

## Assembly Bill No. 1

### CHAPTER 3

An act to amend Section 12698.30 of the Insurance Code, and to amend Sections 14005.36 and 15926 of, to amend and repeal Sections 14005.38, 14011.16, 14011.17, and 14012 of, to amend, repeal, and add Sections 14005.30, 14005.37, 14016.5, and 14016.6 of, to add Sections 14005.60, 14005.61, 14005.64, 14013.3, 14015.7, 14015.8, 14055, 14102.5, and 14103 to, and to add and repeal Section 14015.5 of, the Welfare and Institutions Code, relating to health.

[Approved by Governor June 27, 2013. Filed with  
Secretary of State June 27, 2013.]

#### LEGISLATIVE COUNSEL'S DIGEST

AB 1, John A. Pérez. Medi-Cal: eligibility.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions.

This bill would, commencing January 1, 2014, implement various provisions of the federal Patient Protection and Affordable Care Act (Affordable Care Act), as amended, by, among other things, modifying provisions relating to determining eligibility for certain groups. The bill would, in this regard, extend Medi-Cal eligibility to specified adults and would require that income eligibility be determined based on modified adjusted gross income (MAGI), as prescribed. The bill would prohibit the use of an asset or resources test for individuals whose financial eligibility for Medi-Cal is determined based on the application of MAGI. The bill would require that individuals who are enrolled in the Low Income Health Program as of December 31, 2013, under a specified waiver who are at or below 133% of the federal poverty level be transitioned directly to the Medi-Cal program, as prescribed. The bill would provide that the implementation of the optional expansion of Medi-Cal benefits to adults who meet specified eligibility requirements shall be contingent on the federal medical assistance percentage (FMAP) payable to the state under the Affordable Care Act is not being reduced below specified percentages, as specified.

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

The bill would require the California Health Benefit Exchange (Exchange) to implement a workflow transfer protocol, as prescribed, for persons calling the customer service center operated by the Exchange for the purpose of

applying for an insurance affordability program, to ascertain which individuals are potentially eligible for Medi-Cal. This bill would also prescribe the authority the department, the Exchange, and the counties would have, until July 1, 2015, to perform Medi-Cal eligibility determinations. The bill would require the department to verify the accuracy of certain information that is provided as part of the application or redetermination process when determining whether an individual is eligible for Medi-Cal benefits, as prescribed. The bill would require the department, any other government agency that is determining eligibility for, or enrollment in, the Medi-Cal program or any other program administered by the department, or collecting protected information for those purposes, and the Exchange to share specified information with each other as necessary to enable them to perform their respective statutory and regulatory duties under state and federal law.

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

This bill would revise these provisions to, among other things, require the department to develop a program to allow individuals or their authorized representatives to select Medi-Cal managed care plans via the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERs).

Existing law requires Medi-Cal beneficiaries, with some exceptions, to file semiannual status reports to ensure that beneficiaries make timely and accurate reports of any change in circumstance that may affect their eligibility and requires, with some exceptions, a county to promptly redetermine eligibility whenever a county receives information about changes in a beneficiary's circumstances that may affect eligibility for Medi-Cal benefits.

This bill would, commencing January 1, 2014, revise these provisions to, among other things, delete the semiannual status report requirement and require a county to perform redeterminations every 12 months. The bill would require any forms signed by the beneficiary for purposes of redetermining eligibility to be signed under penalty of perjury. By expanding the crime of perjury, the bill would impose a state-mandated local program.

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 with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

This bill would become operative only if SB 1 of the 2013–14 First Extraordinary Session is enacted and takes effect.

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

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

(a) The United States is the only industrialized country in the world without a universal health insurance system.

(b) (1) In 2006, the United States Census reported that 46 million Americans did not have health insurance.

(2) In California in 2009, according to the UCLA Center for Health Policy Research’s “The State of Health Insurance in California: Findings from the 2009 California Health Interview Survey,” 7.1 million Californians were uninsured in 2009, amounting to 21.1 percent of nonelderly Californians who had no health insurance coverage for all or some of 2009, up nearly 2 percentage points from 2007.

(c) On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (Public Law 111-148), which was amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and together are referred to as the Affordable Care Act of 2010 (Affordable Care Act).

(d) The Affordable Care Act is the culmination of decades of movement toward health reform, and is the most fundamental legislative transformation of the United States health care system in 40 years.

(e) As a result of the enactment of the Affordable Care Act, according to estimates by the UCLA Center for Health Policy Research and the UC Berkeley Labor Center, using the California Simulation of Insurance Markets, in 2019, after the Affordable Care Act is fully implemented:

(1) Between 89 and 92 percent of Californians under 65 years of age will have health coverage.

(2) Between 1.2 and 1.6 million individuals will be newly enrolled in Medi-Cal.

(f) It is the intent of the Legislature to ensure full implementation of the Affordable Care Act, including the Medi-Cal expansion for individuals with incomes below 133 percent of the federal poverty level, so that millions of uninsured Californians can receive health care coverage.

SEC. 2. Section 12698.30 of the Insurance Code is amended to read:

12698.30. (a) (1) Subject to paragraph (2), at a minimum, coverage shall be provided to subscribers during one pregnancy, and for 60 days thereafter, and to children less than two years of age who were born of a

pregnancy covered under this program to a woman enrolled in the program before July 1, 2004.

(2) Commencing January 1, 2014, at a minimum, coverage shall be provided to subscribers during one pregnancy, and until the end of the month in which the 60th day thereafter occurs, and to children less than two years of age who were born of a pregnancy covered under this program to a woman enrolled in the program before July 1, 2004.

(b) Coverage provided pursuant to this part shall include, at a minimum, those services required to be provided by health care service plans approved by the United States Secretary of Health and Human Services as a federally qualified health care service plan pursuant to Section 417.101 of Title 42 of the Code of Federal Regulations.

(c) Coverage shall include health education services related to tobacco use.

(d) Medically necessary prescription drugs shall be a required benefit in the coverage provided under this part.

SEC. 3. Section 14005.30 of the Welfare and Institutions Code is amended to read:

14005.30. (a) (1) To the extent that federal financial participation is available, 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, including any options under Section 1396u-1(b)(2)(C) made available to and exercised by the state.

(2) The department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code to adopt less restrictive income and resource eligibility standards and methodologies to the extent necessary to allow all recipients of benefits under Chapter 2 (commencing with Section 11200) to be eligible for Medi-Cal under paragraph (1).

(3) To the extent federal financial participation is available, the department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code authorizing the state to disregard all changes in income or assets of a beneficiary until the next annual redetermination under Section 14012. The department shall implement this paragraph only if, and to the extent that the State Child Health Insurance Program waiver described in Section 12693.755 of the Insurance Code extending Healthy Families Program eligibility to parents and certain other adults is approved and implemented.

(b) To the extent that federal financial participation is available, the department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary to expand eligibility for Medi-Cal under subdivision (a) by establishing the amount of countable resources individuals or families are allowed to retain at the same amount medically needy individuals and families are allowed to retain, except that a family of one shall be allowed to retain countable resources in the amount of three thousand dollars (\$3,000).

(c) To the extent federal financial participation is available, the department shall, commencing March 1, 2000, adopt an income disregard for applicants equal to the difference between the income standard under the program adopted pursuant to Section 1931(b) of the federal Social Security Act (42 U.S.C. Sec. 1396u-1) and the amount equal to 100 percent of the federal poverty level applicable to the size of the family. A recipient shall be entitled to the same disregard, but only to the extent it is more beneficial than, and is substituted for, the earned income disregard available to recipients.

