

## Senate Bill No. 1

### CHAPTER 4

An act to amend Sections 11026, 14005.39, and 14132 of, to amend and repeal Section 14008.85 of, to amend, repeal, and add Sections 14005.28, 14005.31, 14005.32, 14007.1, and 14007.6 of, to add Sections 14000.7, 14005.63, 14005.65, 14005.66, 14005.67, 14005.68, 14007.15, 14011.66, 14014.5, 14057, 14102, 14103, 14132.02, and 14132.03 to, and to add Article 5.9 (commencing with Section 14189) to Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to health.

[Approved by Governor June 27, 2013. Filed with  
Secretary of State June 27, 2013.]

#### LEGISLATIVE COUNSEL'S DIGEST

SB 1, 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 former foster children. The bill would also add, commencing January 1, 2014, mental health services and substance use disorder services 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, as specified. The bill would require the department to seek approval from the United States Secretary of Health and Human Services to provide, effective January 1, 2014, specified individuals with an alternative benefit package, which would provide the same schedule of benefits provided to full-scope Medi-Cal beneficiaries qualifying under the modified adjusted gross income (MAGI) income standard, except as specified. The bill would provide that the implementation of the optional expansion of Medi-Cal benefits to adults who meet specified eligibility requirements shall be contingent on the federal medical assistance percentage (FMAP) payable to the state under the Affordable Care Act not being reduced to specified percentages, as specified.

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.

This bill would require that a person who wishes to apply for an insurance affordability program, as defined, be allowed to file an application on his or her own behalf or on behalf of his or her family and would authorize a person to be accompanied, assisted, and represented in the application and renewal process by an individual or organization of his or her choice. This bill would also require the department, to the extent required by federal law, to provide assistance to any applicant or beneficiary who requests help with the application or redetermination. The bill would require the department to file a state plan amendment to exercise a federal option to allow beneficiaries to use projected annual household income and to allow applicants and beneficiaries to use reasonably predictable annual income, as specified.

This bill would require the department to seek any federal waivers necessary to use eligibility information of certain individuals who have been determined eligible for the CalFresh program to determine their eligibility for Medi-Cal and to automatically enroll parents who apply for Medi-Cal who have one or more children who are eligible based on determined income level at or below a specified standard. The bill would authorize the department to seek any federal waivers or state plan amendments necessary to use the eligibility information of individuals determined eligible for other state-only funded health care programs and county general assistance programs to determine an applicant's Medi-Cal eligibility to the extent that there is no General Fund impact.

This bill would require the department to provide Medi-Cal benefits during the presumptive eligibility period to individuals who have been determined eligible on the basis of preliminary information by a qualified hospital, as specified.

Existing law requires the department to adopt regulations for use by the county in determining whether an applicant is a resident of the state and of the county, subject to the requirements of federal law. Existing law requires that the regulations require that state residency be established only if certain requirements are met, including the requirement that the applicant makes specified declarations under penalty of perjury.

This bill would revise those provisions to, among other things, further prescribe the circumstances under which state residency may be established and to require the department to electronically verify an individual's state residency using certain sources and would set forth how an individual may establish state residency if the department is unable to electronically verify his or her state residency. The bill would, for purposes of establishing state residency, authorize an individual to make various declarations under penalty of perjury, and would authorize other individuals, such as parents or legal guardians, to make various declarations under penalty of perjury regarding the individual's state residency if the individual is incapable of indicating intent. By expanding the crime of perjury, the bill would impose a state-mandated local program.

This bill would provide that any individual who is 21 years of age or older, does not have minor children eligible for Medi-Cal benefits, would

be eligible for Medi-Cal benefits but for a specified five-year eligibility limitation, and who is enrolled in and covered through the California Health Benefit Exchange with an advanced premium tax credit shall be eligible for specified Medi-Cal benefits and insurance premium costs and cost-sharing charges paid by the department, as specified.

Under existing law, one of the ways by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans.

This bill would require Medi-Cal managed care plans to provide mental health benefits covered by the state plan, as prescribed.

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 with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

This bill would become operative only if AB 1 of the First Extraordinary Session is enacted and takes effect.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) The United States is the only industrialized country in the world without a universal health insurance system.

(b) (1) In 2006, the United States Census reported that 46 million Americans did not have health insurance.

(2) In California in 2009, according to the UCLA Center for Health Policy Research's "The State of Health Insurance in California: Findings from the 2009 California Health Interview Survey," 7.1 million Californians were uninsured in 2009, amounting to 21.1 percent of nonelderly Californians who had no health insurance coverage for all or some of 2009, up nearly 2 percentage points from 2007.

(c) On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (Public Law 111-148), which was amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and together are referred to as the Affordable Care Act of 2010 (Affordable Care Act).

(d) The Affordable Care Act is the culmination of decades of movement toward health reform, and is the most fundamental legislative transformation of the United States health care system in 40 years.

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

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

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

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

SEC. 2. Section 11026 of the Welfare and Institutions Code is amended to read:

11026. (a) Notwithstanding any other provision of law, the State Department of Social Services and the State Department of Health Care Services shall annually inform the Franchise Tax Board of the names and social security numbers of all applicants or recipients of public social services or public assistance programs. The Franchise Tax Board, upon receipt of that information, shall furnish to the departments the information required by Section 19555 of the Revenue and Taxation Code.

(b) This section shall be implemented only to the extent it is funded in the annual Budget Act.

SEC. 3. Section 14000.7 is added to the Welfare and Institutions Code, to read:

14000.7. (a) The department shall provide assistance to any applicant or beneficiary that requests help with the application or redetermination process to the extent required by federal law.

