AMENDED IN SENATE JANUARY 9, 2014

SENATE BILL No. 508

Introduced by Senator Hernandez

February 21, 2013

An act to ~~add Chapter 5 (commencing with Section 128955) to Part 5 of Division 107 of the Health and Safety Code, relating to public health.~~ *amend Sections 14005.20, 14005.26, 14005.27, 14005.28, 14005.30, 14005.64, 14051, 14148, and 14148.5 of, and to add Section 14005.285 to, the Welfare and Institutions Code, relating to Medi-Cal.*

LEGISLATIVE COUNSEL'S DIGEST

SB 508, as amended, Hernandez. ~~Health disparity report.~~ *Medi-Cal: eligibility.*

(1) 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 requires, with some exceptions, a Medi-Cal applicant's or beneficiary's income and resources be determined based on modified adjusted gross income (MAGI), as specified. Existing law requires the department to establish income eligibility thresholds for those eligibility groups whose eligibility will be determined using MAGI-based financial methods.

This bill would codify the income eligibility thresholds established by the department and would make other related and conforming changes.

(2) Existing law requires the department to implement specified provisions of federal law to provide Medi-Cal benefits to an individual

who is in foster care on his or her 18th birthday until his or her 26th birthday, as specified.

This bill would instead require the department to implement those provisions to provide Medi-Cal benefits to an individual until his or her 26th birthday if he or she was in foster care on his or her 18th birthday or lost his or her eligibility for foster care assistance due to having reached the maximum age for that assistance. The bill would also require the department to exercise its option under federal law to extend Medi-Cal benefits to independent foster care adolescents, as specified.

Because counties are required to make eligibility determinations and this will would expand Medi-Cal eligibility, the bill would impose a state-mandated local program

(3) Existing law, for purposes of determining eligibility, defines, in part, a medically need family person as a parent or caretaker relative of a child who meets the deprivation requirements of Aid to Families with Dependent Children.

This bill would delete the requirement that the parent or caretaker relative meet the deprivation requirements.

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

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

~~Existing law provides that the Office of Statewide Health Planning and Development, within the California Health and Human Services Agency, is the single state agency designated to prescribe health facility or clinic data for use by all state agencies.~~

~~This bill would require the office, with support from the agency, to develop a health disparity report based upon the inpatient hospital discharge data set. The bill would require the report to focus on specified areas of concern, such as cardiovascular disease and breast cancer. The bill would also require the office and agency, by January 1, 2016, to complete and deliver the report to the Legislature.~~

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

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

SECTION 1. Section 14005.20 of the Welfare and Institutions Code is amended to read:

14005.20. (a) The State Department of Health *Care* Services shall adopt the option made available under ~~Section 13603 of the federal Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)~~ *Section 1902(a)(10)(A)(ii)(XII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XII))* to pay allowable tuberculosis related services for persons infected with tuberculosis.

~~(b) The~~

(b) (1) Except as provided in paragraph (2), the income and resources of these persons may not exceed the maximum amount for a disabled person as described in Section 1902(a)(10)(A)(i) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)).

(2) Effective January 1, 2014, the income and resources of individuals eligible under this section may not exceed the maximum amount for a disabled person as described in Section 1902(a)(10)(A)(i) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)), as determined, counted, and valued in accordance with the requirements of Section 14005.64.

(c) The amendments made by the act that added this subdivision shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

SEC. 2. Section 14005.26 of the Welfare and Institutions Code is amended to read:

14005.26. (a) ~~The~~ *Except as provided in subdivision (b), the* department shall exercise the option pursuant to Section 1902(a)(l0)(A)(ii)(XIV) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIV)) to provide full-scope benefits with no share of cost under this chapter and Chapter 8 (commencing with Section 14200) to optional targeted low-income children pursuant to Section 1905(u)(2)(B) of the federal Social Security Act (42 U.S.C. Sec. 1396d(u)(2)(B)), with family incomes up to and including 200 percent of the federal poverty level. The department shall seek federal approval of a state plan amendment to implement this subdivision.

~~(b) Pursuant to Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)), the department shall adopt the option to use less restrictive income and resource methodologies to exempt all resources and disregard income at or above 200 percent and up to and including 250 percent of the federal poverty level for the individuals described in subdivision (a). The department shall seek federal approval of a state plan amendment to implement this subdivision.~~

(b) Effective January 1, 2014, the federal poverty level percentage income eligibility threshold used pursuant to subdivision (c) of Section 14005.64 to determine eligibility for medical assistance under subdivision (a) shall equal 261 percent of the federal poverty level.

(c) For purposes of carrying out the provisions of this section, the department may adopt the option pursuant to Section 1902(e)(13) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(13)) to rely upon findings of the Managed Risk Medical Insurance Board (MRMIB) regarding one or more components of eligibility.

~~(d) (1) The~~

(d) (1) (A) Except as provided in subparagraph (B), the department shall exercise the option pursuant to Section 1916A of the federal Social Security Act (42 U.S.C. Sec. 1396o-1) to impose premiums for individuals described in subdivision (a) whose family income has been determined to be above 150 percent and up to and including 200 percent of the federal poverty level~~, after application of the income disregard pursuant to subdivision (b)~~. The department shall not impose premiums under this subdivision for individuals described in subdivision (a) whose family income has been determined to be at or below 150 percent of the federal poverty level~~, after application of the income disregard pursuant to subdivision (b)~~. The department shall obtain federal approval for the implementation of this subdivision.

(B) Effective January 1, 2014, the department shall impose a premium pursuant to subparagraph (A) for individuals whose family income has been determined to be above 160 percent and up to and including 261 percent of the federal poverty level, as determined, counted, and valued in accordance with the requirements of Section 14005.64.