(d) 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.

(e) Subdivision (b) shall be applied retroactively to January 1, 1998.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement, without taking regulatory action, subdivisions (a) and (b) of this section by means of an all-county letter or similar instruction. 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.

(g) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 4. Section 14005.30 is added to the Welfare and Institutions Code, to read:

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

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

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

(c) For purposes of calculating income under this section during any calendar year, increases in social security benefit payments under Title II of the federal Social Security Act (42 U.S.C. Sec. 401 et seq.) arising from cost-of-living adjustments shall be disregarded commencing in the month that these social security benefit payments are increased by the cost-of-living adjustment through the month before the month in which a change in the

federal poverty level requires the department to modify the income disregard pursuant to subdivision (c) and in which new income limits for the program established by this section are adopted by the department.

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

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

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

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

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

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

SEC. 5. Section 14005.36 of the Welfare and Institutions Code is amended to read:

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

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

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

(2) When a managed care plan obtains a beneficiary’s updated contact information, the managed care plan shall ask the beneficiary for approval to provide the beneficiary’s updated contact information to the appropriate county. If the managed care plan does not obtain approval from the beneficiary to provide the appropriate county with the updated contact

information, the county shall attempt to verify the plan is accurate, which may include, but is not limited to, making contact with the beneficiary, before updating the beneficiary's case file. The contact shall first be attempted using the method of contact identified by the beneficiary as the preferred method of contact, if a method has been identified.

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

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

SEC. 6. Section 14005.37 of the Welfare and Institutions Code is amended to read:

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

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

(c) A loss of contact, as evidenced by the return of mail marked in such a way as to indicate that it could not be delivered to the intended recipient or that there was no forwarding address, shall require a prompt redetermination according to the procedures set forth in this section.

(d) Except as otherwise provided in this section, Medi-Cal eligibility shall continue during the redetermination process described in this section. A Medi-Cal beneficiary's eligibility shall not be terminated under this section until the county makes a specific determination based on facts clearly demonstrating that the beneficiary is no longer eligible for Medi-Cal under any basis and due process rights guaranteed under this division have been met.

(e) For purposes of acquiring information necessary to conduct the eligibility determinations described in subdivisions (a) to (d), inclusive, a county shall make every reasonable effort to gather information available to the county that is relevant to the beneficiary's Medi-Cal eligibility prior

to contacting the beneficiary. Sources for these efforts shall include, but are not limited to, Medi-Cal, CalWORKs, and CalFresh case files of the beneficiary or of any of his or her immediate family members, which are open or were closed within the last 45 days, and wherever feasible, other sources of relevant information reasonably available to the counties.

(f) If a county cannot obtain information necessary to redetermine eligibility pursuant to subdivision (e), the county shall attempt to reach the beneficiary by telephone in order to obtain this information, either directly or in collaboration with community-based organizations so long as confidentiality is protected.

(g) If a county's efforts pursuant to subdivisions (e) and (f) to obtain the information necessary to redetermine eligibility have failed, the county shall send to the beneficiary a form, which shall highlight the information needed to complete the eligibility determination. The county shall not request information or documentation that has been previously provided by the beneficiary, that is not absolutely necessary to complete the eligibility determination, or that is not subject to change. The form shall be accompanied by a simple, clear, consumer-friendly cover letter, which shall explain why the form is necessary, the fact that it is not necessary to be receiving CalWORKs benefits to be receiving Medi-Cal benefits, the fact that receipt of Medi-Cal benefits does not count toward any time limits imposed by the CalWORKs program, the various bases for Medi-Cal eligibility, including disability, and the fact that even persons who are employed can receive Medi-Cal benefits. The cover letter shall include a telephone number to call in order to obtain more information. The form and the cover letter shall be developed by the department in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers. A Medi-Cal beneficiary shall have no less than 20 days from the date the form is mailed pursuant to this subdivision to respond. Except as provided in subdivision (h), failure to respond prior to the end of this 20-day period shall not impact his or her Medi-Cal eligibility.

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

(i) If, within 20 days of the date of mailing of a form to the Medi-Cal beneficiary pursuant to subdivision (g), a beneficiary does not submit the completed form to the county, the county shall send the beneficiary a written notice of action stating that his or her eligibility shall be terminated 10 days from the date of the notice and the reasons for that determination, unless the beneficiary submits a completed form prior to the end of the 10-day period.

(j) If, within 20 days of the date of mailing of a form to the Medi-Cal beneficiary pursuant to subdivision (g), the beneficiary submits an incomplete form, the county shall attempt to contact the beneficiary by



telephone and in writing to request the necessary information. If the beneficiary does not supply the necessary information to the county within 10 days from the date the county contacts the beneficiary in regard to the incomplete form, a 10-day notice of termination of Medi-Cal eligibility shall be sent.

(k) If, within 30 days of termination of a Medi-Cal beneficiary's eligibility pursuant to subdivision (h), (i), or (j), the beneficiary submits to the county a completed form, eligibility shall be determined as though the form was submitted in a timely manner and if a beneficiary is found eligible, the termination under subdivision (h), (i), or (j) shall be rescinded.

(l) If the information reasonably available to the county pursuant to the redetermination procedures of subdivisions (d), (e), (g), and (m) does not indicate a basis of eligibility, Medi-Cal benefits may be terminated so long as due process requirements have otherwise been met.

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

(n) This section shall be implemented on or before July 1, 2001, but only to the extent that federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is available.

(o) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking any regulatory action, implement this section by means of all-county letters or similar instructions. 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. Comprehensive implementing instructions shall be issued to the counties no later than March 1, 2001.

(p) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 7. Section 14005.37 is added to the Welfare and Institutions Code, to read:

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

redetermining Medi-Cal eligibility described in this section shall apply to all Medi-Cal beneficiaries.

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

(c) A loss of contact, as evidenced by the return of mail marked in such a way as to indicate that it could not be delivered to the intended recipient or that there was no forwarding address, shall require a prompt redetermination according to the procedures set forth in this section.

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

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

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

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

(2) In the case of an annual redetermination, if, based upon information obtained pursuant to paragraph (1), the county is able to make a

determination of continued eligibility, the county shall notify the beneficiary of both of the following:

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

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

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

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

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

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

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

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

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

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

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

(4) If the beneficiary responds to the written request for information during the 60-day period pursuant to paragraph (1) but the information

provided is not complete, the county shall follow the procedures set forth in paragraph (3) of subdivision (g) to work with the beneficiary to complete the information.

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

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

(g) (1) In the case of a redetermination due to change in circumstances, if a county cannot obtain sufficient information to redetermine eligibility pursuant to subdivision (e), the county shall send to the beneficiary a form that is prepopulated with the information that the county has obtained and that states the information needed to renew eligibility. The county shall only request information related to the change in circumstances. The county shall not request information or documentation that has been previously provided by the beneficiary, that is not absolutely necessary to complete the eligibility determination, or that is not subject to change. The county shall only request information for nonapplicants necessary to make an eligibility determination or for a purpose directly related to the administration of the state Medicaid plan. The form shall advise the individual to provide any necessary information to the county via the Internet, by telephone, by mail, in person, or through other commonly available electronic means and, if the individual will provide the form by mail or in person, to sign the form. The form shall include a telephone number to call in order to obtain more information. The form shall be developed by the department in consultation with the counties, representatives of consumers, and eligibility workers. A Medi-Cal beneficiary shall have 30 days from the date the form is mailed pursuant to this subdivision to respond. Except as provided in paragraph (2), failure to respond prior to the end of this 30-day period shall not impact his or her Medi-Cal eligibility.