(b) The assistance provided under subdivision (a) shall be available to the individual in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who have limited English proficiency.

(c) To the extent otherwise required by Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall adopt emergency regulations implementing this section no later than July 1, 2015. The department may thereafter readopt the emergency regulations pursuant to that chapter. The adoption and readoption, by the department, of regulations implementing this section shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

(d) This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

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

SEC. 4. Section 14005.28 of the Welfare and Institutions Code is amended to read:

14005.28. (a) To the extent federal financial participation is available pursuant to an approved state plan amendment, the department shall exercise

its option under Section 1902(a)(10)(A)(ii)(XVII) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XVII)) to extend Medi-Cal benefits to independent foster care adolescents, as defined in Section 1905(w)(1) of the federal Social Security Act (42 U.S.C. Sec. 1396d(w)(1)).

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

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

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

SEC. 5. Section 14005.28 is added to the Welfare and Institutions Code, to read:

14005.28. (a) To the extent federal financial participation is available pursuant to an approved state plan amendment, the department shall implement Section 1902(a)(10)(A)(i)(IX) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(IX)) to provide Medi-Cal benefits to an individual who is in foster care on his or her 18th birthday until his or her 26th birthday. In addition, the department shall implement the federal option to provide Medi-Cal benefits to individuals who were in foster care and enrolled in Medicaid in any state.

(1) A foster care adolescent who is in foster care in this state on his or her 18th birthday shall be enrolled to receive benefits under this section without any interruption in coverage and without requiring a new application.

(2) The department shall develop procedures to identify and enroll individuals who meet the criteria for Medi-Cal eligibility in this subdivision, including, but not limited to, former foster care adolescents who were in foster care on their 18th birthday and who lost Medi-Cal coverage as a result of attaining 21 years of age. The department shall work with counties to identify and conduct outreach to former foster care adolescents who lost Medi-Cal coverage during the 2013 calendar year as a result of attaining 21 years of age, to ensure they are aware of the ability to reenroll under the coverage provided pursuant to this section.

(3) (A) The department shall develop and implement a simplified redetermination form for this program. A beneficiary qualifying for the benefits extended pursuant to this section shall fill out and return this form only if information known to the department is no longer accurate or is materially incomplete.

(B) The department shall seek federal approval to institute a renewal process that allows a beneficiary receiving benefits under this section to

remain on Medi-Cal after a redetermination form is returned as undeliverable and the county is otherwise unable to establish contact. If federal approval is granted, the recipient shall remain eligible for services under the Medi-Cal fee-for-service program until the time contact is reestablished or ineligibility is established, and to the extent federal financial participation is available.

(C) The department shall terminate eligibility only after it determines that the recipient is no longer eligible and all due process requirements are met in accordance with state and federal law.

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

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

SEC. 6. Section 14005.31 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

she should review his or her circumstances to determine if changes have occurred that should be reported to the Medi-Cal eligibility worker.

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

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

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

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

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

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

SEC. 7. Section 14005.31 is added to the Welfare and Institutions Code, to read:

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

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

(b) The department, in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers, shall prepare a simple, clear, consumer-friendly notice to be used by the counties to inform Medi-Cal beneficiaries whose eligibility for cash aid under Chapter 2 (commencing with Section 11200) has ended, but whose eligibility for benefits under Section 14005.30 continues pursuant to subdivision (a), that

their benefits will continue. To the extent feasible, the notice shall be sent out at the same time as the notice of discontinuation of cash aid, and shall include all of the following:

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

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

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

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

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

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

(c) This section shall be implemented only to the extent that federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is available.

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

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

SEC. 8. Section 14005.32 of the Welfare and Institutions Code is amended to read:

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



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

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

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

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

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

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

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

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

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

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

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

Government Code. Comprehensive implementing instructions shall be issued to the counties no later than March 1, 2001.

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

SEC. 9. Section 14005.32 is added to the Welfare and Institutions Code, to read:

14005.32. (a) (1) If the county has evidence clearly demonstrating that a beneficiary is not eligible for benefits under this chapter pursuant to Section 14005.30, but is eligible for benefits under this chapter pursuant to other provisions of law, the county shall transfer the individual to the corresponding Medi-Cal program in conformity with and subject to the requirements of Section 14005.37. Eligibility under Section 14005.30 shall continue until the transfer is complete.

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

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

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

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

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

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

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

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

(c) This section shall be implemented only to the extent that federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is available.

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

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

SEC. 10. Section 14005.39 of the Welfare and Institutions Code is amended to read:

14005.39. (a) If a county has facts clearly demonstrating that a Medi-Cal beneficiary cannot be eligible for Medi-Cal due to an event, such as death or change of state residency, Medi-Cal benefits shall be terminated without a redetermination under Section 14005.37.

(b) Whenever Medi-Cal eligibility is terminated without a redetermination, as provided in subdivision (a), the Medi-Cal eligibility worker shall record that fact or event causing the eligibility termination in the beneficiary's file, along with a certification that a full redetermination could not result in a finding of Medi-Cal eligibility. Following this certification, a notice of action specifying the basis for termination of Medi-Cal eligibility shall be sent to the beneficiary.

(c) This section shall be implemented only if and to the extent that federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et. seq.) is available and necessary federal approvals have been obtained.