(2) (A) Monthly premiums imposed under this section shall equal thirteen dollars ($13) per child with a maximum contribution of thirty-nine dollars ($39) per family.

(B) Families that pay three months of required premiums in advance shall receive the fourth consecutive month of coverage with no premium required. For purposes of the discount provided by this subparagraph, family contributions paid in the Healthy Families Program for children transitioned to Medi-Cal pursuant to Section 14005.27 shall be credited as Medi-Cal premiums paid.

(C) Families that pay the required premium by an approved means of electronic funds transfer, including credit card payment, shall receive a 25-percent discount from the required premium. If the department and the Managed Risk Medical Insurance Board determine that it is feasible, the department shall treat an authorization for electronic funds transfer or credit card payment to the Healthy Families Program as an authorization for electronic funds transfer or credit card payment to Medi-Cal.

(e) This section shall be implemented only to the extent that all necessary federal approvals and waivers described in this section have been obtained and the enhanced rate of federal financial participation under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.) is available for targeted low-income children pursuant to that act.

(f) The department shall not enroll targeted low-income children described in this section in the Medi-Cal program until all necessary federal approvals and waivers have been obtained, and no sooner than January 1, 2013.

(g) (1) To the extent the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is not fully operational, for the purposes of implementing this section, for individuals described in subdivision (a) whose family income has been determined to be up to and including ~~150~~ *160* percent of the federal poverty level~~, as determined pursuant to subdivision (b)~~, the department shall utilize the budgeting methodology for this population as contained in the November 2011 Medi-Cal Local Assistance Estimate for Medi-Cal county administration costs for eligibility operations.

(2) For purposes of implementing this section, the department shall include in the Medi-Cal Local Assistance Estimate an amount for Medi-Cal eligibility operations associated with the individuals

whose family income is determined to be above ~~150~~ *160* percent and up to and including ~~200~~ *261* percent of the federal poverty level~~, after application of the income disregard pursuant to subdivision (b)~~. In developing an estimate for this activity, the department shall consider the projected number of final eligibility determinations each county will process and projected county costs. Within 60 days of the passage of the annual Budget Act, the department shall notify each county of their allocation for this activity based upon the amount allotted in the annual Budget Act for this purpose.

(h) When the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is fully operational, the new budget methodology shall be utilized to reimburse counties for eligibility determinations made for individuals pursuant to this section.

(i) Eligibility determinations and annual redeterminations made pursuant to this section shall be performed by county eligibility workers.

(j) In conducting eligibility determinations for individuals pursuant to this section and Section 14005.27, the following reporting and performance standards shall apply to all counties:

(1) Counties shall report to the department, in a manner and for a time period prescribed by the department, in consultation with the County Welfare Directors Association, the number of applications processed on a monthly basis, a breakout of the applications based on income using the federal percentage of poverty levels, the final disposition of each application, including information on the approved Medi-Cal program, if applicable, and the average number of days it took to make the final eligibility determination for applications submitted directly to the county and from the single point of entry (SPE).

(2) Notwithstanding any other provision of law, the following performance standards shall be applied to counties regarding eligibility determinations for individuals eligible pursuant to this section:

(A) For children whose applications are received by the county human services department from the SPE, the following standards shall apply:

(i) Applications for children who are granted accelerated enrollment by the SPE shall be processed according to the timeframes specified in subdivision (d) of Section 14154.

(ii) Applications for children who are not granted accelerated enrollment by the SPE due to the existence of an already active Medi-Cal case shall be processed according to the timeframes specified in subdivision (d) of Section 14154.

(iii) For applications for children who are not described in clause (i) or (ii), 90 percent shall be processed within 10 working days of being received, complete and without client errors.

(iv) If an application described in this section also contains adults, and the adult applicants are required to submit additional information beyond the information provided for the children, the county shall process the eligibility for the child or children without delay, consistent with this section while gathering the necessary information to process eligibility for the adults.

(B) The department, in consultation with the County Welfare Directors Association, shall develop reporting requirements for the counties to provide regular data to the state regarding the timeliness and outcomes of applications processed by the counties that are received from the SPE.

(C) Performance thresholds and corrective action standards as set forth in Section 14154 shall apply.

(D) For applications submitted directly to the county, these applications shall be processed by the counties in accordance with the performance standards established under subdivision (d) of Section 14154.

(3) This subdivision shall be implemented no sooner than January 1, 2013.

(4) Twelve months after implementation of this section pursuant to subdivision (f), the department shall provide enrollment information regarding individuals determined eligible pursuant to subdivision (a) to the fiscal and appropriate policy committees of the Legislature.

(k) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, for purposes of this transition, 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. It is the intent of the Legislature that the department be allowed temporary authority as necessary to implement program changes until completion of the regulatory process.

(2) To the extent otherwise required by Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall adopt emergency regulations implementing this section no later than July 1, 2014. The department may thereafter readopt the emergency regulations pursuant to that chapter. The adoption and readoption, by the department, of regulations implementing this section shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

(*l*) To implement this section, the department may enter into and continue contracts with the Healthy Families Program administrative vendor, for the purposes of implementing and maintaining the necessary systems and activities for providing health care coverage to optional targeted low-income children in the Medi-Cal program for purposes of accelerated enrollment application processing by single point of entry, noneligibility-related case maintenance and premium collection, maintenance of the Health-E-App Web portal, call center staffing and operations, certified application assistant services, and reporting capabilities. To further implement this section, the department may also enter into a contract with the Health Care Options Broker of the department for purposes of managed care enrollment activities. The contracts entered into or amended under this section may initially be completed on a noncompetitive bid basis and are exempt from the Public Contract Code. Contracts thereafter shall be entered into or amended on a competitive bid basis and shall be subject to the Public Contract Code.

