AMENDED IN SENATE APRIL 5, 2016

SENATE BILL No. 1300

Introduced by Senator Hernandez

February 19, 2016

An act to ~~amend Section 15926~~ *add Article 3.91 (commencing with Section 14129) to Chapter 7 of Part 3 of Division 9* of the Welfare and Institutions Code, relating to ~~health care.~~ *Medi-Cal, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.*

LEGISLATIVE COUNSEL'S DIGEST

SB 1300, as amended, Hernandez. ~~Health care: eligibility and enrollment.~~ *Medi-Cal: emergency medical transport providers: quality assurance fee.*

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a quality assurance fee program for skilled nursing and intermediate care facilities, as prescribed.

This bill, commencing July 1, 2017, and subject to federal approval, would impose a quality assurance fee for each transport provided by an emergency medical transport provider, as defined, subject to the quality assurance fee in accordance with a prescribed methodology. The bill would authorize the director to exempt categories of emergency medical transport providers from the quality assurance fee if necessary to obtain federal approval. The bill would require the Director of Health Care Services to deposit the collected quality assurance fee into the

Medi-Cal Emergency Medical Transport Fund, which the bill would create in the State Treasury, to be continuously appropriated, thereby making an appropriation, to the department to be used exclusively in a specified order of priority to enhance federal financial participation for ambulance services under the Medi-Cal program, and to provide additional reimbursement to, and to support quality improvement efforts of, emergency medical transport providers, to pay for state administrative costs, and to provide funding for health care coverage for Californians. The bill, on or before August 15, 2016, would require each emergency medical transport provider to report to the department specified data, including data on gross receipts, as defined, from the provision of emergency medical transports, as specified, in a manner and form prescribed by the department and, commencing on October 1, 2016, and each fiscal quarter thereafter, would require each emergency medical transport provider to report this data to the department. The bill would authorize the department to establish an Internet Web site for the submission of these data reports. The bill would authorize the department to require a certification by each emergency medical transport provider, under penalty of perjury, of the truth of these data reports. By expanding the scope of the crime of perjury, the bill would impose a state-mandated local program. The bill would authorize the department, upon written notice to the emergency medical transport provider, to impose a $100 per day penalty against the provider for each day that the provider fails to make a report within 5 business days of the date upon which the data report was due. The bill would provide that the failure to make a report under these provisions within 90 days of the date upon which the report was due shall be considered a violation that relates to his or her licensed activities for purposes of a specified section of the Vehicle Code, which authorizes the Commissioner of the California Highway Patrol to suspend, revoke, or take other disciplinary action against a license if the licensee violates any section of the Vehicle Code that relates to his or her licensed activities.

The bill, commencing July 1, 2017, and subject to federal approval, would increase the Medi-Cal reimbursement to private emergency medical transport providers for emergency medical transports, including both fee-for-service transports paid by the department and managed care transports paid by Medi-Cal managed care health plans, as specified.

The bill would authorize the department to adopt regulations as necessary to implement these provisions, as specified.

The bill would provide that the provisions of the bill shall cease to be implemented if any of certain conditions, including continued federal approval, are no longer satisfied.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

~~Existing law establishes various programs to provide health care coverage to persons with limited financial resources, including the Medi-Cal program and the State's Children's Health Insurance Program. Existing law establishes the California Health Benefit Exchange (Exchange), pursuant to the federal Patient Protection and Affordable Care Act (PPACA), and specifies the duties and powers of the board governing the Exchange relative to determining eligibility for enrollment in the Exchange and arranging for coverage under qualified health plans, and facilitating the purchase of qualified health plans through the Exchange. Existing law, the Health Care Reform Eligibility, Enrollment, and Retention Planning Act, requires the State Department of Social Services in consultation with specified entities, to establish standardized single, accessible, application forms and related renewal procedures for insurance affordability programs, as defined, in accordance with specified requirements relating to the forms and notices developed for these purposes.~~

~~This bill would make technical, nonsubstantive changes to those provisions.~~

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

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

SECTION 1. Article 3.91 (commencing with Section 14129) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 3.91. Medi-Cal Emergency Medical Transportation Reimbursement Act

14129. The Legislature finds and declares all of the following:

(a) The Legislature recognizes the essential role that emergency medical transport providers play in serving the state's Medi-Cal beneficiaries. To that end, it has been and remains the intent of the Legislature to improve funding for emergency medical transport providers and obtain all available federal funds to make supplemental Medi-Cal payments to emergency medical transport providers.