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

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

information to the county within the 30-day limit, a 10-day notice of termination of Medi-Cal eligibility shall be sent.

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

(i) If within 90 days of termination of a Medi-Cal beneficiary's eligibility or a change in eligibility status pursuant to this section, the beneficiary submits to the county a signed and completed form or otherwise provides the needed information to the county, eligibility shall be redetermined by the county and if the beneficiary is found eligible, or the beneficiary's status has not changed, whichever applies, the termination shall be rescinded as though the form were submitted in a timely manner.

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

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

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

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

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

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

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

(q) The requirements to provide information in subdivisions (e) and (g), and to report changes in circumstances in subdivision (h), may be provided

through any of the modes of submission allowed in Section 435.907(a) of Title 42 of the Code of Federal Regulations, including an Internet Web site identified by the department, telephone, mail, in person, and other commonly available electronic means as authorized by the department.

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

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

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

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

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

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

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

SEC. 8. Section 14005.38 of the Welfare and Institutions Code is amended to read:

14005.38. (a) To the extent feasible, the department shall use the redetermination form required by subdivision (g) of Section 14005.37 as the annual reaffirmation form.

(b) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 9. Section 14005.60 is added to the Welfare and Institutions Code, to read:

14005.60. (a) Commencing January 1, 2014, the department shall provide Medi-Cal benefits for individuals who meet eligibility requirements of Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)).

(b) An individual eligible under this section shall not have income that exceeds 133 percent of the federal poverty level as determined, counted, and valued in accordance with the requirements of Section 1396a(e)(14) of Title 42 of the United States Code, as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148), and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

(c) (1) Individuals who are eligible under this section shall be required to mandatorily enroll into a Medi-Cal managed care health plan in those counties where a Medi-Cal managed care health plan is available.

(2) (A) Individuals residing in a county where no Medi-Cal managed care health plan is available shall be provided services under the Medi-Cal fee-for-service delivery system subject to subparagraph (B).

(B) If a Medi-Cal managed care health plan becomes available to individuals referenced in subparagraph (A), those individuals shall be enrolled in a Medi-Cal managed care health plan.

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

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

SEC. 10. Section 14005.61 is added to the Welfare and Institutions Code, to read:

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

(h) The director may, with federal approval, suspend, delay, or otherwise modify the requirement for LIHP program eligibility redeterminations in 2013 to facilitate the process of transitioning LIHP enrollees to other health coverage in 2014.

(i) The county LIHPs and their designees shall work with the department and its designees during the 2013 and 2014 calendar years to facilitate

continuity of care and data sharing for the purposes of delivering Medi-Cal services in the 2014 calendar year.

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

SEC. 11. Section 14005.64 is added to the Welfare and Institutions Code, 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. 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.

(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. 12. Section 14011.16 of the Welfare and Institutions Code is amended to read:

14011.16. (a) Commencing August 1, 2003, the department shall implement a requirement for beneficiaries to file semiannual status reports as part of the department’s procedures to ensure that beneficiaries make timely and accurate reports of any change in circumstance that may affect their eligibility. The department shall develop a simplified form to be used for this purpose. The department shall explore the feasibility of using a form that allows a beneficiary who has not had any changes to so indicate by checking a box and signing and returning the form.

(b) Beneficiaries who have been granted continuous eligibility under Section 14005.25 shall not be required to submit semiannual status reports. To the extent federal financial participation is available, all children under 19 years of age shall be exempt from the requirement to submit semiannual status reports.

(c) For any period of time that the continuous eligibility period described in paragraph (1) of subdivision (a) of Section 14005.25 is reduced to six months, subdivision (b) shall become inoperative, and all children under 19 years of age shall be required to file semiannual status reports.

(d) Beneficiaries whose eligibility is based on a determination of disability or on their status as aged or blind shall be exempt from the semiannual status report requirement described in subdivision (a). The department may exempt other groups from the semiannual status report requirement as necessary for simplicity of administration.

(e) When a beneficiary has completed, signed, and filed a semiannual status report that indicated a change in circumstance, eligibility shall be redetermined.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of all-county letters or similar instructions without taking regulatory action. 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.

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

(h) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 13. Section 14011.17 of the Welfare and Institutions Code is amended to read:

14011.17. The following persons shall be exempt from the semiannual reporting requirements described in Section 14011.16:

(a) Pregnant women whose eligibility is based on pregnancy.

(b) Beneficiaries receiving Medi-Cal through Aid for Adoption of Children Program.

(c) Beneficiaries who have a public guardian.

(d) Medically indigent children who are not living with a parent or relative and who have a public agency assuming their financial responsibility.

(e) Individuals receiving minor consent services.

(f) Beneficiaries in the Breast and Cervical Cancer Treatment Program.

(g) Beneficiaries who are CalWORKs recipients and custodial parents whose children are CalWORKs recipients.

(h) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 14. Section 14012 of the Welfare and Institutions Code is amended to read:

14012. (a) Reaffirmation shall be filed annually and may be required at other times in accordance with general standards established by the department.

(b) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 15. Section 14013.3 is added to the Welfare and Institutions Code, to read:

14013.3. (a) When determining whether an individual is eligible for Medi-Cal benefits, the department shall verify the accuracy of the information identified in this section that is provided as a part of the application or redetermination process in conformity with this section.

(b) Prior to requesting additional verification from an applicant or beneficiary for information he or she provides as part of the application or redetermination process, the department shall obtain information about an individual that is available electronically from other state and federal agencies and programs in determining an individual's eligibility for Medi-Cal benefits or for potential eligibility for an insurance affordability program offered through the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code. Needed information shall be obtained from the following sources, as well as any other source the department determines is useful:

(1) Information related to wages, net earnings from self-employment, unearned income, and resources from any of the following:

(A) The State Wage Information Collection Agency.

(B) The federal Internal Revenue Service.

(C) The federal Social Security Administration.

(D) The Employment Development Department.

(E) The state administered supplementary payment program under Section 1382e of Title 42 of the United States Code.

(F) Any state program administered under a plan approved under Titles I, X, XIV, or XVI of the federal Social Security Act.

(2) Information related to eligibility or enrollment from any of the following:

(A) The CalFresh program pursuant to Chapter 10 (commencing with Section 18900) of Part 6.

(B) The CalWORKS program.

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

(D) The California Health Benefit Exchange established pursuant Title 22 (commencing with Section 100500) of the Government Code.

(E) The electronic service established in accordance with Section 435.949 of Title 42 of the Code of Federal Regulations.

(c) (1) If the income information obtained by the department pursuant to subdivision (b) is reasonably compatible with the information provided by or on behalf of the individual, the department shall accept the information provided by or on behalf of the individual as being accurate.

(2) If the income information obtained by the department is not reasonably compatible with the information provided by or on behalf of the individual, the department shall require that the individual provide additional information that reasonably explains the discrepancy.

(3) For the purposes of this subdivision, income information obtained by the department is reasonably compatible with information provided by or on behalf of an individual if any of the following conditions are met:

(A) Both state that the individual's income is above the applicable income standard or other relevant income threshold for eligibility.