SEC. 11. Section 14005.63 is added to the Welfare and Institutions Code, to read:

14005.63. (a) A person who wishes to apply for an insurance affordability program shall be allowed to file an application on his or her own behalf or on behalf of his or her family. Subject to the requirements of Section 14014.5, an individual also may be accompanied, assisted, and represented in the application and renewal process by an individual or organization of his or her own choice. If the individual, for any reason, is unable to apply or renew on his or her own behalf, any of the following persons may assist in the application process or during a renewal of eligibility:

(1) The individual's guardian, conservator, a person authorized to make health care decisions on behalf of the individual pursuant to an advance health care directive, or executor or administrator of the individual's estate.

(2) A public agency representative.

(3) The individual's legal counsel, relative, friend, or other spokesperson of his or her choice.

(b) A person who wishes to challenge a decision concerning his or her eligibility for or receipt of benefits from an insurance affordability program has the right to represent himself or herself or use legal counsel, a relative, a friend, or other spokesperson of his or her choice subject to the requirements of Section 14014.5.

(c) To the extent otherwise required by Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall adopt emergency regulations implementing this section no later than July 1, 2015. The department may thereafter readopt the emergency regulations pursuant to that chapter. The adoption and readoption, by the department, of regulations implementing this section shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

(d) This section shall be implemented on October 1, 2013, or when all necessary federal approvals have been obtained, whichever is later, and only if and to the extent that federal financial participation is available.

SEC. 12. Section 14005.65 is added to the Welfare and Institutions Code, to read:

14005.65. (a) The department shall file a state plan amendment to exercise the federal option under subdivision (h) of Section 435.603 of Title 42 of the Code of Federal Regulations to allow beneficiaries to use projected annual household income and to allow applicants and beneficiaries to use reasonably predictable annual income as set forth in this section when determining their eligibility for Medi-Cal benefits.

(b) (1) Beneficiaries shall be allowed to use projected annual household income to establish eligibility for Medi-Cal benefits for the remainder of the calendar year in which that projected income is used to determine eligibility if the current monthly income would render the beneficiary ineligible due to an increase in income.

(2) If projected annual household income has been used by the beneficiary, the department shall redetermine the beneficiary's Medi-Cal benefits at the end of the calendar year.

(c) (1) Applicants and beneficiaries shall be allowed to use reasonably predictable annual income to establish eligibility for Medi-Cal benefits.

(2) Before being allowed to use reasonably predictable annual income pursuant to establishing eligibility for Medi-Cal benefits, the applicant or beneficiary shall provide the department with adequate evidence of the predicted change, including, but not limited to, a signed contract for employment, clear proof of a history of predictable fluctuations in income, or other clear indicia of such future changes in income.

(d) This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

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

SEC. 13. Section 14005.66 is added to the Welfare and Institutions Code, to read:

14005.66. The department shall seek any federal waivers necessary to use the eligibility information of individuals who have been determined eligible for the CalFresh program under Chapter 10 (commencing with Section 18900) of Part 6, and who are under 65 years of age and are not disabled, to determine their Medi-Cal eligibility.

SEC. 14. Section 14005.67 is added to the Welfare and Institutions Code, to read:

14005.67. The department shall seek any federal waivers necessary to automatically enroll parents in the Medi-Cal program who apply for Medi-Cal benefits and have one or more children who are eligible for Medi-Cal benefits based upon a determined income level that is at or below the applicable income standard for eligibility under Section 14005.60.

SEC. 15. Section 14005.68 is added to the Welfare and Institutions Code, to read:

14005.68. The department may seek any federal waivers or state plan amendments necessary to use the eligibility information of individuals determined eligible for other state-only funded health care programs and county general assistance programs to determine an applicant's Medi-Cal eligibility to the extent that there is no General Fund impact.

SEC. 16. Section 14007.1 of the Welfare and Institutions Code is amended to read:

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

(1) The applicant produces one of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 17. Section 14007.1 is added to the Welfare and Institutions Code, to read:

14007.1. (a) The department shall electronically verify an individual’s state residency using information from the federal Supplemental Nutrition Assistance Program, the CalWORKs program, the California Health Benefit Exchange, the Franchise Tax Board, the Department of Motor Vehicles, the Employment Development Department, or the electronic service established in accordance with Section 435.949 of Title 42 of the Code of Federal Regulations, and other available sources. If the department is unable to electronically verify an individual’s state residency using these electronic data sources, an individual shall verify state residency as set forth in this section.

(b) If the individual is 21 years of age or older, is capable of indicating intent, and is not residing in an institution, state residency is established when the individual provides one of the following:

(1) A recent California rent or mortgage receipt or utility bill in the individual’s name.

(2) A current California motor vehicle driver’s license or California Identification Card issued by the Department of Motor Vehicles in the individual’s name.

(3) A current California motor vehicle registration in the individual’s name.

(4) A document showing that the individual is employed in this state or is seeking employment in the state.

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

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

(7) Evidence that the individual is receiving public assistance in this state. For purposes of this paragraph, “public assistance” shall not include unemployment insurance benefits.

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

(9) A declaration by the individual under penalty of perjury that he or she intends to reside in this state and does not have a fixed address and cannot provide any of the documents identified in paragraphs (1) to (8), inclusive.

(10) A declaration by the individual under penalty of perjury that he or she has entered the state with a job commitment or is seeking employment in the state and cannot provide any of the documents identified in paragraphs (1) to (8), inclusive.

(c) If the individual is 21 years of age or older, is incapable of indicating intent, and is not residing in an institution, state residency is established when the parent, legal guardian of the individual, or any other person with knowledge declares, under penalty of perjury, that the individual is residing in this state.