(b) It is the intent of the Legislature to impose a quality assurance fee to be paid by emergency medical transport providers, which will be used to increase federal financial participation in order to increase Medi-Cal payments to emergency medical transport providers.

(c) It is the intent of the Legislature to increase the Medi-Cal emergency medical transport reimbursement by increasing the fee-for-service payment schedule for emergency medical transports to support quality improvement efforts by emergency medical transport providers, including, but not limited to, the provision of advanced life support services, as defined in Section 1797.52 of the Health and Safety Code.

(d) It is the further intent of the Legislature that the increased fee-for-service payment schedule amounts pursuant to this article shall not result in any expenditure from the General Fund.

14129.1. For purposes of this article, the following definitions shall apply:

(a) "Annual quality assurance fee rate" means the quality assurance fee assessed on each emergency medical transport applicable to each state fiscal year.

(b) "Aggregate fee schedule increase amount" means the product of the quotient described in paragraph (2) of subdivision (a) of Section 14129.4 and the Medi-Cal emergency medical transports, including both fee-for-service transports paid by the department and managed care transports paid by Medi-Cal managed care health plans, utilizing the billing codes for emergency medical transport for the state fiscal year.

(c) "Available fee amount" shall be calculated as the sum of the following:

(1) The amount deposited in the Medi-Cal Emergency Transportation Fund established under Section 14129.3 during the applicable state fiscal year, less the amounts described in subparagraphs (A) and (B) of paragraph (2) of subdivision (f) of Section 14129.3.

(2) Any federal financial participation obtained as a result of the deposit of the amount described in paragraph (1) in the Medi-Cal Emergency Transportation Fund for the applicable fiscal year.

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

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

(f) "Effective state medical assistance percentage" means a ratio of the aggregate expenditures from state-only sources for the Medi-Cal program divided by the aggregate expenditures from state and federal sources for the Medi-Cal program for a state fiscal year.

(g) "Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations that are billed with billing codes A0429 BLS Emergency, A0427 ALS Emergency, and A0433 ALS2, and any equivalent, predecessor, or successor billing codes as may be determined by the director. "Emergency medical transports" shall not include transportation of beneficiaries by passenger car, taxicabs, litter vans, wheelchair vans, or other forms of public or private conveyances, nor shall it include transportation by an air ambulance provider. An "emergency medical transport" does not occur when, following evaluation of a patient, a transport is not provided.

(h) "Gross receipts" means gross payments received as patient care revenue for emergency medical transports, determined on a cash basis of accounting.

(i) "Emergency medical transport provider" means any provider of emergency medical transports.

(j) "Emergency medical transport provider subject to the fee" means all emergency medical transport providers that bill and receive patient care revenue from the provision of emergency medical transports, except emergency medical transport providers that are exempt pursuant to subdivision (c) of Section 14129.8.

(k) "Medi-Cal managed care health plan" means a "managed health care plan" as that term is defined in subdivision (ab) of Section 14169.51.

14129.2. (a) On or before August 15, 2016, each emergency medical transport provider shall report to the department data on the number of actual emergency medical transports by payor type, including, without limitation, Medi-Cal fee-for-service emergency medical transports and Medi-Cal managed care emergency medical transports, and gross receipts from the provision of emergency medical transports provided in each quarter from July 1, 2015, through June 30, 2016, inclusive, in a manner and format prescribed by the department.

