

ASSEMBLY BILL

No. 1

**Introduced by Assembly Member John A. Pérez
(Coauthor: Assembly Member Pan)**

January 28, 2013

An act to amend Section 12698.30 of the Insurance Code, and to amend Sections 14005.31, 14005.32, 14132, and 15926 of, to amend and repeal Sections 14008.85, 14011.16, and 14011.17 of, to amend, repeal, and add Sections 14005.18, 14005.28, 14005.30, 14005.37, 14007.1, 14007.6, and 14012 of, and to add Sections 14005.60, 14005.62, 14005.63, 14005.64, 14005.65, and 14132.02 to, the Welfare and Institutions Code, relating to health.

LEGISLATIVE COUNSEL'S DIGEST

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

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

This bill would, commencing January 1, 2014, implement various provisions of the federal Patient Protection and Affordable Care Act (Affordable Care Act), as amended, by, among other things, modifying provisions relating to determining eligibility for certain groups. The bill would, in this regard, extend Medi-Cal eligibility to specified adults and would require that income eligibility be determined based on modified adjusted gross income (MAGI), as prescribed. The bill would prohibit the use of an asset or resources test for individuals whose financial eligibility for Medi-Cal is determined based on the application

of MAGI. The bill would also add, commencing January 1, 2014, benefits, services, and coverage included in the essential health benefits package, as adopted by the state and approved by the United States Secretary of Health and Human Services, to the schedule of Medi-Cal benefits.

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

The 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.

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

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

- 1 SECTION 1. The Legislature finds and declares all of the
- 2 following:
- 3 (a) The United States is the only industrialized country in the
- 4 world without a universal health insurance system.
- 5 (b) (1) In 2006, the United States Census reported that 46
- 6 million Americans did not have health insurance.
- 7 (2) In California in 2009, according to the UCLA Center for
- 8 Health Policy Research's "The State of Health Insurance in
- 9 California: Findings from the 2009 California Health Interview
- 10 Survey," 7.1 million Californians were uninsured in 2009,
- 11 amounting to 21.1 percent of nonelderly Californians who had no
- 12 health insurance coverage for all or some of 2009, up nearly 2
- 13 percentage points from 2007.
- 14 (c) On March 23, 2010, President Obama signed the Patient
- 15 Protection and Affordable Care Act (Public Law 111-148), which
- 16 was amended by the Health Care and Education Reconciliation
- 17 Act of 2010 (Public Law 111-152), and together are referred to as
- 18 the Affordable Care Act of 2010 (Affordable Care Act).
- 19 (d) The Affordable Care Act is the culmination of decades of
- 20 movement toward health reform, and is the most fundamental

1 legislative transformation of the United States health care system
2 in 40 years.

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

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

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

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

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

19 12698.30. (a) *At(1) Subject to paragraph (2), at a minimum,*
20 *coverage shall be provided to subscribers during one pregnancy,*
21 *and for 60 days thereafter, and to children less than two years of*
22 *age who were born of a pregnancy covered under this program to*
23 *a woman enrolled in the program before July 1, 2004.*

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

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

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

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

SEC. 3. Section 14005.18 of the Welfare and Institutions Code is amended to read:

14005.18. (a) A woman is eligible, to the extent required by federal law, as though she were pregnant, for all pregnancy-related and postpartum services for a 60-day period beginning on the last day of pregnancy.

For purposes of this section, “postpartum services” means those services provided after childbirth, child delivery, or miscarriage.

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

SEC. 4. Section 14005.18 is added to the Welfare and Institutions Code, to read:

14005.18. (a) To help prevent premature delivery and low birthweights, the leading causes of infant and maternal morbidity and mortality, and to promote women’s overall health, well-being, and financial security and that of their families, it is imperative that pregnant women enrolled in Medi-Cal be provided with all medically necessary services. Therefore, a woman is eligible, to the extent required by federal law, as though she were pregnant, for all pregnancy-related and postpartum services for a 60-day period beginning on the last day of pregnancy and continuing until the end of the month in which the 60th day of postpartum occurs.

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

(1) “Pregnancy-related services” means, at a minimum, all services required under the state plan unless federal approval is granted after January 1, 2014, pursuant to the procedure under the Preamble to the Final Rule at page 17149 of volume 77 of the Federal Register (March 23, 2012) to provide fewer benefits during pregnancy.

(2) “Postpartum services” means those services provided after child birth, child delivery, or miscarriage.

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

SEC. 5. Section 14005.28 of the Welfare and Institutions Code is amended to read:

14005.28. (a) To the extent federal financial participation is available pursuant to an approved state plan amendment, the department shall exercise its option under Section ~~1902(a)(10)(A)(XV)~~ 1902(a)(10)(A)(ii)(XVII) of the federal Social

Security Act (42 U.S.C. Sec. ~~1396a(a)(10)(A)(XV)~~
~~1396a(a)(10)(A)(ii)(XVII)~~ to extend Medi-Cal benefits to
independent foster care adolescents, as defined in Section
~~1905(v)(1)~~ 1905(w)(1) of the federal Social Security Act (42 U.S.C.
Sec. ~~1396d(v)(1)~~ 1396d(w)(1)).

(b) Notwithstanding Chapter 3.5 (commencing with Section
11340) of Part 1 of Division 3 of Title 2 of the Government Code,
and if the state plan amendment described in subdivision (a) is
approved by the federal Health Care Financing Administration,
the department may implement subdivision (a) without taking any
regulatory action and by means of all-county letters or similar
instructions. Thereafter, the department shall adopt regulations in
accordance with the requirements of Chapter 3.5 (commencing
with Section 11340) of Part 1 of Division 3 of Title 2 of the
Government Code.

(c) The department shall implement subdivision (a) on October
1, 2000, but only if, and to the extent that, the department has
obtained all necessary federal approvals.

*(d) The department shall identify and track all former
independent foster care adolescents who, on or after January 1,
2013, lost Medi-Cal coverage as a result of attaining 21 years of
age.*

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

SEC. 6. Section 14005.28 is added to the Welfare and
Institutions Code, to read:

14005.28. (a) Commencing January 1, 2014, and to the extent
federal financial participation is available pursuant to an approved
state plan amendment, the department shall implement Section
1902(a)(10)(A)(i)(IX) of the federal Social Security Act (42 U.S.C.
Sec. 1396a(a)(10)(A)(i)(IX)) to provide Medi-Cal benefits to a
former foster care adolescent until his or her 26th birthday.

(1) A foster care adolescent who was in foster care on his or
her 18th birthday shall be deemed eligible for the benefits provided
pursuant to this section and shall be enrolled to receive these
benefits until his or her 26th birthday without any interruption in
coverage and without requiring a new application.

(2) The department shall develop procedures to identify
individuals who meet the criteria in paragraph (1), including, but

1 not limited to, former foster care adolescents who lost Medi-Cal
2 coverage as a result of attaining 21 years of age, and reenroll them
3 in Medi-Cal.

4 (3) The department shall develop and implement a simplified
5 redetermination form for this program. A recipient qualifying for
6 the benefits extended pursuant to this section shall fill out and
7 return this form only if information previously reported to the
8 department is no longer accurate. Failure to return the form alone
9 will not constitute a basis for termination of Medi-Cal. If the form
10 is returned as undeliverable and the county is otherwise unable to
11 establish contact, the recipient shall remain eligible for
12 fee-for-service Medi-Cal until such time as contact is reestablished
13 or ineligibility is established, and to the extent federal financial
14 participation is available. The department may terminate eligibility
15 if it determines that the recipient is no longer eligible only after
16 ineligibility is established and all due process requirements are
17 met in accordance with state and federal law.

18 (4) This section shall be implemented to the extent that federal
19 financial participation is available, and any necessary federal
20 approvals are obtained.

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

22 SEC. 7. Section 14005.30 of the Welfare and Institutions Code
23 is amended to read:

24 14005.30. (a) (1) To the extent that federal financial
25 participation is available, Medi-Cal benefits under this chapter
26 shall be provided to individuals eligible for services under Section
27 1396u-1 of Title 42 of the United States Code, including any
28 options under Section 1396u-1(b)(2)(C) made available to and
29 exercised by the state.