(B) Both state that the individual's income is at or below the applicable income standard or other relevant income threshold for eligibility.

(C) The information provided by or on behalf of the individual states that the individual's income is above, and the information obtained by the department states that the individual's income is at or below, the applicable income standard or other relevant income threshold for eligibility.

(4) If subparagraph (C) of paragraph (3) applies, the individual shall be informed that the income information provided by him or her was higher than the information that was electronically verified and that he or she may request a reconciliation of the difference. This paragraph shall be implemented no later than January 1, 2015.

(d) (1) The department shall accept the attestation of the individual regarding whether she is pregnant unless the department has information that is not reasonably compatible with the attestation.

(2) If the information obtained by the department is not reasonably compatible with the information provided by or on behalf of the individual under paragraph (1), the department shall require that the individual provide additional information that reasonably explains the discrepancy.

(e) If any information not described in subdivision (c) or (d) that is needed for an eligibility determination or redetermination and is obtained by the department is not reasonably compatible with the information provided by or on behalf of the individual, the department shall require that the individual provide additional information that reasonably explains the discrepancy.

(f) The department shall develop, and update as it is modified, a verification plan describing the verification policies and procedures adopted by the department to verify eligibility information. If the department determines that any state or federal agencies or programs not previously identified in the verification plan are useful in determining an individual's eligibility for Medi-Cal benefits or for potential eligibility, for an insurance affordability program offered through the California Health Benefit Exchange, the department shall update the verification plan to identify those additional agencies or programs. The development and modification of the verification plan shall be undertaken in consultation with representatives from county human services departments, legal aid advocates, and the Legislature. This verification plan shall conform to all federal requirements and shall be posted on the department's Internet Web site.

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

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

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

SEC. 16. Section 14015.5 is added to the Welfare and Institutions Code, to read:

14015.5. (a) Notwithstanding any other provision of state law, the department shall retain or delegate the authority to perform Medi-Cal eligibility determinations as set forth in this section.

(b) If after an assessment and verification for potential eligibility for Medi-Cal benefits using the applicable MAGI-based income standard of all persons that apply through an electronic or a paper application processed by CalHEERS, which is jointly managed by the department and the Exchange, and to the extent required by federal law and regulation is completed, the Exchange and the department is able to electronically determine the applicant's eligibility for Medi-Cal benefits using only the information initially provided online, or through the written application submitted by, or on behalf of, the applicant, and without further staff review to verify the accuracy of the submitted information, the Exchange and the department shall determine that applicant's eligibility for the Medi-Cal program using the applicable MAGI-based income standard.

(c) Except as provided in subdivision (b) and Section 14015.7, the county of residence shall be responsible for eligibility determinations and ongoing case management for the Medi-Cal program.

(d) (1) Notwithstanding any other provision of state law, the Exchange shall be authorized to provide information regarding available Medi-Cal managed health care plan selection options to applicants determined to be eligible for Medi-Cal benefits using the MAGI-based income standard and allow those applicants to choose an available managed health care plan.

(2) The Exchange is authorized to record an applicant's health plan selection into CalHEERS for reporting to the department. CalHEERS shall have the ability to report to the department the results of an applicant's health plan selection.

(e) 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.

(f) For the 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 amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

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

(3) “Exchange” means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(4) “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 ACA and any subsequent amendments.

(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 October 1, 2013.

(i) This section shall remain in effect only until July 1, 2015, and as of that date is repealed, unless a later enacted statute, that is enacted before July 1, 2015, deletes or extends that date.

SEC. 17. Section 14015.7 is added to the Welfare and Institutions Code, to read:

14015.7. (a) (1) Notwithstanding any other provision of law, for persons who call the customer service center operated by the Exchange for the purpose of applying for an insurance affordability program, the Exchange shall implement a workflow transfer protocol that consists of only those questions that are essential to reliably ascertain whether the caller’s household appears to include any individuals who are potentially eligible for Medi-Cal benefits and to determine an appropriate point of transferral. The workflow transfer protocol and transferral procedures used by the Exchange shall be developed and implemented in conjunction with and subject to review and approval by the department.

(2) (A) Except as provided in paragraph (3), if, after applying the transfer protocol specified in paragraph (1), the Exchange determines that the caller’s household appears to include one or more individuals who are potentially eligible for Medi-Cal benefits using the applicable MAGI-based income standard, the Exchange shall transfer the caller to his or her county of residence or other appropriate county resource for completion of the federally required assessment. The county shall proceed with the assessment and also perform any required eligibility determination.

(B) Subject to any income limitations that may be imposed by the Exchange, and subject to review and approval from the department, if after applying the transfer protocol specified in paragraph (1) the Exchange determines that the caller’s household appears to include an individual who is pregnant, or who is potentially eligible for Medi-Cal benefits on a basis other than using a MAGI-based income standard because an applicant is potentially disabled, 65 years of age or older, or potentially in need of long-term care services, the Exchange shall transfer the caller to his or her county of residence or other appropriate county resource for completion of



the federally required assessment. The county shall proceed with the assessment and also perform any required eligibility determination.

(3) Notwithstanding any other provision of law, only during the initial open enrollment period established by the Exchange, and in no case after June 30, 2014, if after applying the transfer protocol specified in paragraph (1) the Exchange determines that the caller's household appears to include both individuals who are potentially eligible for Medi-Cal benefits using the applicable MAGI-based income standard and individuals who are not potentially eligible for Medi-Cal benefits, the Exchange shall proceed with its assessment and if it is subsequently determined that an applicant or applicants are potentially eligible for Medi-Cal benefits using the applicable MAGI-based income standard, the Exchange shall initially determine the applicant's or applicants' eligibility for Medi-Cal benefits. If determined eligible, the applicant's or applicants' coverage shall start on January 1, 2014, or on the date of the determination, whichever is later. The county of residence shall be responsible for final confirmation of eligibility determinations relying on data provided by and verifications done by the Exchange and the county shall perform only that additional work that is necessary for the county to prepare and send out the required notice to the applicant regarding the result of the eligibility determination and shall not impose any additional burdens upon the applicant. The county of residence shall be responsible for sending out the required notices of all Medi-Cal eligibility determinations.

(4) Notwithstanding any other provision of law, if after applying the transfer protocol specified in paragraph (1) the Exchange determines that the caller's household appears to only include individuals who are not potentially eligible for Medi-Cal benefits, the Exchange shall proceed with its assessment of eligibility. If it is subsequently determined that an applicant or applicants are potentially eligible for Medi-Cal benefits using the applicable MAGI-based income standard, the Exchange shall initially determine the applicant or applicants eligibility for Medi-Cal benefits. If determined eligible, the applicant's or applicants' coverage shall start on January 1, 2014, or on the date of the determination, whichever is later. The county of residence shall be responsible for final confirmation of eligibility determinations relying on data provided by and verifications done by the Exchange and the county shall perform only that additional work that is necessary for the county to prepare and send out the required notice to the applicant regarding the result of the eligibility determination and shall not impose any additional burdens upon the applicant. The county of residence shall be responsible for sending out the required notices of all Medi-Cal eligibility determinations.