(m) (1) If at any time the director determines that this section or any part of this section 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, or any additional federal funds

that the director, in consultation with the Department of Finance, determines would be advantageous to the state, the director shall give notice to the fiscal and policy committees of the Legislature and to the Department of Finance. After giving notice, this section or any part of this section shall become inoperative on the date that the director executes a declaration stating that the department has determined, in consultation with the Department of Finance, that it is necessary to cease to implement this section or a part or parts thereof, in order to receive federal financial participation, any increase in the federal medical assistance percentage available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, has determined would be advantageous to the state.

(2) The director shall retain the declaration described in paragraph (1), shall provide a copy of the declaration to the Secretary of the State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel, and shall post the declaration on the department's Internet Web site.

(3) In the event that the director makes a determination under paragraph (1) and this section ceases to be implemented, the children shall be enrolled back into the Healthy Families Program.

SEC. 3. Section 14005.27 of the Welfare and Institutions Code is amended to read:

14005.27. (a) Individuals enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code on June 27, 2012, and who are determined eligible to receive benefits pursuant to subdivisions (a) ~~and~~ *or* (b) of Section 14005.26, shall be transitioned into Medi-Cal, pursuant to this section.

(b) To the extent necessary and for the purposes of carrying out the provisions of this section, in performing initial eligibility determinations for children enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code, the department shall adopt the option pursuant to Section 1902(e)(13) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(13)) to allow the department or county human services departments to rely upon findings made by the Managed Risk Medical Insurance Board (MRMIB) regarding one or more components of eligibility. The department

shall seek federal approval of a state plan amendment to implement this subdivision.

(c) To the extent necessary, the department shall seek federal approval of a state plan amendment or a waiver to provide presumptive eligibility for the optional targeted low-income category of eligibility pursuant to Section 14005.26 for individuals presumptively eligible for or enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code. The presumptive eligibility shall be based upon the most recent information contained in the individual's Healthy Families Program file. The timeframe for the presumptive eligibility shall begin no sooner than January 1, 2013, and shall continue until a determination of Medi-Cal eligibility is made, which determination shall be performed within one year of the individual's Healthy Families Program annual review date.

(d) (1) The California Health and Human Services Agency, in consultation with the Managed Risk Medical Insurance Board, the State Department of Health Care Services, the Department of Managed Health Care, and diverse stakeholders groups, shall provide the fiscal and policy committees of the Legislature with a strategic plan for the transition of the Healthy Families Program pursuant to this section by no later than October 1, 2012. This strategic plan shall, at a minimum, address all of the following:

(A) State, county, and local administrative components which facilitate a successful subscriber transition such as communication and outreach to subscribers and applicants, eligibility processing, enrollment, communication, and linkage with health plan providers, payments of applicable premiums, and overall systems operation functions.

(B) Methods and processes for diverse stakeholder engagement throughout the entire transition, including all phases of the transition.

(C) State monitoring of managed care health plans' performance and accountability for provision of services, and initial quality indicators for children and adolescents transitioning to Medi-Cal.

(D) Health care and dental delivery system components such as standards for informing and enrollment materials, network adequacy, performance measures and metrics, fiscal solvency, and related factors that ensure timely access to quality health and dental care for children and adolescents transitioning to Medi-Cal.

(E) Inclusion of applicable operational steps, timelines, and key milestones.

(F) A time certain for the transfer of the Healthy Families Advisory Board, as described in Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code, to the State Department of Health Care Services.

(2) The intent of this strategic plan is to serve as an overall guide for the development of each plan for each phase of this transition, pursuant to paragraphs (1) to (8), inclusive, of subdivision (e), to ensure clarity and consistency in approach and subscriber continuity of care. This strategic plan may also be updated by the California Health and Human Services Agency as applicable and provided to the Legislature upon completion.

(e) (1) The department shall transition individuals from the Healthy Families Program to the Medi-Cal program in four phases, as follows:

(A) Phase 1. Individuals enrolled in a Healthy Families Program health plan that is a Medi-Cal managed care health plan shall be enrolled in the same plan no earlier than January 1, 2013, pursuant to the requirements of this section and Section 14011.6, and to the extent the individual is otherwise eligible under this chapter and Chapter 8 (commencing with Section 14200).

(B) Phase 2. Individuals enrolled in a Healthy Families Program managed care health plan that is a subcontractor of a Medi-Cal managed health care plan, to the extent possible, shall be enrolled into a Medi-Cal managed health care plan that includes the individuals' current plan pursuant to the requirements of this section and Section 14011.6, and to the extent the individuals are otherwise eligible under this chapter and Chapter 8 (commencing with Section 14200). The transition of individuals described in this subparagraph shall begin no earlier than April 1, 2013.

(C) Phase 3. Individuals enrolled in a Healthy Families Program plan that is not a Medi-Cal managed care plan and does not contract or subcontract with a Medi-Cal managed care plan shall be enrolled in a Medi-Cal managed care plan in that county. Enrollment shall include consideration of the individuals' primary care providers pursuant to the requirements of this section and Section 14011.6, and to the extent the individuals are otherwise eligible under this chapter and Chapter 8 (commencing with Section 14200). The

transition of individuals described in this subparagraph shall begin no earlier than August 1, 2013.

(D) Phase 4.

(i) Individuals residing in a county that is not a Medi-Cal managed care county shall be provided services under the Medi-Cal fee-for-service delivery system, subject to clause (ii). The transition of individuals described in this subparagraph shall begin no earlier than September 1, 2013.

(ii) In the event the department creates a managed health care system in the counties described in clause (i), individuals residing in those counties shall be enrolled in managed health care plans pursuant to this chapter and Chapter 8 (commencing with Section 14200).