(b) Commencing with the fiscal quarter beginning on October 1, 2016, and each fiscal quarter thereafter, on or before the 45th day of the quarter, each emergency medical transport provider shall report to the department data on the number of actual emergency medical transports by payor type, including, without limitation, Medi-Cal fee-for-service emergency medical transports and Medi-Cal managed care emergency medical transports, and gross receipts from the provision of emergency medical transports provided in the quarter preceding the quarter in which the report is due, in a manner and format prescribed by the department.

(c) The department may establish an Internet Web site for the submission of reports required by this section.

(d) The department may require a certification by each emergency medical transport under penalty of perjury of the truth of the reports required under this section. Upon written notice to an emergency medical transport provider, the department may impose a penalty of one hundred dollars ($100) per day against an emergency medical transport provider for every day that an emergency medical transport provider fails to make a report required by this section within five days of the date upon which the report was due. If an emergency medical transport provider has not made a report as required by this section within 90 days of the date upon which the report was due, the failure to make the

report shall be considered a violation of a section of the Vehicle Code that relates to the emergency medical transport provider's licensed activities for the purposes of Section 2542 of the Vehicle Code.

14129.3. (a) Commencing with the state fiscal quarter beginning on July 1, 2017, and continuing each fiscal quarter thereafter, there shall be imposed a quality assurance fee for each transport provided by each emergency medical transport provider subject to the fee in accordance with this section.

(b) (1) On or before June 15, 2017, and each June 15 thereafter, the director shall calculate the annual quality assurance fee rate applicable to the following state fiscal year based on the most recently collected data collected from emergency medical transport providers pursuant to Section 14129.2, and publish the annual quality assurance fee rate on its Internet Web site. In no case shall the fees calculated pursuant to this subdivision and collected pursuant to this article exceed the amounts allowable under federal law.

(A) For state fiscal year 2017–18, the annual quality assurance fee rate shall be calculated by multiplying the projected total annual gross receipts for all emergency medical transport providers subject to the fee by 5.5 percent, which resulting product shall be divided by the projected total annual emergency medical transports by all emergency medical transport providers subject to the fee for the state fiscal year.

(B) For state fiscal years 2018–19 and thereafter, the annual quality assurance fee rate shall be calculated by a ratio, the numerator of which shall be the sum of the product of the projected aggregate fee schedule amount and the effective state medical assistance percentage, and the amount described in subparagraph (A) of paragraph (2) of subdivision (f), and the denominator of which shall be 95 percent of the projected total annual emergency medical transports by all emergency medical transport providers subject to the fee for the state fiscal year.

(2) On or before June 15, 2017, and each June 15 thereafter, the director shall publish the annual quality assurance fee rate on its Internet Web site.

(3) In no case shall the fees calculated pursuant to this subdivision and collected pursuant to this article exceed the amounts allowable under federal law.

(4) If, during a state fiscal year, the actual or projected available fee amount exceeds or is less than the actual or projected aggregate fee schedule amount by more than 1 percent, the director shall adjust the annual quality assurance fee rate so that the available fee amount for the state fiscal year will approximately equal the aggregate fee schedule amount for the state fiscal year. The available fee amount for a state fiscal year will be considered to equal the aggregate fee schedule amount for the state fiscal year if the difference between the available fee amount for the state fiscal year and the aggregate fee schedule amount for the state fiscal year constitutes less than 1 percent of the aggregate fee schedule amount for the state fiscal year.

(c) (1) Each emergency medical transport provider subject to the fee shall remit to the department an amount equal to the annual quality assurance fee rate for the 2017–18 state fiscal year multiplied by the number of transports reported or that should have been reported by the emergency medical transport provider pursuant to subdivision (b) of Section 14129.2 in the quarter commencing April 1, 2017, based on a schedule established by the director. The schedule established by the director for the fee payment described in this paragraph shall not require payment of any of the fee payment prior to July 1, 2017, and shall not require payment of more than 50 percent of the fee payment prior to August 1, 2017.