(d) If the individual is 21 years of age or older, is residing in an institution, and became incapable of indicating intent before reaching 21 years of age, state residency is established by any of the following:

(1) When the parent applying for Medi-Cal on the individual's behalf (A) declares under penalty of perjury that the individual's parents reside in separate states and (B) establishes that he or she (the parent) is a resident of this state in accordance with the requirements of this section.

(2) When the legal guardian applying for Medi-Cal on the individual's behalf (A) declares under penalty of perjury that parental rights have been terminated and (B) establishes that he or she (the legal guardian) is a resident of this state in accordance with the requirements of this section.

(3) When the parent or parents applying for Medi-Cal on the individual's behalf establishes in accordance with the requirements of this section that he, she, or they (the parent or parents), were a resident of this state at the time the individual was placed in the institution.

(4) When the legal guardian applying for Medi-Cal on the individual's behalf (A) declares under penalty of perjury that parental rights have been terminated and (B) establishes in accordance with the requirements of this section that he or she (the legal guardian) was a resident of this state at the time the individual was placed in the institution.

(5) When the parent, or parents, applying for Medi-Cal on the individual's behalf (A) provides a document from the institution that demonstrates that the individual is institutionalized in this state and (B) establishes in accordance with the requirements of this section that he, she, or they (the parent or parents), are a resident of this state.

(6) When the legal guardian applying for Medi-Cal on the individual's behalf (A) provides a document from the institution that demonstrates that the individual is institutionalized in this state, (B) declares under penalty of perjury that parental rights have been terminated, and (C) establishes in accordance with the requirements of this section that he or she (the legal guardian) is a resident of this state.

(7) When the individual or party applying for Medi-Cal on the individual's behalf (A) provides a document from the institution that

demonstrates that the individual is institutionalized in this state, (B) declares under penalty of perjury that the individual has been abandoned by his or her parents and does not have a legal guardian, and (C) establishes that he or she (the individual or party applying for Medi-Cal on the individual's behalf) is a resident of this state in accordance with the requirements of this section.

(e) Except when another state has placed the individual in the institution, if the individual is 21 years of age or older, is residing in an institution, and became incapable of indicating intent on or after reaching 21 years of age, state residency is established when the person filing the application on the individual's behalf provides a document from the institution that demonstrates that the individual is institutionalized in this state.

(f) If the individual is 21 years of age or older, is capable of indicating intent, and is residing in an institution, state residency is established when the individual (1) provides a document from the institution that demonstrates that the individual is institutionalized in this state, and (2) declares under penalty of perjury that he or she intends to reside in this state.

(g) If the individual is under 21 years of age, is married or emancipated from his or her parents, is capable of indicating intent, and is not residing in an institution, state residency is established in accordance with subdivision (b).

(h) If the individual is under 21 years of age, is not living in an institution, and is not described in subdivision (g), state residency is established by any of the following:

(1) When the individual resides with his or her parent or parents and the parent or parents establish that he, she, or they (the parent or parents), as the case may be, are a resident of this state in accordance with the requirements of subdivision (b).

(2) When the individual resides with a caretaker relative and the caretaker relative establishes that he, she, or they (the caretaker relative or caretaker relatives), are a resident of this state in accordance with the requirements of subdivision (b).

(3) When the person with whom the individual is residing is not the individual's parent or caretaker relative and he or she (A) declares under penalty of perjury that the individual is residing with him or her, and (B) establishes that he or she (the person with whom the individual is residing) is a resident of this state in accordance with the requirements of subdivision (b).

(4) When the individual does not reside with his or her parents or with a caretaker relative and he or she declares under penalty of perjury that he or she is living in this state.

(i) If the individual is under 21 years of age, is institutionalized, and is not married or emancipated, state residency is established in accordance with paragraph (3), (4), (5), (6), or (7) of subdivision (d).

(j) A denial of a determination of residency may be appealed in the same manner as any other denial of eligibility. The administrative law judge shall receive any proof of residency offered by the individual and may inquire



into any facts relevant to the question of residency. A determination of residency shall not be granted unless a preponderance of the credible evidence supports that the individual is a resident of this state under Section 14007.15.

(k) To the extent otherwise required by Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall adopt emergency regulations implementing this section no later than July 1, 2015. The department may thereafter readopt the emergency regulations pursuant to that chapter. The adoption and readoption, by the department, of regulations implementing this section shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

(l) For purposes of this section, the definitions in subdivision (i) of Section 14007.15 shall apply.

(m) This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

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

SEC. 18. Section 14007.15 is added to the Welfare and Institutions Code, immediately following Section 14007.1, to read:

14007.15. (a) Except as provided in subdivision (f), an individual is a resident of this state if he or she is 21 years of age or older, is not residing in an institution, is living in the state, and any of the following apply:

(1) The individual intends to reside in this state, including individuals who do not have a fixed address.

(2) The individual has entered this state with a job commitment or is seeking employment in this state, regardless of whether he or she is currently employed.

(3) The individual is incapable of indicating intent.

(b) Except as provided in subdivision (f), an individual that is 21 years of age or older, is residing in an institution, and became incapable of indicating intent before reaching 21 years of age is a resident of this state if any of the following apply:

(1) The individual's parents reside in separate states and the parent applying for Medi-Cal on the individual's behalf is a resident of this state under this section.

(2) The parental rights have been terminated and a legal guardian has been appointed for the individual and the legal guardian applying for Medi-Cal on the individual's behalf is a resident of this state under this section.

(3) The individual's parent or parents, or legal guardian if parental rights have been terminated, was a resident of this state under this section at the time the individual was placed in the institution.

