WELFARE AND INSTITUTIONS CODE - WIC

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

PART 3.6. Low Income Health Program [15909 - 15916] *(Heading of Part 3.6 amended by Stats. 2011, Ch. 86, Sec. 24.)*

15909. The Legislature finds and declares all of the following:

(a) Pursuant to Section 14180, the Legislature directed the department to apply for a successor federal waiver or demonstration project, in part, to coincide with the end of the waiver described in relevant part in subdivision (b) of Section 15900 to, among other requirements, optimize opportunities to increase federal financial participation and maximize financial resources to address uncompensated care.

(b) Passage of federal health care reform, pursuant to the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), presents new options of federal support for coverage of low-income individuals and significant expansion of state coverage programs in 2014. Through the success of the Health Care Coverage Initiatives established pursuant to Part 3.5 (commencing with Section 15900), and with implementation of a successor federal Medicaid waiver or demonstration project, California is well positioned to develop enrollment and coverage expansion models that will lead the way to full implementation of comprehensive health care reforms in 2014.

(Added by Stats. 2010, Ch. 723, Sec. 2. (AB 342) Effective October 19, 2010.)

15909.1. For purposes of this part, the following definitions shall apply:

(a) “Demonstration project” means a federal waiver or demonstration project described in Section 14180 approved by the federal Centers for Medicare and Medicaid Services that authorizes the implementation of a successor to the Health Care Coverage Initiative under Part 3.5 (commencing with Section 15900).

(b) (1) “Eligible entity” means any of the following:

(A) A county.

(B) A city and county.

(C) A consortium of counties serving a region consisting of more than one county.

(D) A health authority.

(E) A nondesignated public hospital, or the entity with which it is affiliated, if all of the following conditions are met:

(i) The hospital is located in a county that does not have a designated public hospital.

(ii) The county does not intend to operate a LIHP pursuant to Section 15910.5.

(iii) If the county previously filed an application to operate a LIHP, the county has formally withdrawn its application.

(2) For purposes of this section and to the extent allowed under the Special Terms and Conditions of the demonstration project, a County Medical Services Program shall be considered a consortium of counties serving a region consisting of more than one county.

(c) “LIHP” means a local Low Income Health Program authorized pursuant to this part that is comprised of the following populations:

(1) The Medicaid Coverage Expansion (MCE) population, which means low-income individuals 19 to 64 years of age, inclusive, who are not pregnant, have family incomes at or below 133 percent of the federal poverty level, are not eligible for the Medi-Cal program or the Children's Health Insurance Program, are United States citizens, nationals, or have satisfactory immigration status, and meet the county of residence requirements.

(2) The Health Care Coverage Initiative (HCCI) population, which means low-income individuals 19 to 64 years of age, inclusive, who are not pregnant, have family incomes above 133 percent through 200 percent of the federal poverty level, are not eligible for the Medicare Program, the Medi-Cal program, the Children's Health Insurance Program, or other third-party coverage, are United States citizens, nationals, or have satisfactory immigration status, and meet the county of residence requirements.

(d) "Participating entity" means an eligible entity that operates an approved LIHP.

(e) "Designated public hospital" has the same meaning as defined in subdivision (d) of Section 14166.1.

(f) "Nondesignated public hospital" has the same meaning as defined in subdivision (f) of Section 14166.1.

(Amended by Stats. 2012, Ch. 453, Sec. 1. (SB 1081) Effective September 22, 2012.)

15910. (a) Subject to federal approval of a demonstration project effective on or after November 1, 2010, the department shall, by no later than July 1, 2011, authorize local LIHPs to provide scheduled health care services, consistent with the Special Terms and Conditions of the demonstration project, to eligible low-income individuals 19 to 64 years of age, inclusive, who are not otherwise eligible for the Medi-Cal program or the Children's Health Insurance Program, with family incomes at or below 133 percent of the federal poverty level. To the extent federal financial participation is made available under the Special Terms and Conditions of the demonstration project pursuant to Section 15910.1, LIHP health care services may be made available to eligible individuals with family incomes above 133 percent through 200 percent of the federal poverty level.

(b) Eligible entities, consistent with the Special Terms and Conditions of the demonstration project, may perform outreach and enrollment activities to target populations, including, but not limited to, people who are homeless, individuals who frequently use hospital inpatient or emergency department services for avoidable reasons, or people with mental health or substance abuse treatment needs.

