hospital benefits.

15885. The department may permit the exclusion of coverage or benefits for charges or expenses incurred by a subscriber during the first six months

of enrollment in the program for any condition for which, during the six months immediately preceding enrollment in the program medical advice, diagnosis, care, or treatment was recommended or received as to the condition during that period.

However, the exclusion from coverage of this section shall be waived to the extent to which the subscriber was covered under any creditable coverage, as defined in Section 10900 of the Insurance Code, that was terminated, provided the subscriber has applied for enrollment in the program not later than 63 days following termination of the prior coverage, or within 180 days of termination of coverage if the subscriber lost his or her previous creditable coverage because the subscriber's employment ended, the availability of health coverage offered through employment or sponsored by an employer terminated, or an employer's contribution toward health coverage terminated. The exclusion from coverage of this section shall also be waived as to any condition of a subscriber previously receiving coverage under a plan of another state similar to the program established by this chapter if the subscriber was eligible for benefits under that other-state coverage for the condition. The department may establish alternative mechanisms applicable to enrollment in participating health plans. These mechanisms may include, but are not limited to, a postenrollment waiting period.

15885.5. Where more than one participating health plan is offered, the department shall make available to applicants eligible to enroll in the program sufficient information to make an informed choice among the various types of participating health plans. Each applicant shall be issued an appropriate document setting forth or summarizing the services to which an enrollee is entitled, procedures for obtaining major risk medical coverage, a list of contracting health plans and providers, and a summary of grievance procedures.

15886. After the applicant notifies the department in writing of his or her choice of participating health plan, the department shall assist the applicant in enrolling as a subscriber and securing major risk medical coverage for the subscriber and any dependents.

15886.5. A subscriber may request a change in coverage based upon a change in the family status of any dependent, by filing an application within 30 days after the occurrence of the change in family status, or at other times and under conditions as may be prescribed by the department.

15887. Health coverage secured through the program shall permit a covered dependent of a subscriber to elect to continue the same coverage upon the death of the subscriber, or upon the subscriber becoming eligible for Medicare Part A and Part B.

15887.5. A transfer of enrollment from one participating health plan to another may be made by a subscriber at times and under conditions as may be prescribed by the department.

15888. If a subscriber is dissatisfied with any action or failure to act which has occurred in connection with a participating plan's coverage, the subscriber shall have the right to appeal to the department and shall be

accorded an opportunity for a fair hearing. Hearings may be conducted, insofar as practicable, pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

15888.5. Subscribers and their dependents who become eligible for Medicare Part A and Part B, excluding those on Medicare solely because of end-stage renal disease, shall not be enrolled, or continue to be enrolled, in major risk medical coverage afforded by this chapter.

Article 6. Plan Rates and Compensation from the Fund

15890. Upon enrollment as a subscriber in the program, the subscriber shall be responsible for payment of the subscriber contribution. Termination of coverage by a participating health plan for nonpayment of the subscriber contribution shall be governed by the same laws and regulations by which the participating health plan is regulated as to all its subscribers and enrollees.

15890.5. Each health plan contracting with the department pursuant to Article 4 (commencing with Section 15881) shall submit annually to the department rates which it estimates are sufficient to cover the cost of providing major risk medical coverage to its subscribers. The rates shall be submitted on the basis of categories of risk which shall be established by the department.

15891. (a) The department shall establish program contribution amounts for each category of risk for each participating health plan. The program contribution amounts shall be based on the average amount of subsidy funds required for the program as a whole. To determine the average amount of subsidy funds required, the department shall calculate a loss ratio, including all medical costs, administration fees, and risk payments, for the program in the prior calendar year. The loss ratio shall be calculated using 125 percent of the standard average individual rates for comparable coverage as the denominator, and all medical costs, administration fees, and risk payments as the numerator. The average amount of subsidy funds required is calculated by subtracting 100 percent from the program loss ratio. For purposes of calculating the program loss ratio, no participating health plan's loss ratio shall be less than 100 percent and participating health plans with fewer than 1,000 program members shall be excluded from the calculation.

Subscriber contributions shall be established to encourage members to select those health plans requiring subsidy funds at or below the program average subsidy. Subscriber contribution amounts shall be established so that no subscriber receives a subsidy greater than the program average subsidy, except that:

(1) In all areas of the state, at least one plan shall be available to program participants at an average subscriber contribution of 125 percent of the standard average individual rates for comparable coverage.

(2) No subscriber contribution shall be increased by more than 10 percent above 125 percent of the standard average individual rates for comparable coverage.

(3) Subscriber contributions for participating health plans joining the program after January 1, 1997, shall be established at 125 percent of the standard average individual rates for comparable coverage for the first two benefit years the plan participates in the program.

(b) The department shall pay program contribution amounts to participating health plans from the Major Risk Medical Insurance Fund.