(4) The individual is institutionalized in this state and the parent or parents, or legal guardian if parental rights have been terminated, applying for Medi-Cal on the individual's behalf is a resident of this state under this section.

(5) The individual is institutionalized in this state, has been abandoned by his or her parent or parents, does not have a legal guardian, and the individual or party that filed the Medi-Cal application on the individual's behalf is a resident of this state under this section.

(c) Except as provided in subdivision (f) and except where another state has placed the individual in the institution, an individual is a resident of this state if he or she is 21 years of age or older, is institutionalized in this state, and became incapable of indicating intent on or after reaching 21 years of age.

(d) Except as provided in subdivision (f), an individual is a resident of this state if he or she is 21 years of age or older, is institutionalized in this state, and intends to reside in this state.

(e) Except as provided in subdivision (f), an individual that is under 21 years of age is a resident of this state if one of the following apply:

(1) The individual is not residing in an institution, is capable of indicating intent, is married or is emancipated from his or her parents, is living in this state, and one of the following apply:

(A) The individual intends to reside in this state, which includes an individual who does not have a fixed address.

(B) The individual has entered this state with a job commitment or is seeking employment in this state, regardless of whether he or she is currently employed.

(2) The individual is not described in paragraph (1) and is not living in an institution, and any of the following apply:

(A) The individual resides in this state, including without a fixed address.

(B) The individual resides with his or her parent or parents or a caretaker relative who is a resident of this state under this section.

(3) The individual is institutionalized, is not married or emancipated, and any of the following apply:

(A) The individual's parent or parents, or legal guardian if parental rights have been terminated, was a resident of this state under this section at the time of placement in the institution.

(B) The individual is institutionalized in this state and his or her parent or parents, or legal guardian if parental rights have been terminated, who files the application on the individual's behalf is a resident of this state under this section.

(C) The individual is institutionalized in this state, has been abandoned by his or her parents, does not have a legal guardian, and the individual or party that files the application on the individual's behalf is a resident of this state under this section.

(f) An individual who is receiving a state supplementary payment (SSP) is a resident of the state paying the SSP.

(g) An individual who lives in this state and is receiving foster care or adoption assistance under Title IV-E of the federal Social Security Act is a resident of this state.

(h) (1) If this state or an agent of this state arranges for an individual to be placed in an institution located in another state, the individual is a resident of this state.

(2) The following actions do not constitute a placement by this state:

(A) Providing basic information to the individual about another state's Medicaid program and information about the availability of health care services and facilities in another state.

(B) Assisting an individual to locate an institution in another state when the individual is capable of indicating intent and independently decides to move to the other state.

(3) When a competent individual leaves the facility in which he or she was placed by this state, that individual's state of residence is the state where the individual is physically located.

(4) If this state initiates a placement in another state because it lacks an appropriate facility to provide services to the individual, the individual is a resident of this state.

(i) For the purposes of this section and Section 14007.1, the following definitions apply:

(1) "Incapable of indicating intent" means when an individual is considered to be any of the following:

(A) Determined to have an I.Q. of 49 or less or to have a mental age of 7 years or younger based upon tests administered by a properly licensed mental health or developmental disabilities professional.

(B) Found to be incapable of indicating intent based on medical documentation provided by a physician, psychologist, or other person licensed by the state in the field of mental health or developmental disabilities.

(C) Been judicially determined to be legally incompetent.

(2) "Institution" shall have the same meaning as that term is defined in Section 435.1010 of Title 42 of the Code of Federal Regulations. For the purposes of determining residency under subdivision (h), the term also includes licensed foster care homes providing food, shelter, and supportive services to one or more persons unrelated to the proprietor.

(j) To the extent otherwise required by Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall adopt emergency regulations implementing this section no later than July 1, 2015. The department may thereafter readopt the emergency regulations pursuant to that chapter. The adoption and readoption, by the department, of regulations implementing this section shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

(k) This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

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

SEC. 19. Section 14007.6 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

SEC. 20. Section 14007.6 is added to the Welfare and Institutions Code, to read:

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

(b) If a recipient whose services are terminated pursuant to subdivision (a) reapplies for services, services shall be restored provided all other eligibility criteria are met and the individual is considered a resident pursuant to Section 14007.15.

(c) To the extent otherwise required by Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall adopt emergency regulations implementing this section no later than July 1, 2015. The department may thereafter readopt the emergency regulations pursuant to that chapter. The adoption and readoption, by the department, of regulations implementing this section shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

(d) This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

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

SEC. 21. Section 14008.85 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

SEC. 22. Section 14011.66 is added to the Welfare and Institutions Code, to read:

14011.66. (a) Effective January 1, 2014, the department shall provide Medi-Cal benefits during a presumptive eligibility period to individuals who have been determined eligible on the basis of preliminary information by a qualified hospital in accordance with Section 1396a(a)(47)(B) of Title 42 of the United States Code and as set forth in this section.

(b) A hospital may only make presumptive eligibility determinations under this section if it complies with all of following:

(1) It is a participating provider under the state plan or under a federal waiver under Section 1315 of Title 42 of the United States Code.

(2) It has notified the department in writing that it has elected to be a qualified entity for the purpose of making presumptive eligibility determinations.

(3) It agrees to make presumptive eligibility determinations consistent with all applicable policies and procedures.

(4) It has not been disqualified to make presumptive eligibility determinations by the department.

(c) Qualified hospitals may only make presumptive eligibility determinations based upon income for children, pregnant women, parents and other caretaker relatives, and other adults, whose income is calculated using the applicable MAGI-based income standard.