(5) Subject to any income limitations that may be imposed by the Exchange, and subject to review and approval from the department, if after assessing the potential eligibility of an applicant, which shall include enrolling the individual in Exchange-based coverage if eligible and, if the determination is being made pursuant to paragraph (3), initially determining eligibility for MAGI-based Medi-Cal, the Exchange determines that the

applicant is pregnant, or is potentially eligible for Medi-Cal benefits on a basis other than using a MAGI-based income standard because the applicant is potentially disabled, 65 years of age or older, or potentially in need of long-term care services, or if the applicant requests a full Medi-Cal eligibility determination, the Exchange shall, consistent with federal law and regulations, transmit all information provided by or on behalf of the applicant, and any information obtained or verified by the Exchange, to the applicant's county of residence or other appropriate county resource via secure electronic interface, promptly and without undue delay, for a full Medi-Cal eligibility determination.

(6) Except as otherwise provided in this section and subdivision (b) of Section 14015.5, the county of residence shall be responsible for eligibility determinations and ongoing case management for the Medi-Cal program.

(7) Implementation of the protocols and transferral procedures in this subdivision shall be subject to the terms specified in the agreements established under subdivision (b).

(b) The department, Exchange, and each county consortia shall jointly enter into an interagency agreement that specifies the operational parameters and performance standards pertaining to the transfer protocol. After consulting with counties, consumer advocates, and labor organizations that represent employees of the customer service center operated by the Exchange and employees of county customer service centers, the Exchange and the department shall determine and implement the performance standards that shall be incorporated into these agreements.

(c) Prior to October 1, 2014, the Exchange and the department, in consultation with counties, consumer advocates, and labor organizations that represent employees of the customer service center operated by the Exchange and employees of county customer service centers, shall review and determine the efficacy of the enrollment procedures established in this section.

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

(e) For the 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 amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

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

(3) “Exchange” means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(4) “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 ACA and any subsequent amendments.

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

(g) The state shall be responsible for providing the administrative funding to the counties for work associated with this section. Funding shall be subject to the annual state budget process.

(h) This section shall become operative on October 1, 2013.

SEC. 18. Section 14015.8 is added to the Welfare and Institutions Code, to read:

14015.8. The department, any other government agency that is determining eligibility for, or enrollment in, the Medi-Cal program or any other program administered by the department, or collecting protected health information for those purposes, and the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code, shall share information with each other as necessary to enable them to perform their respective statutory and regulatory duties under state and federal law. This information shall include, but not be limited to, personal information, as defined in subdivision (a) of Section 1798.3 of the Civil Code, and protected health information, as defined in Parts 160 and 164 of Title 45 of the Code of Federal Regulations, regarding individual beneficiaries and applicants.

SEC. 19. Section 14016.5 of the Welfare and Institutions Code is amended to read:

14016.5. (a) At the time of determining or redetermining the eligibility of a Medi-Cal program or Aid to Families with Dependent Children (AFDC) program applicant or beneficiary who resides in an area served by a managed health care plan or pilot program in which beneficiaries may enroll, each applicant or beneficiary shall personally attend a presentation at which the applicant or beneficiary is informed of the managed care and fee-for-service options available regarding methods of receiving Medi-Cal benefits. The county shall ensure that each beneficiary or applicant attends this presentation.

(b) The health care options presentation described in subdivision (a) shall include all of the following elements:

(1) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in the fee-for-service sector.

(2) Each beneficiary or eligible applicant shall be provided with the name, address, telephone number, and specialty, if any, of each primary care provider, and each clinic participating in each prepaid managed health care

plan, pilot project, or fee-for-service case management provider option. This information shall be provided under geographic area designations, in alphabetical order by the name of the primary care provider and clinic. The name, address, and telephone number of each specialist participating in each prepaid managed health care plan, pilot project, or fee-for-service case management provider option shall be made available by contacting either the health care options contractor or the prepaid managed health care plan, pilot project, or fee-for-service case management provider.

(3) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in a managed care option, if his or her treating provider is a primary care provider or clinic contracting with any of the prepaid managed health care plans, pilot projects, or fee-for-service case management provider options available, has available capacity, and agrees to continue to treat that beneficiary or applicant.

(4) In areas specified by the director, each beneficiary or eligible applicant shall be informed that if he or she fails to make a choice, or does not certify that he or she has an established relationship with a primary care provider or clinic, he or she shall be assigned to, and enrolled in, a prepaid managed health care plan, pilot project, or fee-for-service case management provider.

(c) No later than 30 days following the date a Medi-Cal or AFDC beneficiary or applicant is determined eligible, the beneficiary or applicant shall indicate his or her choice in writing, as a condition of coverage for Medi-Cal benefits, of either of the following health care options:

(1) To obtain benefits by receiving a Medi-Cal card, which may be used to obtain services from individual providers, that the beneficiary would locate, who choose to provide services to Medi-Cal beneficiaries.

The department may require each beneficiary or eligible applicant, as a condition for electing this option, to sign a statement certifying that he or she has an established patient-provider relationship, or in the case of a dependent, the parent or guardian shall make that certification. This certification shall not require the acknowledgment or guarantee of acceptance, by any indicated Medi-Cal provider or health facility, of any beneficiary making a certification under this section.

(2) (A) To obtain benefits by enrolling in a prepaid managed health care plan, pilot program, or fee-for-service case management provider that has agreed to make Medi-Cal services readily available to enrolled Medi-Cal beneficiaries.

(B) At the time the beneficiary or eligible applicant selects a prepaid managed health care plan, pilot project, or fee-for-service case management provider, the department shall, when applicable, encourage the beneficiary or eligible applicant to also indicate, in writing, his or her choice of primary care provider or clinic contracting with the selected prepaid managed health care plan, pilot project, or fee-for-service case management provider.

(d) (1) In areas specified by the director, a Medi-Cal or AFDC beneficiary or eligible applicant who does not make a choice, or who does not certify that he or she has an established relationship with a primary care provider

or clinic, shall be assigned to and enrolled in an appropriate Medi-Cal managed care plan, pilot project, or fee-for-service case management provider providing service within the area in which the beneficiary resides.

(2) If it is not possible to enroll the beneficiary under a Medi-Cal managed care plan, pilot project, or a fee-for-service case management provider because of a lack of capacity or availability of participating contractors, the beneficiary shall be provided with a Medi-Cal card and informed about fee-for-service primary care providers who do all of the following:

(A) The providers agree to accept Medi-Cal patients.

(B) The providers provide information about the provider's willingness to accept Medi-Cal patients as described in Section 14016.6.

(C) The providers provide services within the area in which the beneficiary resides.

(e) If a beneficiary or eligible applicant does not choose a primary care provider or clinic, or does not select any primary care provider who is available, the managed health care plan, pilot project, or fee-for-service case management provider that was selected by or assigned to the beneficiary shall ensure that the beneficiary selects a primary care provider or clinic within 30 days after enrollment or is assigned to a primary care provider within 40 days after enrollment.

(f) (1) The managed care plan shall have a valid Medi-Cal contract, adequate capacity, and appropriate staffing to provide health care services to the beneficiary.

(2) The department shall establish standards for all of the following:

(A) The maximum distances a beneficiary is required to travel to obtain primary care services from the managed care plan, fee-for-service case management provider, or pilot project in which the beneficiary is enrolled.

(B) The conditions under which a primary care service site shall be accessible by public transportation.

(C) The conditions under which a managed care plan, fee-for-service case management provider, or pilot project shall provide nonmedical transportation to a primary care service site.

