WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000 - 18999.98] *(Division 9 added by Stats. 1965, Ch. 1784.)*

PART 3.3. Health Care Coverage Assistance [15800 - 15895] *(Part 3.3 added by Stats. 2013, Ch. 23, Sec. 68.)*

CHAPTER 3. County Children's Health Initiative Program [15850 - 15864] *(Heading of Chapter 3 amended by Stats. 2023, Ch. 266, Sec. 8.)*

15850. This chapter shall be known, and may be cited, as the County Children's Health Initiative Program (CCHIP).

(Amended by Stats. 2023, Ch. 266, Sec. 9. (AB 614) Effective January 1, 2024.)

15850.1. For purposes of this chapter, the following definitions shall apply:

(a) "Administrative costs" means those expenses that are described in Section 1397ee(a)(1)(D) of Title 42 of the United States Code.

(b) "Applicant" means a county, county agency, a local initiative, or a county organized health system.

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

(d) "Child" means a person under 19 years of age.

(e) "Comprehensive health insurance coverage" means the coverage provided in Section 2103 of the Social Security Act (42 U.S.C. Sec. 1397cc) and shall be equivalent to the coverage provided to state employees through the Public Employees' Retirement System for the most recent plan year preceding the applicable program plan year, except that the plans may provide a mechanism for inpatient hospital care provided under the mental health benefit through which applicants may agree to a treatment plan in which each inpatient day may be substituted for two residential treatment days or three day treatment program days.

(f) "County Children's Health Initiative Program" or "CCHIP" means the program established pursuant to this chapter.

(g) "County organized health system" means a health system implemented pursuant to Article 2.8 (commencing with Section 14087.5) of Chapter 7 of Part 3 of this division and Article 1 (commencing with Section 101675) of Chapter 3 of Part 4 of Division 101 of the Health and Safety Code.

(h) "Fund" means the County Health Initiative Matching Fund.

(i) "Local initiative" means a prepaid health plan that is organized by, or designated by, a county government or county governments, or organized by stakeholders, of a region designated by the department to provide comprehensive health care to eligible Medi-Cal beneficiaries. The entities established pursuant to Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.96 are local initiatives.

(j) "Optional targeted low-income children group" means the population described in Section 1905(u)(2)(B) of the Social Security Act (42 U.S.C. Sec. 1396d(u)(2)(B)) and in Section 14005.26.

(k) "Access program" means the Medi-Cal Access Program under Chapter 2 (commencing with Section 15810).

(l) "Health care service plan" includes Medi-Cal managed care plans contracting with the department under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3.

(Amended by Stats. 2023, Ch. 266, Sec. 10. (AB 614) Effective January 1, 2024.)

15850.5. (a) Notwithstanding any other law, except as provided in subdivision (b), each applicant who was participating in CCHIP, formerly known as the County Health Initiative Matching Fund, on March 23, 2010, pursuant to former Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code, shall participate in the program established by this chapter, maintaining eligibility standards, methodologies, and procedures at least as favorable to eligible individuals as those in effect on March 23, 2010, and in a manner that satisfies the maintenance of effort obligation established in Section 2105(d)(3) of the Social Security Act (42 U.S.C. Sec. 1397ee(d)(3)).

(b) (1) If an applicant county participating in CCHIP, formerly known as the County Health Initiative Matching Fund, on March 23, 2010, elects to cease funding the nonfederal share of program expenditures made pursuant to Section 15852, the department shall administer the program within that applicant county consistent with subdivision (a).

(2) Notwithstanding any other law, the state general fund shall provide funding amounts equal to the total nonfederal share of all expenditures incurred by the department pursuant to paragraph (1).

(3) The nonfederal share amounts described in paragraph (2) shall be deposited in the County Health Initiative Matching Fund created pursuant to Section 15852, and those funds shall be used by the department for purposes otherwise consistent with that section.

(c) Notwithstanding any other law, as of the enactment of this section, the department shall not approve any additional applicant for participation under this chapter other than those applicants participating as of March 23, 2010.

(d) This section shall only be operative to extent that federal financial participation is not jeopardized and any necessary federal approvals are secured.

(e) This section shall become inoperative on the date that the maintenance of effort obligation pursuant to Section 2105(d)(3) of the Social Security Act (42 U.S.C. Sec. 1397ee(d)(3)) is no longer applicable to the state for purposes of this chapter.