(d) The department shall establish a process for determining whether a hospital should be disqualified from being able to make presumptive eligibility determinations under this section.

(e) For purposes of this section, “MAGI-based income” means income calculated using the financial methodologies described in Section 1396a(e)(14) of Title 42 of the United States Code, as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148) and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

(f) This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

SEC. 23. Section 14014.5 is added to the Welfare and Institutions Code, to read:

14014.5. (a) It is the intent of the Legislature to protect individual privacy and the integrity of Medi-Cal and other insurance affordability programs by restricting the disclosure of personal identifying information to prevent identity theft, abuse, or fraud in situations where an insurance affordability program applicant or beneficiary appoints an authorized representative to assist him or her in obtaining health care benefits.

(b) The department, in consultation with the California Health Benefit Exchange, shall implement policies and prescribe forms, notices, and other safeguards to ensure the privacy and protection of the rights of applicants who appoint an authorized representative consistent with the provisions of Section 1902 of the federal Social Security Act (42 U.S.C. Sec. 1396a) and Section 435.908 of Title 42 of the Code of Federal Regulations.

(c) All insurance affordability programs shall obtain completed authorization forms pursuant to subdivision (b) prior to making the final determination concerning the eligibility or renewal to which the authorization applies.

(d) An authorization pursuant to this section shall do both of the following:

(1) Specify what authority the applicant or beneficiary is granting to the authorized representative and what notices, if any, should be sent to the authorized representative in addition to the applicant or beneficiary.

(2) Be effective until the applicant or beneficiary cancels or modifies the authorization or appoints a new authorized representative, or the authorized representative informs the agency that he or she is no longer acting in that

capacity or there is a change in the legal authority on which the authority was based. The notice shall conform to all federal requirements.

(e) An authorization pursuant to this section may be canceled or modified at any time for any reason by the insurance affordability program applicant or beneficiary by submitting notice of cancellation or modification to the appropriate insurance affordability program in accordance with policies and forms developed pursuant to subdivision (b).

(f) The agency shall accept electronic, including telephonically recorded, signatures, and handwritten signatures transmitted by facsimile or other electronic transmission.

(g) For purposes of this section all of the following definitions shall apply:

(1) “Authorized representative” means:

(A) (i) Any individual appointed in writing, on a form designated by the department, by a competent person that is an applicant for or beneficiary of any insurance affordability program, to act in place or on behalf of the applicant or beneficiary for purposes related to the insurance affordability program, including, but not limited to, accompanying, assisting, or representing the applicant in the application process or the beneficiary in the redetermination of eligibility process, as specified by the applicant or beneficiary.

(ii) Legal documentation of authority to act on behalf of the applicant or beneficiary under state law, including, but not limited to, a court order establishing legal guardianship or a valid power of attorney to make health care decisions, shall serve in place of a written appointment by the applicant or beneficiary.

(2) “Competent” means being able to act on one’s own behalf in business and personal matters.

(h) An authorized representative of an applicant or beneficiary of an insurance affordability program who also is employed by or is a contractor for any type of health care provider or facility shall fully disclose in writing to the applicant or beneficiary that the authorized representative is employed by or contracting with such a provider or facility and of any potential conflicts of interest.

(i) All notices regarding the insurance affordability program, including, but not limited to, those related to the application, redetermination, or actions taken by the agency, shall be sent to the applicant or beneficiary, and to the authorized representative if authorized by the applicant or beneficiary.

(j) (1) If an applicant or beneficiary is not competent and has not appointed an appropriately authorized representative pursuant to this section or that appointment is no longer effective, any of the individuals identified in subparagraphs (A) to (C), inclusive, may be recognized by the hearing officer as the authorized representative to represent the applicant or beneficiary at the state hearing regarding a notice of action if, at the hearing, he or she demonstrates that the applicant or beneficiary is not competent and that lack of competency is the reason that he or she has not been authorized by the applicant or beneficiary to act as the applicant’s or

beneficiary's authorized representative. The individuals that may be recognized are:

(A) A relative of the applicant or beneficiary or a person appointed by the relative.

(B) A person with knowledge of the applicant's or beneficiary's circumstances that completed and signed the statement of facts on the applicant's or beneficiary's behalf.

(C) An applicant's or beneficiary's legal counsel or advocate working under the supervision of an attorney.

(2) If an applicant or beneficiary is not competent and has not appointed an appropriately authorized representative pursuant to this section or that appointment is no longer effective, the hearing officer may allow an individual with knowledge about the applicant's or beneficiary's circumstances to represent the applicant or beneficiary at the hearing if (A) the hearing officer determines that the representation is in the applicant or beneficiary's best interests and (B) there is not a person who qualifies under paragraph (1) that is available to represent the applicant or beneficiary.

(k) (1) A provider or staff member or volunteer of an organization who intends to serve as an authorized representative shall comply with, and shall provide, a signed written agreement that he or she will adhere to all federal and state requirements governing his or her appointment as an authorized representative, including, but not limited to, those relating to confidentiality of information, prohibitions against reassignment of provider claims, and conflicts of interest. The department shall work with counties and consumer advocates to develop a standard agreement form that may be used for this purpose.

(2) The standard agreement form developed pursuant to paragraph (1) shall include a notification regarding the requirements of this subdivision and a statement that by signing the agreement, the individual named as an authorized representative agrees to abide by those requirements.