(2) For the transition of individuals pursuant to subparagraphs (A), (B), (C), and (D) of paragraph (1), implementation plans shall be developed to ensure state and county systems readiness, health plan network adequacy, and continuity of care with the goal of ensuring there is no disruption of service and there is continued access to coverage for all transitioning individuals. If an individual is not retained with his or her current primary care provider, the implementation plan shall require the managed care plan to report to the department as to how continuity of care is being provided. Transition of individuals described in subparagraphs (A), (B), (C), and (D) of paragraph (1) shall not occur until 90 days after the department has submitted an implementation plan to the fiscal and policy committees of the Legislature. The implementation plans shall include, but not be limited to, information on health and dental plan network adequacy, continuity of care, eligibility and enrollment requirements, consumer protections, and family notifications.

(3) The following requirements shall be in place prior to implementation of Phase 1, and shall be required for all phases of the transition:

(A) Managed care plan performance measures shall be integrated and coordinated with the Healthy Families Program performance standards including, but not limited to, child-only Healthcare Effectiveness Data and Information Set (HEDIS) measures, and measures indicative of performance in serving children and adolescents. These performance measures shall also be in compliance with all performance 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) and existing Medi-Cal managed care performance measurements and standards as set forth in this chapter and Chapter 8 (commencing with Section 14200) of Title 22 of the California Code of Regulations, and all-plan letters, including, but not limited to, network adequacy and linguistic services, and shall be met prior to the transition of individuals pursuant to Phase 1.

(B) Medi-Cal managed care health plans shall allow enrollees to remain with their current primary care provider. If an individual does not remain with the current primary care provider, the plan shall report to the department as to how continuity of care is being provided.

(4) (A) As individuals are transitioned pursuant to subparagraphs (A), (B), (C), and (D) of paragraph (1), for individuals residing in all counties except the Counties of Sacramento and Los Angeles, their dental coverage shall transition to fee-for-service dental coverage and may be provided by their current provider if the provider is a Medi-Cal fee-for-service dental provider.

(B) For individuals residing in the County of Sacramento, their dental coverage shall continue to be provided by their current dental managed care plan if their plan is a Medi-Cal dental managed care plan. If their plan is not a Medi-Cal dental managed care plan, they shall select a Medi-Cal dental managed care plan. If they do not choose a Medi-Cal dental managed care plan, they shall be assigned to a plan with preference to a plan with which their current provider is a contracted provider. Any children in the Healthy Families Program transitioned into Medi-Cal dental managed care plans shall also have access to the beneficiary dental exception process, pursuant to Section 14089.09. Further, the Sacramento advisory committee, established pursuant to Section 14089.08, shall be consulted regarding the transition of children in the Healthy Families Program into Medi-Cal dental managed care plans.

(C) (i) For individuals residing in the County of Los Angeles, for purposes of continuity of care, their dental coverage shall continue to be provided by their current dental managed care plan if that plan is a Medi-Cal dental managed care plan. If their plan is not a Medi-Cal dental managed care plan, they may select a

Medi-Cal dental managed care plan or choose to move into Medi-Cal fee-for-service dental coverage.

(ii) It is the intent of the Legislature that children transitioning to Medi-Cal under this section have a choice in dental coverage, as provided under existing law.

(5) Dental health plan performance measures and benchmarks shall be in accordance with Section 14459.6.

(6) Medi-Cal managed care health and dental plans shall report to the department, as frequently as specified by the department, specified information pertaining to transition implementation, enrollees, and providers, including, but not limited to, grievances related to access to care, continuity of care requests and outcomes, and changes to provider networks, including provider enrollment and disenrollment changes. The plans shall report this information by county, and in the format requested by the department.

(7) The department may develop supplemental implementation plans to separately account for the transition of individuals from the Healthy Families Program to specific Medi-Cal delivery systems.

(8) The department shall consult with the Legislature and stakeholders, including, but not limited to, consumers, families, consumer advocates, counties, providers, and health and dental plans, in the development of implementation plans described in paragraph (3) for individuals who are transitioned to Medi-Cal in Phase 2, Phase 3, and Phase 4, as described in subparagraphs (B), (C), and (D) of paragraph (1).

(9) (A) The department shall consult and collaborate with the Department of Managed Health Care in assessing Medi-Cal managed care health plan network adequacy in accordance with 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) for purposes of the developed transition plans pursuant to paragraph (2) for each of the phases.

(B) For purposes of individuals transitioning in Phase 1, as described in subparagraph (A) of paragraph (1), network adequacy shall be assessed as described in this paragraph and findings from this assessment shall be provided to the fiscal and appropriate policy committees of the Legislature 60 days prior to the effective date of implementing this transition.

(10) The department shall provide monthly status reports to the fiscal and policy committees of the Legislature on the transition commencing no later than February 15, 2013. This monthly status transition report shall include, but not be limited to, information on health plan grievances related to access to care, continuity of care requests and outcomes, changes to provider networks, including provider enrollment and disenrollment changes, and eligibility performance standards pursuant to subdivision (n). A final comprehensive report shall be provided within 90 days after completion of the last phase of transition.

(f) (1) The department and MRMIB shall work collaboratively in the development of notices for individuals transitioned pursuant to paragraph (1) of subdivision (e).

(2) The state shall provide written notice to individuals enrolled in the Healthy Families Program of their transition to the Medi-Cal program at least 60 days prior to the transition of individuals in Phase 1, as described in subparagraph (A) of paragraph (1) of subdivision (e), and at least 90 days prior to transition of individuals in Phases 2, 3, and 4, as described in subparagraphs (B), (C), and (D) of paragraph (1) of subdivision (e).

