Assembly Bill No. 1494

CHAPTER 28

An act to amend Section 7575 of, and to add Section 7582 to, the Government Code, to amend Sections 123865, 123870, 123875, 123940, and 123955 of the Health and Safety Code, to add Chapter 16.2 (commencing with Section 12694.1) to Part 6.2 of Division 2 of the Insurance Code, and to amend Section 14105.22 of, and to add Sections 14005.26 and 14005.27 to, the Welfare and Institutions Code, relating to health coverage, and making an appropriation therefor, to take effect immediately, bill related to the budget.

[Approved by Governor June 27, 2012. Filed with Secretary of State June 27, 2012.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1494, Committee on Budget. Healthy Families Program: Medi-Cal: program transition: expansion.

Under existing law, the Robert W. Crown California Children's Services Act, the State Department of Health Care Services and each county administer the California Children's Services Program (CCS program) for treatment services for persons under 21 years of age diagnosed with severe chronic disease or severe physical limitations, as specified. Existing law generally limits eligibility for CCS program services to persons in families with an annual adjusted gross income of $40,000 or less. Under existing law, the department, or any designated local agency administering the program, is responsible for providing medically necessary occupational and physical therapy to eligible children, as specified. Existing law requires that specified assessments and therapy treatment services rendered to a child referred to a local education agency for an assessment or a disabled child or youth with an IEP be exempt from financial eligibility standards and family repayment requirements.

This bill would make technical, nonsubstantive changes to these provisions.

Existing law creates the Healthy Families Program, administered by the Managed Risk Medical Insurance Board (MRMIB), to arrange for the provision of health, vision, and dental benefits to eligible children pursuant to a federal program, the Children's Health Insurance Program. Existing law also provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions.

Under existing law, the Director of Health Care Services may contract with any qualified individual, organization, or entity to provide services to,

arrange for, or case manage the care of Medi-Cal beneficiaries, subject to specified requirements. Existing law requires a Medi-Cal applicant or beneficiary to be informed of the managed care and fee-for-service options available regarding methods of receiving Medi-Cal benefits.

This bill would provide for the transition of specified enrollees of the Healthy Families Program to the Medi-Cal program, to the extent that those individuals are otherwise eligible, no sooner than January 1, 2013. This bill would provide that the transition would take place in 4 phases, as specified, for individuals enrolled in either a Healthy Families Program plan that is also a Medi-Cal managed care plan (Phase 1) or enrolled in a Healthy Families Program plan that is a subcontractor of a Medi-Cal managed care plan or other specified plans (Phase 2 and Phase 3), or for individuals residing in a county that is not a Medi-Cal managed care county (Phase 4).

This bill would require the department to exercise certain options under federal law to provide benefits to optional targeted low-income children, as described, and seek appropriate federal approvals and state plan amendments, in order to implement the Healthy Families Program to Medi-Cal program transition and Medi-Cal program expansion provided for in the bill. This bill would require MRMIB to coordinate with the department to implement these provisions, and would make related changes. This bill would make related changes to the California Children's Services Program provisions.

By increasing county responsibilities with respect to determining Medi-Cal eligibility, this bill would impose a state-mandated local program.

Existing law provides that reimbursement for clinical laboratory or laboratory services under the Medi-Cal program, as defined, may not exceed 80% of the lowest maximum allowance established by the federal Medicare Program for the same or similar services.

This bill would, upon federal approval, change the rate methodology for clinical laboratory or laboratory services, as specified. This bill would also require that rates for clinical laboratory or laboratory services be reduced by 10% until federal approval is obtained for this new rate methodology.

This bill would appropriate $400,000 from the Managed Care Fund to the Department of Managed Health Care for administration, as specified.

This bill would make legislative findings and declarations as to the necessity of a special statute for the Counties of Los Angeles and Sacramento.

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

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

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

Appropriation: yes.

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

SECTION 1. Section 7575 of the Government Code is amended to read:

7575. (a) (1) Notwithstanding any other provision of law, the State Department of Health Care Services, or any designated local agency administering the California Children's Services, shall be responsible for the provision of medically necessary occupational therapy and physical therapy, as specified by Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, by reason of medical diagnosis and when contained in the child's individualized education program.