(Amended by Stats. 2023, Ch. 266, Sec. 11. (AB 614) Effective January 1, 2024. Inoperative on date prescribed by its own provisions.)

15852. (a) The County Health Initiative Matching Fund is hereby continued in existence within the State Treasury. The fund shall accept funding, including but not limited to, funding from intergovernmental transfers as follows:

(1) The nonfederal matching fund requirement for federal financial participation through the State Children's Health Insurance Program (Subchapter 21 (commencing with Section 1397aa) of Chapter 7 of Title 42 of the United States Code).

(2) Funding associated with a proposal approved pursuant to subdivision (e) Section 15853.

(3) State general fund amounts pursuant to subdivision (b) of Section 15850.5.

(b) Notwithstanding Section 13340 of the Government Code, amounts deposited in the fund shall be continuously appropriated to the department without regard to fiscal year, and shall be used only for the purposes specified by this section.

(c) The department shall administer this fund and the provisions of this chapter for the express purpose of allowing local or state funds to be used to facilitate increasing the state's ability to utilize federal funds available to California and for costs associated with a proposal pursuant to subdivision (e) of Section 15853 or for costs incurred by the department pursuant to paragraph (1) of subdivision (b) of Section 15850.5. Federal funds shall be used prior to the expiration of their authority for programs designed to improve and expand access for uninsured persons.

(d) The department shall be reimbursed from the fund to cover the cost to administer the program.

(Added by Stats. 2014, Ch. 31, Sec. 89. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15864.)

15853. (a) (1) An applicant that will provide an intergovernmental transfer may submit a proposal to the department for funding for the purpose of providing comprehensive health insurance coverage to any child who meets citizenship and immigration status requirements that are applicable to persons participating in the program established by Title XXI of the Social Security Act, and whose family income is at or below 317 percent of the federal poverty level or, at the option of the applicant, at or below 411 percent of the federal poverty level, in specific geographic areas, as published quarterly in the Federal Register by the United States Department of Health and Human Services, as determined, counted and valued in accordance with the requirements of Section 1396a(e)(14) of Title 42 of the United States Code, as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148) and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments, and which child meets both of the following requirements:

(A) Does not qualify for the optional targeted low-income children group or the Access program.

(B) Does not qualify for Medi-Cal with no share of cost pursuant to Chapter 7 (commencing with Section 14000) of Part 3.

(2) In its application, the applicant shall specify the income level at or below 411 percent of the federal poverty level for which it will provide coverage.

(3) The intergovernmental transfer amount is limited to the expenditures which would be eligible for federal financial participation.

(b) The proposal shall guarantee at least one year of intergovernmental transfer funding by the applicant at a level that ensures compliance with the requirements of any applicable approved federal waiver or state plan amendment as well as the department's

requirements for the sound operation of the proposed project, and shall, on an annual basis, either commit to fully funding the necessary intergovernmental amount or withdraw from the program. The department may identify specific geographical areas that, compared to the national level, have a higher cost of living or housing or a greater need for additional health services, using data obtained from the most recent federal census, the federal Consumer Expenditure Survey, or from other sources. The proposal may include an administrative mechanism for outreach and eligibility.

(c) The applicant may include in its proposal reimbursement of medical, dental, vision, or mental health services delivered to children who are eligible under the Access program or under the Medi-Cal program as an optional targeted low-income children group beneficiary, if these services are part of an overall program with the measurable goal of enrolling served children in the Access program or the optional targeted low-income children group.

(d) If a child is determined to be eligible for benefits for the treatment of an eligible medical condition under the California Children's Services Program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, the health, dental, or vision plan providing services to the child pursuant to this chapter shall not be responsible for the provision of, or payment for, those authorized services for that child. The proposal from an applicant shall contain provisions to ensure that a child whom the health, dental, or vision plan reasonably believes would be eligible for services under the California Children's Services Program is referred to that program. The California Children's Services Program shall provide case management and authorization of services if the child is found to be eligible for the California Children's Services Program. Diagnosis and treatment services that are authorized by the California Children's Services Program shall be performed by paneled providers for that program and approved special care centers of that program and approved by the California Children's Services Program. All other services provided under the proposal from the applicant shall be made available pursuant to this chapter to a child who is eligible for services under the California Children's Services Program.