(c) The LIHP shall be designed and implemented with the systems and program elements necessary to facilitate the transition of those eligible individuals to Medi-Cal coverage, or alternatively, to coverage through the California Health Benefit Exchange, by 2014, pursuant to state and federal law, and the Special Terms and Conditions of the demonstration project.

(d) The department shall authorize a LIHP that meets the requirements set forth in this part and the Special Terms and Conditions of the demonstration project.

(e) (1) By January 1, 2011, or alternatively, 60 days after federal approval of the demonstration project, whichever occurs later, the department shall notify all eligible entities of the opportunity to elect to implement a LIHP, the applicable requirements, and the process for submitting an application for department approval of a LIHP application.

(2) The director shall approve or deny an eligible entity's LIHP application within 60 days of receipt of the application. If the director denies an application, the denial shall be in writing and shall specify the reasons therefor.

(3) Within 10 days of a denial by the director under this subdivision, a participating entity may submit a written request for reconsideration. The director shall respond in writing to a request for reconsideration within 20 days, confirming or reversing the denial, and specifying the reasons for the reconsidered decision.

(f) If the eligible entity had in operation a Health Care Coverage Initiative program under Part 3.5 (commencing with Section 15900) as of November 1, 2010, and the eligible entity elects to continue funding the program, then the existing Health Care Coverage Initiative program shall, to the extent permitted by the Special Terms and Conditions of the demonstration project, remain in effect and receive federal reimbursement in accordance with the Special Terms and Conditions of the demonstration project until the LIHP is effective, but no later than July 1, 2011.

(g) Health care services provided pursuant to this part shall be available to those eligible, low-income individuals enrolled in the applicable LIHP, subject to the limitations of this part and the Special Terms and Conditions of the demonstration project. However, nothing in this part is intended to create an entitlement program of any kind.

(h) Each LIHP may establish an upper income limit for eligible MCE individuals to enroll in the LIHP, which shall be expressed as a percentage between 0 percent and up to, and including, 133 percent of the federal poverty level. If the LIHP elects to enroll HCCI-eligible individuals with family incomes above 133 percent through 200 percent of the federal poverty level, it may also establish an upper income limit between this range. Notwithstanding any established upper income limit, the LIHP may impose a limit on enrollment in the LIHP, which shall be subject to all of the following provisions:

(1) The Special Terms and Conditions required by the federal Centers for Medicare and Medicaid Services for the approval of the demonstration project described in Section 14180 permit a limitation on enrollment in a LIHP.

(2) Any enrollment limitation by a LIHP shall be administered in accordance with the Special Terms and Conditions required by the federal Centers for Medicare and Medicaid Services.

(3) Any enrollment limitation by a LIHP is subject to approval by the director, and notification to the federal Centers for Medicare and Medicaid Services. A LIHP shall establish an income limit at a level that minimizes the need for imposing a limit on enrollment for the MCE population.

(4) Prior to applying for approval from the director, the LIHP shall submit to the director a resolution from its governing board approving the proposed limitation on enrollment by the LIHP.

(i) LIHPs shall be established and implemented only to the extent that federal financial participation is available and only to the extent that available federal financial participation is not jeopardized.

(j) For the purposes of operating a LIHP approved under this part, and notwithstanding Section 14181, participating entities shall be exempt from the provisions of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, shall not be considered Medi-Cal managed care health plans subject to the requirements applicable to the two-plan model and geographic managed care plans, as contained in Article 2.7 (commencing with Section 14087.3), Article 2.81 (commencing with Section 14087.96), and Article 2.91 (commencing with Section 14089) of Chapter 7 of Part 3 and the corresponding regulations, and shall not be considered prepaid health plans as defined in Section 14251.

(Amended by Stats. 2012, Ch. 162, Sec. 228. (SB 1171) Effective January 1, 2013.)

15910.1. (a) For LIHPs serving HCCI-eligible individuals , subject to federal funding limits or requirements that differ from the requirements for individuals described in subdivision (a) of Section 15910, the department shall, in consultation with participating entities, develop a process for allocating the available federal funding to those approved LIHPs that elect to serve the additional group of individuals identified in this subdivision, if the participating entity voluntarily agrees to provide the nonfederal share of the LIHP expenditures for the additional group.