(l) To the extent otherwise required by Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall adopt emergency regulations implementing this section no later than July 1, 2015. The department may thereafter readopt the emergency regulations pursuant to that chapter. The adoption and readoption, by the department, of regulations implementing this section shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

(m) This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

(n) This section shall be implemented on October 1, 2013, or when all necessary federal approvals have been obtained, whichever is later.



SEC. 24. Section 14057 is added to the Welfare and Institutions Code, to read:

14057. (a) For the purposes of this chapter, “insurance affordability program” means a program that is one of the following:

(1) The state’s Medi-Cal program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(2) The state’s children’s health insurance program (CHIP) under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(3) A program that makes available to qualified applicants coverage in a qualified health plan through the California Health Benefit Exchange, established pursuant to Title 22 (commencing with Section 100500) of the Government Code, with advance payment of the premium tax credit established under Section 36B of the Internal Revenue Code.

(4) A program that makes available coverage in a qualified health plan through the California Health Benefit Exchange, established pursuant to Title 22 (commencing with Section 100500) of the Government Code, with cost-sharing reductions established under Section 1402 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), and any subsequent amendments to that act.

(b) This section shall become operative on October 1, 2013.

SEC. 25. Section 14102 is added to the Welfare and Institutions Code, to read:

14102. (a) Notwithstanding any other provision of law and except as otherwise provided in this section, any individual who is 21 years of age or older, who does not have minor children eligible for Medi-Cal benefits and would be eligible for Medi-Cal benefits pursuant to Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)) but for the five-year eligibility limitation under Section 1613 of Title 8 of the United States Code, and who is enrolled in coverage through the Exchange with an advanced premium tax credit shall be eligible for the following:

(1) Those Medi-Cal benefits for which he or she would have been eligible but for the five-year eligibility limitation only to the extent that they are not available through his or her individual health plan.

(2) The department shall pay on behalf of the beneficiary:

(A) The beneficiary’s insurance premium costs for an individual health plan, minus the beneficiary’s premium tax credit authorized by Section 36B of Title 26 of the United States Code and its implementing regulations.

(B) The beneficiary’s cost-sharing charges so that the individual has the same cost-sharing charges as he or she would have in the Medi-Cal program.

(b) (1) If an individual is eligible for benefits under subdivision (a) and he or she is otherwise eligible for state-only funded full-scope benefits, but (A) he or she is barred from enrolling in an Exchange qualified health plan because he or she is outside of an available enrollment period for coverage or (B) the Exchange and the department do not have the operational capability to implement the benefits under subdivision (a), he or she shall

remain eligible for those state-only funded benefits subject to paragraph (2).

(2) On the first date that an individual referenced in paragraph (1) is eligible for and can enroll in coverage under a qualified health plan offered through the Exchange, he or she shall be ineligible for the state-only funded full-scope benefits referenced in paragraph (1) unless the Exchange and the department do not have the operational capability to implement the benefits under subdivision (a).

(c) The department shall inform and assist individuals eligible under this section on enrolling in coverage through the Exchange with the premium assistance, cost sharing, and benefits described in subdivision (a), including, but not limited to, developing processes to coordinate with the county entities that administer eligibility for coverage in Medi-Cal and the Exchange.

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

(1) “Cost-sharing charges” means any expenditure required by or on behalf of an enrollee by his or her individual health plan with respect to essential health benefits and includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, and spending for noncovered services.

(2) “Exchange” means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(e) Benefits for services under this section shall be provided with state-only funds only if federal financial participation is not available for those services. The department shall maximize federal financial participation in implementing this section to the extent allowable.

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

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

SEC. 26. Section 14103 is added to the Welfare and Institutions Code, to read:

14103. (a) The implementation of the optional expansion of Medi-Cal benefits to adults who meet the eligibility requirements of Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), shall be contingent upon the following:

(1) If the federal medical assistance percentage payable to the state under the ACA for the optional expansion of Medi-Cal benefits to adults is reduced below 90 percent, that reduction shall be addressed in a timely manner

through the annual state budget or legislative process. Upon receiving notification of any reduction in federal assistance pursuant to this paragraph, the Director of Finance shall immediately notify the Chairpersons of the Senate and Assembly Health Committees and the Chairperson of the Joint Legislative Budget Committee.

(2) If, prior to January 1, 2018, the federal medical assistance percentage payable to the state under the ACA for the optional expansion of Medi-Cal benefits to adults is reduced to 70 percent or less, the implementation of any provision in this chapter authorizing the optional expansion of Medi-Cal benefits to adults shall cease 12 months after the effective date of the federal law or other action reducing the federal medical assistance percentage.

(b) For purposes of this section, “ACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148) as originally enacted and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

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

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

(a) Outpatient services are covered as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetist services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and X-ray services are covered, subject to utilization

controls. Nothing in this subdivision shall be construed to require prior authorization for anesthesiologist services provided as part of an outpatient medical procedure or for portable X-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

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

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

(A) Periodontal treatment is not a benefit.

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

(C) Laboratory processed crowns are not a benefit.

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

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

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

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

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

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

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

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

modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (1) Level of care and cost of care evaluations.
- (2) Expenses, directly attributable to home care activities, for materials.
- (3) Physician fees for home visits.
- (4) Expenses directly attributable to home care activities for shelter and modification to shelter.
- (5) Expenses directly attributable to additional costs of special diets, including tube feeding.
- (6) Medically related personal services.
- (7) Home nursing education.
- (8) Emergency maintenance repair.
- (9) Home health agency personnel benefits which permit coverage of care during periods when regular personnel are on vacation or using sick leave.
- (10) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.
- (11) Emergency and nonemergency medical transportation.
- (12) Medical supplies.