(3) In developing the standards required by paragraph (2), the department shall take into account, on a geographic basis, the means of transportation used and distances typically traveled by Medi-Cal beneficiaries to obtain fee-for-service primary care services and the experience of managed care plans in delivering services to Medi-Cal enrollees. The department shall also consider the provider's ability to render culturally and linguistically appropriate services.

(g) To the extent possible, the arrangements for carrying out subdivision (d) shall provide for the equitable distribution of Medi-Cal beneficiaries among participating managed care plans, fee-for-service case management providers, and pilot projects.

(h) If, under the provisions of subdivision (d), a Medi-Cal beneficiary or applicant does not make a choice or does not certify that he or she has an established relationship with a primary care provider or clinic, the person may, at the option of the department, be provided with a Medi-Cal card or

be assigned to and enrolled in a managed care plan providing service within the area in which the beneficiary resides.

(i) Any Medi-Cal or AFDC beneficiary who is dissatisfied with the provider or managed care plan, pilot project, or fee-for-service case management provider shall be allowed to select or be assigned to another provider or managed care plan, pilot project, or fee-for-service case management provider.

(j) The department or its contractor shall notify a managed care plan, pilot project, or fee-for-service case management provider when it has been selected by or assigned to a beneficiary. The managed care plan, pilot project, or fee-for-service case management provider that has been selected by, or assigned to, a beneficiary, shall notify the primary care provider or clinic that it has been selected or assigned. The managed care plan, pilot project, or fee-for-service case management provider shall also notify the beneficiary of the managed care plan, pilot project, or fee-for-service case management provider or clinic selected or assigned.

(k) (1) The department shall ensure that Medi-Cal beneficiaries eligible under Title XVI of the Social Security Act are provided with information about options available regarding methods of receiving Medi-Cal benefits as described in subdivision (c).

(2) (A) The director may waive the requirements of subdivisions (c) and (d) until a means is established to directly provide the presentation described in subdivision (a) to beneficiaries who are eligible for the federal Supplemental Security Income for the Aged, Blind, and Disabled Program (Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code).

(B) The director may elect not to apply the requirements of subdivisions (c) and (d) to beneficiaries whose eligibility under the Supplemental Security Income program is established before January 1, 1994.

(l) In areas where there is no prepaid managed health care plan or pilot program that has contracted with the department to provide services to Medi-Cal beneficiaries, and where no other enrollment requirements have been established by the department, no explicit choice need be made, and the beneficiary or eligible applicant shall receive a Medi-Cal card.

(m) The following definitions contained in this subdivision shall control the construction of this section, unless the context requires otherwise:

(1) “Applicant,” “beneficiary,” and “eligible applicant,” in the case of a family group, mean any person with legal authority to make a choice on behalf of dependent family members.

(2) “Fee-for-service case management provider” means a provider enrolled and certified to participate in the Medi-Cal fee-for-service case management program the department may elect to develop in selected areas of the state with the assistance of and in cooperation with California physician providers and other interested provider groups.

(3) “Managed health care plan” and “managed care plan” mean a person or entity operating under a Medi-Cal contract with the department under this chapter or Chapter 8 (commencing with Section 14200) to provide, or

arrange for, health care services for Medi-Cal beneficiaries as an alternative to the Medi-Cal fee-for-service program that has a contractual responsibility to manage health care provided to Medi-Cal beneficiaries covered by the contract.

(n) (1) Whenever a county welfare department notifies a public assistance recipient or Medi-Cal beneficiary that the recipient or beneficiary is losing Medi-Cal eligibility, the county shall include, in the notice to the recipient or beneficiary, notification that the loss of eligibility shall also result in the recipient's or beneficiary's disenrollment from Medi-Cal managed health care or dental plans, if enrolled.

(2) (A) Whenever the department or the county welfare department processes a change in a public assistance recipient's or Medi-Cal beneficiary's residence or aid code that will result in the recipient's or beneficiary's disenrollment from the managed health care or dental plan in which he or she is currently enrolled, a written notice shall be given to the recipient or beneficiary.

(B) This paragraph shall become operative and the department shall commence sending the notices required under this paragraph on or before the expiration of 12 months after the effective date of this section.

(o) This section shall be implemented in a manner consistent with any federal waiver required to be obtained by the department in order to implement this section.

(p) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 20. Section 14016.5 is added to the Welfare and Institutions Code, to read:

14016.5. (a) At the time of determining or redetermining the eligibility of a Medi-Cal program or Aid to Families with Dependent Children (AFDC) program applicant or beneficiary who resides in an area served by a managed health care plan or pilot program in which beneficiaries may enroll, each applicant or beneficiary shall be informed of the managed care and fee-for-service options available regarding methods of receiving Medi-Cal benefits.

(b) The information described in subdivision (a) shall include all of the following elements:

(1) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in the fee-for-service sector.

(2) Each beneficiary or eligible applicant shall be provided with the name, address, telephone number, and specialty, if any, of each primary care provider, and each clinic participating in each prepaid managed health care plan, pilot project, or fee-for-service case management provider option. This information shall be provided under geographic area designations, in alphabetical order by the name of the primary care provider and clinic. The name, address, and telephone number of each specialist participating in each prepaid managed health care plan, pilot project, or fee-for-service case

management provider option shall be made available by contacting either the health care options contractor or the prepaid managed health care plan, pilot project, or fee-for-service case management provider.

(3) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in a managed care option, if his or her treating provider is a primary care provider or clinic contracting with any of the prepaid managed health care plans, pilot projects, or fee-for-service case management provider options available, has available capacity, and agrees to continue to treat that beneficiary or applicant.

(4) In areas specified by the director, each beneficiary or eligible applicant shall be informed that if he or she fails to make a choice, or does not certify that he or she has an established relationship with a primary care provider or clinic, he or she shall be assigned to, and enrolled in, a prepaid managed health care plan, pilot project, or fee-for-service case management provider.

(c) No later than 30 days following the date a Medi-Cal or AFDC beneficiary or applicant is determined eligible, the beneficiary or applicant shall indicate his or her choice in writing, as a condition of coverage for Medi-Cal benefits, of either of the following health care options:

(1) To obtain benefits by receiving a Medi-Cal card, which may be used to obtain services from individual providers, that the beneficiary would locate, that choose to provide services to Medi-Cal beneficiaries.

The department may require each beneficiary or eligible applicant, as a condition for electing this option, to sign a statement certifying that he or she has an established patient-provider relationship, or in the case of a dependent, the parent or guardian shall make that certification. This certification shall not require the acknowledgment or guarantee of acceptance, by any indicated Medi-Cal provider or health facility, of any beneficiary making a certification under this section.

(2) (A) To obtain benefits by enrolling in a prepaid managed health care plan, pilot program, or fee-for-service case management provider that has agreed to make Medi-Cal services readily available to enrolled Medi-Cal beneficiaries.

(B) At the time the beneficiary or eligible applicant selects a prepaid managed health care plan, pilot project, or fee-for-service case management provider, the department shall, when applicable, encourage the beneficiary or eligible applicant to also indicate, in writing, his or her choice of primary care provider or clinic contracting with the selected prepaid managed health care plan, pilot project, or fee-for-service case management provider.

(d) (1) In areas specified by the director, a Medi-Cal or AFDC beneficiary or eligible applicant who does not make a choice, or who does not certify that he or she has an established relationship with a primary care provider or clinic, shall be assigned to and enrolled in an appropriate Medi-Cal managed care plan, pilot project, or fee-for-service case management provider providing service within the area in which the beneficiary resides.