(b) To the extent permitted by the Special Terms and Conditions of the demonstration project, the allocation of funding under this section shall ensure that a Health Care Coverage Initiative program under Part 3.5 (commencing with Section 15900) as of November 1, 2010, that elects to continue as a participating entity under this part receives, at a minimum, an allocation in an amount adequate to ensure that their existing eligible enrollees can continue to receive services under their LIHP.

(c) If a LIHP elects to serve eligible persons with incomes above 133 percent through 200 percent of the federal poverty level, the LIHP shall also serve eligible persons with incomes up to 133 percent of the federal poverty level.

(d) Section 15910 and Section 15910.2 shall apply with respect to LIHPs funded under this section, as appropriate.

(e) Reimbursements to LIHPs approved under this section shall be made in accordance with Section 15910.3 or through another mechanism authorized under the Special Terms and Conditions for the demonstration project.

(f) The nonfederal share of funding for LIHP expenditures authorized under this section shall be provided in accordance with Section 15911 or through another mechanism authorized by the Special Terms and Conditions of the demonstration project.

(g) Any unused federal funds shall be distributed in accordance with the Special Terms and Conditions of the demonstration project.

(Amended by Stats. 2011, Ch. 86, Sec. 27. (AB 1066) Effective July 15, 2011.)

15910.2. (a) The eligible entity shall meet both of the following requirements and any additional requirements imposed by the Special Terms and Conditions of the demonstration project in order for the department to authorize the LIHP proposed by the eligible entity:

(1) The eligible entity shall voluntarily agree to commit, on an annual basis, to provide the nonfederal share of LIHP expenditures for health care services to eligible individuals for the LIHP.

(2) The LIHP proposed by the eligible entity shall include the LIHP elements set forth in subdivision (b).

(b) The LIHP elements shall include all of the following, subject to the Special Terms and Conditions of the demonstration project:

(1) Development of standardized eligibility and enrollment procedures that interface with Medi-Cal processes by December 31, 2013, according to the milestones developed in consultation with the counties, county health departments, public hospitals, and county human service departments. LIHPs shall migrate to the standardized procedures in accordance with the Special Terms and Conditions of the demonstration project and subdivision (c) of Section 15910.

(2) Eligibility for LIHP benefits may be provided retroactively for any of the three months prior to the enrollment date in which the individual would have been found eligible had he or she applied during that month. If an individual is determined to be retroactively

eligible, LIHP coverage for the retroactive period shall be limited to those services provided within the approved LIHP network or out-of-network emergency services as authorized under the Special Terms and Conditions of the demonstration project.

(3) The LIHP shall perform annual eligibility redeterminations for persons participating in the LIHP to assess if they remain eligible for the LIHP or are eligible for Medi-Cal or the Healthy Families Program.

(4) (A) Assignment of eligible individuals to a medical home. For purposes of this paragraph and subject to the Special Terms and Conditions of the demonstration project, "medical home" means a single provider, facility, or health care team that maintains an individual's medical information, and coordinates health care services for enrolled individuals. The medical home shall provide, at a minimum, all of the following elements, which shall be considered in the contracting process:

(i) A primary health care contact who facilitates the enrollee's access to preventive, primary, specialty, mental health, or chronic illness treatment, as appropriate.

(ii) An intake assessment of each new enrollee's general health status.

(iii) Referrals to qualified professionals, community resources, or other agencies as needed.

(iv) Care coordination for the enrollees across the service delivery system, as agreed to between the medical home and the LIHP. This may include facilitating communication among enrollee's health care providers, including appropriate outreach to mental health providers.

(v) Care management, case management, and transitions among levels of care, if needed and as agreed to between the medical home and the LIHP.

(vi) Use of clinical guidelines and other evidence-based medicine when applicable for treatment of the enrollee's health care issues and timing of clinical preventive services.

(vii) Focus on continuous improvement in quality of care.

(viii) Timely access to qualified health care interpretation as needed and as appropriate for enrollees with limited English proficiency, as determined by applicable federal guidelines.

(ix) Health information, education, and support to beneficiaries and, where appropriate, their families, if and when needed, in a culturally competent manner.