(2) Related services or designated instruction and services not deemed to be medically necessary by the State Department of Health Care Services, that the individualized education program team determines are necessary in order to assist a child to benefit from special education, shall be provided by the local education agency by qualified personnel whose employment standards are covered by the Education Code and implementing regulations.

(b) The department shall determine whether a California Children's Services eligible pupil, or a pupil with a private medical referral needs medically necessary occupational therapy or physical therapy. A medical referral shall be based on a written report from a licensed physician and surgeon who has examined the pupil. The written report shall include the following:

(1) The diagnosed neuromuscular, musculoskeletal, or physical disabling condition prompting the referral.

(2) The referring physician's treatment goals and objectives.

(3) The basis for determining the recommended treatment goals and objectives, including how these will ameliorate or improve the pupil's diagnosed condition.

(4) The relationship of the medical disability to the pupil's need for special education and related services.

(5) Relevant medical records.

(c) The department shall provide the service directly or by contracting with another public agency, qualified individual, or a state-certified nonpublic nonsectarian school or agency.

(d) Local education agencies shall provide necessary space and equipment for the provision of occupational therapy and physical therapy in the most efficient and effective manner.

(e) The department shall also be responsible for providing the services of a home health aide when the local education agency considers a less restrictive placement from home to school for a pupil for whom both of the following conditions exist:

(1) The California Medical Assistance Program provides a life-supporting medical service via a home health agency during the time in which the pupil would be in school or traveling between school and home.

(2) The medical service provided requires that the pupil receive the personal assistance or attention of a nurse, home health aide, parent or

guardian, or some other specially trained adult in order to be effectively delivered.

SEC. 2. Section 7582 is added to the Government Code, to read:

7582. Assessments and therapy treatment services provided under programs of the State Department of Health Care Services, or its designated local agencies, rendered to a child referred by a local education agency for an assessment or a disabled child or youth with an individualized education program, shall be exempt from financial eligibility standards and family repayment requirements for these services when rendered pursuant to this chapter.

SEC. 3. Section 123865 of the Health and Safety Code is amended to read:

123865. If the parents or estate of a handicapped child is wholly or partly unable to furnish for the child necessary services, the parents or guardian may apply to the agency of the county that has been designated by the board of supervisors of the county of residence under the terms of Section 123850 to administer the provisions for handicapped children. Residence shall be determined in accordance with Sections 243 and 244 of the Government Code.

SEC. 4. Section 123870 of the Health and Safety Code is amended to read:

123870. (a) The department shall establish standards of financial eligibility for treatment services under the California Children's Services Program (CCS program).

(1) Financial eligibility for treatment services under this program shall be limited to persons in families with an adjusted gross income of forty thousand dollars ($40,000) or less in the most recent tax year, as calculated for California state income tax purposes. If a person is enrolled in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the financial documentation required for that program in Section 2699.6600 of Title 10 of the California Code of Regulations may be used instead of the person's California state income tax return. If a person is enrolled in the Medi-Cal program pursuant to Section 14005.26 of the Welfare and Institutions Code, the financial documentation required to establish eligibility for the Medi-Cal program may be used instead of the person's California state income tax return. However, the director may authorize treatment services for persons in families with higher incomes if the estimated cost of care to the family in one year is expected to exceed 20 percent of the family's adjusted gross income.

(2) Children enrolled in the Healthy Families Program, or enrolled in the Medi-Cal program pursuant to Section 14005.26 of the Welfare and Institutions Code, who have a CCS program eligible medical condition under Section 123830, and whose families do not meet the financial eligibility requirements of paragraph (1), shall be deemed financially eligible for CCS program benefits.

(b) Necessary medical therapy treatment services under the California Children's Services Program rendered in the public schools shall be exempt from financial eligibility standards and enrollment fee requirements for the services when rendered to any handicapped child whose educational or physical development would be impeded without the services.

(c) All counties shall use the uniform standards for financial eligibility and enrollment fees established by the department. All enrollment fees shall be used in support of the California Children's Services Program.

(d) Annually, every family with a child eligible to receive services under this article shall pay a fee of twenty dollars ($20), that shall be in addition to any other program fees for which the family is liable. This assessment shall not apply to any child who is eligible for full scope Medi-Cal benefits without a share of cost, for children receiving therapy through the California Children's Services Program as a related service in their individualized education plans, for children from families having incomes of less than 100 percent of the federal poverty level, or for children covered under the Healthy Families Program.