(2) If it is not possible to enroll the beneficiary under a Medi-Cal managed care plan, pilot project, or a fee-for-service case management provider



because of a lack of capacity or availability of participating contractors, the beneficiary shall be provided with a Medi-Cal card and informed about fee-for-service primary care providers who do all of the following:

(A) The providers agree to accept Medi-Cal patients.

(B) The providers provide information about the provider's willingness to accept Medi-Cal patients as described in Section 14016.6.

(C) The providers provide services within the area in which the beneficiary resides.

(e) If a beneficiary or eligible applicant does not choose a primary care provider or clinic, or does not select any primary care provider who is available, the managed health care plan, pilot project, or fee-for-service case management provider that was selected by or assigned to the beneficiary shall ensure that the beneficiary selects a primary care provider or clinic within 30 days after enrollment or is assigned to a primary care provider within 40 days after enrollment.

(f) (1) The managed care plan shall have a valid Medi-Cal contract, adequate capacity, and appropriate staffing to provide health care services to the beneficiary.

(2) The department shall establish standards for all of the following:

(A) The maximum distances a beneficiary is required to travel to obtain primary care services from the managed care plan, fee-for-service case management provider, or pilot project in which the beneficiary is enrolled.

(B) The conditions under which a primary care service site shall be accessible by public transportation.

(C) The conditions under which a managed care plan, fee-for-service case management provider, or pilot project shall provide nonmedical transportation to a primary care service site.

(3) In developing the standards required by paragraph (2), the department shall take into account, on a geographic basis, the means of transportation used and distances typically traveled by Medi-Cal beneficiaries to obtain fee-for-service primary care services and the experience of managed care plans in delivering services to Medi-Cal enrollees. The department shall also consider the provider's ability to render culturally and linguistically appropriate services.

(g) To the extent possible, the arrangements for carrying out subdivision (d) shall provide for the equitable distribution of Medi-Cal beneficiaries among participating managed care plans, fee-for-service case management providers, and pilot projects.

(h) If, under the provisions of subdivision (d), a Medi-Cal beneficiary or applicant does not make a choice or does not certify that he or she has an established relationship with a primary care provider or clinic, the person may, at the option of the department, be provided with a Medi-Cal card or be assigned to and enrolled in a managed care plan providing service within the area in which the beneficiary resides.

(i) Any Medi-Cal or AFDC beneficiary who is dissatisfied with the provider or managed care plan, pilot project, or fee-for-service case management provider shall be allowed to select or be assigned to another

provider or managed care plan, pilot project, or fee-for-service case management provider.

(j) The department or its contractor shall notify a managed care plan, pilot project, or fee-for-service case management provider when it has been selected by or assigned to a beneficiary. The managed care plan, pilot project, or fee-for-service case management provider that has been selected by, or assigned to, a beneficiary, shall notify the primary care provider or clinic that it has been selected or assigned. The managed care plan, pilot project, or fee-for-service case management provider shall also notify the beneficiary of the managed care plan, pilot project, or fee-for-service case management provider or clinic selected or assigned.

(k) (1) The department shall ensure that Medi-Cal beneficiaries eligible under Title XVI of the federal Social Security Act are provided with information about options available regarding methods of receiving Medi-Cal benefits as described in subdivision (c).

(2) (A) The director may waive the requirements of subdivisions (c) and (d) until a means is established to directly provide the information described in subdivision (a) to beneficiaries who are eligible for the federal Supplemental Security Income for the Aged, Blind, and Disabled Program (Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code).

(B) The director may elect not to apply the requirements of subdivisions (c) and (d) to beneficiaries whose eligibility under the Supplemental Security Income program is established before January 1, 1994.

(l) In areas where there is no prepaid managed health care plan or pilot program that has contracted with the department to provide services to Medi-Cal beneficiaries, and where no other enrollment requirements have been established by the department, no explicit choice need be made, and the beneficiary or eligible applicant shall receive a Medi-Cal card.

(m) The following definitions contained in this subdivision shall control the construction of this section, unless the context requires otherwise:

(1) “Applicant,” “beneficiary,” and “eligible applicant,” in the case of a family group, mean any person with legal authority to make a choice on behalf of dependent family members.

(2) “Fee-for-service case management provider” means a provider enrolled and certified to participate in the Medi-Cal fee-for-service case management program the department may elect to develop in selected areas of the state with the assistance of and in cooperation with California physician providers and other interested provider groups.

(3) “Managed health care plan” and “managed care plan” mean a person or entity operating under a Medi-Cal contract with the department under this chapter or Chapter 8 (commencing with Section 14200) to provide, or arrange for, health care services for Medi-Cal beneficiaries as an alternative to the Medi-Cal fee-for-service program that has a contractual responsibility to manage health care provided to Medi-Cal beneficiaries covered by the contract.

(n) (1) Whenever a county welfare department notifies a public assistance recipient or Medi-Cal beneficiary that the recipient or beneficiary is losing Medi-Cal eligibility, the county shall include, in the notice to the recipient or beneficiary, notification that the loss of eligibility shall also result in the recipient's or beneficiary's disenrollment from Medi-Cal managed health care or dental plans, if enrolled.

(2) Whenever the department or the county welfare department processes a change in a public assistance recipient's or Medi-Cal beneficiary's residence or aid code that will result in the recipient's or beneficiary's disenrollment from the managed health care or dental plan in which he or she is currently enrolled, a written notice shall be given to the recipient or beneficiary.

(o) This section shall be implemented in a manner consistent with any federal waiver required to be obtained by the department in order to implement this section.

(p) (1) If the functionality is available in the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), individuals or their authorized representatives may select Medi-Cal managed care plans via CalHEERS.

(A) Any person that assists a Medi-Cal beneficiary who is eligible for the program based on modified adjusted gross income (MAGI) to select a Medi-Cal managed care plan via CalHEERS shall complete a training program that includes all of the following:

(i) The right to select a plan, to designate a plan at a later date, to have plan choice materials sent by mail, and that if the person does not select a plan, one will be selected for them.

(ii) All plan enrollment options and requirements with regard to MAGI Medi-Cal eligibility.

(iii) Any applicable timeframes in which the plan choice must be designated and the mechanism for designating plan choice.

(iv) How to use provider directories, how to identify which providers are in a particular plan network, and the applicable characteristics of primary care and specialty care providers and providers of other services, such as languages spoken, whether they are accepting new patients, and office locations.

(v) To the extent applicable, how to access Medi-Cal services prior to plan enrollment, including the right to retroactive Medi-Cal benefits.

(B) Any person that assists a Medi-Cal beneficiary who is not eligible for Medi-Cal on the basis of MAGI to select a Medi-Cal managed care plan shall complete a training program that includes all of the following:

(i) All of the information included in the training program described in subparagraph (A).

(ii) The enrollment options and requirements with regard to each Medi-Cal eligibility category, including whether enrollment is mandatory, how to obtain medical exemptions and continuity of care, waiver programs, carved-out services, and the California Children's Services Program, as applicable.

(2) The department shall consult with a group of stakeholders through either a group currently in existence or convened for this purpose that includes representatives of plans, providers, consumer advocates, counties, eligibility workers, CalHEERS, the California Health Benefit Exchange (Exchange), and the Legislature to review process, timelines, scripts, training curricula, monitoring and oversight plans, and plan marketing and informational materials.