(B) In implementing this section, and the Special Terms and Conditions of the demonstration project, the department may alter the medical home elements described in this paragraph as necessary to secure the increased federal financial participation associated with the provision of medical assistance in conjunction with a health home, as made available under the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and codified in Section 1945 of Title XIX of the federal Social Security Act.

(5) A minimum set of core benefits or services required under the Special Terms and Conditions of the demonstration project that shall be limited to those services provided within an approved LIHP provider network and service delivery system as required under the Special Terms and Conditions of the demonstration project.

(6) A provider network and service delivery system that seeks to promote the viability of the existing safety net health care system that serves the population to be covered by the LIHP. The provider network and service delivery system shall meet the standards established in the Special Terms and Conditions of the demonstration project.

(7) Development of an outreach and enrollment plan that reaches potential project enrollees and begins to prepare to transition eligible individuals to Medi-Cal coverage in 2014, or alternatively, to coverage through the California Health Benefit Exchange.

(8) A quality measurement and quality monitoring system.

(9) Data tracking systems to provide the department with required data for quality monitoring, quality improvement, and evaluation.

(10) Demonstration of how the LIHP will provide consumer assistance to individuals applying for, participating in, or accessing, services in the LIHP, including the availability of materials that provide information on all of the following:

(A) The scope of covered services.

(B) The exceptions, reductions, and limitations that apply to covered services.

(C) Any premium, copayment, or deductible requirements that may be incurred by the enrollee.

(D) The participating providers in the LIHP network.

(E) The medical homes within the LIHP network from which the enrollee may select.

(F) The LIHP telephone number or numbers that may be used by an enrollee to receive additional information about the covered services or participating providers.

(11) Ability to meet program requirements, standards, and performance measurements developed by the department, in consultation with participating entities for the LIHP.

(Amended by Stats. 2011, Ch. 86, Sec. 28. (AB 1066) Effective July 15, 2011.)

15910.3. (a) In consultation with participating entities, the department shall determine actuarially sound per enrollee capitation rates for LIHPs that are adequate and sufficient to ensure access to services for enrollees and to at least cover the projected cost of care. As part of the rate development process, each LIHP shall submit a detailed proposal to the department outlining proposed methodologies and rates that have been certified by county-employed or county-retained actuaries using state and federal Medicaid principles and the standards provided in this section.

(b) Rates determined under this section shall be based on utilization and cost data specific to the enrolled population or comparable data, including where available, project- and county- specific data. In setting actuarially sound rates, the department shall apply appropriate factors to ensure sufficient access to primary and specialty care, and shall take into account the cost of the services specified under the approved LIHP, administrative costs, graduate medical education costs, the utilization and intensity of services expected for LIHP enrollees, and an appropriate case management fee.

(c) The department may include risk corridors to allow for adjustments to rates if the actual cost or utilization of a LIHP exceeds the projected cost.

(d) The department may develop additional payment mechanisms that provide for incentive payments to LIHPs that meet designated performance criteria for quality of and access to care.

(e) The rate shall be determined annually, and shall be effective either the first day of each LIHP year, or another date agreed upon by the participating entity and the department. Rates may be adjusted outside the annual determination process if there is a change in federal or state law or regulation that increases the cost of fulfilling the obligations of a LIHP.

(f) Notwithstanding any other provision of law, payments to LIHPs shall not be limited by an estimate of the reimbursement that would be available for program services if those services were provided to Medi-Cal beneficiaries under the Medi-Cal fee-for-service program.

(g) LIHPs shall be paid actuarially sound rates as determined under this section at the beginning of each quarter based on enrollment. If payments are based on estimated enrollment data, the payments shall be reconciled to actual enrollment on an annual basis.

(Amended by Stats. 2011, Ch. 86, Sec. 29. (AB 1066) Effective July 15, 2011.)

15910.4. As a condition of participation in the voluntary program provided under this part, a LIHP shall comply with Section 14169.7.5.

(Added by Stats. 2011, Ch. 286, Sec. 9. (SB 335) Effective September 16, 2011.)

