AMENDED IN ASSEMBLY JUNE 4, 2013

CALIFORNIA LEGISLATURE—2013–14 FIRST EXTRAORDINARY SESSION

SENATE BILL No. 1

Introduced by Senators Hernandez and Steinberg
(Coauthors: Senators Calderon, Correa, De León, Hueso, and Lara)
(Coauthors: Assembly Members Alejo, Blumenfield, Campos, Eggman, Garcia, Gomez, Roger Hernández, V. Manuel Pérez, and Quirk-Silva)

January 28, 2013

An act to amend Section 12698.30 of the Insurance Code, and to amend Sections ~~14005.31, 14005.32,~~ *14005.36, 14005.39,* 14132, and 15926 of, to amend and repeal Sections *14005.38,* 14008.85, 14011.16, and 14011.17 of, to amend, repeal, and add Sections 14005.18, 14005.28, 14005.30, *14005.31, 14005.32,* 14005.37, 14007.1, 14007.6, and 14012 of, ~~and~~ to add Sections *14000.7,* 14005.60, 14005.62, 14005.63, 14005.64, 14005.65, *14007.15, 14014.5, 14015.7, 14055, 14057, 14102, 14102.5,* and 14132.02 to, *and to add and repeal Section 14015.5 of,* the Welfare and Institutions Code, relating to health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1, as amended, Hernandez. Medi-Cal: eligibility.

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

This bill would, commencing January 1, 2014, implement various provisions of the federal Patient Protection and Affordable Care Act (Affordable Care Act), as amended, by, among other things, modifying provisions relating to determining eligibility for certain groups. The

bill would, in this regard, extend Medi-Cal eligibility to specified adults *and former foster children* and would require that income eligibility be determined based on modified adjusted gross income (MAGI), as prescribed. The bill would prohibit the use of an asset or resources test for individuals whose financial eligibility for Medi-Cal is determined based on the application of MAGI. The bill would also add, commencing January 1, 2014, benefits, services, and coverage included in the essential health benefits package, as adopted by the state and approved by the United States Secretary of Health and Human Services, to the schedule of Medi-Cal benefits.

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

~~The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.~~

~~This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.~~

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 California Health Benefit Exchange (Exchange) to implement a workflow transfer protocol, as prescribed, for persons calling the customer service center operated by the Exchange for the purpose of applying for an insurance affordability program, to ascertain which individuals are potentially eligible for Medi-Cal. This bill would also prescribe the authority the department, the Exchange, and the counties would have, until July 1, 2015, to perform Medi-Cal eligibility determinations.

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.

Existing law requires Medi-Cal beneficiaries, with some exceptions, to file semiannual status reports to ensure that beneficiaries make timely and accurate reports of any change in circumstance that may affect their eligibility and requires, with some exceptions, a county to promptly redetermine eligibility whenever a county receives information about changes in a beneficiary's circumstances that may affect eligibility for Medi-Cal benefits.

This bill would, commencing January 1, 2014, revise these provisions to, among other things, delete the semiannual status report requirement and require a county to perform redeterminations every 12 months. The bill would require any forms signed by the beneficiary for purposes of redetermining eligibility to be signed under penalty of perjury. By expanding the crime of perjury, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that 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.

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

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 12698.30 of the Insurance Code is amended to read:

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

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

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

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

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

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. 3.~~

SEC. 4. Section 14005.18 of the Welfare and Institutions Code is amended to read:

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

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

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

~~SEC. 4.~~

SEC. 5. Section 14005.18 is added to the Welfare and Institutions Code, to read:

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

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

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

(2) "Postpartum services" means those services provided after childbirth, child delivery, or miscarriage.

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

~~SEC. 5.~~

SEC. 6. 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) The department shall identify and track all former independent foster care adolescents who, on or after January 1, 2013, lost Medi-Cal coverage as a result of attaining 21 years of age.~~

~~(e)~~

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

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

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

~~(2) The department shall develop procedures to identify individuals who meet the criteria in paragraph (1), including, but not limited to, former foster care adolescents who lost Medi-Cal coverage as a result of attaining 21 years of age, and reenroll them in Medi-Cal.~~

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

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

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

SEC. 7. 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 option in paragraph (3) of subdivision (b) of Section 435.150 of Title 42 of the Code of Federal Regulations to provide Medi-Cal benefits to individuals that were in foster care and enrolled in Medicaid in any state.

(1) A foster care adolescent who is in foster care 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. 7.~~

SEC. 8. Section 14005.30 of the Welfare and Institutions Code is amended to read:

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

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

(3) To the extent federal financial participation is available, the department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code authorizing the state to disregard all changes in income or assets of a beneficiary until the next annual redetermination under Section 14012. The department shall implement this paragraph only if, and to the extent that the State Child Health Insurance Program waiver described in Section 12693.755 of the Insurance Code extending Healthy Families Program eligibility to parents and certain other adults is approved and implemented.

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

of one shall be allowed to retain countable resources in the amount of three thousand dollars ($3,000).