SEC. 5. Section 123875 of the Health and Safety Code is amended to read:

123875. If the California Children's Service medical therapy unit conference team, based on a medical referral recommending medically necessary occupational or physical therapy in accordance with subdivision (b) of Section 7575 of the Government Code, finds that a handicapped child, as defined in Section 123830, needs medically necessary occupational or physical therapy, that child shall be determined to be eligible for therapy services. If the California Children's Services medical consultant disagrees with the determination of eligibility by the California Children's Services medical therapy unit conference team, the medical consultant shall communicate with the conference team to ask for further justification of its determination, and shall weigh the conference team's arguments in support of its decision in reaching his or her own determination.

This section shall not change eligibility criteria for the California Children's Services programs as described in Sections 123830 and 123860.

This section shall not apply to children diagnosed as specific learning disabled, unless they otherwise meet the eligibility criteria of the California Children's Services.

SEC. 6. Section 123940 of the Health and Safety Code is amended to read:

123940. (a) (1) Annually, the board of supervisors shall appropriate a sum of money for services for handicapped children of the county, including diagnosis, treatment, and therapy services for physically handicapped children in public schools, equal to 25 percent of the actual expenditures for the county program under this article for the 1990–91 fiscal year, except as specified in paragraph (2).

(2) If the state certifies that a smaller amount is needed in order for the county to pay 25 percent of costs of the county's program from this source.

The smaller amount certified by the state shall be the amount that the county shall appropriate.

(b) In addition to the amount required by subdivision (a), the county shall allocate an amount equal to the amount determined pursuant to subdivision (a) for purposes of this article from revenues allocated to the county pursuant to Chapter 6 (commencing with Section 17600) of Division 9 of the Welfare and Institutions Code.

(c) (1) The state shall match county expenditures for this article from funding provided pursuant to subdivisions (a) and (b).

(2) County expenditures shall be waived for payment of services for children who are eligible pursuant to paragraph (2) of subdivision (a) of Section 123870.

(d) The county may appropriate and expend moneys in addition to those set forth in subdivision (a) and (b) and the state shall match the expenditures, on a dollar-for-dollar basis, to the extent that state funds are available for this article.

(e) County appropriations under subdivisions (a) and (b) shall include county financial participation in the nonfederal share of expenditures for services for children who are enrolled in the Medi-Cal program pursuant to Section 14005.26 of the Welfare and Institutions Code, and who are eligible for services under this article pursuant to paragraph (1) of subdivision (a) of Section 123870, to the extent that federal financial participation is available at the enhanced federal reimbursement rate under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.) and funds are appropriated for the California Children's Services Program in the State Budget.

(f) Nothing in this section shall require the county to expend more than the amount set forth in subdivision (a) plus the amount set forth in subdivision (b) nor shall it require the state to expend more than the amount of the match set forth in subdivision (c).

(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 further regulatory action, shall implement this section by means of California Children's Services numbered letters.

SEC. 7. Section 123955 of the Health and Safety Code is amended to read:

123955. (a) The state and the counties shall share in the cost of administration of the California Children's Services Program at the local level.

(b) (1) The director shall adopt regulations establishing minimum standards for the administration, staffing, and local implementation of this article subject to reimbursement by the state.

(2) The standards shall allow necessary flexibility in the administration of county programs, taking into account the variability of county needs and resources, and shall be developed and revised jointly with state and county representatives.

(c) The director shall establish minimum standards for administration, staffing and local operation of the program subject to reimbursement by the state.

(d) Until July 1, 1992, reimbursable administrative costs, to be paid by the state to counties, shall not exceed 4.1 percent of the gross total expenditures for diagnosis, treatment and therapy by counties as specified in Section 123940.

(e) Beginning July 1, 1992, this subdivision shall apply with respect to all of the following:

(1) Counties shall be reimbursed by the state for 50 percent of the amount required to meet state administrative standards for that portion of the county caseload under this article that is ineligible for Medi-Cal to the extent funds are available in the State Budget for the California Children's Services Program.

(2) Counties shall be reimbursed by the state for 50 percent of the nonfederal share of the amount required to meet state administrative standards for that portion of the county caseload under this article that is enrolled in the Medi-Cal program pursuant to Section 14005.26 of the Welfare and Institutions Code and who are eligible for services under this article pursuant to subdivision (a) of Section 123870, to the extent that federal financial participation is available at the enhanced federal reimbursement rate under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.) and funds are appropriated for the California Children's Services Program in the State Budget.