15910.5. (a) An application to operate a Low Income Health Program (LIHP) by a nondesignated public hospital, pursuant to subparagraph (E) of paragraph (1) of subdivision (b) of Section 15909.1, shall be provided to the county in which the nondesignated public hospital is located at the same time that it is provided to the department. If a county that previously withdrew an application to operate a LIHP does not indicate in writing to the department, within 30 days from the date of application by the nondesignated public hospital, that it rescinds the withdrawal of its application and intends to proceed with its application to implement a LIHP, the department shall consider the application of the nondesignated public hospital to operate the LIHP.

(b) The department shall seek any necessary federal approvals for the implementation of this section. This section shall be implemented only if and to the extent that any necessary federal approvals are obtained.

(Added by Stats. 2012, Ch. 453, Sec. 2. (SB 1081) Effective September 22, 2012.)

15911. (a) Funding for each LIHP shall be based on all of the following:

(1) The amount of funding that the participating entity voluntarily provides for the nonfederal share of LIHP expenditures.

(2) For a LIHP that had in operation a Health Care Coverage Initiative program under Part 3.5 (commencing with Section 15900) as of November 1, 2010, and elects to continue funding the program, the amount of funds requested to ensure that eligible

enrollees continue to receive health care services for persons enrolled in the Health Care Coverage Initiative program as of November 1, 2010.

(3) Any limitations imposed by the Special Terms and Conditions of the demonstration project.

(4) The total allocations requested by participating entities for Health Care Coverage Initiative eligible individuals.

(5) Whether funding under this part would result in the reduction of other payments under the demonstration project.

(b) Nothing in this part shall be construed to require a political subdivision of the state to participate in a LIHP as set forth in this part, and those local funds expended or transferred for the nonfederal share of LIHP expenditures under this part shall be considered voluntary contributions for purposes of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5), as amended by the federal Patient Protection and Affordable Care Act.

(c) No state General Fund moneys shall be used to fund LIHP services, nor to fund any related administrative costs incurred by counties or any other political subdivision of the state.

(d) Subject to the Special Terms and Conditions of the demonstration project, if a participating entity elects to fund the nonfederal share of a LIHP, the nonfederal funding and payments to the LIHP shall be provided through one of the following mechanisms, at the options of the participating entity:

(1) On a quarterly basis, the participating entity shall transfer to the department for deposit in the LIHP Fund established for the participating counties and pursuant to subparagraph (A), the amount necessary to meet the nonfederal share of estimated payments to the LIHP for the next quarter under subdivision (g) Section 15910.3.

(A) The LIHP Fund is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, all moneys in the fund shall be continuously appropriated to the department for the purposes specified in this part. The fund shall contain all moneys deposited into the fund in accordance with this paragraph.

(B) The department shall obtain the related federal financial participation and pay the rates established under Section 15910.3, provided that the intergovernmental transfer is transferred in accordance with the deadlines imposed under the Medi-Cal Checkwrite Schedule, no later than the next available warrant release date. This payment shall be a nondiscretionary obligation of the department, enforceable under a writ of mandate pursuant to Section 1085 of the Code of Civil Procedure. Participating entities may request expedited processing within seven business days of the transfer as made available by the Controller’s office, provided that the participating entity prepay the department for the additional administrative costs associated with the expedited processing.

(C) Total quarterly payment amounts shall be determined in accordance with estimates of the number of enrollees in each rate category, subject to annual reconciliation to final enrollment data.

(2) If a participating entity operates its LIHP through a contract with another entity, the participating entity may pay the operating entity based on the per enrollee rates established under Section 15910.3 on a quarterly basis in accordance with estimates of the number of enrollees in each rate category, subject to annual reconciliation to final enrollment data.

(A) (i) On a quarterly basis, the participating entity shall certify the expenditures made under this paragraph and submit the report of certified public expenditures to the department.

(ii) The department shall report the certified public expenditures of a participating entity under this paragraph on the next available quarterly report as necessary to obtain federal financial participation for the expenditures. The total amount of federal financial participation associated with the participating entity’s expenditures under this paragraph shall be reimbursed to the participating entity.

(B) At the option of the participating entity, the LIHP may be reimbursed on a cost basis in accordance with the methodology applied to Health Care Coverage Initiative programs established under Part 3.5 (commencing with Section 15900) including interim quarterly payments.