30 (2) The department shall exercise its option under Section
31 1396u-1(b)(2)(C) of Title 42 of the United States Code to adopt
32 less restrictive income and resource eligibility standards and
33 methodologies to the extent necessary to allow all recipients of
34 benefits under Chapter 2 (commencing with Section 11200) to be
35 eligible for Medi-Cal under paragraph (1).

36 (3) To the extent federal financial participation is available, the
37 department shall exercise its option under Section 1396u-1(b)(2)(C)
38 of Title 42 of the United States Code authorizing the state to
39 disregard all changes in income or assets of a beneficiary until the
40 next annual redetermination under Section 14012. The department

shall implement this paragraph only if, and to the extent that the State Child Health Insurance Program waiver described in Section 12693.755 of the Insurance Code extending Healthy Families Program eligibility to parents and certain other adults is approved and implemented.

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

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

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

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

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement, without taking regulatory action,

subdivisions (a) and (b) of this section by means of an all county letter or similar instruction. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

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

SEC. 8. Section 14005.30 is added to the Welfare and Institutions Code, to read:

14005.30. (a) (1) To the extent that federal financial participation is available, Medi-Cal benefits under this chapter shall be provided to individuals eligible for services under Section 1396u-1 of Title 42 of the United States Code, known as the Section 1931(b) program, including any options under Section 1396u-1(b)(2)(C) made available to and exercised by the state.

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

(b) Commencing January 1, 2014, pursuant to Section 1396a(e)(14)(C) of Title 42 of the United States Code, there shall be no assets test and no deprivation test for any individual under this section.

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

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

SEC. 9. Section 14005.31 of the Welfare and Institutions Code is amended to read:

14005.31. (a) (1) Subject to paragraph (2), for any person whose eligibility for benefits under Section 14005.30 has been determined with a concurrent determination of eligibility for cash aid under Chapter 2 (commencing with Section 11200), loss of eligibility or termination of cash aid under Chapter 2 (commencing with Section 11200) shall not result in a loss of eligibility or termination of benefits under Section 14005.30 absent the existence of a factor that would result in loss of eligibility for benefits under Section 14005.30 for a person whose eligibility under Section 14005.30 was determined without a concurrent determination of eligibility for benefits under Chapter 2 (commencing with Section 11200).

(2) Notwithstanding paragraph (1), a person whose eligibility would otherwise be terminated pursuant to that paragraph shall not have his or her eligibility terminated until the transfer procedures set forth in Section 14005.32 or the redetermination procedures set forth in Section 14005.37 and all due process requirements have been met.

(b) The department, in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers, shall prepare a simple, clear, consumer-friendly notice to be used by the counties, to inform Medi-Cal beneficiaries whose eligibility for cash aid under Chapter 2 (commencing with Section 11200) has ended, but whose eligibility for benefits under Section 14005.30 continues pursuant to subdivision (a), that their benefits will continue. To the extent feasible, the notice shall be sent out at the same time as the notice of discontinuation of cash aid, and shall include all of the following:

(1) A statement that Medi-Cal benefits will continue even though cash aid under the CalWORKs program has been terminated.

(2) A statement that continued receipt of Medi-Cal benefits will not be counted against any time limits in existence for receipt of cash aid under the CalWORKs program.

(3) (A) A statement that the Medi-Cal beneficiary does not need to fill out monthly status reports in order to remain eligible for Medi-Cal, but ~~shall~~ *may* be required to submit a semiannual status report and annual reaffirmation forms. The notice shall remind individuals whose cash aid ended under the CalWORKs program as a result of not submitting a status report that he or she should review his or her circumstances to determine if changes

1 have occurred that should be reported to the Medi-Cal eligibility
2 worker.

3 (B) Commencing January 1, 2014, the semiannual status report
4 requirement shall not be included in the statement described in
5 subparagraph (A).

6 (4) A statement describing the responsibility of the Medi-Cal
7 beneficiary to report to the county, within 10 days, significant
8 changes that may affect eligibility.

9 (5) A telephone number to call for more information.

10 (6) A statement that the Medi-Cal beneficiary's eligibility
11 worker will not change, or, if the case has been reassigned, the
12 new worker's name, address, and telephone number, and the hours
13 during which the county's eligibility workers can be contacted.

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

18 (d) Notwithstanding Chapter 3.5 (commencing with Section
19 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
20 the department shall, without taking any regulatory action,
21 implement this section by means of all county letters or similar
22 instructions. Thereafter, the department shall adopt regulations in
23 accordance with the requirements of Chapter 3.5 (commencing
24 with Section 11340) of Part 1 of Division 3 of Title 2 of the
25 Government Code. Comprehensive implementing instructions
26 shall be issued to the counties no later than March 1, 2001.

27 SEC. 10. Section 14005.32 of the Welfare and Institutions
28 Code is amended to read:

29 14005.32. (a) (1) If the county has evidence clearly
30 demonstrating that a beneficiary is not eligible for benefits under
31 this chapter pursuant to Section 14005.30, but is eligible for
32 benefits under this chapter pursuant to other provisions of law, the
33 county shall transfer the individual to the corresponding Medi-Cal
34 program. Eligibility under Section 14005.30 shall continue until
35 the transfer is complete.

36 (2) The department, in consultation with the counties and
37 representatives of consumers, managed care plans, and Medi-Cal
38 providers, shall prepare a simple, clear, consumer-friendly notice
39 to be used by the counties, to inform beneficiaries that their
40 Medi-Cal benefits have been transferred pursuant to paragraph (1)

1 and to inform them about the program to which they have been
2 transferred. To the extent feasible, the notice shall be issued with
3 the notice of discontinuance from cash aid, and shall include all
4 of the following:

5 (A) A statement that Medi-Cal benefits will continue under
6 another program, even though aid under Chapter 2 (commencing
7 with Section 11200) has been terminated.

8 (B) The name of the program under which benefits will continue,
9 and an explanation of that program.

10 (C) A statement that continued receipt of Medi-Cal benefits will
11 not be counted against any time limits in existence for receipt of
12 cash aid under the CalWORKs program.

13 (D) (i) A statement that the Medi-Cal beneficiary does not need
14 to fill out monthly status reports in order to remain eligible for
15 Medi-Cal, but ~~shall~~ may be required to submit a semiannual status
16 report and annual reaffirmation forms. In addition, if the person
17 or persons to whom the notice is directed has been found eligible
18 for transitional Medi-Cal as described in Section 14005.8 ;
19 ~~14005.81~~, or 14005.85, the statement shall explain the reporting
20 requirements and duration of benefits under those programs, and
21 shall further explain that, at the end of the duration of these
22 benefits, a redetermination, as provided for in Section 14005.37
23 shall be conducted to determine whether benefits are available
24 under any other provision of law.

25 (ii) *Commencing January 1, 2014, the semiannual status report*
26 *requirement shall not be included in the statement described in*
27 *clause (i).*

28 (E) A statement describing the beneficiary's responsibility to
29 report to the county, within 10 days, significant changes that may
30 affect eligibility or share of cost.

31 (F) A telephone number to call for more information.

32 (G) A statement that the beneficiary's eligibility worker will
33 not change, or, if the case has been reassigned, the new worker's
34 name, address, and telephone number, and the hours during which
35 the county's Medi-Cal eligibility workers can be contacted.

36 (b) No later than September 1, 2001, the department shall submit
37 a federal waiver application seeking authority to eliminate the
38 reporting requirements imposed by transitional medicaid under
39 Section 1925 of the federal Social Security Act (Title 42 U.S.C.
40 Sec. 1396r-6).

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

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

SEC. 11. Section 14005.37 of the Welfare and Institutions Code is amended to read:

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

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

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

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

1 and due process rights guaranteed under this division have been
2 met.