(3) On or before September 15 of each year, each county program implementing this article shall submit an application for the subsequent fiscal year that provides information as required by the state to determine if the county administrative staff and budget meet state standards.

(4) The state shall determine the maximum amount of state funds available for each county from state funds appropriated for CCS county administration. If the amount appropriated for any fiscal year in the Budget Act for county administration under this article differs from the amounts approved by the department, each county shall submit a revised application in a form and at the time specified by the department.

(f) The department and counties shall maximize the use of federal funds for administration of the programs implemented pursuant to this article, including using state and county funds to match funds claimable under Title XIX or Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.; 42 U.S.C. Sec. 1397aa et seq.).

SEC. 8. Chapter 16.2 (commencing with Section 12694.1) is added to Part 6.2 of Division 2 of the Insurance Code, to read:

Chapter 16.2. Transition of Healthy Families Program Enrollees to Medi-Cal

12694.1. (a) Pursuant to Sections 14005.26 and 14005.27 of the Welfare and Institutions Code, subscribers enrolled in the Healthy Families Program pursuant to this part shall, no sooner than January 1, 2013, transition to the Medi-Cal program pursuant to Sections 14005.26 and 14005.27 of the Welfare and Institutions Code to the extent they are otherwise eligible. AIM-linked infants, as defined in Section 12695.03, with incomes above 250 percent of the federal poverty level are exempt from this transition.

(b) The board shall coordinate with the State Department of Health Care Services to implement Sections 14005.26 and 14005.27 of the Welfare and Institutions Code.

(c) The board's actions to coordinate with the State Department of Health Care Services to implement Sections 14005.26 and 14005.27 of the Welfare and Institutions Code, as specified in subdivision (b), shall include, but not be limited to, all of the following:

(1) Notwithstanding Section 12693.74, disenrollment of subscribers in the manner, and at the times, specified in Section 14005.27 of the Welfare and Institutions Code. The board may retain a subscriber in the program for longer than 12 months if needed to ensure a smooth transition to the Medi-Cal program.

(2) In coordination with the State Department of Health Care Services, provision of reasonable notice to applicants concerning disenrollment of subscribers consistent with Section 14005.27 of the Welfare and Institutions Code.

(3) Notwithstanding Section 12693.51 of the Insurance Code, transfers of subscribers from one participating plan to another at the times and under the conditions prescribed by the board, without the obligation that the board provide an annual opportunity for subscribers to transfer from one participating plan to another.

(d) Nothing in subdivision (e) of Section 12693.43 shall be construed to require any refund or adjustment of family contributions if an applicant has paid for three months of required family contributions in advance and the subscriber for whom the applicant has paid these family contributions is disenrolled pursuant to this section, or for any other reason, without receiving a fourth consecutive month of coverage.

(e) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the board shall, without taking any further regulatory action, implement, interpret, or make specific this section by means of business rules, program bulletins, program correspondence to subscribers and contractors, letters, or similar instructions.

(2) The board may adopt and readopt emergency regulations implementing this section. The adoption and readoption, by the board, of regulations implementing this section shall be deemed 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 board 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.

(f) The Healthy Families Program, pursuant to this part, shall cease to enroll new subscribers no sooner than the date transition begins pursuant to subdivision (a), and any transition of children shall be in compliance with the implementation plan or plans as contained in Section 14005.27 of the Welfare and Institutions Code.

12694.2. All civil service employees who are currently employed by the Managed Risk Medical Insurance Board, whose functions are transferred to the State Department of Health Care Services as a result of the act adding this section, shall retain their positions, status, and rights pursuant to Section 19050.9 of the Government Code and the State Civil Service Act (Part 2 (commencing with Section 18500) of Division 5 of Title 2 of the Government Code).

SEC. 9. Section 14105.22 of the Welfare and Institutions Code, as added by Section 64 of Chapter 230 of the Statutes of 2003, is amended to read:

14105.22. (a) (1) Reimbursement for clinical laboratory or laboratory services, as defined in Section 51137.2 of Title 22 of the California Code of Regulations, may not exceed 80 percent of the lowest maximum allowance established by the federal Medicare Program for the same or similar services.

