

Introduced by Senators Hernandez and SteinbergDecember 3, 2012

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, and 14012 of, to add Sections 14005.60, 14005.62, 14005.63, 14005.64, 14132.02, and 15926.2 to, the Welfare and Institutions Code, relating to health.

LEGISLATIVE COUNSEL'S DIGEST

SB 28, as introduced, Hernandez. 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
21 legislative transformation of the United States health care system
22 in 40 years.

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

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

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

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

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

17 12698.30. (a) ~~At~~*(1) Subject to paragraph (2), at a minimum,*
18 *coverage shall be provided to subscribers during one pregnancy,*
19 *and for 60 days thereafter, and to children less than two years of*
20 *age who were born of a pregnancy covered under this program to*
21 *a woman enrolled in the program before July 1, 2004.*

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

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

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

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

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

1 14005.18. (a) A woman is eligible, to the extent required by
 2 federal law, as though she were pregnant, for all pregnancy-related
 3 and postpartum services for a 60-day period beginning on the last
 4 day of pregnancy.

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

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

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

12 14005.18. (a) To help prevent premature delivery and low
 13 birthweights, the leading causes of infant and maternal morbidity
 14 and mortality, and to promote women’s overall health, well-being,
 15 and financial security and that of their families, it is imperative
 16 that pregnant women enrolled in Medi-Cal be provided with all
 17 medically necessary services. Therefore, a woman is eligible, to
 18 the extent required by federal law, as though she were pregnant,
 19 for all pregnancy-related and postpartum services for a 60-day
 20 period beginning on the last day of pregnancy and continuing until
 21 the end of the month in which the 60th day of postpartum occurs.

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

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

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

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

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

35 14005.28. (a) To the extent federal financial participation is
 36 available pursuant to an approved state plan amendment, the
 37 department shall exercise its option under Section
 38 ~~1902(a)(10)(A)(XV)~~ 1902(a)(10)(A)(ii)(XVII) of the federal Social
 39 Security Act (42 U.S.C. Sec. ~~1396a(a)(10)(A)(XV)~~
 40 1396a(a)(10)(A)(ii)(XVII)) to extend Medi-Cal benefits to

1 independent foster care adolescents, as defined in Section
2 ~~1905(v)(1)~~ 1905(w)(1) of the federal Social Security Act (42 U.S.C.
3 ~~Sec. 1396d(v)(1)~~ 1396(w)(1)).

4 (b) Notwithstanding Chapter 3.5 (commencing with Section
5 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
6 and if the state plan amendment described in subdivision (a) is
7 approved by the federal Health Care Financing Administration,
8 the department may implement subdivision (a) without taking any
9 regulatory action and by means of all-county letters or similar
10 instructions. Thereafter, the department shall adopt regulations in
11 accordance with the requirements of Chapter 3.5 (commencing
12 with Section 11340) of Part 1 of Division 3 of Title 2 of the
13 Government Code.

14 (c) The department shall implement subdivision (a) on October
15 1, 2000, but only if, and to the extent that, the department has
16 obtained all necessary federal approvals.

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

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

22 14005.28. (a) Commencing January 1, 2014, and to the extent
23 federal financial participation is available pursuant to an approved
24 state plan amendment, the department shall implement Section
25 1902(a)(10)(A)(i)(IX) of the federal Social Security Act (42 U.S.C.
26 Sec. 1396a(a)(10)(A)(i)(IX)) to extend Medi-Cal benefits to a
27 foster care adolescent, until his or her 26th birthday.

28 (1) A foster care adolescent who is in foster care on his or her
29 18th birthday shall be deemed eligible for the benefits extended
30 pursuant to this section and shall be enrolled to receive these
31 benefits until his or her 26th birthday without any interruption in
32 coverage and without requiring a new application.

33 (2) The department shall develop and implement a simplified
34 redetermination form for this program. A recipient qualifying for
35 the benefits extended pursuant to this section shall fill out and
36 return this form only if information previously reported to the
37 department is no longer accurate. Failure to return the form alone
38 will not constitute a basis for termination of Medi-Cal. If the form
39 is returned as undeliverable and the county is otherwise unable to
40 establish contact, the recipient shall remain eligible for

1 fee-for-service Medi-Cal until such time as contact is reestablished
2 or ineligibility is established, and to the extent federal financial
3 participation is available. The department may terminate eligibility
4 if it determines that the recipient is no longer eligible only after
5 ineligibility is established and all due process requirements are
6 met in accordance with state and federal law.

7 (3) This section shall be implemented to the extent that federal
8 financial participation is available, and any necessary federal
9 approvals are obtained.

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 and if the state plan amendment described in subdivision (a) is
13 approved by the federal Centers for Medicare and Medicaid
14 Services, the department may implement this section without taking
15 any regulatory action and by means of all-county letters or similar
16 instructions. Thereafter, the department shall adopt regulations in
17 accordance with the requirements of Chapter 3.5 (commencing
18 with Section 11340) of Part 1 of Division 3 of Title 2 of the
19 Government Code.

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

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

23 14005.30. (a) (1) To the extent that federal financial
24 participation is available, Medi-Cal benefits under this chapter
25 shall be provided to individuals eligible for services under Section
26 1396u-1 of Title 42 of the United States Code, including any
27 options under Section 1396u-1(b)(2)(C) made available to and
28 exercised by the state.

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

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

1 the State Child Health Insurance Program waiver described in
2 Section 12693.755 of the Insurance Code extending Healthy
3 Families Program eligibility to parents and certain other adults is
4 approved and implemented.

5 (b) To the extent that federal financial participation is available,
6 the department shall exercise its option under Section
7 1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary
8 to expand eligibility for Medi-Cal under subdivision (a) by
9 establishing the amount of countable resources individuals or
10 families are allowed to retain at the same amount medically needy
11 individuals and families are allowed to retain, except that a family
12 of one shall be allowed to retain countable resources in the amount
13 of three thousand dollars (\$3,000).

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

24 (d) For purposes of calculating income under this section during
25 any calendar year, increases in social security benefit payments
26 under Title II of the federal Social Security Act (42 U.S.C. Sec.
27 401 and following) arising from cost-of-living adjustments shall
28 be disregarded commencing in the month that these social security
29 benefit payments are increased by the cost-of-living adjustment
30 through the month before the month in which a change in the
31 federal poverty level requires the department to modify the income
32 disregard pursuant to subdivision (c) and in which new income
33 limits for the program established by this section are adopted by
34 the department.

35 (e) Subdivision (b) shall be applied retroactively to January 1,
36 1998.