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

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

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

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

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

~~SEC. 8.~~

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

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

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

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

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

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

~~SEC. 9.~~

SEC. 10. Section 14005.31 of the Welfare and Institutions Code is amended to read:

14005.31. (a) (1) Subject to paragraph (2), for any person whose eligibility for benefits under Section 14005.30 has been determined with a concurrent determination of eligibility for cash aid under Chapter 2 (commencing with Section 11200), loss of eligibility or termination of cash aid under Chapter 2 (commencing with Section 11200) shall not result in a loss of eligibility or termination of benefits under Section 14005.30 absent the existence of a factor that would result in loss of eligibility for benefits under Section 14005.30 for a person whose eligibility under Section

14005.30 was determined without a concurrent determination of eligibility for benefits under Chapter 2 (commencing with Section 11200).

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

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

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

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

(3) ~~(A)~~ A statement that the Medi-Cal beneficiary does not need to fill out monthly status reports in order to remain eligible for Medi-Cal, but ~~may~~ *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.

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

(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~~ *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. 11. 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) 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.

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

~~SEC. 10.~~

SEC. 12. 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) ~~(i)~~ 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~~ *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.

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

(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~~ *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. 13. 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.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this 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.

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

SEC. 14. Section 14005.36 of the Welfare and Institutions Code is amended to read:

14005.36. (a) The county shall undertake outreach efforts to beneficiaries receiving benefits under this chapter, in order to maintain the most up-to-date home addresses, telephone numbers, and other necessary contact information, and to encourage and assist with timely submission of the annual reaffirmation form, and, when applicable, transitional Medi-Cal program reporting forms and to facilitate the Medi-Cal redetermination process when one is required as provided in Section 14005.37. In implementing this subdivision, a county may collaborate with community-based organizations, provided that confidentiality is protected.

(b) The department shall encourage and facilitate efforts by managed care plans to report updated beneficiary contact information to counties.

(c) The department and each county shall incorporate, in a timely manner, updated contact information received from managed care plans pursuant to subdivision (b) into the beneficiary's Medi-Cal case file and into all systems used to inform plans of their beneficiaries' enrollee status. Updated Medi-Cal beneficiary contact information shall be limited to the beneficiary's telephone number, change of address information, and change of name. The county ~~may~~ *shall* attempt to verify that the information it receives from

the plan is accurate, *which may include, but is not limited to, making contact with the beneficiary,* before updating the beneficiary's case file. ~~The department shall develop a consent form that may be used by the counties to record the beneficiary's consent to use the information received from a managed care plan to update the beneficiary's file.~~

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

~~(e) 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) 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.

~~SEC. 11.~~

SEC. 15. Section 14005.37 of the Welfare and Institutions Code is amended to read:

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

procedures for redetermining Medi-Cal eligibility described in this section shall apply to all Medi-Cal beneficiaries.

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

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

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

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

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

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

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

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

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

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

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

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

(n) 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.

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

accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Comprehensive implementing instructions shall be issued to the counties no later than March 1, 2001.

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

~~SEC. 12.~~

SEC. 16. Section 14005.37 is added to the Welfare and Institutions Code, to read:

14005.37. (a) Except as provided in Section 14005.39, *a county shall perform redeterminations of eligibility for Medi-Cal beneficiaries every 12 months and shall promptly redetermine eligibility* whenever ~~a~~ *the* county receives information about changes in a beneficiary's circumstances that may affect eligibility for Medi-Cal ~~benefits, the county shall promptly redetermine eligibility~~ *benefits*. The procedures for redetermining Medi-Cal eligibility described in this section shall apply to all Medi-Cal beneficiaries.

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

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

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

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

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

(2) In the case of an annual redetermination, if, based upon information obtained pursuant to paragraph (1), the county is able to make a determination of continued eligibility, the county shall notify the beneficiary of both of the following:

(A) The eligibility determination and ~~basis~~ *the information it is based on*.

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

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

(4) In the case of a redetermination due to a change in circumstances, if a county determines that the change in circumstances does not affect the beneficiary's eligibility status, the county shall not send the beneficiary a notice unless required to do so by federal law.

(f) (1) In the case of an annual eligibility redetermination, if the county is unable to determine continued eligibility based on the information obtained pursuant to paragraph (1) of subdivision (e), the beneficiary shall be so informed and shall be provided with an annual renewal form that is prepopulated with information that the county has obtained and that identifies any additional information needed by the county to determine eligibility. The form shall be accompanied by a cover letter advising the beneficiary of all of the following:

(A) The requirement that he or she provide any necessary information to the county within 60 days of the date that the form is sent to the beneficiary.

(B) That the beneficiary may respond to the county via the Internet, by mail, by telephone, in person, or through other commonly available electronic means if those means are available in that county.

(C) That if the beneficiary chooses to return the form to the county in person or via mail, the beneficiary shall sign the form in order for it to be considered complete.

(D) The phone number to call in order to obtain more information.