(3) Notices developed pursuant to this subdivision shall ensure individuals are informed regarding the transition, including, but not limited to, how individuals' systems of care may change, when the changes will occur, and whom they can contact for assistance when choosing a Medi-Cal managed care plan, if applicable, including a toll-free telephone number, and with problems they may encounter. The department shall consult with stakeholders regarding notices developed pursuant to this subdivision. These notices shall be developed using plain language, and written translation of the notices shall be available for those who are limited English proficient or non-English speaking in all Medi-Cal threshold languages.

(4) The department shall designate department liaisons responsible for the coordination of the Healthy Families Program and may establish a children's-focused section for this purpose and to facilitate the provision of health care services for children enrolled in Medi-Cal.

(5) The department shall provide a process for ongoing stakeholder consultation and make information publicly available,

including the achievement of benchmarks, enrollment data, utilization data, and quality measures.

(g) (1) In order to aid the transition of Healthy Families Program enrollees, MRMIB, on the effective date of the act that added this section and continuing through the completion of the transition of Healthy Families Program enrollees to the Medi-Cal program, shall begin requesting and collecting from health plans contracting with MRMIB pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code, information about each health plan's provider network, including, but not limited to, the primary care and all specialty care providers assigned to individuals enrolled in the health plan. MRMIB shall obtain this information in a manner that coincides with the transition activities described in subdivision (d), and shall provide all of the collected information to the department within 60 days of the department's request for this information to ensure timely transitions of Healthy Family Program enrollees.

(2) The department shall analyze the existing Healthy Families Program delivery system network and the Medi-Cal fee-for-service provider networks, including, but not limited to, Medi-Cal dental providers, to determine overlaps of the provider networks in each county for which there are no Medi-Cal managed care plans or dental managed care plans. To the extent there is a lack of existing Medi-Cal fee-for-service providers available to serve the Healthy Families Program enrollees, the department shall work with the Healthy Families Program provider community to encourage participation of those providers in the Medi-Cal program, and develop a streamlined process to enroll them as Medi-Cal providers.

(3) (A) MRMIB, within 60 days of a request by the department, shall provide the department any data, information, or record concerning the Healthy Families Program as is necessary to implement the transition of enrollment required pursuant to this section.

(B) Notwithstanding any other provision of law, all of the following shall apply:

(i) The term "data, information, or record" shall include, but is not limited to, personal information as defined in Section 1798.3 of the Civil Code.

(ii) Any 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 Title 1 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 data, information, or record to the department.

(iii) The provision of any such data, information, or record to the department shall not constitute a waiver of any evidentiary privilege or exemption from disclosure.

(iv) The department shall keep all data, information, or records provided by MRMIB 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 Title 1 of the Government Code), and consistent with MRMIB's contractual obligations to keep the data, information, or records confidential.

(h) This section shall be implemented only to the extent that all necessary federal approvals and waivers have been obtained and the enhanced rate of federal financial participation under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.) is available for targeted low-income children pursuant to that act.

~~(i) (1) The~~

(i) (1) (A) Except as provided in subparagraph (B), the department shall exercise the option pursuant to Section 1916A of the federal Social Security Act (42 U.S.C. Sec. 1396o-1) to impose premiums for individuals described in subdivision (a) *or (b)* of Section 14005.26 whose family income has been determined to be above 150 percent and up to and including 200 percent of the federal poverty level~~, after application of the income disregard pursuant to subdivision (b) of Section 14005.26~~. The department shall not impose premiums under this subdivision for individuals described in subdivision (a) *or (b)* of Section 14005.26 whose family income has been determined to be at or below 150 percent of the federal poverty level~~, after application of the income disregard pursuant to subdivision (b) of Section 14005.26~~. The department shall obtain federal approval for the implementation of this subdivision.

(B) Effective January 1, 2014, the family income range for the imposition of premiums pursuant to subparagraph (A) shall be above 160 percent and shall go up to and include 261 percent of

the federal poverty level as determined, counted, and valued in accordance with the requirements of Section 14005.64. The department shall not impose premiums for eligible individuals whose family income has been determined to be at or below 160 percent of the federal poverty level.

(2) All premiums imposed under this section shall equal the family contributions described in paragraph (2) of subdivision (d) of Section 12693.43 of the Insurance Code and shall be reduced in conformity with subdivisions (e) and (f) of Section 12693.43 of the Insurance Code.

(j) The department shall not enroll targeted low-income children described in this section in the Medi-Cal program until all necessary federal approvals and waivers have been obtained, or no sooner than January 1, 2013.

~~(k) (1) To~~

(k) (1) (A) Except as provided in subparagraph (B), to the extent the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is not fully operational, for the purposes of implementing this section, for individuals described in subdivision (a) whose family income has been determined to be at or below 150 percent of the federal poverty level~~, as determined pursuant to subdivision (b)~~, the department shall utilize the budgeting methodology for this population as contained in the November 2011 Medi-Cal Local Assistance Estimate for Medi-Cal county administration costs for eligibility operations.

(B) Effective January 1, 2014, the federal poverty level percentage used under subparagraph (A) shall equal 160 percent of the federal poverty level as determined, counted, and valued in accordance with the requirements of Section 14005.64.

(2) *(A)* For purposes of implementing this section, the department shall include in the Medi-Cal Local Assistance Estimate an amount for Medi-Cal eligibility operations associated with the transfer of Healthy Families Program enrollees eligible pursuant to subdivision (a) of Section 14005.26 and whose family income is determined to be above ~~150~~ *160* percent and up to and including ~~200~~ *261* percent of the federal poverty level~~, after application of the income disregard pursuant to subdivision (b) of Section 14005.26~~. In developing an estimate for this activity, the department shall consider the projected number of final eligibility determinations each county will process and projected county

costs. Within 60 days of the passage of the annual Budget Act, the department shall notify each county of their allocation for this activity based upon the amount allotted in the annual Budget Act for this purpose.