3 (e) For purposes of acquiring information necessary to conduct
4 the eligibility determinations described in subdivisions (a) to (d),
5 inclusive, a county shall make every reasonable effort to gather
6 information available to the county that is relevant to the
7 beneficiary's Medi-Cal eligibility prior to contacting the
8 beneficiary. Sources for these efforts shall include, but are not
9 limited to, Medi-Cal, CalWORKs, and CalFresh case files of the
10 beneficiary or of any of his or her immediate family members,
11 which are open or were closed within the last 45 days, and
12 wherever feasible, other sources of relevant information reasonably
13 available to the counties.

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

20 (g) If a county's efforts pursuant to subdivisions (e) and (f) to
21 obtain the information necessary to redetermine eligibility have
22 failed, the county shall send to the beneficiary a form, which shall
23 highlight the information needed to complete the eligibility
24 determination. The county shall not request information or
25 documentation that has been previously provided by the
26 beneficiary, that is not absolutely necessary to complete the
27 eligibility determination, or that is not subject to change. The form
28 shall be accompanied by a simple, clear, consumer-friendly cover
29 letter, which shall explain why the form is necessary, the fact that
30 it is not necessary to be receiving CalWORKs benefits to be
31 receiving Medi-Cal benefits, the fact that receipt of Medi-Cal
32 benefits does not count toward any time limits imposed by the
33 CalWORKs program, the various bases for Medi-Cal eligibility,
34 including disability, and the fact that even persons who are
35 employed can receive Medi-Cal benefits. The cover letter shall
36 include a telephone number to call in order to obtain more
37 information. The form and the cover letter shall be developed by
38 the department in consultation with the counties and representatives
39 of consumers, managed care plans, and Medi-Cal providers. A
40 Medi-Cal beneficiary shall have no less than 20 days from the date

1 the form is mailed pursuant to this subdivision to respond. Except
2 as provided in subdivision (h), failure to respond prior to the end
3 of this 20-day period shall not impact his or her Medi-Cal
4 eligibility.

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

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

19 (j) If, within 20 days of the date of mailing of a form to the
20 Medi-Cal beneficiary pursuant to subdivision (g), the beneficiary
21 submits an incomplete form, the county shall attempt to contact
22 the beneficiary by telephone and in writing to request the necessary
23 information. If the beneficiary does not supply the necessary
24 information to the county within 10 days from the date the county
25 contacts the beneficiary in regard to the incomplete form, a 10-day
26 notice of termination of Medi-Cal eligibility shall be sent.

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

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

38 (m) The department shall, with the counties and representatives
39 of consumers, including those with disabilities, and Medi-Cal
40 providers, develop a timeframe for redetermination of Medi-Cal

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

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

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

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

SEC. 12. Section 14005.37 is added to the Welfare and Institutions Code, to read:

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

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

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

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

(e) (1) For purposes of acquiring information necessary to conduct the eligibility determinations described in subdivisions (a) to (d), inclusive, a county shall gather information available to the county that is relevant to the beneficiary's Medi-Cal eligibility prior to contacting the beneficiary. Sources for these efforts shall include, but are not limited to, Medi-Cal, CalWORKs, and CalFresh case files of the beneficiary or of any of his or her immediate family members, which are open or were closed within the last 45 days, information accessed through any databases accessed by the agency under Sections 435.948, 435.949, and 435.956 of Title 42 of the Code of Federal Regulations, and wherever feasible, other sources of relevant information reasonably available to the counties.

(2) If the county is able to renew eligibility based on such information, the county shall notify the individual of both of the following:

(A) The eligibility determination and basis.

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

(3) The county shall make all reasonable efforts not to send multiple notices during the same time period about eligibility. The

notice of eligibility renewal shall contain other related information such as if the individual is in a new Medi-Cal program.

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

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

(h) If the purpose for a redetermination under this section is a loss of contact with the Medi-Cal beneficiary, as evidenced by the

1 return of mail marked in such a way as to indicate that it could not
2 be delivered to the intended recipient or that there was no
3 forwarding address, a return of the form described in subdivision
4 (g) marked as undeliverable shall result in an immediate notice of
5 action terminating Medi-Cal eligibility.

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

13 (j) If, within 20 days of the date of mailing of a form to the
14 Medi-Cal beneficiary pursuant to subdivision (g), the beneficiary
15 submits an incomplete form, the county shall attempt to contact
16 the beneficiary by telephone, in writing, and other commonly
17 available electronic means, in counties where such electronic
18 communication is available, to request the necessary information.
19 If the beneficiary does not supply the necessary information to the
20 county within 10 days from the date the county contacts the
21 beneficiary in regard to the incomplete form, a 10-day notice of
22 termination of Medi-Cal eligibility shall be sent.

23 (k) (1) Until January 1, 2014, if within 30 days of termination
24 of a Medi-Cal beneficiary's eligibility pursuant to subdivision (h),
25 (i), or (j), the beneficiary submits to the county a completed form,
26 eligibility shall be determined as though the form was submitted
27 in a timely manner and if a beneficiary is found eligible, the
28 termination under subdivision (h), (i), or (j) shall be rescinded.

29 (2) Commencing January 1, 2014, if within 90 days of
30 termination of a Medi-Cal beneficiary's eligibility pursuant to
31 subdivision (h), (i), or (j), the beneficiary submits to the county a
32 completed form, eligibility shall be determined as though the form
33 was submitted in a timely manner and if a beneficiary is found
34 eligible, the termination under subdivision (h), (i), or (j) shall be
35 rescinded.

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

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

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

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

(p) If a county has enough information available to it to renew eligibility with respect to all eligibility criteria, the county shall begin a new 12-month eligibility period.

(q) For individuals determined ineligible for Medi-Cal, the county shall determine eligibility for other state health subsidy programs and comply with the procedures in Section 15926.

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

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

SEC. 13. Section 14005.60 is added to the Welfare and Institutions Code, to read:

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

(b) Persons who qualify under subdivision (a) and are currently enrolled in a Low Income Health Program (LIHP) under California's Bridge to Reform Section 1115(a) Medicaid Demonstration shall be transitioned to the Medi-Cal program under this section in accordance with the transition plan as approved by

1 the federal Centers for Medicare and Medicaid Services. With
2 respect to plan enrollment, a LIHP enrollee shall be all of the
3 following:

4 (1) Notified which Medi-Cal health plan or plans contain his or
5 her existing medical home provider.

6 (2) Notified that he or she can select a health plan that contains
7 his or her existing medical home provider.

8 (3) Provided the opportunity to choose a different health plan
9 if there is more than one plan available in the county where he or
10 she resides.

11 (4) Informed that if he or she does not affirmatively choose a
12 plan or there is only one plan in the county where he or she resides,
13 he or she shall be enrolled into the Medi-Cal managed care plan
14 that contains his or her LIHP medical home provider, if the medical
15 home provider contracts with a Medi-Cal managed care plan.

16 (c) In order to ensure that no persons lose health care coverage
17 in the course of the transition, the department shall require that
18 notices of the January 1, 2014, change be sent to LIHP enrollees
19 upon their LIHP redetermination in 2013 and again at least 90 days
20 prior to the transition. Pursuant to Section 1902(k)(1) and Section
21 1937(b)(1)(D) of the federal Social Security Act (42 U.S.C. Sec.
22 1396a(k)(1); 42 U.S.C. Sec. 1396u-7(b)(1)(D)), the department
23 shall seek approval from the United States Secretary of Health and
24 Human Services to establish a benchmark benefit package that
25 includes the same benefits, services, and coverage that are provided
26 to all other full-scope Medi-Cal enrollees, supplemented by any
27 benefits, services, and coverage included in the essential health
28 benefits package adopted by the state and approved by the United
29 States Secretary of Health and Human Services under Section
30 18022 of Title 42 of the United States Code.

31 SEC. 14. Section 14005.62 is added to the Welfare and
32 Institutions Code, to read:

33 14005.62. Commencing January 1, 2014, the department shall
34 accept an individual's attestation of information and verify
35 information pursuant to Section 15926.2.