37 (f) Notwithstanding Chapter 3.5 (commencing with Section
38 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
39 the department shall implement, without taking regulatory action,
40 subdivisions (a) and (b) of this section by means of an all county

1 letter or similar instruction. Thereafter, the department shall adopt
2 regulations in accordance with the requirements of Chapter 3.5
3 (commencing with Section 11340) of Part 1 of Division 3 of Title
4 2 of the Government Code.

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

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

10 14005.30. (a) (1) To the extent that federal financial
11 participation is available, Medi-Cal benefits under this chapter
12 shall be provided to individuals eligible for services under Section
13 1396u-1 of Title 42 of the United States Code, known as the
14 Section 1931(b) program, including any options under Section
15 1396u-1(b)(2)(C) made available to and exercised by the state.

16 (2) The department shall exercise its option under Section
17 1396u-1(b)(2)(C) of Title 42 of the United States Code to adopt
18 less restrictive income and resource eligibility standards and
19 methodologies to the extent necessary to allow all recipients of
20 benefits under Chapter 2 (commencing with Section 11200) to be
21 eligible for Medi-Cal under paragraph (1).

22 (b) Commencing January 1, 2014, pursuant to Section
23 1396a(e)(14)(C) of Title 42 of the United States Code, there shall
24 be no assets test and no deprivation test for any individual under
25 this section.

26 (c) For purposes of calculating income under this section during
27 any calendar year, increases in social security benefit payments
28 under Title II of the federal Social Security Act (42 U.S.C. Sec.
29 401 et seq.) arising from cost-of-living adjustments shall be
30 disregarded commencing in the month that these social security
31 benefit payments are increased by the cost-of-living adjustment
32 through the month before the month in which a change in the
33 federal poverty level requires the department to modify the income
34 disregard pursuant to subdivision (c) and in which new income
35 limits for the program established by this section are adopted by
36 the department.

37 (d) Notwithstanding Chapter 3.5 (commencing with Section
38 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
39 the department shall implement, without taking regulatory action,
40 this section by means of an all-county letter or similar instruction.

1 Thereafter, the department shall adopt regulations in accordance
2 with the requirements of Chapter 3.5 (commencing with Section
3 11340) of Part 1 of Division 3 of Title 2 of the Government Code.
4 Beginning six months after the effective date of this section, the
5 department shall provide a status report to the Legislature on a
6 semiannual basis until regulations have been adopted.

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

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

10 14005.31. (a) (1) Subject to paragraph (2), for any person
11 whose eligibility for benefits under Section 14005.30 has been
12 determined with a concurrent determination of eligibility for cash
13 aid under Chapter 2 (commencing with Section 11200), loss of
14 eligibility or termination of cash aid under Chapter 2 (commencing
15 with Section 11200) shall not result in a loss of eligibility or
16 termination of benefits under Section 14005.30 absent the existence
17 of a factor that would result in loss of eligibility for benefits under
18 Section 14005.30 for a person whose eligibility under Section
19 14005.30 was determined without a concurrent determination of
20 eligibility for benefits under Chapter 2 (commencing with Section
21 11200).

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

28 (b) The department, in consultation with the counties and
29 representatives of consumers, managed care plans, and Medi-Cal
30 providers, shall prepare a simple, clear, consumer-friendly notice
31 to be used by the counties, to inform Medi-Cal beneficiaries whose
32 eligibility for cash aid under Chapter 2 (commencing with Section
33 11200) has ended, but whose eligibility for benefits under Section
34 14005.30 continues pursuant to subdivision (a), that their benefits
35 will continue. To the extent feasible, the notice shall be sent out
36 at the same time as the notice of discontinuation of cash aid, and
37 shall include all of the following:

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

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

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

13 (B) *Commencing January 1, 2014, the semiannual status report*
14 *requirement shall not be included in the statement described in*
15 *subparagraph (A).*

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

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

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

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

28 (d) Notwithstanding Chapter 3.5 (commencing with Section
29 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
30 the department shall, without taking any regulatory action,
31 implement this section by means of all county letters or similar
32 instructions. Thereafter, the department shall adopt regulations in
33 accordance with the requirements of Chapter 3.5 (commencing
34 with Section 11340) of Part 1 of Division 3 of Title 2 of the
35 Government Code. Comprehensive implementing instructions
36 shall be issued to the counties no later than March 1, 2001.

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

39 14005.32. (a) (1) If the county has evidence clearly
40 demonstrating that a beneficiary is not eligible for benefits under

1 this chapter pursuant to Section 14005.30, but is eligible for
2 benefits under this chapter pursuant to other provisions of law, the
3 county shall transfer the individual to the corresponding Medi-Cal
4 program. Eligibility under Section 14005.30 shall continue until
5 the transfer is complete.

6 (2) The department, in consultation with the counties and
7 representatives of consumers, managed care plans, and Medi-Cal
8 providers, shall prepare a simple, clear, consumer-friendly notice
9 to be used by the counties, to inform beneficiaries that their
10 Medi-Cal benefits have been transferred pursuant to paragraph (1)
11 and to inform them about the program to which they have been
12 transferred. To the extent feasible, the notice shall be issued with
13 the notice of discontinuance from cash aid, and shall include all
14 of the following:

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

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

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

23 (D) (i) A statement that the Medi-Cal beneficiary does not need
24 to fill out monthly status reports in order to remain eligible for
25 Medi-Cal, but ~~shall~~ *may* be required to submit a semiannual status
26 report and annual reaffirmation forms. In addition, if the person
27 or persons to whom the notice is directed has been found eligible
28 for transitional Medi-Cal as described in Section 14005.8 ;
29 ~~14005.81~~, or 14005.85, the statement shall explain the reporting
30 requirements and duration of benefits under those programs, and
31 shall further explain that, at the end of the duration of these
32 benefits, a redetermination, as provided for in Section 14005.37
33 shall be conducted to determine whether benefits are available
34 under any other provision of law.

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

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

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

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

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

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

15 (d) Notwithstanding Chapter 3.5 (commencing with Section
16 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
17 the department shall, without taking any regulatory action,
18 implement this section by means of all county letters or similar
19 instructions. Thereafter, the department shall adopt regulations in
20 accordance with the requirements of Chapter 3.5 (commencing
21 with Section 11340) of Part 1 of Division 3 of Title 2 of the
22 Government Code. Comprehensive implementing instructions
23 shall be issued to the counties no later than March 1, 2001.

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

26 14005.37. (a) Except as provided in Section 14005.39,
27 whenever a county receives information about changes in a
28 beneficiary's circumstances that may affect eligibility for Medi-Cal
29 benefits, the county shall promptly redetermine eligibility. The
30 procedures for redetermining Medi-Cal eligibility described in this
31 section shall apply to all Medi-Cal beneficiaries.