(2) The county shall attempt to contact the beneficiary via the Internet, by telephone, or through other commonly available electronic means, if those means are available in that county, during the 60-day period to collect the necessary information.

(3) If the beneficiary has not provided any response to the written request for information sent pursuant to paragraph (1) within 60 days from the date the form is sent, the county shall terminate his or her eligibility for Medi-Cal benefits following the provision of timely notice.

(4) If the beneficiary responds to the written request for information during the 60-day period pursuant to paragraph (1) but the information provided is not complete, the county shall follow the procedures set forth in subdivision (g) to work with the beneficiary to complete the information.

(5) (A) The form and cover letter required by this subdivision shall be developed by the department in consultation with the counties and representatives of eligibility workers and consumers.

(B) For beneficiaries whose eligibility is not determined using MAGI-based financial methods, the county may use existing

renewal forms until the state develops prepopulated renewal forms to provide to beneficiaries. The department shall develop prepopulated renewal forms for use with beneficiaries whose eligibility is not determined using MAGI-based financial methods by January 1, 2015.

~~(f) If~~

(g) (1) In the case of a redetermination due to change in circumstances, if a county cannot obtain *sufficient* information ~~necessary~~ to redetermine eligibility pursuant to subdivision (e), the county shall attempt to reach the beneficiary by telephone and other commonly available electronic means, in counties where such electronic communication is available, in order to obtain this information, either directly or in collaboration with community-based organizations so long as confidentiality is protected.

~~(g)~~

(2) If a county's efforts pursuant to ~~subdivisions~~ *subdivision* (e) and ~~(f)~~ *paragraph (1) of this subdivision* to obtain the information necessary to redetermine eligibility have failed, the county shall send to the beneficiary a form ~~containing~~ *stating the* information ~~available to the county~~ needed to renew eligibility. *The county shall only request information related to the change in circumstances.* The county shall not request information or documentation that has been previously provided by the beneficiary, that is not absolutely necessary to complete the eligibility determination, or that is not subject to change. The county shall ~~not~~ *only* request information for nonapplicants necessary to make an eligibility ~~determination. The form shall be accompanied by a simple, clear, consumer-friendly cover letter, that shall explain why the form is necessary, the fact that it is not necessary to be receiving CalWORKs benefits to be receiving Medi-Cal benefits, the fact that receipt of Medi-Cal benefits does not count toward any time limits imposed by the CalWORKs program, the various bases for Medi-Cal eligibility, including disability, and the fact that even persons who are employed can receive Medi-Cal benefits~~ *determination or for a purpose directly related to the administration of the state Medicaid plan*. The form shall advise the individual to provide any necessary information to the county via the Internet, by telephone, by mail, in person, or through other commonly available electronic means and, *if the*

individual will provide the form by mail or in person, to sign the ~~renewal~~ form. The ~~cover letter~~ *form* shall include a telephone number to call in order to obtain more information. The form ~~and the cover letter~~ shall be developed by the department in consultation with the counties ~~and~~, representatives of consumers, ~~managed care plans, and Medi-Cal providers~~ *and eligibility workers*. A Medi-Cal beneficiary shall have no less than 20 days from the date the form is mailed pursuant to this subdivision to respond. Except as provided in ~~subdivision (h)~~ *paragraph (3)*, failure to respond prior to the end of this 20-day period shall not impact his or her Medi-Cal eligibility.

~~(h)~~

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

~~(i)~~

(4) If, within 20 days of the date of mailing of a form to the Medi-Cal beneficiary pursuant to *this* subdivision ~~(g)~~, a beneficiary does not submit the completed form to the county *or otherwise provide the needed information to the county*, the county shall send the beneficiary a written notice of action stating that his or her eligibility shall be terminated 10 days from the date of the notice and the reasons for that determination, unless the beneficiary submits a completed form *or otherwise provides the needed information to the county* prior to the end of the 10-day period.

~~(j)~~

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

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

~~(2) Commencing January 1, 2014, if~~

(h) If within 90 days of termination of a Medi-Cal beneficiary's eligibility *or a change in eligibility status* pursuant to ~~subdivision (h), (i), or (j)~~ *this section,* the beneficiary submits to the county a *signed and* completed form *or otherwise provides the needed information to the county*, eligibility shall be ~~determined as though the form was submitted in a timely manner~~ *redetermined by the county* and if ~~a~~ *the* beneficiary is found eligible, the termination ~~under subdivision (h), (i), or (j)~~ shall be rescinded.

~~(l)~~

(i) If the information available to the county pursuant to the redetermination procedures of ~~subdivisions (d), (e), (g), and (m)~~ *this section* does not indicate a basis of eligibility, Medi-Cal benefits may be terminated so long as due process requirements have otherwise been met.