36 SEC. 15. Section 14005.63 is added to the Welfare and
37 Institutions Code, to read:

38 14005.63. (a) Commencing January 1, 2014, a person who
39 wishes to apply for a state health subsidy program, as defined in
40 subdivision (a) of Section 15926, shall be allowed to file an

application on his or her own behalf or on behalf of his or her family. The individual also has the right to be accompanied, assisted, and represented in the application and renewal process by an individual or organization of his or her own choice. If the individual for any reason is unable to apply or renew on his or her own behalf, any of the following persons may file the application for the applicant:

- (1) The individual's guardian, conservator, or executor.
- (2) A public agency representative.
- (3) The individual's legal counsel, relative, friend, or other spokesperson of his or her choice.

(b) A person who wishes to challenge a decision concerning his or her eligibility for or receipt of benefits from a state health subsidy program has the right to represent himself or herself or use legal counsel, a relative, a friend, or other spokesperson of his or her choice.

SEC. 16. Section 14005.64 is added to the Welfare and Institutions Code, to read:

14005.64. (a) This section implements Section 1902(e)(14)(C) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(14)(C)) and Section 435.603(g) of Title 42 of the Code of Federal Regulations, which prohibits the use of an assets test for individuals whose income eligibility is determined based on modified adjusted gross income (MAGI), and Section 2002 of the federal Patient Protection and Affordable Care Act (Affordable Care Act) (42 U.S.C. Sec. 1396a(e)(14)(I)) and Section 435.603(d) of Title 42 of the Code of Federal Regulations, which requires a 5-percent income disregard for individuals whose income eligibility is determined based on MAGI.

(b) In the case of individuals whose financial eligibility for Medi-Cal is determined based on the application of MAGI pursuant to Section 435.603 of Title 42 of the Code of Federal Regulations, the eligibility determination shall not include any assets or resources test.

(c) The department shall implement the 5-percent income disregard for individuals whose income eligibility is determined based on MAGI in Section 2002 of the Affordable Care Act (42 U.S.C. Sec. 1396a(e)(14)(I)) and Section 435.603(d) of Title 42 of the Code of Federal Regulations.

(d) The department shall adopt an equivalent income level for each eligibility group whose income level will be converted to MAGI. The equivalent income level shall not be less than the dollar amount of all income exemptions, exclusions, deductions, and disregards in effect on March 23, 2010, plus the existing income level expressed as a percent of the federal poverty level for each eligibility group so as to ensure that the use of MAGI income methodology does not result in populations who would have been eligible under this chapter and Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code losing coverage.

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

SEC. 17. Section 14005.65 is added to the Welfare and Institutions Code, to read:

14005.65. In accordance with the state's options under Section 435.603(h) of Title 42 of the Code of Federal Regulations, the department shall adopt procedures to take into account projected future changes in income and family size, for individuals whose Medi-Cal income eligibility is determined using MAGI-based methods, in order to grant or maintain eligibility for those individuals who may be ineligible or become ineligible if only the current monthly income and family size are considered.

(a) For current beneficiaries whose eligibility has already been approved, the department shall base financial eligibility on projected annual household income for the remainder of the current calendar year if the current monthly income would render the beneficiary ineligible due to fluctuating income.

(b) For applicants, the department shall, in determining the current monthly household income and family size, base an initial determination of eligibility on the projected annual household income and family size for the upcoming year if considering the current monthly income and family size in isolation would render an applicant ineligible.

(c) In the procedures adopted pursuant to this section, the department shall implement a reasonable method to account for a reasonably predictable decrease in income and increase in family size, as evidenced by a history of predictable fluctuations in income or other clear indicia of a future decrease in income and increase in family size. The department shall not assume potential future increases in income or decreases in family size to make an applicant or beneficiary ineligible in the current month.

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

SEC. 18. Section 14007.1 of the Welfare and Institutions Code is amended to read:

14007.1. (a) The department shall adopt regulations for use by the county welfare department in determining whether an applicant is a resident of this state and of the county subject to the requirements of federal law. The regulations shall require that state residency is not established unless the applicant does both of the following.

(1) The applicant produces one of the following:

(A) A recent California rent or mortgage receipt or utility bill in the applicant's name.

(B) A current California motor vehicle driver's license or California Identification Card issued by the California Department of Motor Vehicles in the applicant's name.

(C) A current California motor vehicle registration in the applicant's name.

(D) A document showing that the applicant is employed in this state.

(E) A document showing that the applicant has registered with a public or private employment service in this state.

(F) Evidence that the applicant has enrolled his or her children in a school in this state.

(G) Evidence that the applicant is receiving public assistance in this state.

(H) Evidence of registration to vote in this state.

(2) The applicant declares, under penalty of perjury, that all of the following apply:

(A) The applicant does not own or lease a principal residence outside this state.

(B) The applicant is not receiving public assistance outside this state. As used in this subdivision, "public assistance" does not include unemployment insurance benefits.

(b) A denial of a determination of residency may be appealed in the same manner as any other denial of eligibility. The Administrative Law Judge shall receive any proof of residency offered by the applicant and may inquire into any facts relevant to the question of residency. A determination of residency shall not be granted unless a preponderance of the credible evidence supports the applicant's intent to remain indefinitely in this state.

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

4 SEC. 19. Section 14007.1 is added to the Welfare and
5 Institutions Code, to read:

6 14007.1. (a) An individual 21 years of age or older shall be
7 considered a resident of this state for the purposes of determining
8 his or her eligibility for Medi-Cal benefits if he or she attests that
9 he or she lives in this state and that he or she either intends to reside
10 in this state or has entered this state with a job commitment or to
11 seek employment. The individual shall not be required to have a
12 fixed address or to be currently employed to be considered a
13 resident of this state.

14 (b) (1) An individual under 21 years of age shall be considered
15 a resident of this state for the purposes of determining his or her
16 eligibility for Medi-Cal benefits if he or she satisfies the
17 requirements of subdivision (a), is capable of indicating intent,
18 and is emancipated from his or her parent or parents or is married.

19 (2) An individual under 21 years of age who does not satisfy
20 the requirements of paragraph (1), and who is not living in an
21 institution, not eligible for Medi-Cal based on his or her receipt
22 of assistance under Title IV-E of the federal Social Security Act,
23 and not receiving a state supplementary payment, as defined in
24 Section 435.403(f) of Title 42 of the Code of Federal Regulations,
25 shall be considered a resident of this state for the purposes of
26 determining his or her eligibility for Medi-Cal benefits if he or she
27 lives in this state, whether or not he or she has a fixed address, or
28 his or her parent or parents, or other caretaker, with whom he or
29 she resides satisfies the requirements of subdivision (a).

30 (c) The state of residency for an individual who is incapable of
31 stating intent or who is living in an institution shall be determined
32 in accordance with Section 435.403 of Title 42 of the Code of
33 Federal Regulations.

34 (d) A denial of a determination of residency may be appealed
35 in the same manner as any other denial of eligibility. The
36 administrative law judge shall receive any proof of residency
37 offered by the individual and may inquire into any facts relevant
38 to the question of residency. A determination of residency shall
39 be granted if a preponderance of the credible evidence supports a

1 finding that the individual meets the requirements of either
2 subdivision (a) or (b).

3 (e) This section shall be interpreted in a manner consistent with
4 federal law.

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

6 SEC. 20. Section 14007.6 of the Welfare and Institutions Code
7 is amended to read:

8 14007.6. (a) A recipient who maintains a residence outside of
9 this state for a period of at least two months shall not be eligible
10 for services under this chapter where the county has made inquiry
11 of the recipient pursuant to Section 11100, and where the recipient
12 has not responded to this inquiry by clearly showing that he or she
13 has (1) not established residence elsewhere; and (2) been prevented
14 by illness or other good cause from returning to this state.

15 (b) If a recipient whose services are terminated pursuant to
16 subdivision (a) reapplies for services, services shall be restored
17 provided all other eligibility criteria are met if this individual can
18 prove both of the following:

19 (1) His or her permanent residence is in this state.

20 (2) That residence has not been established in any other state
21 which can be considered to be of a permanent nature.