(e) Notwithstanding Section 15910.3 and subdivision (d) of this section, if the participating entity cannot reach an agreement with the department as to the appropriate rate to be paid under Section 15910.3, at the option of the participating entity, the LIHP shall be reimbursed on a cost basis in accordance with the methodology applied to Health Care Coverage Initiative programs established under Part 3.5 (commencing with Section 15900), including interim quarterly payments. If the participating entity and the department reach an agreement as to the appropriate rate, the rate shall be applied no earlier than the first day of the LIHP year in which the parties agree to the rate.

(f) If authorized under the Special Terms and Conditions of the demonstration project, pending the department’s development of rates in accordance with Section 15910.3, the department shall make interim quarterly payments to approved LIHPs for

expenditures based on estimated costs submitted for ratesetting.

(g) Participating entities that operate a LIHP directly or through contract with another entity shall be entitled to any federal financial participation available for administrative expenditures incurred in the operation of the Medi-Cal program or the demonstration project, including, but not limited to, outreach, screening and enrollment, program development, data collection, reporting and quality monitoring, and contract administration, but only to the extent that the expenditures are allowable under federal law and only to the extent the expenditures are not taken into account in the determination of the per enrollee rates under Section 15910.3.

(h) On and after January 1, 2014, the state shall implement comprehensive health care reform for the populations targeted by the LIHP in compliance with federal health care reform law, regulation, and policy, including the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and subsequent amendments.

(i) Subject to the Special Terms and Conditions of the demonstration project, a participating entity may elect to include, in collaboration with the department, as the nonfederal share of LIHP expenditures, voluntary intergovernmental transfers or certified public expenditures of another governmental entity, as long as the intergovernmental transfer or certified public expenditure is consistent with federal law.

(j) Participation in the LIHP under this part is voluntary on the part of the eligible entity for purposes of all applicable federal laws. As part of its voluntary participation under this article, the participating entity shall agree to reimburse the state for the nonfederal share of state staffing and administrative costs directly attributable to the cost of administering that LIHP, including, but not limited to, the state administrative costs related to certified public expenditures and intergovernmental transfers. This section shall be implemented only to the extent federal financial participation is not jeopardized.

(Amended by Stats. 2013, Ch. 23, Sec. 69. (AB 82) Effective June 27, 2013.)

15911.1. Upon the order of the Director of Finance, the Controller shall draw warrants against General Fund cash to provide cashflow loans as follows:

(a) The Director of Finance may approve cashflow loans of no more than a total of one hundred million dollars ($100,000,000) in the 2012–13 and 2013–14 fiscal years for County Medical Services Program governing board expenses that are associated with a Low Income Health Program operated by the governing board pursuant to this part.

(b) The terms and conditions of any cashflow loan provided pursuant to this section shall be subject to approval by the Director of Finance. Interest shall be charged at the rate earned by moneys in the Pooled Money Investment Account.

(c) The Department of Finance shall notify the Legislature within 15 days of authorizing a cashflow loan pursuant to this section, unless prior notification of the cashflow loan was included when the Medi-Cal estimates were submitted pursuant to Section 14100.5.

(d) Any cashflow loans made pursuant to this section shall be short term and shall not constitute General Fund expenditures. These loans and the repayment of these loans shall not affect the General Fund reserve.

(Added by Stats. 2012, Ch. 23, Sec. 118. (AB 1467) Effective June 27, 2012.)

15912. (a) Subject to the Special Terms and Conditions of the demonstration project, the department shall ensure that the LIHPs established under this part are evaluated to determine to what extent the projects have met the standards and performance measures described in paragraph (9) of subdivision (b) of Section 15910.2, and the extent to which the LIHPs have complied with the department's program to implement the transition of eligible LIHP enrollees to Medi-Cal coverage, or alternatively, to coverage through the California Health Benefit Exchange, in 2014.

(b) The department may seek federal or private funds or enter into partnership with an independent, nonprofit group or foundation, an academic institution, or a governmental entity providing grants for health-related activities, to evaluate the programs funded under this part.

(Amended by Stats. 2011, Ch. 86, Sec. 31. (AB 1066) Effective July 15, 2011.)