(c) Commencing January 1, 2013, in addition to the amount of subsidy funds required pursuant to subdivision (a), the department may further subsidize subscriber contributions so that the amount paid by each subscriber is below 125 percent of the standard average individual risk rate for comparable coverage but no less than 100 percent of the standard average individual risk rate for comparable coverage. For purposes of calculating premiums for the following products, any reference to, or use of, subscriber contributions, premiums, average premiums, or amounts paid by subscribers in the program shall be construed to mean subscriber contributions as described in subdivision (a) without application of the additional subsidies permitted by this subdivision:

(1) Standard benefit plans pursuant to Section 10127.16 of the Insurance Code and Section 1373.622 of the Health and Safety Code.

(2) Health benefit plans and health care service plan contracts for federally eligible defined individuals pursuant to Sections 10901.3 and 10901.9 of the Insurance Code and Sections 1399.805 and 1399.811 of the Health and Safety Code.

(3) Conversion coverage pursuant to Section 12682.1 of the Insurance Code and Section 1373.6 of the Health and Safety Code.

15891.5. A participating health plan may charge subscriber contributions under this article that do not exceed the difference between its plan rate for the category of risk and the program contribution amount for the category of risk.

Article 7. Major Risk Medical Insurance Fund

15893. (a) There is hereby continued in existence in the State Treasury a special fund known as the Major Risk Medical Insurance Fund that is, notwithstanding Section 13340 of the Government Code, continuously appropriated to the department for the purposes specified in Section 15894, Section 10127.16 of the Insurance Code, and Section 1373.622 of the Health and Safety Code.

(b) Funds may be deposited in the Major Risk Medical Insurance Fund from one or more of the following accounts in the Cigarette and Tobacco Products Surtax Fund:

(1) The Hospital Services Account.

(2) The Physician Services Account.

(3) The Unallocated Account.

15893.5. Notwithstanding Section 15893, funds placed in the Major Risk Medical Insurance Fund pursuant to Section 1341.45 of the Health and Safety Code shall not be continuously appropriated.

15894. Except as provided in Section 15894.5, the department shall authorize the expenditure of money in the fund to cover program expenses, including program expenses that exceed subscriber contributions, and to cover expenses relating to Section 10127.16 of the Insurance Code, or to Section 1373.622 of the Health and Safety Code. The department shall determine the amount of funds expended for each of these purposes, taking into consideration the requirements of this chapter, Section 10127.16 of the Insurance Code, and Section 1373.622 of the Health and Safety Code.

15894.5. From money appropriated by the Legislature to the fund, the department may expend sufficient funds to carry out the purposes of this chapter and of Section 10127.16 of the Insurance Code, and Section 1373.622 of the Health and Safety Code.

However, the state shall not be liable beyond the assets of the fund for any obligations incurred, or liabilities sustained, in the operation of the California Major Risk Medical Insurance Program or for the expenditures described in Section 10127.16 of the Insurance Code, and Section 1373.622 of the Health and Safety Code.

15895. Any moneys remaining in the fund at the end of any fiscal year may be carried forward to the next succeeding fiscal year.

15895.5. The department shall establish a reserve which is sufficient to prudently operate the program.

SEC. 91. The balances of the funds for the appropriations provided by Item 4560-001-3085 of Section 2.00 of the Budget Act of 2011, as added by Chapter 33 of the Statutes of 2011, payable from the Mental Health Services Fund, are hereby reappropriated and, notwithstanding any other law, shall be available for encumbrance until June 30, 2015.

SEC. 92. Between July 1, 2014, and October 31, 2015, inclusive, the State Department of Public Health shall convene a quarterly meeting of stakeholders, including, but not limited to, community organizations, food banks, nonprofit organizations, program contractors, and counties, to solicit input and receive feedback on the development, integration, and evaluation of nutrition education and obesity prevention programs, and to help minimize any disruption to services in the Supplemental Nutrition Assistance Program Education (SNAP-Ed) program during the transition of work from contracted vendors to the civil service.

SEC. 93. By August 1, 2014, the State Department of Health Care Services shall establish a work group composed of stakeholders, including health care providers, county representatives, labor, health plans and insurance representatives, consumer advocates, immigrant policy advocates, and employers of low-wage workers to develop a plan to utilize available Major Risk Medical Insurance Fund moneys, including moneys in the Managed Care Administrative Fines and Penalties Fund transferred pursuant to paragraph (2) of subdivision (c) of Section 1341.45 of the Health and

Safety Code, and any other available funds in the Cigarette and Tobacco Products Surtax Fund, in order to provide subsidized health care coverage for individuals not eligible for or receiving comprehensive health care.

SEC. 94. By August 1, 2014, the State Department of Health Care Services shall work with stakeholders, including consumer advocates, county representatives, and health care providers, to develop a notice to be sent or made available to individuals who both (1) are enrolled in a state health care program administered by the State Department of Health Care Services that does not provide minimum essential coverage and (2) have been determined, by the State Department of Health Care Services, to potentially be eligible for Medi-Cal or coverage through California Health Benefit Exchange. The notice shall inform the enrollees that they may qualify for Medi-Cal or comprehensive coverage through Covered California. The notice shall also include information about the open enrollment period for the California Health Benefit Exchange and shall indicate that there is continuous enrollment for the Medi-Cal program. The notice may be made available through means that include, but not limited to, health care provider offices and postings on Internet Web sites.