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

25 SEC. 21. Section 14007.6 is added to the Welfare and
26 Institutions Code, to read:

27 14007.6. (a) A recipient who maintains a residence outside of
28 this state for a period of at least two months shall not be eligible
29 for services under this chapter where the county has made inquiry
30 of the recipient pursuant to Section 11100, and where the recipient
31 has not responded to this inquiry by clearly showing that he or she
32 has (1) not established residence elsewhere; or (2) been prevented
33 by illness or other good cause from returning to this state.

34 (b) If a recipient whose services are terminated pursuant to
35 subdivision (a) reapplies for services, services shall be restored
36 provided all other eligibility criteria are met if this individual can
37 prove both of the following:

38 (1) His or her residence is in this state.

39 (2) That residence has not been established in any other state
40 which can be considered to be of a permanent nature.

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

SEC. 22. Section 14008.85 of the Welfare and Institutions Code is amended to read:

14008.85. (a) To the extent federal financial participation is available, a parent who is the principal wage earner shall be considered an unemployed parent for purposes of establishing eligibility based upon deprivation of a child where any of the following applies:

(1) The parent works less than 100 hours per month as determined pursuant to the rules of the Aid to Families with Dependent Children program as it existed on July 16, 1996, including the rule allowing a temporary excess of hours due to intermittent work.

(2) The total net nonexempt earned income for the family is not more than 100 percent of the federal poverty level as most recently calculated by the federal government. The department may adopt additional deductions to be taken from a family's income.

(3) The parent is considered unemployed under the terms of an existing federal waiver of the 100-hour rule for recipients under the program established by Section 1931(b) of the federal Social Security Act (42 U.S.C. Sec. 1396u-1).

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of an all county letter or similar instruction without taking regulatory action. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

~~(c) This section shall become operative March 1, 2000.~~

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

SEC. 23. Section 14011.16 of the Welfare and Institutions Code is amended to read:

14011.16. (a) Commencing August 1, 2003, the department shall implement a requirement for beneficiaries to file semiannual status reports as part of the department's procedures to ensure that beneficiaries make timely and accurate reports of any change in circumstance that may affect their eligibility. The department shall develop a simplified form to be used for this purpose. The

department shall explore the feasibility of using a form that allows a beneficiary who has not had any changes to so indicate by checking a box and signing and returning the form.

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

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

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

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

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

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

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

SEC. 24. Section 14011.17 of the Welfare and Institutions Code is amended to read:

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

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

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

3 (c) Beneficiaries who have a public guardian.

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

7 (e) Individuals receiving minor consent services.

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

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

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

15 SEC. 25. Section 14012 of the Welfare and Institutions Code
16 is amended to read:

17 14012. (a) Reaffirmation shall be filed annually and may be
18 required at other times in accordance with general standards
19 established by the department.

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

23 SEC. 26. Section 14012 is added to the Welfare and Institutions
24 Code, to read:

25 14012. (a) This section implements Section 435.916(a)(1) of
26 Title 42 of the Code of Federal Regulations, which applies to the
27 eligibility of Medi-Cal beneficiaries whose financial eligibility is
28 determined using modified adjusted gross income (MAGI) based
29 income.

30 (b) To the extent required by federal law or regulations, the
31 eligibility of Medi-Cal beneficiaries whose financial eligibility is
32 determined using a MAGI-based income shall be renewed once
33 every 12 months, and no more frequently than every 12 months.

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

35 SEC. 27. Section 14132 of the Welfare and Institutions Code
36 is amended to read:

37 14132. The following is the schedule of benefits under this
38 chapter:

39 (a) Outpatient services are covered as follows:

1 Physician, hospital or clinic outpatient, surgical center,
2 respiratory care, optometric, chiropractic, psychology, podiatric,
3 occupational therapy, physical therapy, speech therapy, audiology,
4 acupuncture to the extent federal matching funds are provided for
5 acupuncture, and services of persons rendering treatment by prayer
6 or healing by spiritual means in the practice of any church or
7 religious denomination insofar as these can be encompassed by
8 federal participation under an approved plan, subject to utilization
9 controls.

10 (b) (1) Inpatient hospital services, including, but not limited
11 to, physician and podiatric services, physical therapy and
12 occupational therapy, are covered subject to utilization controls.

13 (2) For Medi-Cal fee-for-service beneficiaries, emergency
14 services and care that are necessary for the treatment of an
15 emergency medical condition and medical care directly related to
16 the emergency medical condition. This paragraph shall not be
17 construed to change the obligation of Medi-Cal managed care
18 plans to provide emergency services and care. For the purposes of
19 this paragraph, “emergency services and care” and “emergency
20 medical condition” shall have the same meanings as those terms
21 are defined in Section 1317.1 of the Health and Safety Code.

22 (c) Nursing facility services, subacute care services, and services
23 provided by any category of intermediate care facility for the
24 developmentally disabled, including podiatry, physician, nurse
25 practitioner services, and prescribed drugs, as described in
26 subdivision (d), are covered subject to utilization controls.
27 Respiratory care, physical therapy, occupational therapy, speech
28 therapy, and audiology services for patients in nursing facilities
29 and any category of intermediate care facility for the
30 developmentally disabled are covered subject to utilization controls.

31 (d) (1) Purchase of prescribed drugs is covered subject to the
32 Medi-Cal List of Contract Drugs and utilization controls.

33 (2) Purchase of drugs used to treat erectile dysfunction or any
34 off-label uses of those drugs are covered only to the extent that
35 federal financial participation is available.

36 (3) (A) To the extent required by federal law, the purchase of
37 outpatient prescribed drugs, for which the prescription is executed
38 by a prescriber in written, nonelectronic form on or after April 1,
39 2008, is covered only when executed on a tamper resistant
40 prescription form. The implementation of this paragraph shall

1 conform to the guidance issued by the federal Centers of Medicare
2 and Medicaid Services but shall not conflict with state statutes on
3 the characteristics of tamper resistant prescriptions for controlled
4 substances, including Section 11162.1 of the Health and Safety
5 Code. The department shall provide providers and beneficiaries
6 with as much flexibility in implementing these rules as allowed
7 by the federal government. The department shall notify and consult
8 with appropriate stakeholders in implementing, interpreting, or
9 making specific this paragraph.

10 (B) Notwithstanding Chapter 3.5 (commencing with Section
11 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
12 the department may take the actions specified in subparagraph (A)
13 by means of a provider bulletin or notice, policy letter, or other
14 similar instructions without taking regulatory action.

15 (4) (A) (i) For the purposes of this paragraph, nonlegend has
16 the same meaning as defined in subdivision (a) of Section
17 14105.45.

18 (ii) Nonlegend acetaminophen-containing products, with the
19 exception of children's acetaminophen-containing products,
20 selected by the department are not covered benefits.

21 (iii) Nonlegend cough and cold products selected by the
22 department are not covered benefits. This clause shall be
23 implemented on the first day of the first calendar month following
24 90 days after the effective date of the act that added this clause,
25 or on the first day of the first calendar month following 60 days
26 after the date the department secures all necessary federal approvals
27 to implement this section, whichever is later.

28 (iv) Beneficiaries under the Early and Periodic Screening,
29 Diagnosis, and Treatment Program shall be exempt from clauses
30 (ii) and (iii).

31 (B) Notwithstanding Chapter 3.5 (commencing with Section
32 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
33 the department may take the actions specified in subparagraph (A)
34 by means of a provider bulletin or notice, policy letter, or other
35 similar instruction without taking regulatory action.

36 (e) Outpatient dialysis services and home hemodialysis services,
37 including physician services, medical supplies, drugs and
38 equipment required for dialysis, are covered, subject to utilization
39 controls.

(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetist services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and X-ray services are covered, subject to utilization controls. Nothing in this subdivision shall be construed to require prior authorization for anesthesiologist services provided as part of an outpatient medical procedure or for portable X-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses which are lost or destroyed due to circumstances beyond the beneficiary's control. Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions that preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children Services Program.

(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:

(A) Periodontal treatment is not a benefit.

(B) Endodontic therapy is not a benefit except for vital pulpotomy.

(C) Laboratory processed crowns are not a benefit.

(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.