(*l*) When the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is fully operational, the new budget methodology shall be utilized to reimburse counties for eligibility determinations made for individuals pursuant to this section.

(m) Except as provided in subdivision (b), eligibility determinations and annual redeterminations made pursuant to this section shall be performed by county eligibility workers.

(n) In conducting the eligibility determinations for individuals pursuant to this section and Section 14005.26, the following reporting and performance standards shall apply to all counties:

(1) Counties shall report to the department, in a manner and for a time period determined by the department, in consultation with the County Welfare Directors Association, the number of applications processed on a monthly basis, a breakout of the applications based on income using the federal percentage of poverty levels, the final disposition of each application, including information on the approved Medi-Cal program, if applicable, and the average number of days it took to make the final eligibility determination for applications submitted directly to the county and from the single point of entry (SPE).

(2) Notwithstanding any other law, the following performance standards shall be applied to counties for eligibility determinations for individuals eligible pursuant to this section:

(A) For children whose applications are received by the county human services department from the SPE, the following standards shall apply:

(i) Applications for children who are granted accelerated enrollment by the SPE shall be processed according to the timeframes specified in subdivision (d) of Section 14154.

(ii) Applications for children who are not granted accelerated enrollment by the SPE due to the existence of an already active Medi-Cal case shall be processed according to the timeframes specified in subdivision (d) of Section 14154.

(iii) For applications for children who are not described in clause (i) or (ii), 90 percent shall be processed within 10 working days of being received, complete and without client errors.

(iv) If an application described in this section also contains adults, and the adult applicants are required to submit additional information beyond the information provided for the children, the county shall process the eligibility for the child or children without delay, consistent with this section while gathering the necessary information to process eligibility for the adults.

(B) The department, in consultation with the County Welfare Directors Association, shall develop reporting requirements for the counties to provide regular data to the state regarding the timeliness and outcomes of applications processed by the counties that are received from the SPE.

(C) Performance thresholds and corrective action standards as set forth in Section 14154 shall apply.

(D) For applications received directly by the county, these applications shall be processed by the counties in accordance with the performance standards established under subdivision (d) of Section 14154.

(3) This subdivision shall be implemented no sooner than January 1, 2013.

(4) Twelve months after implementation of this section pursuant to subdivision (e), the department shall provide enrollment information regarding individuals determined eligible pursuant to subdivision (a) to the fiscal and appropriate policy committees of the Legislature.

(o) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, for purposes of this transition, 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. It is the intent of the Legislature that the department be allowed temporary authority as necessary to implement program changes until completion of the regulatory process.

(2) To the extent otherwise required by Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall adopt emergency

regulations implementing this section no later than July 1, 2014. The department may thereafter readopt the emergency regulations pursuant to that chapter. The adoption and readoption, by the department, of regulations implementing this section shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

(p) To implement this section, the department may enter into and continue contracts with the Healthy Families Program administrative vendor, for the purposes of implementing and maintaining the necessary systems and activities for providing health care coverage to optional targeted low-income children in the Medi-Cal program for purposes of accelerated enrollment application processing by single point of entry, noneligibility-related case maintenance and premium collection, maintenance of the Health-E-App Web portal, call center staffing and operations, certified application assistant services, and reporting capabilities. To further implement this section, the department may also enter into a contract with the Health Care Options Broker of the department for purposes of managed care enrollment activities. The contracts entered into or amended under this section may initially be completed on a noncompetitive bid basis and are exempt from the Public Contract Code. Contracts thereafter shall be entered into or amended on a competitive bid basis and shall be subject to the Public Contract Code.

(q) (1) If at any time the director determines that this section or any part of this section 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, or any additional federal funds that the director, in consultation with the Department of Finance, determines would be advantageous to the state, the director shall give notice to the fiscal and policy committees of the Legislature and to the Department of Finance. After giving notice, this section or any part of this section shall become inoperative on the date that the director executes a declaration stating that the department has determined, in consultation with the Department of Finance,

that it is necessary to cease to implement this section or a part or parts thereof in order to receive federal financial participation, any increase in the federal medical assistance percentage available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, has determined would be advantageous to the state.

(2) The director shall retain the declaration described in paragraph (1), shall provide a copy of the declaration to the Secretary of the State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel, and shall post the declaration on the department's Internet Web site.

(3) In the event that the director makes a determination under paragraph (1) and this section ceases to be implemented, the children shall be enrolled back into the Healthy Families Program.

SEC. 4. Section 14005.28 of the Welfare and Institutions Code is amended to read:

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

(1) A foster care adolescent who ~~is~~ *was* in foster care in this state on his or her 18th birthday, *or who has lost his or her eligibility for foster care assistance in this state due to having reached the maximum age for that assistance,* shall be enrolled to receive benefits under this section without any interruption in coverage and without requiring a new application.

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

coverage during the 2013 calendar year as a result of attaining 21 years of age, to ensure they are aware of the ability to reenroll under the coverage provided pursuant to this section.

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

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

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

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 1, 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 effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

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

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

SEC. 5. Section 14005.285 is added to the Welfare and Institutions Code, to read:

14005.285. (a) To the extent federal financial participation is available pursuant to an approved state plan amendment, the department shall exercise its option under Section 1902(a)(10)(A)(ii)(XVII) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XVII)) to extend Medi-Cal benefits to independent foster care adolescents, as defined in Section 1905(w)(1) of the federal Social Security Act (42 U.S.C. Sec. 1396d(w)(1)).