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

39 (c) A loss of contact, as evidenced by the return of mail marked
40 in such a way as to indicate that it could not be delivered to the

1 intended recipient or that there was no forwarding address, shall
2 require a prompt redetermination according to the procedures set
3 forth in this section.

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

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

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

29 (g) If a county's efforts pursuant to subdivisions (e) and (f) to
30 obtain the information necessary to redetermine eligibility have
31 failed, the county shall send to the beneficiary a form, which shall
32 highlight the information needed to complete the eligibility
33 determination. The county shall not request information or
34 documentation that has been previously provided by the
35 beneficiary, that is not absolutely necessary to complete the
36 eligibility determination, or that is not subject to change. The form
37 shall be accompanied by a simple, clear, consumer-friendly cover
38 letter, which shall explain why the form is necessary, the fact that
39 it is not necessary to be receiving CalWORKs benefits to be
40 receiving Medi-Cal benefits, the fact that receipt of Medi-Cal

1 benefits does not count toward any time limits imposed by the
2 CalWORKs program, the various bases for Medi-Cal eligibility,
3 including disability, and the fact that even persons who are
4 employed can receive Medi-Cal benefits. The cover letter shall
5 include a telephone number to call in order to obtain more
6 information. The form and the cover letter shall be developed by
7 the department in consultation with the counties and representatives
8 of consumers, managed care plans, and Medi-Cal providers. A
9 Medi-Cal beneficiary shall have no less than 20 days from the date
10 the form is mailed pursuant to this subdivision to respond. Except
11 as provided in subdivision (h), failure to respond prior to the end
12 of this 20-day period shall not impact his or her Medi-Cal
13 eligibility.

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

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

28 (j) If, within 20 days of the date of mailing of a form to the
29 Medi-Cal beneficiary pursuant to subdivision (g), the beneficiary
30 submits an incomplete form, the county shall attempt to contact
31 the beneficiary by telephone and in writing to request the necessary
32 information. If the beneficiary does not supply the necessary
33 information to the county within 10 days from the date the county
34 contacts the beneficiary in regard to the incomplete form, a 10-day
35 notice of termination of Medi-Cal eligibility shall be sent.

36 (k) If, within 30 days of termination of a Medi-Cal beneficiary's
37 eligibility pursuant to subdivision (h), (i), or (j), the beneficiary
38 submits to the county a completed form, eligibility shall be
39 determined as though the form was submitted in a timely manner

1 and if a beneficiary is found eligible, the termination under
2 subdivision (h), ~~(i)~~, or (j) shall be rescinded.

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

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

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

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

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

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

38 14005.37. (a) Except as provided in Section 14005.39,
39 whenever a county receives information about changes in a
40 beneficiary's circumstances that may affect eligibility for Medi-Cal

1 benefits, the county shall promptly redetermine eligibility. The
2 procedures for redetermining Medi-Cal eligibility described in this
3 section shall apply to all Medi-Cal beneficiaries.

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

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

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

24 (e) (1) For purposes of acquiring information necessary to
25 conduct the eligibility determinations described in subdivisions
26 (a) to (d), inclusive, a county shall gather information available to
27 the county that is relevant to the beneficiary's Medi-Cal eligibility
28 prior to contacting the beneficiary. Sources for these efforts shall
29 include, but are not limited to, Medi-Cal, CalWORKs, and
30 CalFresh case files of the beneficiary or of any of his or her
31 immediate family members, which are open or were closed within
32 the last 45 days, information accessed through any databases
33 accessed by the agency under Sections 435.948, 435.949, and
34 435.956 of Title 42 of the Code of Federal Regulations, and
35 wherever feasible, other sources of relevant information reasonably
36 available to the counties.

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

40 (A) The eligibility determination and basis.

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

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

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

19 (g) If a county's efforts pursuant to subdivisions (e) and (f) to
20 obtain the information necessary to redetermine eligibility have
21 failed, the county shall send to the beneficiary a form containing
22 information available to the county needed to renew eligibility.
23 The county shall not request information or documentation that
24 has been previously provided by the beneficiary, that is not
25 absolutely necessary to complete the eligibility determination, or
26 that is not subject to change. The county shall not request
27 information for nonapplicants necessary to make an eligibility
28 determination. The form shall be accompanied by a simple, clear,
29 consumer-friendly cover letter, that shall explain why the form is
30 necessary, the fact that it is not necessary to be receiving
31 CalWORKs benefits to be receiving Medi-Cal benefits, the fact
32 that receipt of Medi-Cal benefits does not count toward any time
33 limits imposed by the CalWORKs program, the various bases for
34 Medi-Cal eligibility, including disability, and the fact that even
35 persons who are employed can receive Medi-Cal benefits. The
36 form shall advise the individual to provide any necessary
37 information to the county via the Internet, by telephone, by mail,
38 in person, or through other commonly available electronic means
39 and to sign the renewal form. The cover letter shall include a
40 telephone number to call in order to obtain more information. The

1 form and the cover letter shall be developed by the department in
2 consultation with the counties and representatives of consumers,
3 managed care plans, and Medi-Cal providers. A Medi-Cal
4 beneficiary shall have no less than 20 days from the date the form
5 is mailed pursuant to this subdivision to respond. Except as
6 provided in subdivision (h), failure to respond prior to the end of
7 this 20-day period shall not impact his or her Medi-Cal eligibility.

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

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

22 (j) If, within 20 days of the date of mailing of a form to the
23 Medi-Cal beneficiary pursuant to subdivision (g), the beneficiary
24 submits an incomplete form, the county shall attempt to contact
25 the beneficiary by telephone, in writing, and other commonly
26 available electronic means, in counties where such electronic
27 communication is available, to request the necessary information.
28 If the beneficiary does not supply the necessary information to the
29 county within 10 days from the date the county contacts the
30 beneficiary in regard to the incomplete form, a 10-day notice of
31 termination of Medi-Cal eligibility shall be sent.

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

38 (2) Commencing January 1, 2014, if within 90 days of
39 termination of a Medi-Cal beneficiary's eligibility pursuant to
40 subdivision (h), (i), or (j), the beneficiary submits to the county a

1 completed form, eligibility shall be determined as though the form
2 was submitted in a timely manner and if a beneficiary is found
3 eligible, the termination under subdivision (h), (i), or (j) shall be
4 rescinded.

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

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

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

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

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

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

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

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

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

1 14005.60. (a) Commencing January 1, 2014, the department
2 shall provide eligibility for Medi-Cal benefits for any person who
3 meets the eligibility requirements of Section
4 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security
5 Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)).