(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

(F) Notwithstanding the conditions specified in subparagraphs (A) to (E), inclusive, the department may approve services for persons with special medical disorders subject to utilization review.

(3) Paragraph (2) shall become inoperative July 1, 1995.

(i) Medical transportation is covered, subject to utilization controls.

(j) Home health care services are covered, subject to utilization controls.

(k) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated, is covered subject to utilization controls. When there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.

Therapeutic shoes and inserts are covered when provided to beneficiaries with a diagnosis of diabetes, subject to utilization controls, to the extent that federal financial participation is available.

(l) Hearing aids are covered, subject to utilization controls. Utilization controls shall allow replacement of hearing aids necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls shall allow the replacement of durable medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary's control. The utilization controls shall allow authorization of durable medical equipment needed to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian, subject to the availability of federal financial participation. The department shall adopt emergency

1 regulations to define and establish criteria for assistive durable
2 medical equipment in accordance with the rulemaking provisions
3 of the Administrative Procedure Act (Chapter 3.5 (commencing
4 with Section 11340) of Part 1 of Division 3 of Title 2 of the
5 Government Code).

6 (n) Family planning services are covered, subject to utilization
7 controls.

8 (o) Inpatient intensive rehabilitation hospital services, including
9 respiratory rehabilitation services, in a general acute care hospital
10 are covered, subject to utilization controls, when either of the
11 following criteria are met:

12 (1) A patient with a permanent disability or severe impairment
13 requires an inpatient intensive rehabilitation hospital program as
14 described in Section 14064 to develop function beyond the limited
15 amount that would occur in the normal course of recovery.

16 (2) A patient with a chronic or progressive disease requires an
17 inpatient intensive rehabilitation hospital program as described in
18 Section 14064 to maintain the patient's present functional level as
19 long as possible.

20 (p) (1) Adult day health care is covered in accordance with
21 Chapter 8.7 (commencing with Section 14520).

22 (2) Commencing 30 days after the effective date of the act that
23 added this paragraph, and notwithstanding the number of days
24 previously approved through a treatment authorization request,
25 adult day health care is covered for a maximum of three days per
26 week.

27 (3) As provided in accordance with paragraph (4), adult day
28 health care is covered for a maximum of five days per week.

29 (4) As of the date that the director makes the declaration
30 described in subdivision (g) of Section 14525.1, paragraph (2)
31 shall become inoperative and paragraph (3) shall become operative.

32 (q) (1) Application of fluoride, or other appropriate fluoride
33 treatment as defined by the department, other prophylaxis treatment
34 for children 17 years of age and under, are covered.

35 (2) All dental hygiene services provided by a registered dental
36 hygienist in alternative practice pursuant to Sections 1768 and
37 1770 of the Business and Professions Code may be covered as
38 long as they are within the scope of Denti-Cal benefits and they
39 are necessary services provided by a registered dental hygienist
40 in alternative practice.

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of Section 1482 of the article.

(2) All providers enrolled under this subdivision shall satisfy all applicable statutory and regulatory requirements for becoming a Medi-Cal provider.

(3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.

(s) In-home medical care services are covered when medically appropriate and subject to utilization controls, for beneficiaries who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be provided to patients placed in shared or congregate living arrangements, if a home setting is not medically appropriate or available to the beneficiary. As used in this section, “in-home medical care service” includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

As used in this subdivision, in-home medical care services, include, but are not limited to:

- (1) Level of care and cost of care evaluations.
- (2) Expenses, directly attributable to home care activities, for materials.
- (3) Physician fees for home visits.
- (4) Expenses directly attributable to home care activities for shelter and modification to shelter.
- (5) Expenses directly attributable to additional costs of special diets, including tube feeding.
- (6) Medically related personal services.
- (7) Home nursing education.
- (8) Emergency maintenance repair.

1 (9) Home health agency personnel benefits which permit
2 coverage of care during periods when regular personnel are on
3 vacation or using sick leave.

4 (10) All services needed to maintain antiseptic conditions at
5 stoma or shunt sites on the body.

6 (11) Emergency and nonemergency medical transportation.

7 (12) Medical supplies.

8 (13) Medical equipment, including, but not limited to, scales,
9 gurneys, and equipment racks suitable for paralyzed patients.

10 (14) Utility use directly attributable to the requirements of home
11 care activities which are in addition to normal utility use.

12 (15) Special drugs and medications.

13 (16) Home health agency supervision of visiting staff which is
14 medically necessary, but not included in the home health agency
15 rate.

16 (17) Therapy services.

17 (18) Household appliances and household utensil costs directly
18 attributable to home care activities.

19 (19) Modification of medical equipment for home use.

20 (20) Training and orientation for use of life-support systems,
21 including, but not limited to, support of respiratory functions.

22 (21) Respiratory care practitioner services as defined in Sections
23 3702 and 3703 of the Business and Professions Code, subject to
24 prescription by a physician and surgeon.

25 Beneficiaries receiving in-home medical care services are entitled
26 to the full range of services within the Medi-Cal scope of benefits
27 as defined by this section, subject to medical necessity and
28 applicable utilization control. Services provided pursuant to this
29 subdivision, which are not otherwise included in the Medi-Cal
30 schedule of benefits, shall be available only to the extent that
31 federal financial participation for these services is available in
32 accordance with a home- and community-based services waiver.

33 (t) Home- and community-based services approved by the
34 United States Department of Health and Human Services may be
35 covered to the extent that federal financial participation is available
36 for those services under waivers granted in accordance with Section
37 1396n of Title 42 of the United States Code. The director may
38 seek waivers for any or all home- and community-based services
39 approvable under Section 1396n of Title 42 of the United States

1 Code. Coverage for those services shall be limited by the terms,
2 conditions, and duration of the federal waivers.

3 (u) Comprehensive perinatal services, as provided through an
4 agreement with a health care provider designated in Section
5 14134.5 and meeting the standards developed by the department
6 pursuant to Section 14134.5, subject to utilization controls.

7 The department shall seek any federal waivers necessary to
8 implement the provisions of this subdivision. The provisions for
9 which appropriate federal waivers cannot be obtained shall not be
10 implemented. Provisions for which waivers are obtained or for
11 which waivers are not required shall be implemented
12 notwithstanding any inability to obtain federal waivers for the
13 other provisions. No provision of this subdivision shall be
14 implemented unless matching funds from Subchapter XIX
15 (commencing with Section 1396) of Chapter 7 of Title 42 of the
16 United States Code are available.

17 (v) Early and periodic screening, diagnosis, and treatment for
18 any individual under 21 years of age is covered, consistent with
19 the requirements of Subchapter XIX (commencing with Section
20 1396) of Chapter 7 of Title 42 of the United States Code.

21 (w) Hospice service which is Medicare-certified hospice service
22 is covered, subject to utilization controls. Coverage shall be
23 available only to the extent that no additional net program costs
24 are incurred.

25 (x) When a claim for treatment provided to a beneficiary
26 includes both services which are authorized and reimbursable
27 under this chapter, and services which are not reimbursable under
28 this chapter, that portion of the claim for the treatment and services
29 authorized and reimbursable under this chapter shall be payable.

30 (y) Home- and community-based services approved by the
31 United States Department of Health and Human Services for
32 beneficiaries with a diagnosis of AIDS or ARC, who require
33 intermediate care or a higher level of care.

34 Services provided pursuant to a waiver obtained from the
35 Secretary of the United States Department of Health and Human
36 Services pursuant to this subdivision, and which are not otherwise
37 included in the Medi-Cal schedule of benefits, shall be available
38 only to the extent that federal financial participation for these
39 services is available in accordance with the waiver, and subject to
40 the terms, conditions, and duration of the waiver. These services

shall be provided to individual beneficiaries in accordance with the client's needs as identified in the plan of care, and subject to medical necessity and applicable utilization control.

The director may under this section contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to eligible beneficiaries. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract Code.

(z) Respiratory care when provided in organized health care systems as defined in Section 3701 of the Business and Professions Code, and as an in-home medical service as outlined in subdivision (s).