(2) Commencing with the state fiscal quarter beginning on October 1, 2017, and each fiscal quarter thereafter, on or before the first day of each state fiscal quarter, each emergency medical transport provider subject to the fee shall remit to the department an amount equal to the annual quality assurance fee rate for the applicable state fiscal year multiplied by the number of transports reported or that should have been reported by the emergency medical transport provider pursuant to subdivision (b) of Section 14129.2 in the immediately preceding quarter.

(d) (1) Interest shall be assessed on quality assurance fees not paid on the date due at the greater of 10 percent per annum or the rate at which the department assesses interest on Medi-Cal program overpayments to hospitals that are not repaid when due. Interest shall begin to accrue the day after the date the payment was due and shall be deposited in the Medi-Cal Emergency Medical Transport Fund established in subdivision (f).

(2) In the event that any fee payment is more than 60 days overdue, the department may deduct the unpaid fee and interest owed from any Medi-Cal reimbursement payments owed to the provider until the full amount of the fee and interest are recovered. Any deduction made pursuant to this subdivision shall be made only after the department gives the provider written notification. Any deduction made pursuant to this subdivision may be deducted over a period of time that takes into account the financial condition of the provider.

(3) In the event that any fee payment is more than 60 days overdue, a penalty equal to the interest charge described in paragraph (1) shall be assessed and due for each month for which the payment is not received after 60 days.

(e) The department shall accept an emergency medical transport provider's payment even if the payment is submitted in a rate year subsequent to the rate year in which the fee was assessed.

(f) (1) The director shall deposit the quality assurance fee collected pursuant to this section in the Medi-Cal Emergency Medical Transport Fund, which is hereby created in the State Treasury and, notwithstanding Section 13440 of the Government Code, is continuously appropriated without regard to fiscal years to the department for the purposes specified in this article. Notwithstanding Section 16305.7 of the Government Code, the fund shall also include interest and dividends earned on moneys in the fund.

(2) The moneys in the Medi-Cal Emergency Medical Transport Fund, including any interest and dividends earned on money in the fund, shall be available exclusively to enhance federal financial participation for ambulance services under the Medi-Cal program and to provide additional reimbursement to, and to support quality improvement efforts of, emergency medical transport providers, as well as to pay for the state's administrative costs and to provide funding for health care coverage for Californians, in the following order of priority:

(A) To pay for the department's staffing and administrative costs directly attributable to implementing this article, not to exceed three hundred fifty thousand dollars ($350,000) for each fiscal year, exclusive of any federal matching funds.

(B) To pay for the health care coverage in each fiscal year in the amount of 5 percent of the projected quality assurance fee

revenue for that fiscal year, as calculated by the department on or before June 15 preceding that fiscal year, exclusive of any federal matching funds.

(C) To make increased payments to emergency medical transport providers pursuant to this article.

(D) To provide additional support for health care coverage of Californians.

14129.4. (a) Effective July 1, 2017, the Medi-Cal fee-for-service payment schedule governing reimbursement to emergency medical transport providers for emergency medical transports shall be increased. The resulting fee-for-service payment schedule amounts after the application of this section shall be equal to the sum of (1) the Medi-Cal fee-for-service payment schedule amount for the state fiscal year 2015–16 and (2) the quotient of the projected available fee amount for the state fiscal year 2017–18, divided by the total projected Medi-Cal emergency medical transports, including both fee-for-service transports paid by the department and managed care transports paid by Medi-Cal managed care health plans, utilizing these billing codes for the state fiscal year 2016–17. The department shall calculate the projections required by this subdivision based on the data submitted pursuant to Section 14129.2.

(b) Each Medi-Cal managed care health plan shall satisfy its obligation under Section 438.114(c) of Title 42 of the Code of Federal Regulations for emergency medical transports by providing payment to emergency medical transport providers that is equal to the amount of payment described in Section 1396u-2(b)(2)(D) of Title 42 of the United States Code.