6 (b) Persons who qualify under subdivision (a) and are currently
7 enrolled in a Low Income Health Program (LIHP) under
8 California's Bridge to Reform Section 1115(a) Medicaid
9 Demonstration shall be transitioned to the Medi-Cal program under
10 this section in accordance with the transition plan as approved by
11 the federal Centers for Medicare and Medicaid Services. With
12 respect to plan enrollment, a LIHP enrollee shall be all of the
13 following:

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

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

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

21 (4) Informed that if he or she does not affirmatively choose a
22 plan or there is only one plan in the county where he or she resides,
23 he or she shall be enrolled into the Medi-Cal managed care plan
24 that contains his or her LIHP medical home provider.

25 (c) In order to ensure that no persons lose health care coverage
26 in the course of the transition, the department shall require that
27 notices of the January 1, 2014, change be sent to LIHP enrollees
28 upon their LIHP redetermination in 2013 and again at least 90 days
29 prior to the transition. Pursuant to Section 1902(k)(1) and Section
30 1937(b)(1)(D) of the federal Social Security Act (42 U.S.C. Sec.
31 1396a(k)(1); 42 U.S.C. Sec. 1396u-7(b)(1)(D)), the department
32 shall seek approval from the United States Secretary of Health and
33 Human Services to establish a benchmark benefit package that
34 includes the same benefits, services, and coverage that are provided
35 to all other full-scope Medi-Cal enrollees, supplemented by any
36 benefits, services, and coverage included in the essential health
37 benefits package adopted by the state and approved by the United
38 States Secretary of Health and Human Services under Section
39 18022 of Title 42 of the United States Code.

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

3 14005.62. Commencing January 1, 2014, the department shall
4 accept an individual's attestation of information and verify
5 information pursuant to Section 15926.2.

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

8 14005.63. (a) Commencing January 1, 2014, a person who
9 wishes to apply for a state health subsidy program, as defined in
10 subdivision (a) of Section 15926, shall be allowed to file an
11 application on his or her own behalf or on behalf of his or her
12 family. The individual also has the right to be accompanied,
13 assisted, and represented in the application and renewal process
14 by an individual or organization of his or her own choice. If the
15 individual for any reason is unable to apply or renew on his or her
16 own behalf, any of the following persons may file the application
17 for the applicant:

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

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

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

29 14005.64. (a) This section implements Section 1902(e)(14)(C)
30 of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(14)(C))
31 and Section 435.603(g) of Title 42 of the Code of Federal
32 Regulations, which prohibits the use of an assets test for individuals
33 whose income eligibility is determined based on modified adjusted
34 gross income (MAGI), and Section 2002 of the federal Patient
35 Protection and Affordable Care Act (Affordable Care Act) (42
36 U.S.C. Sec. 1396a(e)(14)(I)) and Section 435.603(d) of Title 42
37 of the Code of Federal Regulations, which requires a 5-percent
38 income disregard for individuals whose income eligibility is
39 determined based on MAGI.

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

6 (c) The department shall implement the 5-percent income
7 disregard for individuals whose income eligibility is determined
8 based on MAGI in Section 2002 of the Affordable Care Act (42
9 U.S.C. Sec. 1396a(e)(14)(I)) and Section 435.603(d) of the Title
10 42 of the Code of Federal Regulations.

11 (d) The department shall adopt an equivalent income level for
12 each eligibility group whose income level will be converted to
13 MAGI. The equivalent income level shall not be less than the dollar
14 amount of all income exemptions, exclusions, deductions, and
15 disregards in effect on March 23, 2010, plus the existing income
16 level expressed as a percent of the federal poverty level for each
17 eligibility group so as to ensure that the use of MAGI income
18 methodology does not result in populations who would have been
19 eligible under this chapter and Part 6.3 (commencing with Section
20 12695) of Division 2 of the Insurance Code losing coverage.

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

22 SEC. 17. Section 14008.85 of the Welfare and Institutions
23 Code is amended to read:

24 14008.85. (a) To the extent federal financial participation is
25 available, a parent who is the principal wage earner shall be
26 considered an unemployed parent for purposes of establishing
27 eligibility based upon deprivation of a child where any of the
28 following applies:

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

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

38 (3) The parent is considered unemployed under the terms of an
39 existing federal waiver of the 100-hour rule for recipients under

1 the program established by Section 1931(b) of the federal Social
2 Security Act (42 U.S.C. Sec. 1396u-1).

3 (b) Notwithstanding Chapter 3.5 (commencing with Section
4 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
5 the department shall implement this section by means of an all
6 county letter or similar instruction without taking regulatory action.
7 Thereafter, the department shall adopt regulations in accordance
8 with the requirements of Chapter 3.5 (commencing with Section
9 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

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

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

14 SEC. 18. Section 14011.16 of the Welfare and Institutions
15 Code is amended to read:

16 14011.16. (a) Commencing August 1, 2003, the department
17 shall implement a requirement for beneficiaries to file semiannual
18 status reports as part of the department's procedures to ensure that
19 beneficiaries make timely and accurate reports of any change in
20 circumstance that may affect their eligibility. The department shall
21 develop a simplified form to be used for this purpose. The
22 department shall explore the feasibility of using a form that allows
23 a beneficiary who has not had any changes to so indicate by
24 checking a box and signing and returning the form.

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

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

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

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

4 (f) Notwithstanding Chapter 3.5 (commencing with Section
5 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
6 the department shall implement this section by means of all-county
7 letters or similar instructions without taking regulatory action.
8 Thereafter, the department shall adopt regulations in accordance
9 with the requirements of Chapter 3.5 (commencing with Section
10 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

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

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

16 SEC. 19. Section 14011.17 of the Welfare and Institutions
17 Code is amended to read:

18 14011.17. The following persons shall be exempt from the
19 semiannual reporting requirements described in Section 14011.16:

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

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

23 (c) Beneficiaries who have a public guardian.

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

27 (e) Individuals receiving minor consent services.

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

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

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

35 SEC. 20. Section 14012 of the Welfare and Institutions Code
36 is amended to read:

37 14012. (a) Reaffirmation shall be filed annually and may be
38 required at other times in accordance with general standards
39 established by the department.

1 (b) *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. 21. Section 14012 is added to the Welfare and Institutions
5 Code, to read:

6 14012. (a) This section implements Section 435.916(a)(1) of
7 Title 42 of the Code of Federal Regulations, which applies to the
8 eligibility of Medi-Cal beneficiaries whose financial eligibility is
9 determined using modified adjusted gross income (MAGI) based
10 income.