(aa) (1) There is hereby established in the department, a program to provide comprehensive clinical family planning services to any person who has a family income at or below 200 percent of the federal poverty level, as revised annually, and who is eligible to receive these services pursuant to the waiver identified in paragraph (2). This program shall be known as the Family Planning, Access, Care, and Treatment (Family PACT) Program.

(2) The department shall seek a waiver in accordance with Section 1315 of Title 42 of the United States Code, or a state plan amendment adopted in accordance with Section ~~1396a(a)(10)(A)(ii)(XXI)(ii)(2)~~ *1396a(a)(10)(A)(ii)(XXI)* of Title 42 of the United States Code, which was added to Section 1396a of Title 42 of the United States Code by Section 2303(a)(2) of the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), for a program to provide comprehensive clinical family planning services as described in paragraph (8). Under the waiver, the program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. Under the state plan amendment, which shall replace the waiver and shall be known as the Family PACT successor state plan amendment, the program shall be operated only in accordance with this subdivision and the statutes and regulations in paragraph (4). The state shall use the standards and processes imposed by the state on January 1, 2007, including the application of an eligibility discount factor to the extent required by the federal Centers for Medicare and Medicaid Services, for purposes of determining eligibility as permitted under Section

1 ~~1396a(a)(10)(A)(ii)(XXI)(ii)(2)~~ 1396a(a)(10)(A)(ii)(XXI) of Title
2 42 of the United States Code. To the extent that federal financial
3 participation is available, the program shall continue to conduct
4 education, outreach, enrollment, service delivery, and evaluation
5 services as specified under the waiver. The services shall be
6 provided under the program only if the waiver and, when
7 applicable, the successor state plan amendment are approved by
8 the federal Centers for Medicare and Medicaid Services and only
9 to the extent that federal financial participation is available for the
10 services. Nothing in this section shall prohibit the department from
11 seeking the Family PACT successor state plan amendment during
12 the operation of the waiver.

13 (3) Solely for the purposes of the waiver or Family PACT
14 successor state plan amendment and notwithstanding any other
15 provision of law, the collection and use of an individual's social
16 security number shall be necessary only to the extent required by
17 federal law.

18 (4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005,
19 and 24013, and any regulations adopted under these statutes shall
20 apply to the program provided for under this subdivision. No other
21 provision of law under the Medi-Cal program or the State-Only
22 Family Planning Program shall apply to the program provided for
23 under this subdivision.

24 (5) Notwithstanding Chapter 3.5 (commencing with Section
25 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
26 the department may implement, without taking regulatory action,
27 the provisions of the waiver after its approval by the federal Health
28 Care Financing Administration and the provisions of this section
29 by means of an all-county letter or similar instruction to providers.
30 Thereafter, the department shall adopt regulations to implement
31 this section and the approved waiver in accordance with the
32 requirements of Chapter 3.5 (commencing with Section 11340) of
33 Part 1 of Division 3 of Title 2 of the Government Code. Beginning
34 six months after the effective date of the act adding this
35 subdivision, the department shall provide a status report to the
36 Legislature on a semiannual basis until regulations have been
37 adopted.

38 (6) In the event that the Department of Finance determines that
39 the program operated under the authority of the waiver described
40 in paragraph (2) or the Family PACT successor state plan

1 amendment is no longer cost effective, this subdivision shall
2 become inoperative on the first day of the first month following
3 the issuance of a 30-day notification of that determination in
4 writing by the Department of Finance to the chairperson in each
5 house that considers appropriations, the chairpersons of the
6 committees, and the appropriate subcommittees in each house that
7 considers the State Budget, and the Chairperson of the Joint
8 Legislative Budget Committee.

9 (7) If this subdivision ceases to be operative, all persons who
10 have received or are eligible to receive comprehensive clinical
11 family planning services pursuant to the waiver described in
12 paragraph (2) shall receive family planning services under the
13 Medi-Cal program pursuant to subdivision (n) if they are otherwise
14 eligible for Medi-Cal with no share of cost, or shall receive
15 comprehensive clinical family planning services under the program
16 established in Division 24 (commencing with Section 24000) either
17 if they are eligible for Medi-Cal with a share of cost or if they are
18 otherwise eligible under Section 24003.

19 (8) For purposes of this subdivision, “comprehensive clinical
20 family planning services” means the process of establishing
21 objectives for the number and spacing of children, and selecting
22 the means by which those objectives may be achieved. These
23 means include a broad range of acceptable and effective methods
24 and services to limit or enhance fertility, including contraceptive
25 methods, federal Food and Drug Administration approved
26 contraceptive drugs, devices, and supplies, natural family planning,
27 abstinence methods, and basic, limited fertility management.
28 Comprehensive clinical family planning services include, but are
29 not limited to, preconception counseling, maternal and fetal health
30 counseling, general reproductive health care, including diagnosis
31 and treatment of infections and conditions, including cancer, that
32 threaten reproductive capability, medical family planning treatment
33 and procedures, including supplies and followup, and
34 informational, counseling, and educational services.
35 Comprehensive clinical family planning services shall not include
36 abortion, pregnancy testing solely for the purposes of referral for
37 abortion or services ancillary to abortions, or pregnancy care that
38 is not incident to the diagnosis of pregnancy. Comprehensive
39 clinical family planning services shall be subject to utilization
40 control and include all of the following:

1 (A) Family planning related services and male and female
2 sterilization. Family planning services for men and women shall
3 include emergency services and services for complications directly
4 related to the contraceptive method, federal Food and Drug
5 Administration approved contraceptive drugs, devices, and
6 supplies, and followup, consultation, and referral services, as
7 indicated, which may require treatment authorization requests.

8 (B) All United States Department of Agriculture, federal Food
9 and Drug Administration approved contraceptive drugs, devices,
10 and supplies that are in keeping with current standards of practice
11 and from which the individual may choose.

12 (C) Culturally and linguistically appropriate health education
13 and counseling services, including informed consent, that include
14 all of the following:

- 15 (i) Psychosocial and medical aspects of contraception.
- 16 (ii) Sexuality.
- 17 (iii) Fertility.
- 18 (iv) Pregnancy.
- 19 (v) Parenthood.
- 20 (vi) Infertility.
- 21 (vii) Reproductive health care.
- 22 (viii) Preconception and nutrition counseling.
- 23 (ix) Prevention and treatment of sexually transmitted infection.
- 24 (x) Use of contraceptive methods, federal Food and Drug
25 Administration approved contraceptive drugs, devices, and
26 supplies.
- 27 (xi) Possible contraceptive consequences and followup.
- 28 (xii) Interpersonal communication and negotiation of
29 relationships to assist individuals and couples in effective
30 contraceptive method use and planning families.

31 (D) A comprehensive health history, updated at the next periodic
32 visit (between 11 and 24 months after initial examination) that
33 includes a complete obstetrical history, gynecological history,
34 contraceptive history, personal medical history, health risk factors,
35 and family health history, including genetic or hereditary
36 conditions.

37 (E) A complete physical examination on initial and subsequent
38 periodic visits.

1 (F) Services, drugs, devices, and supplies deemed by the federal
2 Centers for Medicare and Medicaid Services to be appropriate for
3 inclusion in the program.

4 (9) In order to maximize the availability of federal financial
5 participation under this subdivision, the director shall have the
6 discretion to implement the Family PACT successor state plan
7 amendment retroactively to July 1, 2010.

8 (ab) (1) Purchase of prescribed enteral nutrition products is
9 covered, subject to the Medi-Cal list of enteral nutrition products
10 and utilization controls.

11 (2) Purchase of enteral nutrition products is limited to those
12 products to be administered through a feeding tube, including, but
13 not limited to, a gastric, nasogastric, or jejunostomy tube.
14 Beneficiaries under the Early and Periodic Screening, Diagnosis,
15 and Treatment Program shall be exempt from this paragraph.