SEC. 95. (a) Beginning October 2014, the State Department of Public Health shall, on a quarterly basis, report to the fiscal and appropriate policy committees of the Legislature and post on its Internet Web Site all of the following:

(1) Beginning with 2011–12 by fiscal year and by quarter for the budget year, workload and performance metrics related to the volume, timeliness of initiation, timeliness of completion, and disposition of all of the following:

(A) Investigations of complaints related to paraprofessionals certified by the State Department of Public Health.

(B) Investigations of complaints and entity-reported incidents related to long-term care facilities licensed or certified by the State Department of Public Health, including the number of complaint investigations initiated within 10 days and the number of complaint investigations prioritized as involving immediate jeopardy initiated within 24 hours.

(C) State relicensing and federal recertification surveys.

(2) Information on Licensing and Certification Program vacancy rates and hiring by position classification, including any positions established administratively.

(3) By October 2016, the State Department of Public Health shall begin reporting workload and performance metrics related to the volume, timeliness of initiation, timeliness of completion, and disposition of complaints for all facility types.

(b) Beginning August 2014, the State Department of Public Health shall hold semiannual meetings for all interested stakeholders to provide feedback on improving the Licensing and Certification Program to ensure that Californians receive the highest quality of medical care in health facilities. Once they are available under subdivision (a), the State Department of Public Health shall present the quarterly workload and performance metrics at these meetings.

(c) The State Department of Public Health shall report to the fiscal and appropriate policy committees of the Legislature and post on its Internet Web site, all of the following:

(1) By October 2014, the status and use of the $1.4 million appropriated in the 2014–15 fiscal year from the Internal Departmental Quality Improvement Account for the Licensing and Certification Program Evaluation and the outcomes from this effort. The State Department of Public Health shall report on the status of the fund thereafter in the Licensing and Certification Estimate.

(2) By October 2014, and in the Licensing and Certification Program November Licensing and Certification Estimate, for the 2015–16 fiscal year an update on the State Department of Public Health's efforts to evaluate and reform the Licensing and Certification Program timekeeping systems and estimate methodology.

(3) By October 2014, and annually thereafter in the Licensing and Certification Program Estimate, an update on the Los Angeles County contract and Licensing and Certification's oversight of this contract.

(4) By December 1, 2014, an assessment of the possibilities of using professional position classifications other than Health Facility Evaluator Nurses to perform licensing and certification survey or complaint workload.

(d) Any reports required to be submitted to the fiscal and appropriate policy committees of the Legislature pursuant to this section shall be submitted notwithstanding Section 10231.5 of the Government Code.

SEC. 96. The Legislature finds and declares that Section 45 of this act clarifies procedures and terms of the Mental Health Services Act within the meaning of Section 18 of the Mental Health Services Act.

SEC. 97. The Legislature finds and declares all of the following:

(a) During the 2009–10 Regular Session of the Legislature, the Legislature enacted Assembly Bill 2599 (Chapter 267 of the Statutes of 2011), which, among other things, recognizes the importance of facilitating the success of a new, nonprofit hospital to serve the population of South Los Angeles that was formerly served by the Los Angeles County Martin Luther King, Jr.-Harbor Hospital.

(b) It remains the intent of the Legislature that adequate and predictable funding in support of the new hospital be provided through current Medi-Cal funding or equivalent funding under successor or modified Medi-Cal payment systems, for purposes related to meeting the health care needs of the population formerly served by the Los Angeles County Martin Luther King, Jr.-Harbor Hospital.

(c) It is the intent of the Legislature that the State Department of Health Care Services, the County of Los Angeles, and the new, nonprofit hospital operating on the site of the former Los Angeles County Martin Luther King, Jr.-Harbor Hospital campus shall annually determine the best means to provide funding to the new hospital in a manner that will be federally approved.

(d) It is the intent of the Legislature that funding to the new hospital will be claimed and provided in a manner that maximizes federal Medicaid

funding to the state by considering the overall aggregate impact on funding with respect to Medi-Cal hospital providers in the state.

SEC. 98. Through its courts, statutes, and under its Constitution, California protects a woman's right to reproductive privacy. The Legislature hereby reaffirms these protections and specifically the California Supreme Court decisions in People v. Belous (1969) 71 Cal.2d 954, Committee To Defend Reproductive Rights v. Myers (1981) 29 Cal.3d 252, and American Academy of Pediatrics v. Lungren (1997) 16 Cal.4th 307. It is the intent of the Legislature that this act not be interpreted to limit a woman's rights under the California Constitution and these California Supreme Court decisions.

SEC. 99. The Legislature finds and declares that Section 2 of this act, which amends Section 6254 of the Government Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to protect the confidentiality of certain negotiations, negotiated rates, and privileged work product, it is necessary that this act limit the public's right of access to that information.

SEC. 100. 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. 101. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.

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