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

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

16 SEC. 22. Section 14132 of the Welfare and Institutions Code
17 is amended to read:

18 14132. The following is the schedule of benefits under this
19 chapter:

20 (a) Outpatient services are covered as follows:

21 Physician, hospital or clinic outpatient, surgical center,
22 respiratory care, optometric, chiropractic, psychology, podiatric,
23 occupational therapy, physical therapy, speech therapy, audiology,
24 acupuncture to the extent federal matching funds are provided for
25 acupuncture, and services of persons rendering treatment by prayer
26 or healing by spiritual means in the practice of any church or
27 religious denomination insofar as these can be encompassed by
28 federal participation under an approved plan, subject to utilization
29 controls.

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

33 (2) For Medi-Cal fee-for-service beneficiaries, emergency
34 services and care that are necessary for the treatment of an
35 emergency medical condition and medical care directly related to
36 the emergency medical condition. This paragraph shall not be
37 construed to change the obligation of Medi-Cal managed care
38 plans to provide emergency services and care. For the purposes of
39 this paragraph, “emergency services and care” and “emergency

1 medical condition” shall have the same meanings as those terms
2 are defined in Section 1317.1 of the Health and Safety Code.

3 (c) Nursing facility services, subacute care services, and services
4 provided by any category of intermediate care facility for the
5 developmentally disabled, including podiatry, physician, nurse
6 practitioner services, and prescribed drugs, as described in
7 subdivision (d), are covered subject to utilization controls.
8 Respiratory care, physical therapy, occupational therapy, speech
9 therapy, and audiology services for patients in nursing facilities
10 and any category of intermediate care facility for the
11 developmentally disabled are covered subject to utilization controls.

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

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

17 (3) (A) To the extent required by federal law, the purchase of
18 outpatient prescribed drugs, for which the prescription is executed
19 by a prescriber in written, nonelectronic form on or after April 1,
20 2008, is covered only when executed on a tamper resistant
21 prescription form. The implementation of this paragraph shall
22 conform to the guidance issued by the federal Centers of Medicare
23 and Medicaid Services but shall not conflict with state statutes on
24 the characteristics of tamper resistant prescriptions for controlled
25 substances, including Section 11162.1 of the Health and Safety
26 Code. The department shall provide providers and beneficiaries
27 with as much flexibility in implementing these rules as allowed
28 by the federal government. The department shall notify and consult
29 with appropriate stakeholders in implementing, interpreting, or
30 making specific this paragraph.

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 instructions without taking regulatory action.

36 (4) (A) (i) For the purposes of this paragraph, nonlegend has
37 the same meaning as defined in subdivision (a) of Section
38 14105.45.

1 (ii) Nonlegend acetaminophen-containing products, with the
2 exception of children’s acetaminophen-containing products,
3 selected by the department are not covered benefits.

4 (iii) Nonlegend cough and cold products selected by the
5 department are not covered benefits. This clause shall be
6 implemented on the first day of the first calendar month following
7 90 days after the effective date of the act that added this clause,
8 or on the first day of the first calendar month following 60 days
9 after the date the department secures all necessary federal approvals
10 to implement this section, whichever is later.

11 (iv) Beneficiaries under the Early and Periodic Screening,
12 Diagnosis, and Treatment Program shall be exempt from clauses
13 (ii) and (iii).

14 (B) Notwithstanding Chapter 3.5 (commencing with Section
15 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
16 the department may take the actions specified in subparagraph (A)
17 by means of a provider bulletin or notice, policy letter, or other
18 similar instruction without taking regulatory action.

19 (e) Outpatient dialysis services and home hemodialysis services,
20 including physician services, medical supplies, drugs and
21 equipment required for dialysis, are covered, subject to utilization
22 controls.

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

33 (g) Blood and blood derivatives are covered.

34 (h) (1) Emergency and essential diagnostic and restorative
35 dental services, except for orthodontic, fixed bridgework, and
36 partial dentures that are not necessary for balance of a complete
37 artificial denture, are covered, subject to utilization controls. The
38 utilization controls shall allow emergency and essential diagnostic
39 and restorative dental services and prostheses that are necessary
40 to prevent a significant disability or to replace previously furnished

1 prostheses which are lost or destroyed due to circumstances beyond
2 the beneficiary's control. Notwithstanding the foregoing, the
3 director may by regulation provide for certain fixed artificial
4 dentures necessary for obtaining employment or for medical
5 conditions that preclude the use of removable dental prostheses,
6 and for orthodontic services in cleft palate deformities administered
7 by the department's California Children Services Program.

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

11 (A) Periodontal treatment is not a benefit.

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

14 (C) Laboratory processed crowns are not a benefit.

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

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

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

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

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

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

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

35 Orthopedic and conventional shoes are covered when provided
36 by a prosthetic and orthotic supplier on the prescription of a
37 physician and when at least one of the shoes will be attached to a
38 prosthesis or brace, subject to utilization controls. Modification
39 of stock conventional or orthopedic shoes when medically
40 indicated, is covered subject to utilization controls. When there is

1 a clearly established medical need that cannot be satisfied by the
2 modification of stock conventional or orthopedic shoes,
3 custom-made orthopedic shoes are covered, subject to utilization
4 controls.

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

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

13 (m) Durable medical equipment and medical supplies are
14 covered, subject to utilization controls. The utilization controls
15 shall allow the replacement of durable medical equipment and
16 medical supplies when necessary because of loss or destruction
17 due to circumstances beyond the beneficiary's control. The
18 utilization controls shall allow authorization of durable medical
19 equipment needed to assist a disabled beneficiary in caring for a
20 child for whom the disabled beneficiary is a parent, stepparent,
21 foster parent, or legal guardian, subject to the availability of federal
22 financial participation. The department shall adopt emergency
23 regulations to define and establish criteria for assistive durable
24 medical equipment in accordance with the rulemaking provisions
25 of the Administrative Procedure Act (Chapter 3.5 (commencing
26 with Section 11340) of Part 1 of Division 3 of Title 2 of the
27 Government Code).

28 (n) Family planning services are covered, subject to utilization
29 controls.

30 (o) Inpatient intensive rehabilitation hospital services, including
31 respiratory rehabilitation services, in a general acute care hospital
32 are covered, subject to utilization controls, when either of the
33 following criteria are met:

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

38 (2) A patient with a chronic or progressive disease requires an
39 inpatient intensive rehabilitation hospital program as described in

1 Section 14064 to maintain the patient’s present functional level as
2 long as possible.

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

5 (2) Commencing 30 days after the effective date of the act that
6 added this paragraph, and notwithstanding the number of days
7 previously approved through a treatment authorization request,
8 adult day health care is covered for a maximum of three days per
9 week.