15912.1. (a) The department, in collaboration with the State Department of Public Health, shall develop policies and guidance on the transition of persons diagnosed with HIV/AIDS from federal Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White Act) funded programs, pursuant to Section 131019 of the Health and Safety Code, to the Low Income Health Program (LIHP) pursuant to this part. These policies and guidance shall be provided to local LIHPs, federal Ryan White Act providers, and to persons receiving services pursuant to the federal Ryan White Act, as applicable. Guidance shall include, but not be limited to, operational processes and procedures supporting the transition of persons receiving services pursuant to the federal Ryan White Act in order to minimize disruption of access to and availability of care and services.

(b) The department, in collaboration with the State Department of Public Health, shall consult with stakeholders, including administrators, advocates, providers, and persons receiving services pursuant to the federal Ryan White Act, to obtain advice in

forming the policy decisions regarding the transition of persons receiving services pursuant to the federal Ryan White Act to the local LIHPs.

(c) Notwithstanding any other law, for the purpose of implementing LIHP, pursuant to this part, the State Department of Public Health may share relevant data related to a beneficiary's enrollment in federal Ryan White Act funded programs who may be eligible for LIHP services with the participating entity, as defined in Section 15909.1, operating a LIHP, and the participating entity may share relevant data relating to persons diagnosed with HIV/AIDS with the State Department of Public Health.

(1) The information provided by the State Department of Public Health pursuant to this section shall not be further disclosed by a participating entity, as defined in Section 15909.1, operating a LIHP, except to any of the following:

(A) The person to whom the information pertains or the designated representative of the person.

(B) The health care provider that provides HIV/AIDS care to the person to whom the information pertains.

(C) The Office of AIDS within the State Department of Public Health.

(2) Information shared pursuant to this section is subject to the confidentiality protections of subdivisions (d) and (e) of Section 121025 of the Health and Safety Code.

(Amended by Stats. 2012, Ch. 438, Sec. 29. (AB 1468) Effective September 22, 2012.)

15913. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this part, and the terms and conditions of the demonstration project secured pursuant to subdivision (a) of Section 15910, by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions. Prior to issuing any letter or similar instrument authorized pursuant to this section, the department shall notify and consult with stakeholders, including advocates, providers, and beneficiaries. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

(Added by Stats. 2010, Ch. 723, Sec. 2. (AB 342) Effective October 19, 2010.)

15914. The application process used by the department to authorize entities to operate LIHPs and any agreements entered into by, or modified by, the department for purposes of this part shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

(Amended by Stats. 2011, Ch. 86, Sec. 32. (AB 1066) Effective July 15, 2011.)

15915. In the event of a conflict between a provision of this part and a term or condition of the successor federal waiver or demonstration project pursuant to subdivision (a) of Section 15910, the terms and conditions of the successor federal waiver or demonstration project shall control.

(Added by Stats. 2010, Ch. 723, Sec. 2. (AB 342) Effective October 19, 2010.)

15916. (a) It is the intent of the Legislature that the State Department of Health Care Services and all other departments take all appropriate steps to fully maximize and claim all available expenditures for Designated State Health Programs listed in the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Demonstration under the safety net care pool (SNCP) for an applicable demonstration year.

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

(1) "California's Bridge to Reform Section 1115(a) Demonstration" means the Section 1115(a) Medicaid demonstration project, No. 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services (CMS), effective for the period of November 1, 2010, through October 31, 2015.

(2) "Demonstration year" means a specific period of time during California's Bridge to Reform Section 1115(a) Wavier as identified in the Special Terms and Conditions. "Demonstration year" may be denominated in yearly increments, which correspond with the yearly increments identified in the Special Terms and Conditions.

(3) "Designated public hospital" has the meaning given in subdivision (d) of Section 14166.1.

(4) "Excess certified public expenditures" means the amount of allowable uncompensated care expenditures reported and certified for the applicable demonstration year under Section 14166.8 by designated public hospitals (DPHs), including the governmental entities with which they are affiliated, that is in excess of the amount necessary to draw the maximum amount of federal funding for DPHs for uncompensated care under the safety net care pool and for disproportionate share hospital payments without regard to subdivision (c) or to the amount authorized pursuant to paragraph (5).

(5) “Reserved SNCP funds for DSHP” means the amount of SNCP uncompensated care funds used to fund expenditures for the Designated State Health Programs, as specified in the Special Terms and Conditions of California’s Bridge to Reform Section 1115(a) Demonstration.