~~(m)~~

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

~~(n)~~

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

~~(o)~~

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

~~(p)~~

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

~~(q)~~

(n) For individuals determined ineligible for Medi-Cal *by a county following the redetermination procedures set forth in this section*, the county shall determine eligibility for other ~~state health subsidy~~ *insurance affordability* programs and ~~comply with the procedures in Section 15926~~ *if the individual is found to be eligible, the county shall, as appropriate, transfer the individual's electronic account to other insurance affordability programs via a secure electronic interface.*

~~(r)~~

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

(p) The requirements to provide information in subdivision (b) and to report changes in circumstances in subdivision (c) may be provided through any of the modes of submission allowed in Section 435.907(a) of Title 42 of the Code of Federal Regulations, including an Internet Web site identified by the department, telephone, mail, in person, and other commonly available electronic means as authorized by the department.

(q) Forms required to be signed by a beneficiary pursuant to this section shall be signed under penalty of perjury. Electronic signatures, telephonic signatures, and handwritten signatures transmitted by electronic transmission shall be accepted.

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

(s) 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.

~~(s)~~

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

SEC. 17. Section 14005.38 of the Welfare and Institutions Code is amended to read:

14005.38. *(a)* To the extent feasible, the department shall use the redetermination form required by subdivision (g) of Section 14005.37 as the annual reaffirmation form.

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

SEC. 18. 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 ~~document~~ *record* that fact or event causing the eligibility termination in the beneficiary's file, along with a ~~written~~ certification that a full redetermination could not result in a finding of Medi-Cal eligibility. Following this ~~written~~ 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 ~~on or before July 1, 2001, but~~ only *if and* to the extent that federal financial participation under Title XIX of the federal Social Security Act ~~(Title 42~~ *(42* U.S.C. Sec. 1396~~ and following)~~ *et. seq.)* is available *and necessary federal approvals have been obtained*.

(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~~ *all-county* letters or similar instructions. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title

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

~~SEC. 13.~~

SEC. 19. Section 14005.60 is added to the Welfare and Institutions Code, to read:

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

(b) Persons who qualify under subdivision (a) and are currently enrolled in a Low Income Health Program (LIHP) under California's Bridge to Reform Section 1115(a) Medicaid Demonstration shall be transitioned to the Medi-Cal program under this section in accordance with the transition plan as approved by the federal Centers for Medicare and Medicaid Services. With respect to plan enrollment, a LIHP enrollee shall be *simultaneously notified by the department at least 60 days prior to January 1, 2014, of* all of the following:

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

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

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

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

(2) That the LIHP enrollee, subject to his or her ability to choose or change plans as described in paragraph (3), will be assigned to a health plan that includes his or her medical home and will be enrolled effective January 1, 2014. If the enrollee wants to keep his or her medical home, no additional action will be required.

(3) The opportunity to choose a different health plan prior to January 1, 2014, if there is more than one plan available in the county where he or she resides. Instructions on how to choose or

change plans shall be included in the notice, along with a packet of information about the available plans in the LIHP enrollee's county.

(4) If his or her existing medical home provider is not contracted with any Medi-Cal managed care health plan, he or she will receive all provider and health plan information required to be sent to new enrollees. If he or she does not affirmatively select one of the available Medi-Cal managed care plans within 30 days of receipt of the notice, he or she will automatically be assigned a plan through the department prescribed auto-assignment process.

(c) In counties where no Medi-Cal managed care health plans are available, LIHP enrollees shall be (1) notified that they will be transitioned to fee-for-service Medi-Cal as of January 1, 2014, (2) informed if their LIHP medical home provider is a Medi-Cal fee-for-service provider, (3) provided instructions on how to access services, (4) given a list of Medi-Cal fee-for-service providers by area of practice with contact information for each provider, and (5) provided any other information that is required to be sent to new enrollees.

(d) The department shall consult with stakeholders in developing the notice required by this section, including representatives of Medi-Cal beneficiaries, representatives of public hospitals, and representatives of county social service departments.

~~(c)~~

(e) In order to ensure that no persons lose health care coverage in the course of the transition, the department shall require that notices of the January 1, 2014, change be sent to LIHP enrollees upon their LIHP redetermination in 2013 and again at least 90 days prior to the transition. Pursuant to Section 1902(k)(1) and Section 1937(b)(1)(D) of the federal Social Security Act (42 U.S.C. Sec. 1396a(k)(1); 42 U.S.C. Sec. 1396u-7(b)(1)(D)), the department shall seek approval from the United States Secretary of Health and Human Services to establish a benchmark benefit package that includes the same benefits, services, and coverage that are provided to all other full-scope Medi-Cal enrollees, supplemented by any benefits, services, and coverage 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*, and any successor essential health benefit package adopted by the state*.

~~SEC. 14.~~

SEC. 20. Section 14005.62 is added to the Welfare and Institutions Code, to read:

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

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

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

~~(1) The individual's guardian, conservator, or executor.~~

~~(2) A public agency representative.~~

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

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

SEC. 21. 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. 16.~~

SEC. 22. Section 14005.64 is added to the Welfare and Institutions Code, to read:

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

Protection and Affordable Care Act (Affordable Care Act) (42 U.S.C. Sec. 1396a(e)(14)(I)) and Section 435.603(d) of Title 42 of the Code of Federal Regulations, which requires a 5-percent income disregard for individuals whose income eligibility is determined based on MAGI.