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 1, 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 effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

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

SEC. 6. Section 14005.30 of the Welfare and Institutions Code is amended to read:

14005.30. (a) Medi-Cal benefits under this chapter shall be provided to individuals eligible for services under Section 1396u-1 of Title 42 of the United States Code *with family incomes that do not exceed 109 percent of the federal poverty level*.

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

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

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

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

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

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

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

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 1, 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 effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status

report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(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.

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

SEC. 7. Section 14005.64 of the Welfare and Institutions Code is amended to read:

14005.64. (a) Effective January 1, 2014, and notwithstanding any other provision of law, when determining eligibility for Medi-Cal benefits, an applicant's or beneficiary's income and resources shall be determined, counted, and valued in accordance with the requirements of Section 1902(e)(14) of the federal Social Security Act (42 U.S.C. *Sec.* 1396a(e)(14)), as added by the ACA, which prohibits the use of an assets or resources test for individuals whose income eligibility is determined based on modified adjusted gross income.

(b) When determining the eligibility of applicants and beneficiaries using the MAGI-based financial methods, the 5-percent income disregard required under Section 1902(e)(14)(B)(I) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(14)(B)(I)) shall be applied.

(c) (1) The department shall establish income eligibility thresholds for those Medi-Cal eligibility groups whose eligibility will be determined using MAGI-based financial methods. The income eligibility thresholds shall be developed using the financial methodologies described in Section 1396a(e)(14) of Title 42 of the United States Code and in conformity with Section 1396a(gg) of Title 42 of the United States Code as added by the ACA.

(2) In utilizing state data or the national standard methodology with Survey of Income and Program Participation data to develop the converted modified adjusted gross income standard for Medi-Cal applicants and beneficiaries, the department shall ensure that the financial methodology used for identifying the equivalent income eligibility threshold preserves Medi-Cal eligibility for applicants and beneficiaries to the extent required by federal law. The department shall report to the Legislature on the expected changes in income eligibility thresholds using the chosen methodology for individuals whose income is determined on the

basis of a converted dollar amount or federal poverty level percentage. The department shall convene stakeholders, including the Legislature, counties, and consumer advocates regarding the results of the converted standards and shall review with them the information used for the specific calculations before adopting its final methodology for the equivalent income eligibility threshold level.

(3) The income eligibility threshold levels required under this subdivision shall be as follows for the identified coverage groups:

(A) For those pregnant women and infants eligible under Section 1396a(a)(10)(A)(i)(IV) of Title 42 of the United States Code, 208 percent of the federal poverty level.

(B) For those children 1 to 5 years of age, inclusive, eligible under Section 1396a(a)(10)(A)(i)(VI) of Title 42 of the United States Code, 142 percent of the federal poverty level.

(C) For those children 6 to 18 years of age, inclusive, eligible under Section 1396a(a)(10)(A)(i)(VII) of Title 42 of the United States Code, 133 percent of the federal poverty level.

(d) The department shall include individuals under 19 years of age, or in the case of full-time students, under 21 years of age, in the household for purposes of determining eligibility under Section 1396a(e)(14) of Title 42 of the United States Code, as added by the ACA.

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

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

(2) "MAGI-based financial methods" means income calculated using the financial methodologies described in Section 1396a(e)(14) of Title 42 of the United States Code, and as added by the ACA.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. Thereafter, the

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 on a semiannual basis 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. 8. Section 14051 of the Welfare and Institutions Code is amended to read:

14051. (a) "Medically needy person" means any of the following:

(1) An aged, blind, or disabled person who meets the definition of aged, blind, or disabled under the Supplemental Security Income Program and whose income and resources are insufficient to provide for the costs of health care or coverage.

(2) A child in foster care for whom public agencies are assuming financial responsibility, in whole or in part, or a person receiving aid under Chapter 2.1 (commencing with Section 16115) of Part 4.

(3) A child who is eligible to receive Medi-Cal benefits pursuant to interstate agreements for adoption assistance and related services and benefits entered into under Chapter 2.6 (commencing with Section 16170) of Part 4, to the extent federal financial participation is available.

(b) "Medically needy family person" means a parent or caretaker relative of a child ~~who meets the deprivation requirements of Aid to Families with Dependent Children~~ or a child under 21 years of age or a pregnant woman of any age with a confirmed pregnancy, exclusive of those persons specified in subdivision (a), whose income and resources are insufficient to provide for the costs of health care or coverage.

SEC. 9. Section 14148 of the Welfare and Institutions Code is amended to read:

14148. (a) ~~The~~ *(1) (A) Except as provided in paragraph (2), the* department shall adopt the federal option provided under Section 4101 of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) to extend eligibility for medical assistance

under Medicaid to all pregnant women and infants with family incomes not in excess of 185 percent of the federal poverty level. ~~If~~

(B) If a premium is imposed, the amount of the premium shall not exceed 10 percent of the amount by which the family's income, less actual child care costs, exceeds 150 percent of the federal poverty level as ~~required by Section 4101 (a) of the 1987 Medicaid Budget Reconciliation Agreement~~ *provided in Section 1916(c) of the federal Social Security Act (42 U.S.C. Sec. 1396o(c)) as determined, counted, and valued in accordance with the requirements of Section 14005.64.* The department shall implement this section by emergency regulation.

(2) Effective January 1, 2014, the federal poverty level percentage income eligibility threshold used pursuant to subdivision (c) of Section 14005.64 to determine eligibility for medical assistance under this section pursuant to paragraph (1) shall equal 208 percent of the federal poverty level.

(b) Upon order of the Department of Finance, the State Controller shall transfer funds from Item 4260-101-001 of the Budget Act of 1988 to Item 4260-111-001 of the Budget Act of 1988 during the 1988-89 fiscal year for the purpose of funding outreach efforts for perinatal services.