(3) In developing materials, scripts, and processes, the department and the Exchange shall consult with or test the materials, scripts, and processes with stakeholders that have expertise in health plan selection, and in assisting populations of diverse demographic characteristics such as race, ethnicity, language spoken, geographic region, sexual orientation, and gender identity or preference.

(4) The department, CalHEERS, the Exchange, and counties may adopt the recommendations of the advisory body convened in paragraph (2) and specify the reasons if the recommendations are not adopted.

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

SEC. 21. Section 14016.6 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

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

(ii) The department shall use the edited materials in informing beneficiaries and applicants of their choices for receiving Medi-Cal benefits.

(b) Provision of information that is necessary to implement this program in a manner that fairly and objectively explains to beneficiaries and applicants their choices for methods of receiving Medi-Cal benefits, including information prepared by the department emphasizing the benefits and limitations to beneficiaries of enrolling in managed health care plans and pilot projects as opposed to the fee-for-service system.

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

(d) Training of specialized county employees to carry out the program.

(e) Monitoring the implementation of the program in those county welfare offices where choices are made available in order to assure that beneficiaries and applicants may make a well-informed choice, without duress.

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

(g) The responsibilities outlined in this section shall, at the option of the department, be carried out by a specially trained county or state employee or by an independent contractor paid by the department. If a county sponsored prepaid health plan or pilot program is offered, the responsibilities outlined in this section shall be carried out either by a specially trained state employee or by an independent contractor paid by the department.

(h) The department shall adopt any regulations as are necessary to ensure that the informing of beneficiaries of their health care options is a part of the eligibility determination process.

(i) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 22. Section 14016.6 is added to the Welfare and Institutions Code, to read:

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

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

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

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

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

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

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

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

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

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

(d) Training of specialized county employees to carry out the program.

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

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

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

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

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

SEC. 23. Section 14055 is added to the Welfare and Institutions Code, to read:

14055. (a) For the purposes of this chapter, “caretaker relative” means a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child’s care, and who is one of the following:

(1) The child’s father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, great grandparent, uncle, aunt, nephew, niece, great-great grandparent, great uncle or aunt, first cousin, great-great-great grandparent, great-great uncle or aunt, or first cousin once removed.

(2) The spouse or registered domestic partner of one of the relatives identified in paragraph (1), even after the marriage is terminated by death or divorce or the domestic partnership has been legally terminated.

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

SEC. 24. Section 14102.5 is added to the Welfare and Institutions Code, to read:

14102.5. (a) The department shall, in collaboration with the Exchange, the counties, consumer advocates, and the Statewide Automated Welfare System consortia, develop and prepare one or more reports that shall be issued on at least a quarterly basis and shall be made publicly available within 30 days following the end of each quarter, for the purpose of informing the California Health and Human Services Agency, the Exchange, the Legislature, and the public about the enrollment process for all insurance affordability programs. The reports shall comply with federal reporting requirements and shall, at a minimum, include the following information, to be derived from, as appropriate depending on the data element, CalHEERS, MEDS, or the Statewide Automated Welfare System:

(1) For applications received for insurance affordability programs through any venue, all of the following:

(A) The number of applications received through each venue.

(B) The number of applicants included on those applications.

(C) Applicant demographics, including, but not limited to, gender, age, race, ethnicity, and primary language.

(D) The disposition of applications, including all of the following:

(i) The number of eligibility determinations that resulted in an approval for coverage.

(ii) The program or programs for which the individuals in clause (i) were determined eligible.

(iii) The number of applications that were denied for any coverage and the reason or reasons for the denials.

(E) The number of days for eligibility determinations to be completed.

(2) With regard to health plan selection, all of the following:

(A) The health plans that are selected by applicants enrolled in an insurance affordability program, reported by the program.

(B) The number of Medi-Cal enrollees who do not select a health plan but are defaulted into a plan.

(3) For annual redeterminations conducted for beneficiaries, all of the following:

(A) The number of redeterminations processed.

(B) The number of redeterminations that resulted in continued eligibility for the same insurance affordability program.

(C) The number of redeterminations that resulted in a change in eligibility to a different insurance affordability program.

(D) The number of redeterminations that resulted in a finding of ineligibility for any program and the reason or reasons for the findings of ineligibility.

(E) The number of days for redeterminations to be completed.

(4) With regard to disenrollments not related to a redetermination of eligibility, all of the following:

(A) The number of beneficiary disenrollments.

(B) The reasons for the disenrollments.

(C) The number of disenrollments that are caused by an individual disenrolling from one insurance affordability program and enrolling into another.

(5) The number of applications for insurance affordability programs that were filed with the help of an assister or navigator.

(6) The total number of grievances and appeals filed by applicants and enrollees regarding eligibility for insurance affordability programs, the basis for the grievance, and the outcomes of the appeals.

(b) The department shall collect the information necessary for these reports and develop these reports using data obtained from the Statewide Automated Welfare System, CalHEERS, MEDS, and any other appropriate state information management systems.

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

(1) “CalHEERS” means the California Healthcare Eligibility, Enrollment, and Retention System developed under Section 15926.

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

(3) “Statewide Automated Welfare System” means the system developed pursuant to Section 10823.

(4) “MEDS” means the Medi-Cal Eligibility Data System that is maintained by the department.

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

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

SEC. 25. Section 14103 is added to the Welfare and Institutions Code, to read:

14103. (a) The implementation of the optional expansion of Medi-Cal benefits to adults who meet the eligibility requirements of Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), shall be contingent upon the following:

(1) If the federal medical assistance percentage payable to the state under the ACA for the optional expansion of Medi-Cal benefits to adults is reduced below 90 percent, that reduction shall be addressed in a timely manner through the annual state budget or legislative process. Upon receiving notification of any reduction in federal assistance pursuant to this paragraph, the Director of Finance shall immediately notify the Chairpersons of the Senate and Assembly Health Committees and the Chairperson of the Joint Legislative Budget Committee.

(2) If, prior to January 1, 2018, the federal medical assistance percentage payable to the state under the ACA for the optional expansion of Medi-Cal benefits to adults is reduced to 70 percent or less, the implementation of any provision in this chapter authorizing the optional expansion of Medi-Cal benefits to adults shall cease 12 months after the effective date of the federal law or other action reducing the federal medical assistance percentage.

(b) For purposes of this section, “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.

SEC. 26. 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 program eligibility requirements and complies with all necessary requests for information moves between programs without any breaks in coverage and without being required to provide any forms, documents, or other information or undergo verification that is duplicative or otherwise unnecessary. The individual shall be informed about how to obtain information about the status of his or her application, renewal, or transfer to another program at any time, and the information shall be promptly provided when requested.

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

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

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

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

(1) The applicant shall be informed of the overpayment penalties under the federal Comprehensive 1099 Taxpayer Protection and Repayment of

Exchange Subsidy Overpayments Act of 2011 (Public Law 112-9), if the individual's annual family income increases by a specified amount or more, calculated on the basis of the individual's current family size and current income, and that penalties are avoided by prompt reporting of income increases throughout the year.

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

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

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

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

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

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

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

SEC. 27. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, 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.

However, if the Commission on State Mandates determines that this act contains other 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.

SEC. 28. This act shall become operative only if Senate Bill 1 of the 2013-14 First Extraordinary Session is enacted and takes effect.

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