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

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

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

(e) The department shall include individuals under 19 years of age, or in the case of full-time students, under 21 years of age, in the household for purposes of determining eligibility under 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, as provided in Section 435.603(f)(3) of Title 42 of the Code of Federal Regulations.

~~(e)~~

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

~~SEC. 17.~~

SEC. 23. Section 14005.65 is added to the Welfare and Institutions Code, to read:

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

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

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

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

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

~~SEC. 18.~~

SEC. 24. 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.~~ *following:*

(1) The applicant produces one of the following:

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

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

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

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

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

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

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

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

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

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

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

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

(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. 19. Section 14007.1 is added to the Welfare and Institutions Code, to read:~~

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

~~fixed address or to be currently employed to be considered a resident of this state.~~

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

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

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

~~(d) 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 be granted if a preponderance of the credible evidence supports a finding that the individual meets the requirements of either subdivision (a) or (b).~~

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

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

SEC. 25. 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 state agency

administering the state's unemployment compensation laws, and 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 may establish 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 does both of the following.

(1) The individual provides one of the following:

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

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

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

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

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

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

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

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

(I) 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 subparagraphs (A) to (H), inclusive.

(J) 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 subparagraphs (A) to (H), inclusive.

(2) The individual declares, under penalty of perjury, that both of the following apply:

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

(B) The individual is not receiving public assistance outside this state. For purposes of this subdivision, "public assistance" shall not include unemployment insurance benefits.

(c) If the individual is 21 years or 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 paragraphs (3), (4), (5), (6) and (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. 26. 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 Med-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. 20.~~

SEC. 27. 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. 21.~~

SEC. 28. 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 ~~if this individual can prove both of the following:~~ *and the individual is considered a resident pursuant to Section 14007.15.*

~~(1) His or her 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) 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.

~~(c)~~

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

~~SEC. 22.~~

SEC. 29. 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~~ *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. 23.~~

SEC. 30. Section 14011.16 of the Welfare and Institutions Code is amended to read:

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

a beneficiary who has not had any changes to so indicate by checking a box and signing and returning the form.

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

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

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

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

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

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

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

~~SEC. 24.~~

SEC. 31. Section 14011.17 of the Welfare and Institutions Code is amended to read:

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

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

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

(c) Beneficiaries who have a public guardian.

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

(e) Individuals receiving minor consent services.

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

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

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

~~SEC. 25.~~

SEC. 32. Section 14012 of the Welfare and Institutions Code is amended to read:

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

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

~~SEC. 26.~~

SEC. 33. Section 14012 is added to the Welfare and Institutions Code, to read:

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

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

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

SEC. 34. 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 service 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) Pursuant to Section 435.923(e) of Title 42 of the Code of Federal Regulations, a provider or staff member or volunteer of an organization who intends to serve as an authorized representative shall provide a signed written agreement that he or she will adhere to requirements set forth in the Code of Federal Regulations for authorized representatives, including Section 447.10 of Title 42, subpart F of Part 431 of Title 45, and Section 155.260(f) of Title 45. The department shall work with counties and consumer advocates to develop a standard agreement form that may be used for this purpose.

(2) Pursuant to 435.923(e) of Title 45 of the Code of Federal Regulations, the regulations developed pursuant to this section shall require authorized representatives to comply with all applicable state and federal laws regarding conflicts of interest and confidentiality of information.

(3) 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. 35. Section 14015.5 is added to the Welfare and Institutions Code, to read:

14015.5. (a) Notwithstanding any other provision of state law, the department shall retain or delegate the authority to perform Medi-Cal eligibility determinations as set forth in this section.

(b) If after an assessment and verification for potential eligibility for Medi-Cal benefits using the applicable MAGI-based income standard of all persons that apply through an electronic or a paper application processed by CalHEERS, which is jointly managed by the department and the Exchange, and to the extent required by federal law and regulation is completed, the Exchange and the department may electronically determine the applicant's eligibility for Medi-Cal benefits using only the information initially provided online, or through the written application submitted by, or on behalf of, the applicant, and without further staff review to verify the accuracy of the submitted information, the Exchange and the department shall determine that applicant's eligibility for the Medi-Cal program using the applicable MAGI-based income standard.

(c) Except as provided in subdivision (b) and Section 14015.7, the county of residence shall be responsible for eligibility determinations and ongoing case management for the Medi-Cal program.

(d) (1) Notwithstanding any other provision of state law, the Exchange shall be authorized to provide information regarding available Medi-Cal managed health care plan selection options to applicants determined to be eligible for Medi-Cal benefits using the MAGI-based income standard and allow those applicants to choose an available managed health care plan.

(2) The Exchange is authorized to record an applicant's health plan selection into CalHEERS for reporting to the department. CalHEERS shall have the ability to report to the department the results of an applicant's health plan selection.