(6) “Redirected SNCP funds” means the amount of federal funding available for a specified demonstration year that would otherwise be restricted for expenditures associated with the Health Care Coverage Initiative (HCCI) program, for which there are insufficient HCCI expenditures to draw the federal funds and which CMS has authorized to be available for uncompensated care expenditures under the safety net care pool in either the demonstration year for which the funds were initially reserved or a subsequent demonstration year.

(7) “Safety net care pool” or “SNCP” means the federal funds available under the Medi-Cal Hospital/Uninsured Care Demonstration Project and the successor demonstration project, California’s Bridge to Reform, to ensure continued government support for the provision of health care services to uninsured populations.

(c) Notwithstanding any other provision of law, the state shall annually seek authority from CMS under the Special Terms and Conditions of California’s Bridge to Reform Section 1115(a) Demonstration to redirect to the uncompensated care category within the SNCP the portion of the restricted funds used to fund expenditures under the HCCI that will not be fully utilized by the end of the demonstration year for use in any demonstration year.

(d) Designated public hospitals may utilize the redirected SNCP funds described in subdivision (c) as follows:

(1) Designated public hospitals may opt to utilize excess certified public expenditures to claim the redirected SNCP funds.

(2) As a condition of exercising the option in paragraph (1), DPHs voluntarily agree that, up to the amount of redirected SNCP funds available, the excess certified public expenditures are to be allocated equally between the state and the DPHs, such that for every dollar of excess certified public expenditure used by the DPHs, the DPHs will voluntarily allow the state to use a corresponding excess certified public expenditure amount for claiming purposes.

(3) As a condition of receiving any of the funding in paragraph (2), DPHs voluntarily agree that, to the extent the state is unable to fully claim the maximum annual amount of reserved SNCP funds for DSHP, the excess certified public expenditures will be used to enable the state to receive total SNCP uncompensated care funds, in conjunction with its claims for expenditures for DSHP, to the maximum amount described in paragraph (5) of subdivision (b).

(e) Participation in the utilization of the excess certified public expenditures and redirected SNCP funds under this section is voluntary on the part of the DPHs for the purpose of all applicable federal laws.

(f) The department shall consult with DPH representatives regarding the availability of excess certified public expenditures, how to optimize the level of claimable federal Medicaid funding, and the appropriate allocation of SNCP funds under paragraphs (2) and (3) of subdivision (d). The department may make interim determinations and allocations of such SNCP funds, provided that the interim determinations and allocations take into account adjustments to reported expenditures for possible audit disallowances, consistent with the type of adjustments applied in prior projects years under Article 5.2 (commencing with Section 14166). Any interim determinations and allocations of redirected SNCP funds based on excess certified public expenditures shall be subject to interim and final reconciliations.

(g) Notwithstanding any other provision of law, upon the receipt of a notice of disallowance or deferral from the federal government related to any certified public expenditures for uncompensated care incurred by DPHs that are used for federal claiming under the SNCP pursuant to California’s Bridge to Reform Section 1115(a) Demonstration after this section is implemented, and subject to the processes described in subdivisions (a) through (d) of Section 14166.24, the following shall apply with respect to the disallowance or deferral:

(1) The department and the DPH shall each be responsible for half of the repayment of the federal portion of any federal disallowance or deferral for the applicable demonstration year, up to the amount claimed and allocated pursuant to paragraph (2) of subdivision (d) for that particular year.

(2) If there are additional disallowances or deferrals beyond those described in paragraph (1), the department shall be solely responsible for the repayment of the federal portion of any federal disallowance or deferral for the applicable demonstration year, up to the amount claimed and allocated pursuant to paragraph (3) of subdivision (d) for that particular year.

(3) If there are additional disallowances or deferrals beyond those described in paragraphs (1) and (2) for the applicable demonstration year, the DPH shall be solely responsible for the repayment of the federal portion of all remaining federal disallowances or deferrals for that particular year.

(h) The department shall obtain federal approvals or waivers as necessary to implement this section and to obtain federal financial participation to the maximum extent permitted by federal law. This section shall be implemented only to the extent other federal financial participation is not jeopardized.

(Amended by Stats. 2012, Ch. 23, Sec. 120. (AB 1467) Effective June 27, 2012.)