(e) Notwithstanding any other provision of this section, an applicant may submit a proposal to the department for the purposes of providing comprehensive health insurance coverage to children whose coverage is not eligible for funding under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa, et seq.), or to a combination of children whose coverage is eligible for funding under Title XXI of the Social Security Act and children whose coverage is not eligible for that funding. To be approved by the department, these proposals shall comply with both of the following requirements:

(1) Meet all applicable requirements for funding under this chapter, except for availability of funding through Title XXI of the Social Security Act.

(2) Provide for the administration of children's coverage by the department through the administrative infrastructure serving the Medi-Cal program, and through health care service plans serving the Medi-Cal program.

(f) Implementation of this section is conditioned on the department obtaining necessary federal approval of these provisions.

(g) Notwithstanding any other provision of this part, the status of any application previously submitted to, and approved by, the Managed Risk Medical Insurance Board pursuant to former Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code shall not be altered as a result of the assumption by the department, pursuant to this chapter, of the responsibilities previously exercised by the Managed Risk Medical Insurance Board.

(h) (1) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, and the conditions described in paragraph (1) of subdivision (k) of Section 15853, as added by Section 21 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2025, or the date certified by the department pursuant to paragraph (2) of subdivision (k) of Section 15853, as added by Section 21 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

(2) If the voters do not approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, and the conditions described in paragraph (1) of subdivision (k) of Section 15853, as added by Section 21 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2026, or the date certified by the department pursuant to paragraph (2) of subdivision (k) of Section 15853, as added by Section 21 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

(Amended (as amended by Stats. 2022, Ch. 738, Sec. 20) by Stats. 2024, Ch. 40, Sec. 79. (SB 159) Effective June 29, 2024. Conditionally inoperative on or after January 1, 2025, as prescribed by its own provisions. Conditionally repealed January 1 following the inoperative date. See later operative version as amended by Sec. 80 of Stats. 2024, Ch. 40.)

15853. (a) (1) An applicant that will provide an intergovernmental transfer may submit a proposal to the department for funding for the purpose of providing comprehensive health insurance coverage to any child who meets citizenship and immigration status requirements that are applicable to persons participating in the program established by Title XXI of the Social Security Act, and whose family income is at or below 317 percent of the federal poverty level or, at the option of the applicant, at or below 411 percent of the federal poverty level, in specific geographic areas, as published quarterly in the Federal Register by the United States Department of Health and Human Services, as determined, counted, and valued in accordance with the requirements of Section 1396a(e)(14) of Title 42 of the United States Code, as added by the federal Patient Protection and Affordable Care Act (Public Law

111-148) and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments, and which child meets both of the following requirements:

(A) Does not qualify for the optional targeted low-income children group or the Access program.

(B) Does not qualify for Medi-Cal with no share of cost pursuant to Chapter 7 (commencing with Section 14000) of Part 3.

(2) In its application, the applicant shall specify the income level at or below 411 percent of the federal poverty level for which it will provide coverage.

(3) The intergovernmental transfer amount is limited to the expenditures which would be eligible for federal financial participation.

(b) The proposal shall guarantee at least one year of intergovernmental transfer funding by the applicant at a level that ensures compliance with the requirements of any applicable approved federal waiver or state plan amendment as well as the department's requirements for the sound operation of the proposed project, and shall, on an annual basis, either commit to fully funding the necessary intergovernmental amount or withdraw from the program. The department may identify specific geographical areas that, compared to the national level, have a higher cost of living or housing or a greater need for additional health services, using data obtained from the most recent federal census, the federal Consumer Expenditure Survey, or from other sources. The proposal may include an administrative mechanism for outreach and eligibility.

(c) The applicant may include in its proposal reimbursement of medical, dental, vision, or mental health services delivered to children who are eligible under the Access program or under the Medi-Cal program as an optional targeted low-income children group beneficiary, if these services are part of an overall program with the measurable goal of enrolling served children in the Access program or the optional targeted low-income children group.

(d) If a child is determined to be eligible for benefits for the treatment of an eligible medical condition under the California Children's Services Program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, the health, dental, or vision plan providing services to the child pursuant to this chapter shall not be responsible for the provision of, or payment for, those authorized services for that child. The proposal from an applicant shall contain provisions to ensure that a child whom the health, dental, or vision plan reasonably believes would be eligible for services under the California Children's Services Program is referred to that program. The California Children's Services Program shall provide case management and authorization of services if the child is found to be eligible for the California Children's Services Program. Diagnosis and treatment services that are authorized by the California Children's Services Program shall be performed by paneled providers for that program and approved special care centers of that program and approved by the California Children's Services Program. All other services provided under the proposal from the applicant shall be made available pursuant to this chapter to a child who is eligible for services under the California Children's Services Program.