(e) 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.

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

(1) "ACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(2) "CalHEERS" means the California Healthcare Eligibility, Enrollment, and Retention System developed under Section 15926.

(3) "Exchange" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(4) "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 ACA and any subsequent amendments.

(g) 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.

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

(i) This section shall become inoperative on July 1, 2015, and, as of January 1, 2016, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2016, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 36. Section 14015.7 is added to the Welfare and Institutions Code, to read:

14015.7. (a) (1) Notwithstanding any other law, for persons who call the customer service center operated by the Exchange for the purpose of applying for an insurance affordability program, the Exchange shall implement a workflow transfer protocol that consists of only those questions that are essential to reliably ascertain whether the caller's household appears to include any individuals who are potentially eligible for Medi-Cal benefits and to determine an appropriate point of referral. The workflow transfer protocol and referral procedures used by the Exchange shall be developed and implemented in conjunction with and subject to review and approval by the department.

(2) (A) Except as provided in paragraph (3), if, after applying the transfer protocol specified in paragraph (1), the Exchange determines that the caller's household appears to include one or more individuals who are potentially eligible for Medi-Cal benefits using the applicable MAGI-based income standard, the Exchange shall refer the caller to his or her county of residence or other appropriate county resource for completion of the federally required assessment. The county shall proceed with the assessment and also perform any required eligibility determination.

(B) Subject to any income limitations that may be imposed by the Exchange, and subject to review and approval from the department, if after applying the transfer protocol specified in paragraph (1) the Exchange determines that the caller's household appears to include an individual who is pregnant, or who is potentially eligible for Medi-Cal benefits on a basis other than using a MAGI-based income standard because an applicant is potentially disabled, 65 years of age or older, or potentially in need of long-term care services, the Exchange shall refer the caller to his or her county of residence or other appropriate county resource for completion of the federally required assessment. The county shall proceed with the assessment and also perform any required eligibility determination.

(3) Notwithstanding any other law, only during the initial open enrollment period established by the Exchange, and in no case after June 30, 2014, if after applying the transfer protocol specified in paragraph (1) the Exchange determines that the caller's household appears to include both individuals who are potentially eligible for Medi-Cal benefits using the applicable MAGI-based income standard and individuals who are not potentially eligible for Medi-Cal benefits, the Exchange shall proceed with its assessment and if it is subsequently determined that an applicant or applicants are potentially eligible for Medi-Cal benefits using the applicable MAGI-based income standard, the Exchange shall initially determine the applicant or applicants eligibility for Medi-Cal benefits. If determined eligible, the applicant's or applicants' coverage shall start on January 1, 2014, or on the date of the determination, whichever is later. The county of residence shall be responsible for final confirmation of eligibility determinations relying on data provided by and verifications done by the Exchange and the county shall perform only that additional work that is necessary for the county to prepare and send out the required notice to the applicant regarding the result of the eligibility determination and shall not impose any additional burdens upon the applicant. The county of residence shall be responsible for sending out the required notices of all Medi-Cal eligibility determinations.

(4) Notwithstanding any other law, if after applying the transfer protocol specified in paragraph (1) the Exchange determines that the caller's household appears to only include individuals who are not potentially eligible for Medi-Cal benefits, the Exchange shall proceed with its assessment of eligibility. If it is subsequently determined that an applicant or applicants are potentially eligible for Medi-Cal benefits using the applicable MAGI-based income standard, the Exchange shall initially determine the applicant or applicants eligibility for Medi-Cal benefits. If determined eligible, the applicant's or applicants' coverage shall start on January 1, 2014, or on the date of the determination, whichever is later. The county of residence shall be responsible for final confirmation of eligibility determinations relying on data provided by and verifications done by the Exchange and the county shall perform only that additional work that is necessary for the county to prepare and send out the required notice to the applicant regarding

the result of the eligibility determination and shall not impose any additional burdens upon the applicant. The county of residence shall be responsible for sending out the required notices of all Medi-Cal eligibility determinations.

(5) Subject to any income limitations that may be imposed by the Exchange, and subject to review and approval from the department, if after assessing the potential eligibility of an applicant, which shall include enrolling the individual in Exchange-based coverage if eligible and, if the determination is being made pursuant to subdivision (3), determining initial eligibility for MAGI-based Medi-Cal, the Exchange determines that the applicant is pregnant, or is potentially eligible for Medi-Cal benefits on a basis other than using a MAGI-based income standard because the applicant is potentially disabled, 65 years of age or older, or potentially in need of long-term care services, or if the applicant requests a full Medi-Cal eligibility determination, the Exchange shall, consistent with federal law and regulations, transmit all information provided by or on behalf of the applicant, and any information obtained or verified by the Exchange, to the applicant's county of residence or other appropriate county resource via secure electronic interface, promptly and without undue delay, for a full Medi-Cal eligibility determination.