16 (3) Notwithstanding paragraph (2), the department may deem
17 an enteral nutrition product, not administered through a feeding
18 tube, including, but not limited to, a gastric, nasogastric, or
19 jejunostomy tube, a benefit for patients with diagnoses, including,
20 but not limited to, malabsorption and inborn errors of metabolism,
21 if the product has been shown to be neither investigational nor
22 experimental when used as part of a therapeutic regimen to prevent
23 serious disability or death.

24 (4) Notwithstanding Chapter 3.5 (commencing with Section
25 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
26 the department may implement the amendments to this subdivision
27 made by the act that added this paragraph by means of all-county
28 letters, provider bulletins, or similar instructions, without taking
29 regulatory action.

30 (5) The amendments made to this subdivision by the act that
31 added this paragraph shall be implemented June 1, 2011, or on the
32 first day of the first calendar month following 60 days after the
33 date the department secures all necessary federal approvals to
34 implement this section, whichever is later.

35 (ac) Diabetic testing supplies are covered when provided by a
36 pharmacy, subject to utilization controls.

37 (ad) *Commencing January 1, 2014, any benefits, services, and*
38 *coverage not otherwise described in this section that are included*
39 *in the essential health benefits package adopted by the state and*

1 *approved by the United States Secretary of Health and Human*
2 *Services under Section 18022 of Title 42 of the United States Code.*

3 SEC. 28. Section 14132.02 is added to the Welfare and
4 Institutions Code, to read:

5 14132.02. (a) Pursuant to Sections 1902(k)(1) and
6 1937(b)(1)(D) of the federal Social Security Act (42 U.S.C. Sec.
7 1396a(k)(1); 42 U.S.C. Sec. 1396u-7(b)(1)(D)), the department
8 shall seek approval from the United States Secretary of Health and
9 Human Services to establish a benchmark benefit package that
10 includes the same benefits, services, and coverage as is provided
11 to all other full-scope Medi-Cal enrollees, supplemented by any
12 benefits, services, and coverage included in the essential health
13 benefits package adopted by the state and approved by the secretary
14 under Section 18022 of Title 42 of the United States Code.

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

16 SEC. 29. Section 15926 of the Welfare and Institutions Code
17 is amended to read:

18 15926. (a) The following definitions apply for purposes of
19 this part:

20 (1) "Accessible" means in compliance with Section 11135 of
21 the Government Code, Section 1557 of the PPACA, and regulations
22 or guidance adopted pursuant to these statutes.

23 (2) "Limited-English-proficient" means not speaking English
24 as one's primary language and having a limited ability to read,
25 speak, write, or understand English.

26 (3) "State health subsidy programs" means the programs
27 described in Section 1413(e) of the PPACA.

28 (b) An individual shall have the option to apply for state health
29 subsidy programs in person, by mail, online, by telephone, or by
30 other commonly available electronic means.

31 (c) (1) A single, accessible, standardized paper, electronic, and
32 telephone application for state health subsidy programs shall be
33 developed by the department in consultation with MRMIB and
34 the board governing the Exchange as part of the stakeholder process
35 described in subdivision (b) of Section 15925. The application
36 shall be used by all entities authorized to make an eligibility
37 determination for any of the state health subsidy programs and by
38 their agents.

39 (2) The application shall be tested and operational by the date
40 as required by the federal Secretary of Health and Human Services.

(3) The application form shall, to the extent not inconsistent with federal statutes, regulations, and guidance, satisfy all of the following criteria:

(A) The form shall include simple, user-friendly language and instructions.

(B) The form may not ask for information related to a nonapplicant that is not necessary to determine eligibility in the applicant's particular circumstances.

(C) The form may require only information necessary to support the eligibility and enrollment processes for state health subsidy programs.

(D) The form may be used for, but shall not be limited to, screening.

(E) The form may ask, or be used otherwise to identify, if the mother of an infant applicant under one year of age had coverage through a state health subsidy program for the infant's birth, for the purpose of automatically enrolling the infant into the applicable program without the family having to complete the application process for the infant.

(F) The form may include questions that are voluntary for applicants to answer regarding demographic data categories, including race, ethnicity, primary language, disability status, and other categories recognized by the federal Secretary of Health and Human Services under Section 4302 of the PPACA.

(d) Nothing in this section shall preclude the use of a provider-based application form or enrollment procedures for state health subsidy programs or other health programs that differs from the application form described in subdivision (c), and related enrollment procedures.

(e) The entity making the eligibility determination shall grant eligibility immediately whenever possible and with the consent of the applicant in accordance with the state and federal rules governing state health subsidy programs.

(f) (1) If the eligibility, enrollment, and retention system has the ability to prepopulate an application form for insurance affordability programs with personal information from available electronic databases, an applicant shall be given the option, with his or her informed consent, to have the application form prepopulated. Before a prepopulated renewal form or, if available, prepopulated application is submitted to the entity authorized to

1 make eligibility determinations, the individual shall be given the
2 opportunity to provide additional eligibility information and to
3 correct any information retrieved from a database.

4 (2) All state health subsidy programs ~~may~~ *shall* accept
5 self-attestation, instead of requiring an individual to produce a
6 document, ~~with respect to all information for age, date of birth,~~
7 *family size, household income, state residence, pregnancy, and*
8 *any other applicable criteria* needed to determine the eligibility
9 of an applicant or recipient, to the extent permitted by state and
10 federal law.

11 (3) An applicant or recipient shall have his or her information
12 electronically verified in the manner required by the PPACA and
13 implementing federal regulations and guidance.

14 (4) Before an eligibility determination is made, the individual
15 shall be given the opportunity to provide additional eligibility
16 information and to correct information.

17 (5) The eligibility of an applicant shall not be delayed or denied
18 for any state health subsidy program unless the applicant is given
19 a reasonable opportunity, of at least the kind provided for under
20 the Medi-Cal program pursuant to Section 14007.5 and paragraph
21 (7) of subdivision (e) of Section 14011.2, to resolve discrepancies
22 concerning any information provided by a verifying entity.

23 (6) To the extent federal financial participation is available, an
24 applicant shall be provided benefits in accordance with the rules
25 of the state health subsidy program, as implemented in federal
26 regulations and guidance, for which he or she otherwise qualifies
27 until a determination is made that he or she is not eligible and all
28 applicable notices have been provided. Nothing in this section
29 shall be interpreted to grant presumptive eligibility if it is not
30 otherwise required by state law, and, if so required, then only to
31 the extent permitted by federal law.

32 (g) The eligibility, enrollment, and retention system shall offer
33 an applicant and recipient assistance with his or her application or
34 renewal for a state health subsidy program in person, over the
35 telephone, and online, and in a manner that is accessible to
36 individuals with disabilities and those who are limited English
37 proficient.

38 (h) (1) During the processing of an application, renewal, or a
39 transition due to a change in circumstances, an entity making
40 eligibility determinations for a state health subsidy program shall

1 ensure that an eligible applicant and recipient of state health
2 subsidy programs that meets all program eligibility requirements
3 and complies with all necessary requests for information moves
4 between programs without any breaks in coverage and without
5 being required to provide any forms, documents, or other
6 information or undergo verification that is duplicative or otherwise
7 unnecessary. The individual shall be informed about how to obtain
8 information about the status of his or her application, renewal, or
9 transfer to another program at any time, and the information shall
10 be promptly provided when requested.

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

21 (3) Renewal procedures shall include all available methods for
22 reporting renewal information, including, but not limited to,
23 face-to-face, telephone, and online renewal.

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

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

35 (1) The applicant shall be informed of the overpayment penalties
36 under the federal Comprehensive 1099 Taxpayer Protection and
37 Repayment of Exchange Subsidy Overpayments Act of 2011
38 (Public Law 112-9), if the individual's annual family income
39 increases by a specified amount or more, calculated on the basis
40 of the individual's current family size and current income, and that

1 penalties are avoided by prompt reporting of income increases
2 throughout the year.

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

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

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

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

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

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

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

3 SEC. 30. If the Commission on State Mandates determines
4 that this act contains costs mandated by the state, reimbursement
5 to local agencies and school districts for those costs shall be made
6 pursuant to Part 7 (commencing with Section 17500) of Division
7 4 of Title 2 of the Government Code.

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