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

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

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

18 (2) All dental hygiene services provided by a registered dental
19 hygienist in alternative practice pursuant to Sections 1768 and
20 1770 of the Business and Professions Code may be covered as
21 long as they are within the scope of Denti-Cal benefits and they
22 are necessary services provided by a registered dental hygienist
23 in alternative practice.

24 (r) (1) Paramedic services performed by a city, county, or
25 special district, or pursuant to a contract with a city, county, or
26 special district, and pursuant to a program established under Article
27 3 (commencing with Section 1480) of Chapter 2.5 of Division 2
28 of the Health and Safety Code by a paramedic certified pursuant
29 to that article, and consisting of defibrillation and those services
30 specified in subdivision (3) of Section 1482 of the article.

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

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

36 (s) In-home medical care services are covered when medically
37 appropriate and subject to utilization controls, for beneficiaries
38 who would otherwise require care for an extended period of time
39 in an acute care hospital at a cost higher than in-home medical
40 care services. The director shall have the authority under this

1 section to contract with organizations qualified to provide in-home
2 medical care services to those persons. These services may be
3 provided to patients placed in shared or congregate living
4 arrangements, if a home setting is not medically appropriate or
5 available to the beneficiary. As used in this section, “in-home
6 medical care service” includes utility bills directly attributable to
7 continuous, 24-hour operation of life-sustaining medical equipment,
8 to the extent that federal financial participation is available.

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

- 11 (1) Level of care and cost of care evaluations.
- 12 (2) Expenses, directly attributable to home care activities, for
13 materials.
- 14 (3) Physician fees for home visits.
- 15 (4) Expenses directly attributable to home care activities for
16 shelter and modification to shelter.
- 17 (5) Expenses directly attributable to additional costs of special
18 diets, including tube feeding.
- 19 (6) Medically related personal services.
- 20 (7) Home nursing education.
- 21 (8) Emergency maintenance repair.
- 22 (9) Home health agency personnel benefits which permit
23 coverage of care during periods when regular personnel are on
24 vacation or using sick leave.
- 25 (10) All services needed to maintain antiseptic conditions at
26 stoma or shunt sites on the body.
- 27 (11) Emergency and nonemergency medical transportation.
- 28 (12) Medical supplies.
- 29 (13) Medical equipment, including, but not limited to, scales,
30 gurneys, and equipment racks suitable for paralyzed patients.
- 31 (14) Utility use directly attributable to the requirements of home
32 care activities which are in addition to normal utility use.
- 33 (15) Special drugs and medications.
- 34 (16) Home health agency supervision of visiting staff which is
35 medically necessary, but not included in the home health agency
36 rate.
- 37 (17) Therapy services.
- 38 (18) Household appliances and household utensil costs directly
39 attributable to home care activities.
- 40 (19) Modification of medical equipment for home use.

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

3 (21) Respiratory care practitioner services as defined in Sections
4 3702 and 3703 of the Business and Professions Code, subject to
5 prescription by a physician and surgeon.

6 Beneficiaries receiving in-home medical care services are entitled
7 to the full range of services within the Medi-Cal scope of benefits
8 as defined by this section, subject to medical necessity and
9 applicable utilization control. Services provided pursuant to this
10 subdivision, which are not otherwise included in the Medi-Cal
11 schedule of benefits, shall be available only to the extent that
12 federal financial participation for these services is available in
13 accordance with a home- and community-based services waiver.

14 (t) Home- and community-based services approved by the
15 United States Department of Health and Human Services may be
16 covered to the extent that federal financial participation is available
17 for those services under waivers granted in accordance with Section
18 1396n of Title 42 of the United States Code. The director may
19 seek waivers for any or all home- and community-based services
20 approvable under Section 1396n of Title 42 of the United States
21 Code. Coverage for those services shall be limited by the terms,
22 conditions, and duration of the federal waivers.

23 (u) Comprehensive perinatal services, as provided through an
24 agreement with a health care provider designated in Section
25 14134.5 and meeting the standards developed by the department
26 pursuant to Section 14134.5, subject to utilization controls.

27 The department shall seek any federal waivers necessary to
28 implement the provisions of this subdivision. The provisions for
29 which appropriate federal waivers cannot be obtained shall not be
30 implemented. Provisions for which waivers are obtained or for
31 which waivers are not required shall be implemented
32 notwithstanding any inability to obtain federal waivers for the
33 other provisions. No provision of this subdivision shall be
34 implemented unless matching funds from Subchapter XIX
35 (commencing with Section 1396) of Chapter 7 of Title 42 of the
36 United States Code are available.

37 (v) Early and periodic screening, diagnosis, and treatment for
38 any individual under 21 years of age is covered, consistent with
39 the requirements of Subchapter XIX (commencing with Section
40 1396) of Chapter 7 of Title 42 of the United States Code.

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

5 (x) When a claim for treatment provided to a beneficiary
6 includes both services which are authorized and reimbursable
7 under this chapter, and services which are not reimbursable under
8 this chapter, that portion of the claim for the treatment and services
9 authorized and reimbursable under this chapter shall be payable.

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

14 Services provided pursuant to a waiver obtained from the
15 Secretary of the United States Department of Health and Human
16 Services pursuant to this subdivision, and which are not otherwise
17 included in the Medi-Cal schedule of benefits, shall be available
18 only to the extent that federal financial participation for these
19 services is available in accordance with the waiver, and subject to
20 the terms, conditions, and duration of the waiver. These services
21 shall be provided to individual beneficiaries in accordance with
22 the client's needs as identified in the plan of care, and subject to
23 medical necessity and applicable utilization control.