(6) Except as otherwise provided in this section and subdivision (b) of Section 14015.5, the county of residence shall be responsible for eligibility determinations and ongoing case management for the Medi-Cal program.

(7) Implementation of the protocols and referral procedures in this subdivision shall be subject to the terms specified in the agreements established under subdivision (b).

(b) The department, Exchange, and each county consortia shall jointly enter into an interagency agreement that specifies the operational parameters and performance standards pertaining to the transfer protocol. After consulting with counties, consumer advocates, and labor organizations that represent employees of the customer service center operated by the Exchange and employees of county customer service centers, the Exchange and the department shall determine and implement the performance standards that shall be incorporated into these agreements.

(c) Prior to October 1, 2014, the Exchange and the department, in consultation with counties, consumer advocates, and labor organizations that represent employees of the customer service center operated by the Exchange and employees of county customer service centers, shall review and determine the efficacy of the enrollment procedures established in this section.

(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, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

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

(1) "ACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(2) "CalHEERS" means the California Healthcare Eligibility, Enrollment, and Retention System developed under Section 15926.

(3) "Exchange" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(4) "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 ACA 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.

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

SEC. 37. Section 14055 is added to the Welfare and Institutions Code, to read:

14055. (a) For the purposes of this chapter, "caretaker relative" means a relative of a dependent child by blood, adoption,

or marriage with whom the child is living, who assumes primary responsibility for the child's care, and who is one of the following:

(1) The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, great grandparent, uncle, aunt, nephew, niece, great-great grandparent, great uncle or aunt, first cousin, great-great-great grandparent, great-great uncle or aunt, or first cousin once removed.

(2) The spouse or registered domestic partner of one of the relatives identified in paragraph (1), even after the marriage is terminated by death or divorce or the domestic partnership has been legally terminated.

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

SEC. 38. 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 January 1, 2014.

SEC. 39. Section 14102 is added to the Welfare and Institutions Code, to read:

14102. (a) (1) Notwithstanding any other 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, and would be eligible for full-scope 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 otherwise eligible for state-only funded full-scope benefits shall be ineligible for those state-only funded benefits if he or she is eligible for, and is not barred from enrolling in because he or she is outside of an available enrollment period for coverage with an advanced premium tax credit offered through the Exchange.

(2) On or after January 1, 2015, if an individual is eligible for and does not enroll in coverage offered through the Exchange with an advanced premium tax credit during his or her first available enrollment period, that individual shall be ineligible for the state-only funded benefits referenced in paragraph (1), except as provided in paragraph (3).

(3) An individual shall be ineligible for Medi-Cal pursuant to this section only if and when he or she is able to receive the premium assistance, cost sharing, and benefits described in subdivision (c). Disenrollment from state-only Medi-Cal shall only occur during an available enrollment period in the Exchange.

(4) The department shall inform and assist such individuals on enrolling in coverage through the Exchange with the premium assistance, cost sharing, and benefits described in subdivision (c) and the process for disenrollment from Medi-Cal, if applicable, in a way that ensures seamless transition between coverage, including, but not limited to, developing processes to coordinate with the county entities that administer eligibility for coverage in Medi-Cal and the Exchange.

(b) (1) An individual who is a state-only Medi-Cal person as defined in Section 14052 shall not be subject to subdivision (a) or (c).

(c) An individual subject to subdivision (a) 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.

(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. 40. Section 14102.5 is added to the Welfare and Institutions Code, to read:

14102.5. (a) The department shall, in collaboration with the Exchange, the counties, consumer advocates, and the Statewide Automated Welfare System consortia, develop and prepare one or more reports that shall be issued on at least a quarterly basis and shall be made publicly available within 30 days following the end of each quarter, for the purpose of informing the California Health and Human Services Agency, the Exchange, the Legislature, and the public about the enrollment process for all insurance affordability programs. The reports shall comply with federal reporting requirements and shall, at a minimum, include the following information, to be derived from, as appropriate depending on the data element, CalHEERS, MEDS, or the Statewide Automated Welfare System:

(1) For applications received for insurance affordability programs through any venue, all of the following:

(A) The number of applications received through each venue.

(B) The number of applicants included on those applications.

(C) Applicant demographics, including, but not limited to, gender, age, race, ethnicity, and primary language.

(D) The disposition of applications, including all of the following:

(i) The number of eligibility determinations that resulted in an approval for coverage.

(ii) The program or programs for which the individuals in clause (i) were determined eligible.

(iii) The number of applications that were denied for any coverage and the reason or reasons for the denials.

(E) The number of days for eligibility determinations.

(2) With regard to health plan selection, all of the following:

(A) The health plans that are selected by applicants enrolled in an insurance affordability program, reported by the program.

(B) The number of Medi-Cal enrollees who do not select a health plan but are defaulted into a plan.

(3) For annual redeterminations conducted for beneficiaries, all of the following:

(A) The number of redeterminations processed.

(B) The number of redeterminations that resulted in continued eligibility for the same program.

(C) The number of redeterminations that resulted in a change in eligibility to a different program.