(c) The fee-for-service payment schedule increase established pursuant to this section shall be funded solely from the following:

(1) The quality assurance fee set forth in Section 14129.3, along with any interest or other investment income thereon.

(2) Federal reimbursement and any other related federal funds.

(d) The proceeds of the quality assurance fee set forth in Section 14129.3, the matching amount provided by the federal government, and any interest earned on those proceeds shall be used to supplement existing funding for emergency medical transports provided by emergency transport providers and not supplant this funding.

14129.5. If there is a delay in the implementation of this article for any reason, including a delay in any required approval of the quality assurance fee and reimbursement methodology specified by the federal Centers for Medicare and Medicaid Services, all of the following shall apply:

(a) An emergency transport provider subject to the fee may be assessed the amount the provider would be required to pay to the department if the fee-for-service payment schedule increases described in Section 14129.4 were already approved, but shall not be required to pay the fee until the fee-for-service payment schedule increases described in Section 14129.4 are approved. The director shall establish a schedule for payment of retroactive fees pursuant to this subdivision in consultation with emergency medical transport providers to minimize the disruption to the cash flow of emergency medical transport providers.

(b) The department may retroactively increase and make payment of supplemental rates to emergency medical transport providers pursuant to Section 14129.4.

14129.6. (a) The director shall administer this article.

(b) The director may adopt regulations as are necessary to implement this article. These regulations may be adopted as emergency regulations in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). For purposes of this article, the first adoption of regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The regulations shall include, but need not be limited to, any regulations necessary for any of the following purposes:

(1) The administration of this article, including the proper imposition of the quality assurance fee and process for its collection, reporting, and refunds. The costs associated with the administration of this article are not to exceed the amounts reasonably necessary to administer this article.

(2) The development of any forms necessary to obtain required information from providers subject to the quality assurance fee.

(3) The provision of details, definitions, formulas, and other requirements.

(c) As an alternative to subdivision (b), and notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the director may implement this article, in whole or in part, by means of a provider bulletin, or other similar instructions, without taking regulatory action, provided that no such bulletin or other similar instructions shall remain in effect after June 30, 2018. It is the intent of the Legislature that the regulations adopted pursuant to subdivision (b) be adopted on or before June 30, 2018.

(d) The director shall ensure that the quality assurance fee per transport imposed pursuant to this article is collected.

14129.7. The moneys in the Medi-Cal Emergency Medical Transport Fund, and any federal matching funds, shall be continuously appropriated, notwithstanding Section 13340 of the Government Code, without regard to fiscal years to the department for the purpose of the increased Medi-Cal fee-for-service payment schedule governing reimbursement to emergency medical transport providers for emergency medical transports described in Section 14129.4.

14129.8. (a) The department shall request approval from the federal Centers for Medicare and Medicaid Services for the use of fees collected pursuant to this article for the purpose of receiving federal matching funds.

(b) The director may alter the methodology specified in this article to the extent necessary to meet the requirements of federal law or regulations or to obtain federal approval. If the director, after consulting with affected emergency medical transport providers, determines that an alteration is needed, the director shall execute a declaration stating that this determination has been made. The director shall retain the declaration and provide a copy, within five working days of the execution of the declaration, to the fiscal and appropriate policy committees of the Legislature.

(c) The director may add categories of exempt emergency medical transport providers or apply a nonuniform fee per transport to emergency medical transport providers that are subject to the fee in order to meet requirements of federal law or regulations. The director may exempt categories of emergency medical transport providers from the fee if necessary to obtain federal approval.

14129.9. (a) This article shall be implemented only if, and as long as, both of the following conditions are met:

(1) The state receives federal approval of the quality assurance fee from the federal Centers for Medicare and Medicaid Services.

(2) The state receives federal approval for the increased fee-for-service payment schedule increases described in subdivision (a) of Section 14129.4.