(e) Notwithstanding any other provision of this section, an applicant may submit a proposal to the department for the purposes of providing comprehensive health insurance coverage to children whose coverage is not eligible for funding under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa, et seq.), or to a combination of children whose coverage is eligible for funding under Title XXI of the Social Security Act and children whose coverage is not eligible for that funding. To be approved by the department, these proposals shall comply with both of the following requirements:

(1) Meet all applicable requirements for funding under this chapter, except for availability of funding through Title XXI of the Social Security Act.

(2) Provide for the administration of children's coverage by the department through the administrative infrastructure serving the Medi-Cal program, and through health care service plans serving the Medi-Cal program.

(f) This section shall be implemented only to the extent any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized.

(g) Notwithstanding any other provision of this part, the status of any application previously submitted to, and approved by, the Managed Risk Medical Insurance Board pursuant to former Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code shall not be altered as a result of the assumption by the department, pursuant to this chapter, of the responsibilities previously exercised by the Managed Risk Medical Insurance Board.

(h) If at any time the director determines that the eligibility criteria established for the program described in 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), any amendment or extension of that act, or any similar federal legislation affecting federal financial participation, the director may alter the eligibility criteria to the extent necessary for the state to receive that federal financial participation.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and Chapter 4 (commencing with Section 12693.25) and Chapter 9 (commencing with 12693.70) of Part 6.2 of Division 2 of the

Insurance Code, the department may implement, interpret, or make specific this section, in whole or in part, through all-county letters or similar instructions, without taking any further regulatory action.

(j) For any child found eligible under this section, they shall remain continuously eligible until they are five years of age. A redetermination of eligibility shall not be conducted before the child reaches five years of age unless the department or county possesses facts indicating that the family has requested the child's voluntary disenrollment, the child is deceased, the child is no longer a state resident, or the child's original enrollment was based on a state or county error or on fraud, abuse, or perjury attributed to the child or the child's representative.

(k) (1) Implementation of this section is contingent on all of the following conditions:

(A) All necessary federal approvals have been obtained by the department pursuant to subdivision (f).

(B) The Legislature has appropriated funding to implement this section after a determination that ongoing General Fund resources are available to support the ongoing implementation of this section in the 2024–25 fiscal year and subsequent fiscal years.

(C) The department has determined that systems have been programmed to implement this section.

(2) The department shall issue a declaration certifying the date that all conditions in paragraph (1) have been met. The department shall post the declaration on its internet website and provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(l) (1) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, this section shall become operative on January 1, 2025, or the date certified by the department pursuant to paragraph (2) of subdivision (k), whichever is later.

(2) If the voters do not approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, this section shall become operative on January 1, 2026, or the date certified by the department pursuant to paragraph (2) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

(Amended (as added by Stats. 2022, Ch. 738, Sec. 21) by Stats. 2024, Ch. 40, Sec. 80. (SB 159) Effective June 29, 2024. Section conditionally operative on January 1, 2025, or later, as prescribed by its own provisions. Conditionally repealed as prescribed by its own provisions.)

15854. (a) The department, in consultation with other appropriate parties, shall establish the criteria for evaluating an applicant's proposal, which shall include, but not be limited to, the following:

(1) The extent to which the program described in the proposal provides comprehensive coverage, including health, dental, and vision benefits.

(2) Whether the proposal includes a promotional component to notify the public of its provision of health insurance to eligible children.

(3) The simplicity of the proposal's procedures for applying to participate and for determining eligibility for participation in its program.

(4) The extent to which the proposal provides for coordination and conformity with benefits provided through the Medi-Cal program.

(5) The extent to which the proposal provides for coordination and conformity with existing Medi-Cal administrative entities in order to prevent administrative duplication and fragmentation.

(6) The ability of the health care providers designated in the proposal to serve the eligible population and the extent to which the proposal includes traditional and safety net providers, as defined by the department.

(7) The extent to which the proposal intends to work with the school districts and county offices of education.

(8) The total amount of funds available to the applicant to implement the program described in its proposal, and the percentage of this amount proposed for administrative costs as well as the cost to the state to administer the proposal.

(9) The extent to which the proposal seeks to minimize the substitution of private employer health insurance coverage for health benefits provided through a governmental source.