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

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

(15) Special drugs and medications.

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

(17) Therapy services.

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

(19) Modification of medical equipment for home use.

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

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

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

(t) Home- and community-based services approved by the United States Department of Health and Human Services are covered to the extent that federal financial participation is available for those services under the state plan or waivers granted in accordance with Section 1315 or 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and community-based services approvable under Section 1315 or 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers.

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

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

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



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

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

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

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

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

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

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

(2) The department shall seek a waiver in accordance with Section 1315 of Title 42 of the United States Code, or a state plan amendment adopted in accordance with Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code, which was added to Section 1396a of Title 42 of the United States Code by Section 2303(a)(2) of the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), for a program to provide comprehensive clinical family planning services as described in paragraph (8). Under the waiver, the program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. Under the state plan amendment, which shall replace the waiver and shall be known as the Family PACT successor state plan amendment, the program shall be operated only in accordance with this subdivision and the statutes and regulations in paragraph (4). The state shall use the standards and processes

imposed by the state on January 1, 2007, including the application of an eligibility discount factor to the extent required by the federal Centers for Medicare and Medicaid Services, for purposes of determining eligibility as permitted under Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code. To the extent that federal financial participation is available, the program shall continue to conduct education, outreach, enrollment, service delivery, and evaluation services as specified under the waiver. The services shall be provided under the program only if the waiver and, when applicable, the successor state plan amendment are approved by the federal Centers for Medicare and Medicaid Services and only to the extent that federal financial participation is available for the services. Nothing in this section shall prohibit the department from seeking the Family PACT successor state plan amendment during the operation of the waiver.

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

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

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

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

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive

family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no share of cost, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a share of cost or if they are otherwise eligible under Section 24003.

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

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

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

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

- (i) Psychosocial and medical aspects of contraception.
- (ii) Sexuality.
- (iii) Fertility.
- (iv) Pregnancy.
- (v) Parenthood.
- (vi) Infertility.
- (vii) Reproductive health care.
- (viii) Preconception and nutrition counseling.
- (ix) Prevention and treatment of sexually transmitted infection.

(x) Use of contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies.

(xi) Possible contraceptive consequences and followup.

(xii) Interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

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

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

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

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

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

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

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

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

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

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

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

14132.02. (a) The department shall seek approval from the United States Secretary of Health and Human Services to provide individuals made eligible pursuant to Section 14005.60 with the alternative benefit package option authorized by Section 1396u-7(b)(1)(D) of Title 42 of the United States Code. Effective January 1, 2014, the alternative benefit package shall provide the same schedule of benefits provided to full-scope Medi-Cal beneficiaries qualifying under the modified adjusted gross income standard pursuant to Section 1396a(e)(14) of Title 42 of the United States Code, except coverage of long-term services and supports shall be excluded unless otherwise required by Section 1396u-7(a)(2) of Title 42 of the United States Code or made available pursuant to subdivision (b). The alternative benefit package shall also include any benefits otherwise required by Section 1396u-7 of Title 42 of the United States Code and any regulations or guidance issued pursuant to that section.

(b) Notwithstanding Section 14005.64, and only to the extent federal approval is obtained, the department shall provide coverage for long-term services and supports to only those individuals who meet the asset requirements imposed under the Medi-Cal program for receipt of such services.

(c) For purposes of this section, long-term services and supports include nursing facility services, a level of care in any institution equivalent to nursing facility services, home- and community-based services furnished under the state plan or a waiver under Section 1315 or 1396n of Title 42 of the United States Code, home health services as described in Section 1396d(a)(7) of Title 42 of the United States Code, and personal care services described in Section 1396d(a)(24) of Title 42 of the United States Code.

(d) The department may seek approval of any necessary state plan amendments or waivers to implement this section.

(e) This section shall be implemented only to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

SEC. 29. Section 14132.03 is added to the Welfare and Institutions Code, to read:

14132.03. (a) The following shall be covered Medi-Cal benefits effective January 1, 2014:

(1) Mental health services included in the essential health benefits package adopted by the state pursuant to Section 1367.005 of the Health and Safety Code and Section 10112.27 of the Insurance Code and approved by the United States Secretary of Health and Human Services under Section 18022 of Title 42 of the United States Code. To the extent behavioral health treatment services are considered mental health services pursuant to the essential health benefits package, these services shall only be provided to individuals who receive services through federally approved waivers or state plan amendments pursuant to the Lanterman Developmental Disability Services Act, at Division 4.5 (commencing with Section 4500).

(2) Substance use disorder services included in the essential health benefits package adopted by the state pursuant to Section 1367.005 of the Health and Safety Code and Section 10112.27 of the Insurance Code and approved by the United States Secretary of Health and Human Services under Section 18022 of Title 42 of the United States Code.

(b) The department may seek approval of any necessary state plan amendments to implement this section.

(c) This section shall be implemented only to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

SEC. 30. Article 5.9 (commencing with Section 14189) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

#### Article 5.9. Medi-Cal Managed Care Plan Mental Health Benefits

14189. Medi-Cal managed care plans shall provide mental health benefits covered in the state plan excluding those benefits provided by county mental health plans under the Specialty Mental Health Services Waiver. The department may require the managed care plans to cover mental health pharmacy benefits to the extent provided in the contracts between the department and the Medi-Cal managed care plans.

SEC. 31. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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

SEC. 32. This act shall become operative only if Assembly Bill 1 of the 2013–14 First Extraordinary Session is enacted and takes effect.

O