(2) This subdivision shall be implemented only until the new rate methodology under subdivision (b) is approved by the federal Centers for Medicare and Medicaid Services (CMS).

(b) (1) It is the intent of the Legislature that the department develop reimbursement rates for clinical laboratory or laboratory services that are comparable to the payment amounts received from other payers for clinical laboratory or laboratory services. Development of these rates will enable the department to reimburse clinical laboratory or laboratory service providers in compliance with state and federal law.

(2) (A) The provisions of Section 51501(a) of Title 22 of the California Code of Regulations shall not apply to laboratory providers reimbursed under the new rate methodology developed for clinical laboratories or laboratory services pursuant to this subdivision.

(B) In addition to subparagraph (A), laboratory providers reimbursed under any payment reductions implemented pursuant to this section shall not be subject to the provisions of Section 51501(a) of Title 22 of the California Code of Regulations for 12 months following the date of implementation of this reduction.

(3) Reimbursement to providers for clinical laboratory or laboratory services shall not exceed the lowest of the following:

(A) The amount billed.

(B) The charge to the general public.

(C) Eighty percent of the lowest maximum allowance established by the federal Medicare Program for the same or similar services.

(D) A reimbursement rate based on an average of the lowest amount that other payers and other state Medicaid programs are paying for similar clinical laboratory or laboratory services.

(4) (A) In addition to the payment reductions implemented pursuant to Section 14105.192, payments shall be reduced by up to 10 percent for clinical laboratory or laboratory services, as defined in Section 51137.2 of Title 22 of the California Code of Regulations, for dates of service on and after July 1, 2012. The payment reductions pursuant to this paragraph shall continue until the new rate methodology under this subdivision has been approved by CMS.

(B) Notwithstanding subparagraph (A), the Family Planning, Access, Care, and Treatment (Family PACT) Program pursuant to subdivision (aa) of Section 14132 shall be exempt from the payment reduction specified in this section.

(5) (A) For purposes of establishing reimbursement rates for clinical laboratory or laboratory services based on the lowest amounts other payers are paying providers for similar clinical laboratory or laboratory services, laboratory service providers shall submit data reports within six months of the date the act that added this paragraph becomes effective and annually thereafter. The data provided shall be based on the previous calendar year and shall specify the provider's lowest amounts other payers are paying, including other state Medicaid programs and private insurance, minus discounts and rebates. The specific data required for submission under this subparagraph and the format for the data submission shall be determined and specified by the department after receiving stakeholder input pursuant to paragraph (7).

(B) The data submitted pursuant to subparagraph (A) may be used to determine reimbursement rates by procedure code based on an average of the lowest amount other payers are paying providers for similar clinical laboratory or laboratory services, excluding significant deviations of cost or volume factors and with consideration to geographical areas. The department shall have the discretion to determine the specific methodology and factors used in the development of the lowest average amount under this subparagraph to ensure compliance with federal Medicaid law and regulations as specified in paragraph (10).

(C) For purposes of subparagraph (B), the department may contract with a vendor for the purposes of collecting payment data reports from clinical laboratories, analyzing payment information, and calculating a proposed rate.

(D) The proposed rates calculated by the vendor described in subparagraph (C) may be used in determining the lowest reimbursement rate for clinical laboratories or laboratory services in accordance with paragraph (3).

(E) Data reports submitted to the department shall be certified by the provider's certified financial officer or an authorized individual.

(F) Clinical laboratory providers that fail to submit data reports within 30 working days from the time requested by the department shall be subject to the suspension provisions of subdivisions (a) and (c) of Section 14123.

(6) Data reports provided to the department pursuant to this section shall be confidential and shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(7) The department shall seek stakeholder input on the ratesetting methodology.

(8) (A) 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 further regulatory action, implement, interpret, or make specific this section by means of provider bulletins or similar instructions until regulations are adopted. It is the intent of the Legislature that the department have temporary authority as necessary to implement program changes until completion of the regulatory process.

(B) The department shall adopt emergency regulations no later than July 1, 2014. The department may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted pursuant to this section. The initial adoption of emergency regulations implementing the amendments to this section and the one readoption of emergency regulations authorized by this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law.

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

(9) To the extent that the director determines that the new methodology or payment reductions are not consistent with the requirements of Section 1396a(a)(30)(A) of Title 42 of the United States Code, the department may revert to the methodology under subdivision (a) to ensure access to care is not compromised.