(10) The extent to which local resources may be available after the depletion of federal funds to continue any current program expansions for persons covered under local health care financing programs or for expanded benefits.

(11) For the purposes of defining an applicant's eligibility for funding under this chapter, the following shall apply:

(A) The same income methodology shall be used for the proposed program that is currently used for the Medi-Cal program.

(B) Only participating Medi-Cal managed care plans may be used. However, the department may permit exceptions to this requirement consistent with the purpose, of this chapter.

(b) The department may, in its sole discretion, approve or disapprove projects for funding pursuant to this chapter on an annual basis.

(c) To the extent that an applicant's proposal pursuant to this chapter provides for health plan or administrative services under a contract entered into by the department or at rates negotiated for the applicant by the department, a contract entered into by the department or by an applicant shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of General Services to the same extent as contracts entered into pursuant to subdivision (p) of Section 14005.26. The department and the applicant shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on the projected or actual subscriber enrollments to a total amount not to exceed the amount appropriated for the project, including family contributions, when applicable.

(Amended by Stats. 2022, Ch. 47, Sec. 141. (SB 184) Effective June 30, 2022.)

15854.5. (a) Effective July 1, 2022, to the extent allowable under federal law, and notwithstanding the provisions of this chapter to the contrary, the department may elect not to impose subscriber contributions for purposes of coverage as described in this chapter for an applicable coverage period.

(b) If the department elects to not impose subscriber contributions for an applicable coverage period pursuant to subdivision (a) or elects to reinstate such subscriber contributions for a subsequent coverage period, the department shall specify that election in the published Medi-Cal Local Assistance Estimate for the impacted state fiscal year or years, subject to appropriation by the annual Budget Act.

(Added by Stats. 2022, Ch. 47, Sec. 142. (SB 184) Effective June 30, 2022.)

15855. The department shall review each funding proposal submitted by an applicant in accordance with the criteria described in Section 15854 and based on that criteria, approve or reject the proposal.

(Added by Stats. 2014, Ch. 31, Sec. 89. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15864.)

15856. (a) Upon its approval of a proposal that shall include any allowable amount of federal funds under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.), the department may provide the applicant reimbursement in an amount equal to the amount that the applicant will contribute to implement the program described in its proposal, plus the appropriate and allowable amount of federal funds. Not more than 10 percent of the County Health Initiative Matching Fund and matching federal funds shall be expended in any one fiscal year for administrative costs, including the costs to the state to administer the proposal, unless the department permits the expenditure consistent with the availability of federal matching funds not needed for the purposes described in paragraph (3) of subdivision (a) of Section 15862, or unless the department determines that an expenditure for administrative costs has no impact on available federal funding. The department may audit the expenses incurred by the applicant in implementing its program to ensure that the expenditures comply with the provisions of this chapter. No reimbursement may be made to an applicant that fails to meet its financial participation obligation under this chapter. The state's reasonable startup costs and ongoing costs for administering the program shall be reimbursed by those entities applying for funding.

(b) Any program approved pursuant to subdivision (e) of Section 15853 that requires any funding not allowable for a federal match under Title XXI of the Social Security Act shall provide the department with the total amount of funds needed to provide that portion of coverage not eligible for federal matching funds, including reasonable startup costs and ongoing costs for administering the program.

(c) Each applicant that is provided funds under this chapter shall submit to the department a plan to limit initial and continuing enrollment in its program in the event the amount of moneys for its program is insufficient to maintain health insurance coverage for those participating in the program.

(d) (1) Notwithstanding any other provision of this chapter, the state shall be held harmless, in accordance with paragraphs (2) and (3), from any federal audit disallowance and interest resulting from payments made to a participating applicant pursuant to this section, for the disallowed claim.

(2) To the extent that a federal audit disallowance and interest results from a claim or claims for which any participating applicant has received reimbursement for services rendered or other activities performed, the department shall recoup from the participating

applicant that submitted the disallowed claim, through offsets or by a direct billing, amounts equal to the amount of the disallowance and interest for the disallowed claim. All subsequent claims submitted to the department applicable to any previously disallowed service, activity, or claim may be held in abeyance, with no payment made, until the federal disallowance issue is resolved.