(b) This article shall cease to be implemented if one of the following conditions is no longer met:

(1) The federal Centers for Medicare and Medicaid Services continues to allow the use of the provider assessment provided in this article.

(2) The Medi-Cal fee-for-service payment schedule increase described in subdivision (a) of Section 14129.4 remains in effect.

(3) The quality assurance fee assessed and collected pursuant to this article remains available for the purposes specified in this article.

(c) If all of the conditions in subdivision (a) are met, this article is implemented. If, subsequently, any one of the conditions in subdivision (b) is not met, this article shall become inoperative notwithstanding that the condition or conditions subsequently may be met.

(d) Notwithstanding subdivisions (a), (b), and (c), in the event of a final judicial determination made by any state or federal court that is not appealed, or by a court of appellate jurisdiction that is not further appealed, in any action by any party, or a final determination by the administrator of the federal Centers for Medicare and Medicaid Services, that federal financial participation is not available with respect to any payment made under the methodology implemented pursuant to this article because the methodology is invalid, unlawful, or contrary to any provision of federal law or regulations or of state law, this article shall become inoperative.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within

the meaning of Section 6 of Article XIII B of the California Constitution.

SEC. 3. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make the necessary changes to increase Medi-Cal payments to emergency ambulance providers and to improve access, at the earliest possible time, to allow this act to be operative as soon as approval from the federal Centers for Medicare and Medicaid Services is obtained by the State Department of Health Care Services, it is necessary that this act take effect immediately.

~~SECTION 1. Section 15926 of the Welfare and Institutions Code is amended to read:~~

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

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

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

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

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

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

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

~~(4) A program that makes available coverage in a qualified health plan through the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code with cost-sharing reductions established~~

~~under Section 1402 of PPACA and any subsequent amendments to that act.~~

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

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

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

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

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

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

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

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

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

~~(E) The form may ask, or be used otherwise to identify, if the mother of an infant applicant under one year of age had coverage~~

~~through an insurance affordability program for the infant's birth, for the purpose of automatically enrolling the infant into the applicable program without the family having to complete the application process for the infant.~~

~~(F) The form may include questions that are voluntary for applicants to answer regarding demographic data categories, including race, ethnicity, primary language, disability status, and other categories recognized by the federal Secretary of Health and Human Services under Section 4302 of the PPACA.~~

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

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

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

~~(f) (1) If the eligibility, enrollment, and retention system has the ability to prepopulate an application form for insurance affordability programs with personal information from available electronic databases, an applicant shall be given the option, with his or her informed consent, to have the application form prepopulated. Before a prepopulated application is submitted to the entity authorized to make eligibility determinations, the individual shall be given the opportunity to provide additional eligibility information and to correct any information retrieved from a database.~~

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

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

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

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

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

~~(g) The eligibility, enrollment, and retention system shall offer an applicant and recipient assistance with his or her application or renewal for an insurance affordability program in person, over the telephone, by mail, online, or through other commonly available electronic means and in a manner that is accessible to individuals with disabilities and those who are limited-English proficient.~~

~~(h) (1) During the processing of an application, renewal, or a transition due to a change in circumstances, an entity making eligibility determinations for an insurance affordability program shall ensure that an eligible applicant and recipient of insurance affordability programs that meets all of the program eligibility~~

~~requirements and complies with all of the necessary requests for information moves between programs without any breaks in coverage and without being required to provide any forms, documents, or other information or undergo verification that is duplicative or otherwise unnecessary. The individual shall be informed about how to obtain information about the status of his or her application, renewal, or transfer to another program at any time, and the information shall be promptly provided when requested.~~

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

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

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

~~(i) Notwithstanding subdivisions (e), (f), and (j), before an online applicant who appears to be eligible for the Exchange with a premium tax credit or reduction in cost sharing, or both, may be enrolled in the Exchange, both of the following shall occur:~~

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

~~penalties are avoided by prompt reporting of income increases throughout the year.~~

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

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

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

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

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

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

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

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