(10) (A) The department shall implement this section in a manner that is consistent with federal Medicaid law and regulations. The director shall seek any necessary federal approvals for the implementation of this section. This section shall be implemented only to the extent that federal approval is obtained.

(B) In determining whether federal financial participation is available, the director shall determine whether the rates and payments comply with applicable federal Medicaid requirements, including those set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code.

(C) To the extent that the director determines that the rates and payments do not comply with applicable federal Medicaid requirements or that federal financial participation is not available with respect to any reimbursement rate, the director retains the discretion not to implement that rate or payment and may revise the rate or payment as necessary to comply with federal Medicaid requirements. The department shall notify the Joint Legislative Budget Committee 10 days prior to revising the rate or payment to comply with federal Medicaid requirements.

SEC. 10. Section 14005.26 is added to the Welfare and Institutions Code, to read:

14005.26. (a) The department shall exercise the option pursuant to Section 1902(a)(l0)(A)(ii)(XIV) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIV)) to provide full-scope benefits with no share of cost under this chapter and Chapter 8 (commencing with Section 14200) to children who have attained six years of age but have not attained 19 years of age, who are optional targeted low-income children pursuant to Section 1905(u)(2)(B) of the federal Social Security Act (42 U.S.C. Sec. 1396d(u)(2)(B)), with family incomes up to and including 200 percent of the federal poverty level. The department shall seek federal approval of a state plan amendment to implement this subdivision.

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

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

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

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

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

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

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

(2) For purposes of implementing this section, the department shall include in the Medi-Cal Local Assistance Estimate an amount for Medi-Cal eligibility operations associated with the individuals whose family income is determined to be above 150 percent and up to and including 200 percent of the federal poverty level, after application of the income disregard pursuant to subdivision (b). In developing an estimate for this activity, the department shall consider the projected number of final eligibility determinations each county will process and projected county costs. Within 60 days of the passage of the annual Budget Act, the department shall notify each county of their allocation for this activity based upon the amount allotted in the annual Budget Act for this purpose.

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) This subdivision shall be implemented 90 days after the effective date of the act that added this section, or October 1, 2012, whichever is later.

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

(k) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, for purposes of this transition, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. It is the intent of the Legislature that the department be allowed temporary authority as necessary to implement program changes until completion of the regulatory process.

(2) To the extent otherwise required by Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall adopt emergency regulations implementing this section no later than July 1, 2014. The department may thereafter readopt the

emergency regulations pursuant to that chapter. The adoption and readoption, by the department, of regulations implementing this section shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

(*l*) (1) If at any time the director determines that this section or any part of this section may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), or any amendment or extension of that act, or any additional federal funds that the director, in consultation with the Department of Finance, determines would be advantageous to the state, the director shall give notice to the fiscal and policy committees of the Legislature and to the Department of Finance. After giving notice, this section or any part of this section shall become inoperative on the date that the director executes a declaration stating that the department has determined, in consultation with the Department of Finance, that it is necessary to cease to implement this section or a part or parts thereof, in order to receive federal financial participation, any increase in the federal medical assistance percentage available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, has determined would be advantageous to the state.

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

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

SEC. 11. Section 14005.27 is added to the Welfare and Institutions Code, to read:

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

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

one or more components of eligibility. The department shall seek federal approval of a state plan amendment to implement this subdivision.

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

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

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

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

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

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

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

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

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

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

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

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

(C) Phase 3. Individuals enrolled in a Healthy Families Program plan that is not a Medi-Cal managed care plan and does not contract or subcontract with a Medi-Cal managed care plan shall be enrolled in a Medi-Cal managed care plan in that county. Enrollment shall include consideration of the individuals' primary care providers pursuant to the requirements of this section and Section 14011.6, and to the extent the individuals are otherwise eligible under this chapter and Chapter 8 (commencing with Section 14200). The transition of individuals described in this subparagraph shall begin no earlier than August 1, 2013.

(D) Phase 4.

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

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

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

care, eligibility and enrollment requirements, consumer protections, and family notifications.