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

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

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

1 (2) The department shall seek a waiver in accordance with
2 Section 1315 of Title 42 of the United States Code, or a state plan
3 amendment adopted in accordance with Section
4 ~~1396a(a)(10)(A)(ii)(XXI)(ii)(2)~~ *1396a(a)(10)(A)(ii)(XXI)* of Title
5 42 of the United States Code, which was added to Section 1396a
6 of Title 42 of the United States Code by Section 2303(a)(2) of the
7 federal Patient Protection and Affordable Care Act (PPACA)
8 (Public Law 111-148), for a program to provide comprehensive
9 clinical family planning services as described in paragraph (8).
10 Under the waiver, the program shall be operated only in accordance
11 with the waiver and the statutes and regulations in paragraph (4)
12 and subject to the terms, conditions, and duration of the waiver.
13 Under the state plan amendment, which shall replace the waiver
14 and shall be known as the Family PACT successor state plan
15 amendment, the program shall be operated only in accordance with
16 this subdivision and the statutes and regulations in paragraph (4).
17 The state shall use the standards and processes imposed by the
18 state on January 1, 2007, including the application of an eligibility
19 discount factor to the extent required by the federal Centers for
20 Medicare and Medicaid Services, for purposes of determining
21 eligibility as permitted under Section
22 ~~1396a(a)(10)(A)(ii)(XXI)(ii)(2)~~ *1396a(a)(10)(A)(ii)(XXI)* of Title
23 42 of the United States Code. To the extent that federal financial
24 participation is available, the program shall continue to conduct
25 education, outreach, enrollment, service delivery, and evaluation
26 services as specified under the waiver. The services shall be
27 provided under the program only if the waiver and, when
28 applicable, the successor state plan amendment are approved by
29 the federal Centers for Medicare and Medicaid Services and only
30 to the extent that federal financial participation is available for the
31 services. Nothing in this section shall prohibit the department from
32 seeking the Family PACT successor state plan amendment during
33 the operation of the waiver.

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

39 (4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005,
40 and 24013, and any regulations adopted under these statutes shall

1 apply to the program provided for under this subdivision. No other
2 provision of law under the Medi-Cal program or the State-Only
3 Family Planning Program shall apply to the program provided for
4 under this subdivision.

5 (5) Notwithstanding Chapter 3.5 (commencing with Section
6 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
7 the department may implement, without taking regulatory action,
8 the provisions of the waiver after its approval by the federal Health
9 Care Financing Administration and the provisions of this section
10 by means of an all-county letter or similar instruction to providers.
11 Thereafter, the department shall adopt regulations to implement
12 this section and the approved waiver in accordance with the
13 requirements of Chapter 3.5 (commencing with Section 11340) of
14 Part 1 of Division 3 of Title 2 of the Government Code. Beginning
15 six months after the effective date of the act adding this
16 subdivision, the department shall provide a status report to the
17 Legislature on a semiannual basis until regulations have been
18 adopted.

19 (6) In the event that the Department of Finance determines that
20 the program operated under the authority of the waiver described
21 in paragraph (2) or the Family PACT successor state plan
22 amendment is no longer cost effective, this subdivision shall
23 become inoperative on the first day of the first month following
24 the issuance of a 30-day notification of that determination in
25 writing by the Department of Finance to the chairperson in each
26 house that considers appropriations, the chairpersons of the
27 committees, and the appropriate subcommittees in each house that
28 considers the State Budget, and the Chairperson of the Joint
29 Legislative Budget Committee.

30 (7) If this subdivision ceases to be operative, all persons who
31 have received or are eligible to receive comprehensive clinical
32 family planning services pursuant to the waiver described in
33 paragraph (2) shall receive family planning services under the
34 Medi-Cal program pursuant to subdivision (n) if they are otherwise
35 eligible for Medi-Cal with no share of cost, or shall receive
36 comprehensive clinical family planning services under the program
37 established in Division 24 (commencing with Section 24000) either
38 if they are eligible for Medi-Cal with a share of cost or if they are
39 otherwise eligible under Section 24003.

1 (8) For purposes of this subdivision, “comprehensive clinical
2 family planning services” means the process of establishing
3 objectives for the number and spacing of children, and selecting
4 the means by which those objectives may be achieved. These
5 means include a broad range of acceptable and effective methods
6 and services to limit or enhance fertility, including contraceptive
7 methods, federal Food and Drug Administration approved
8 contraceptive drugs, devices, and supplies, natural family planning,
9 abstinence methods, and basic, limited fertility management.
10 Comprehensive clinical family planning services include, but are
11 not limited to, preconception counseling, maternal and fetal health
12 counseling, general reproductive health care, including diagnosis
13 and treatment of infections and conditions, including cancer, that
14 threaten reproductive capability, medical family planning treatment
15 and procedures, including supplies and followup, and
16 informational, counseling, and educational services.
17 Comprehensive clinical family planning services shall not include
18 abortion, pregnancy testing solely for the purposes of referral for
19 abortion or services ancillary to abortions, or pregnancy care that
20 is not incident to the diagnosis of pregnancy. Comprehensive
21 clinical family planning services shall be subject to utilization
22 control and include all of the following:

23 (A) Family planning related services and male and female
24 sterilization. Family planning services for men and women shall
25 include emergency services and services for complications directly
26 related to the contraceptive method, federal Food and Drug
27 Administration approved contraceptive drugs, devices, and
28 supplies, and followup, consultation, and referral services, as
29 indicated, which may require treatment authorization requests.

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

34 (C) Culturally and linguistically appropriate health education
35 and counseling services, including informed consent, that include
36 all of the following:

- 37 (i) Psychosocial and medical aspects of contraception.
- 38 (ii) Sexuality.
- 39 (iii) Fertility.
- 40 (iv) Pregnancy.

- 1 (v) Parenthood.
- 2 (vi) Infertility.
- 3 (vii) Reproductive health care.
- 4 (viii) Preconception and nutrition counseling.
- 5 (ix) Prevention and treatment of sexually transmitted infection.
- 6 (x) Use of contraceptive methods, federal Food and Drug
- 7 Administration approved contraceptive drugs, devices, and
- 8 supplies.
- 9 (xi) Possible contraceptive consequences and followup.
- 10 (xii) Interpersonal communication and negotiation of
- 11 relationships to assist individuals and couples in effective
- 12 contraceptive method use and planning families.
- 13 (D) A comprehensive health history, updated at the next periodic
- 14 visit (between 11 and 24 months after initial examination) that
- 15 includes a complete obstetrical history, gynecological history,
- 16 contraceptive history, personal medical history, health risk factors,
- 17 and family health history, including genetic or hereditary
- 18 conditions.
- 19 (E) A complete physical examination on initial and subsequent
- 20 periodic visits.
- 21 (F) Services, drugs, devices, and supplies deemed by the federal
- 22 Centers for Medicare and Medicaid Services to be appropriate for
- 23 inclusion in the program.
- 24 (9) In order to maximize the availability of federal financial
- 25 participation under this subdivision, the director shall have the
- 26 discretion to implement the Family PACT successor state plan
- 27 amendment retroactively to July 1, 2010.
- 28 (ab) (1) Purchase of prescribed enteral nutrition products is
- 29 covered, subject to the Medi-Cal list of enteral nutrition products
- 30 and utilization controls.
- 31 (2) Purchase of enteral nutrition products is limited to those
- 32 products to be administered through a feeding tube, including, but
- 33 not limited to, a gastric, nasogastric, or jejunostomy tube.
- 34 Beneficiaries under the Early and Periodic Screening, Diagnosis,
- 35 and Treatment Program shall be exempt from this paragraph.
- 36 (3) Notwithstanding paragraph (2), the department may deem
- 37 an enteral nutrition product, not administered through a feeding
- 38 tube, including, but not limited to, a gastric, nasogastric, or
- 39 jejunostomy tube, a benefit for patients with diagnoses, including,
- 40 but not limited to, malabsorption and inborn errors of metabolism,

1 if the product has been shown to be neither investigational nor
2 experimental when used as part of a therapeutic regimen to prevent
3 serious disability or death.