(3) Notwithstanding paragraph (2), to the extent that a federal audit disallowance and interest results from a claim or claims for which the participating applicant has received reimbursement for services rendered or activities performed by an entity under contract with, and on behalf of, the participating applicant, the department shall be held harmless by that particular participating applicant for 100 percent of the amount of the federal audit disallowance and interest for the disallowed claim.

(Added by Stats. 2014, Ch. 31, Sec. 89. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15864.)

15857. Each health care service plan, specialized health care service plan, and health insurer that contracts to provide health care benefits under this chapter shall be licensed by the Department of Managed Health Care or the Department of Insurance, or be a Medi-Cal managed care plan.

(Added by Stats. 2014, Ch. 31, Sec. 89. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15864.)

15858. (a) The department shall administer the provisions of this chapter and may do all of the following:

(1) Administer the expenditure of moneys from the fund.

(2) (A) Issue rules and regulations as necessary.

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this chapter and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature pursuant to Section 9795 of the Government Code on a semiannual basis until regulations have been adopted.

(3) Enter into contracts.

(4) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this chapter.

(Added by Stats. 2014, Ch. 31, Sec. 89. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15864.)

15859. All expenses incurred by the department in administering this chapter, including, but not limited to, expenses for developing standards and processes to implement any of the provisions of this chapter, evaluating applications, or processing or granting appeals growing out of any of the provisions of this chapter, shall be paid from the fund or directly by applicants, except that the department may accept funding from a not-for-profit group or foundation, or from a governmental entity providing grants for health-related activities, to administer this chapter.

(Added by Stats. 2014, Ch. 31, Sec. 89. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15864.)

15860. Nothing in this chapter creates a right or an entitlement to the provision of health insurance coverage or health care benefits. Except as provided in Section 15850.5, no costs shall accrue to the state for the provision of these services. The state shall not be liable beyond the assets of the fund for any obligation incurred or liabilities sustained by applicants in the operation of the fund or of the projects authorized by this chapter.

(Added by Stats. 2014, Ch. 31, Sec. 89. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15864.)

15861. To the extent necessary to obtain federal financial participation for projects approved pursuant to this chapter, the department shall apply for one or more waivers or shall file state plan amendments pursuant to the federal State Children's Health Insurance Program (Subchapter 21 (commencing with Section 1397aa) of Chapter 7 of Title 42 of the United States Code) to allow a county agency, local initiative, or county organized health system to apply for matching funds through the federal State Children's Health Insurance Program (Subchapter 21 (commencing with Section 1397aa) of Chapter 7 of Title 42 of the United States Code) using local funds for the state matching funds.

(Added by Stats. 2014, Ch. 31, Sec. 89. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15864.)

15862. (a) The provisions of this chapter shall be implemented only if all of the following conditions are met:

(1) Federal financial participation is available for this purpose.

(2) Federal participation is approved.

(3) The department determines that federal funds under Title XXI of the Social Security Act remain available after providing funds for all current enrollees and eligible children that are likely to enroll in the optional targeted low-income children group and, to the extent funded through the federal Children's Health Insurance Program (Subchapter 21 (commencing with Section 1397aa) of Chapter 7 of Title 42 of the United States Code), the Medi-Cal Access program and Medi-Cal program, as determined by a Department of Finance estimate.

(4) Funds are appropriated specifically for this purpose.

(b) The department may accept funding necessary for the preparation of the federal waiver applications or state plan amendments described in Section 15861 from a not-for-profit group or foundation, but only to the extent that the funding may be eligible for federal financial participation.

(Amended by Stats. 2015, Ch. 303, Sec. 625. (AB 731) Effective January 1, 2016.)

15863. The state shall be held harmless for any federal disallowance resulting from this chapter and any other expenses or liabilities, including, but not limited to, the cost of processing or granting appeals, unless the department is acting pursuant to Section 15850.5. An applicant receiving supplemental reimbursement pursuant to this chapter shall be liable for any reduced federal financial participation, and any other expenses or liabilities, including, but not limited to, the costs of processing or granting appeals, resulting from the implementation of this chapter with respect to that applicant. The state may recoup any federal disallowance from the applicant for which it can be held harmless.

(Added by Stats. 2014, Ch. 31, Sec. 89. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, pursuant to Section 15864.)

15864. This chapter shall become operative on July 1, 2014.

(Added by Stats. 2014, Ch. 31, Sec. 89. (SB 857) Effective June 20, 2014. Note: This section prescribes a delayed operative date (July 1, 2014) for Chapter 3, commencing with Section 15850.)