(c) Notwithstanding subdivision (a), the state may limit implementation of this section during the 1988–89 fiscal year, based upon the availability of department funds. The department may use maternal and child health funds to finance the increased costs of implementing an expansion of Medi-Cal eligibility to women and children with incomes of up to 185 percent of federal poverty levels if both of the following conditions exist:

(1) The department has allocated for expenditure at least sixteen million dollars ($16,000,000) in funds redirected from the Medi-Cal program for that expansion.

(2) If, and to the extent, the department determines that estimates of costs based on actual data indicate that the funds are needed to cover costs.

~~(d) This section shall be fully implemented no later than April 1, 1990.~~

~~(e)~~

(d) To assist Medi-Cal eligible pregnant women in receiving prenatal care promptly, all pregnant women applying for Medi-Cal

shall be determined to have an immediate need. Counties, within existing resources, shall expedite the eligibility determination process for all pregnant women on the basis of their immediate needs. Upon determination of eligibility, a Medi-Cal card shall be issued immediately.

~~(f) To the extent federal financial participation is available, the department shall apply the more liberal income deduction described in Section 1396a(r) of Title 42 of the United States Code when determining eligibility for pregnant women and infants under this section. The amount of this deduction shall be the difference between the 185 percent and the 200 percent federal poverty level applicable to the size of the family.~~

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

SEC. 10. Section 14148.5 of the Welfare and Institutions Code is amended to read:

14148.5. (a) *(1)* State funded perinatal services shall be provided under the Medi-Cal program to pregnant women and state funded medical services to infants up to one year of age in families with incomes above 185 percent, but not more than ~~200~~ *208* percent, of the federal poverty level, in the same manner that these services are being provided to the Medi-Cal population, including eligibility requirements and integration of eligibility determinations and payment of claims~~, except as follows:~~. *When determining eligibility under this section, an applicant's or beneficiary's income and resources shall be determined, counted, and valued in accordance with the methodology set forth in Section 14005.64.*

~~(1) The assets of the family shall not be considered in making the eligibility determination.~~

~~(2) The income deduction specified in subdivision (f) of Section 14148 shall not be applied.~~

(b) Services provided under this section shall not be subject to any share-of-cost requirements.

(c) (1) The department, in implementing the Medi-Cal program and public health programs, in coordination with the Managed Risk Medical Insurance Program's Access for Infants and Mothers component, may provide for outreach activities in order to enhance participation and access to perinatal services. Funding received

pursuant to the federal provisions shall be used to expand perinatal outreach activities. These outreach activities shall be implemented if funding is provided for this purpose by an appropriation in the annual Budget Act or other statute.

(2) Those outreach activities authorized by paragraph (1) shall be targeted toward both Medi-Cal and non-Medi-Cal eligible high risk or uninsured pregnant women and infants. Outreach activities may include, but not be limited to, all of the following:

(A) Education of the targeted women on the availability and importance of early prenatal care and referral to Medi-Cal and other programs.

(B) Information provided through toll-free telephone numbers.

(C) Recruitment and retention of perinatal providers.

(d) Notwithstanding any other provision of law, contracts required to implement the provisions of this section shall be exempt from the approval of the Director of General Services and from the provisions of the Public Contract Code.

~~(e) The programs authorized in this section shall be operative for the entire 1996–97 fiscal year.~~

SEC. 11. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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

~~(a) In California, there is a great risk that the prevalence of health disparities may increase as our population becomes even more multicultural. By the year 2040, it is expected that two out of three Californians will be Latino, Asian American, or African American. As the state becomes increasingly diverse, the vision of a healthy and productive California will rely more on our ability to eliminate racial and ethnic disparities, and our actions to improve the health of our multicultural communities.~~

~~(b) The Office of Statewide Health Planning and Development within the California Health and Human Services Agency maintains the inpatient hospital discharge data set, a consolidated database of health diagnoses and procedures as reported from licensed health facilities throughout the state. This database contains 3.8 million observations per year in 18 variable categories, including~~

~~diagnoses, procedures, race, ethnicity, insurance, and residence ZIP Code. This data set has shown several instances of racial and ethnic health disparities, including African Americans having greater hospitalization rates for ambulatory sensitive conditions such as diabetes and heart failure than any other racial group.~~

~~SEC. 2. Chapter 5 (commencing with Section 128955) is added to Part 5 of Division 107 of the Health and Safety Code, to read:~~

~~CHAPTER 5. HEALTH DISPARITY REPORT~~

~~128955. (a) The Office of Statewide Health Planning and Development, with support from the California Health and Human Services Agency, shall, based on the inpatient hospital discharge data set, develop a health disparity report to assess the levels of measurable health disparities in the state among minorities. The health disparity report shall focus on the following areas of concern, consistent with the Healthy People 2020 priorities:~~

~~(1) Cardiovascular disease.~~

~~(2) Breast cancer.~~

~~(3) Cervical cancer.~~

~~(4) Diabetes.~~

~~(5) HIV/AIDS.~~

~~(6) Infant mortality.~~

~~(7) Asthma.~~

~~(8) Mental health.~~

~~(9) Trauma.~~

~~(b) Key principles of the health disparity report shall include, but not be limited to, both of the following:~~

~~(1) Consideration of the effects of current policies in public health, social welfare, housing, and education that contribute to health disparities.~~

~~(2) The ability of public and private partnerships, including federal, state, local, and community-level efforts, to reduce health disparities.~~

~~(c) By January 1, 2016, the Office of Statewide Health Planning and Development and the California Health and Human Services Agency shall complete the report and deliver it to the Legislature.~~

O