4 (4) Notwithstanding Chapter 3.5 (commencing with Section
5 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
6 the department may implement the amendments to this subdivision
7 made by the act that added this paragraph by means of all-county
8 letters, provider bulletins, or similar instructions, without taking
9 regulatory action.

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

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

17 (ad) *Commencing January 1, 2014, any benefits, services, and*
18 *coverage not otherwise described in this section that are included*
19 *in the essential health benefits package adopted by the state and*
20 *approved by the United States Secretary of Health and Human*
21 *Services under Section 18022 of Title 42 of the United States Code.*

22 SEC. 23. Section 14132.02 is added to the Welfare and
23 Institutions Code, to read:

24 14132.02. (a) Pursuant to Sections 1902(k)(1) and
25 1937(b)(1)(D) of the federal Social Security Act (42 U.S.C. Sec.
26 1396a(k)(1); 42 U.S.C. Sec. 1396u-7(b)(1)(D)), the department
27 shall seek approval from the United States Secretary of Health and
28 Human Services to establish a benchmark benefit package that
29 includes the same benefits, services, and coverage as is provided
30 to all other full-scope Medi-Cal enrollees, supplemented by any
31 benefits, services, and coverage included in the essential health
32 benefits package adopted by the state and approved by the secretary
33 under Section 18022 of Title 42 of the United States Code.

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

35 SEC. 24. Section 15926 of the Welfare and Institutions Code
36 is amended to read:

37 15926. (a) The following definitions apply for purposes of
38 this part:

1 (1) “Accessible” means in compliance with Section 11135 of
2 the Government Code, Section 1557 of the PPACA, and regulations
3 or guidance adopted pursuant to these statutes.

4 (2) “Limited-English-proficient” means not speaking English
5 as one’s primary language and having a limited ability to read,
6 speak, write, or understand English.

7 (3) “State health subsidy programs” means the programs
8 described in Section 1413(e) of the PPACA.

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

12 (c) (1) A single, accessible, standardized paper, electronic, and
13 telephone application for state health subsidy programs shall be
14 developed by the department in consultation with MRMIB and
15 the board governing the Exchange as part of the stakeholder process
16 described in subdivision (b) of Section 15925. The application
17 shall be used by all entities authorized to make an eligibility
18 determination for any of the state health subsidy programs and by
19 their agents.

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

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

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

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

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

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

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

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

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

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

15 (f) (1) If the eligibility, enrollment, and retention system has
16 the ability to prepopulate an application form for insurance
17 affordability programs with personal information from available
18 electronic databases, an applicant shall be given the option, with
19 his or her informed consent, to have the application form
20 prepopulated. Before a prepopulated renewal form or, if available,
21 prepopulated application is submitted to the entity authorized to
22 make eligibility determinations, the individual shall be given the
23 opportunity to provide additional eligibility information and to
24 correct any information retrieved from a database.

25 (2) All state health subsidy programs ~~may~~ shall accept
26 self-attestation, instead of requiring an individual to produce a
27 document, ~~with respect to all information~~ for age, date of birth,
28 family size, household income, state residence, pregnancy, and
29 any other applicable criteria needed to determine the eligibility
30 of an applicant or recipient, to the extent permitted by state and
31 federal law.

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

35 (4) Before an eligibility determination is made, the individual
36 shall be given the opportunity to provide additional eligibility
37 information and to correct information.

38 (5) The eligibility of an applicant shall not be delayed or denied
39 for any state health subsidy program unless the applicant is given
40 a reasonable opportunity, of at least the kind provided for under

1 the Medi-Cal program pursuant to Section 14007.5 and paragraph
2 (7) of subdivision (e) of Section 14011.2, to resolve discrepancies
3 concerning any information provided by a verifying entity.

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

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

19 (h) (1) During the processing of an application, renewal, or a
20 transition due to a change in circumstances, an entity making
21 eligibility determinations for a state health subsidy program shall
22 ensure that an eligible applicant and recipient of state health
23 subsidy programs that meets all program eligibility requirements
24 and complies with all necessary requests for information moves
25 between programs without any breaks in coverage and without
26 being required to provide any forms, documents, or other
27 information or undergo verification that is duplicative or otherwise
28 unnecessary. The individual shall be informed about how to obtain
29 information about the status of his or her application, renewal, or
30 transfer to another program at any time, and the information shall
31 be promptly provided when requested.

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

1 for a state health subsidy program, he or she shall be determined
2 eligible for that program.

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

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

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

17 (1) The applicant shall be informed of the overpayment penalties
18 under the federal Comprehensive 1099 Taxpayer Protection and
19 Repayment of Exchange Subsidy Overpayments Act of 2011
20 (Public Law 112-9), if the individual's annual family income
21 increases by a specified amount or more, calculated on the basis
22 of the individual's current family size and current income, and that
23 penalties are avoided by prompt reporting of income increases
24 throughout the year.

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

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

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

39 (2) Forms and notices developed pursuant to this section shall
40 be developed using plain language and shall be provided in a

1 manner that affords meaningful access to limited-English-proficient
2 individuals, in accordance with applicable state and federal law,
3 and at a minimum, provided in the same threshold languages as
4 required for Medi-Cal managed care plans.

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

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

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

25 SEC. 25. Section 15926.2 is added to the Welfare and
26 Institutions Code, to read:

27 15926.2. In accordance with paragraph (2) of subdivision (f)
28 of Section 15926 and Sections 435.945(a) and 435.956 of Title 42
29 of the Code of Federal Regulations, state health subsidy programs
30 shall accept an individual's attestation, without further
31 documentation from the individual, for age, date of birth, family
32 size, household income, state residence, pregnancy, and any other
33 applicable eligibility criteria for which attestation is permitted by
34 federal law.

35 SEC. 26. If the Commission on State Mandates determines
36 that this act contains costs mandated by the state, reimbursement
37 to local agencies and school districts for those costs shall be made

- 1 pursuant to Part 7 (commencing with Section 17500) of Division
- 2 4 of Title 2 of the Government Code.

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