(D) The number of redeterminations that resulted in a finding of ineligibility for any program and the reason or reasons for the findings of ineligibility.

(E) The number of days for redeterminations to be completed.

(4) With regard to disenrollments not related to a redetermination of eligibility, all of the following:

(A) The number of beneficiary disenrollments.

(B) The reasons for the disenrollments.

(C) The number of disenrollments that are caused by an individual disenrolling from one insurance affordability program and enrolling into another.

(5) The number of applications for insurance affordability programs that were filed with the help of an assister or navigator.

(6) The total number of grievances and appeals filed by applicants and enrollees regarding eligibility for insurance affordability programs, the basis for the grievance, and the outcomes of the appeals.

(b) The department shall collect the information necessary for these reports and develop these reports using data obtained from the Statewide Automated Welfare System, CalHEERS, MEDS, and any other appropriate state information management systems.

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

(1) "CalHEERS" means the California Healthcare Eligibility, Enrollment, and Retention System developed under Section 15926.

(2) "Exchange" means the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code.

(3) "Statewide Automated Welfare System" means the system developed pursuant to Section 10823.

(4) "MEDS" means the Medi-Cal Eligibility Data System.

(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, 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. 27.~~

SEC. 41. 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 ~~of~~ *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 may be covered to the extent that federal financial participation is available for those services under waivers granted in accordance with Section 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 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.

(ad) Commencing January 1, 2014, any benefits, services, and coverage not otherwise described in this ~~section~~ *chapter* that are 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, *and any successor essential health benefit package adopted by the state*.

~~SEC. 28.~~

SEC. 42. Section 14132.02 is added to the Welfare and Institutions Code, to read:

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

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

~~SEC. 29.~~

SEC. 43. Section 15926 of the Welfare and Institutions Code is amended to read:

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

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

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

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

(3) "Insurance affordability program" means a program that is one of the following:

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

(B) The Healthy Families Program under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(C) A program that makes available to qualified individuals 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 PPACA and any subsequent amendments to that act.

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

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

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

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

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

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

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

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

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

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

(G) Until January 1, 2016, the department shall instruct counties to not reject an application that was in existence prior to January 1, 2014, but to accept the application and request any additional information needed from the applicant in order to complete the eligibility determination process. The department shall work with counties and consumer advocates to develop the supplemental questions.

(d) Nothing in this section shall preclude the use of a provider-based application form or enrollment procedures for ~~state health subsidy~~ *insurance affordability* programs or other health programs that differs from the application form described in subdivision (c), and related enrollment procedures. *Nothing in this section shall preclude the use of a joint application, developed by the department and the State Department of Social Services, that allows for an application to be made for multiple programs, including, but not limited to, CalWORKs, CalFresh, and insurance affordability programs.*

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

(f) (1) If the eligibility, enrollment, and retention system has the ability to prepopulate an application form for insurance affordability programs with personal information from available

electronic databases, an applicant shall be given the option, with his or her informed consent, to have the application form prepopulated. Before a prepopulated ~~renewal form or, if available, prepopulated~~ application is submitted to the entity authorized to make eligibility determinations, the individual shall be given the opportunity to provide additional eligibility information and to correct any information retrieved from a database.

(2) All ~~state health subsidy~~ *insurance affordability* programs shall accept self-attestation, instead of requiring an individual to produce a document, for age, date of birth, family size, household income, state residence, pregnancy, and any other applicable criteria needed to determine the eligibility of an applicant or recipient, to the extent permitted by state and federal law.

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

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

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

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

(g) The eligibility, enrollment, and retention system shall offer an applicant and recipient assistance with his or her application or renewal for ~~a state health subsidy~~ *an insurance affordability* program in person, over the telephone, ~~and~~ *by mail,* online, *or through other commonly available electronic means* and in a

manner that is accessible to individuals with disabilities and those who are limited English proficient.

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

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

(3) Renewal procedures shall include all available methods for reporting renewal information, including, but not limited to, face-to-face, telephone, *mail,* and online renewal *or renewal through other commonly available electronic means*.

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

(i) Notwithstanding subdivisions (e), (f), and (j), before an online applicant who appears to be eligible for the Exchange with a

premium tax credit or reduction in cost sharing, or both, may be enrolled in the Exchange, both of the following shall occur:

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

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

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

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

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

(*l*) The department, the California Health and Human Services Agency, MRMIB, and the Exchange board shall establish a process for receiving and acting on stakeholder suggestions regarding the functionality of the eligibility systems supporting the Exchange, including the activities of all entities providing eligibility screening to ensure the correct eligibility rules and requirements are being used. This process shall include consumers and their advocates, be conducted no less than quarterly, and include the recording, review, and analysis of potential defects or enhancements of the eligibility systems. The process shall also include regular updates

on the work to analyze, prioritize, and implement corrections to confirmed defects and proposed enhancements, and to monitor screening.

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

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

~~SEC. 30. If the Commission on State Mandates determines that this act contains 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. 44. 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.

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