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

(A) Managed care plan performance measures shall be integrated and coordinated with the Healthy Families Program performance standards including, but not limited to, child-only Healthcare Effectiveness Data and Information Set (HEDIS) measures, and measures indicative of performance in serving children and adolescents. These performance measures shall also be in compliance with all performance requirements under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and existing Medi-Cal managed care performance measurements and standards as set forth in this chapter and Chapter 8 (commencing with Section 14200), Title 22 of the California Code of Regulations, and all-plan letters, including, but not limited to, network adequacy and linguistic services, and shall be met prior to the transition of individuals pursuant to Phase 1.

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

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

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

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

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

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

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

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

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

(9) (A) The department shall consult and collaborate with the Department of Managed Health Care in assessing Medi-Cal managed care health plan network adequacy in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) for purposes of the developed transition plans pursuant to paragraph (2) for each of the phases.

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

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

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

(2) The state shall provide written notice to individuals enrolled in the Healthy Families Program of their transition to the Medi-Cal program at least 60 days prior to the transition of individuals in Phase 1, as described

in subparagraph (A) of paragraph (1) of subdivision (d), and at least 90 days prior to transition of individuals in Phases 2 and 3, as described in subparagraphs (B) and (C) of paragraph (1) of subdivision (d).

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

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

(5) The department shall provide a process for ongoing stakeholder consultation and make information publicly available, including the achievement of benchmarks, enrollment data, utilization data, and quality measures.

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

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

(3) (A) MRMIB, within 60 days of a request by the department, shall provide the department any data, information, or record concerning the

Healthy Families Program as is necessary to implement the transition of enrollment required pursuant to this section.

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

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

(ii) Any data, information, or record shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of the Government Code) and any other law, to the same extent that it was exempt from disclosure or privileged prior to the provision of the data, information, or record to the department.

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

(iv) The department shall keep all data, information, or records provided by MRMIB confidential to the full extent permitted by law, including, but not limited to, the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of the Government Code, and consistent with MRMIB's contractual obligations to keep the data, information, or records confidential.

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

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

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

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

(k) (1) To the extent the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is not fully operational, for the purposes of implementing this section, for individuals described in

subdivision (a) whose family income has been determined to be at or below 150 percent of the federal poverty level, as determined pursuant to subdivision (b), the department shall utilize the budgeting methodology for this population as contained in the November 2011 Medi-Cal Local Assistance Estimate for Medi-Cal county administration costs for eligibility operations.

(2) For purposes of implementing this section, the department shall include in the Medi-Cal Local Assistance Estimate an amount for Medi-Cal eligibility operations associated with the transfer of Healthy Families Program enrollees eligible pursuant to subdivision (a) of Section 14005.26 and whose family income is determined to be above 150 percent and up to and including 200 percent of the federal poverty level, after application of the income disregard pursuant to subdivision (b) of Section 14005.26. In developing an estimate for this activity, the department shall consider the projected number of final eligibility determinations each county will process and projected county costs. Within 60 days of the passage of the annual Budget Act, the department shall notify each county of their allocation for this activity based upon the amount allotted in the annual Budget Act for this purpose.

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) This subdivision shall be implemented 90 days after enactment of this section or January 1, 2013, whichever is later.

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

(o) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, for purposes of this transition, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. It is the intent of the Legislature that the department be allowed temporary authority as necessary to implement program changes until completion of the regulatory process.

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

(p) (1) If at any time the director determines that this section or any part of this section may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), or any amendment or extension of that act, or any additional federal funds that the director, in consultation with the Department of Finance, determines would be advantageous to the state, the director shall give notice to the fiscal and policy committees of the Legislature and to the Department of Finance. After giving notice, this section or any part of this section shall become inoperative on the date that the director executes a declaration stating that the department has determined, in consultation with the Department of Finance, that it is necessary to cease to implement this section or a part or parts thereof in order to receive federal financial participation, any increase in the federal medical assistance percentage available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, has determined would be advantageous to the state.

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

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

SEC. 12. The sum of four hundred thousand dollars ($400,000) is hereby appropriated from the Managed Care Fund to the Department of Managed Health Care for administration of the call center to assist individuals with the Healthy Families transition, and any other aspects related to health plan readiness and coordination functions with the Department of Health Care Services and the Managed Risk Medical Insurance Board.

SEC. 13. The Legislature finds and declares that a special law is necessary and that a general law cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because the Counties of Los Angeles and Sacramento are the only counties that have Medi-Cal dental managed care arrangements and Sacramento County is the only county with mandatory dental managed care enrollment.

SEC. 14. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 15. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.

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