WELFARE AND INSTITUTIONS CODE - WIC

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

PART 3. AID AND MEDICAL ASSISTANCE [11000 - 15771] *(Part 3 added by Stats. 1965, Ch. 1784.)*

CHAPTER 7. Basic Health Care [14000 - 14199.87] *(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)*

ARTICLE 1. General Provisions [14000 - 14042.2] *(Article 1 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)*

14000. The purpose of this chapter is to afford to qualifying individuals health care and related remedial or preventive services, including related social services that are necessary for those receiving health care under this chapter.

The intent of the Legislature is to provide, to the extent practicable, through the provisions of this chapter, for health care for California residents who lack sufficient income to meet the costs of health care and whose other assets are so limited that their application toward the costs of that care would jeopardize the person or family's future minimum self-maintenance and security. It is intended that, whenever possible and feasible, all of the following shall apply:

(a) The means employed shall allow, to the extent practicable, eligible persons to secure health care in the same manner employed by the public generally, and without discrimination or segregation based purely on their economic disability. The means employed shall include an emphasis on efforts to arrange and encourage access to health care through enrollment in organized, managed care plans of the type available to the general public.

(b) The benefits available under this chapter shall not duplicate those provided under other federal or state laws or under other contractual or legal entitlements of the person or persons receiving them.

(c) In the administration of this chapter and in establishing the means to be used to provide access to health care to persons eligible under this chapter, the department shall emphasize and take advantage of both the efficient organization and ready accessibility and availability of health care facilities and resources through enrollment in managed health care plans and new and innovative fee-for-service managed health care plan approaches to the delivery of health care services.

(d) This section shall become operative January 1, 2026.

(Amended (as amended by Stats. 2022, Ch. 291, Sec. 1) by Stats. 2025, Ch. 21, Sec. 50. (AB 116) Effective June 30, 2025. Operative January 1, 2026, by its own provisions.)

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(d) This section shall become inoperative on January 1, 2026, and as of that date is repealed.

(Amended (as added by Stats. 2022, Ch. 291, Sec. 2) by Stats. 2025, Ch. 21, Sec. 51. (AB 116) Effective June 30, 2025. Repealed as of January 1, 2026, by its own provisions. See later operative version, as amended by Sec. 50 of Stats. 2025, Ch. 21.)

14000.01. The department shall seek federal approval, if necessary, and shall issue all-plan letters or similar instructions to implement subdivision (d) of Section 1367.25 of the Health and Safety Code.

(Added by Stats. 2016, Ch. 499, Sec. 5. (SB 999) Effective January 1, 2017.)

14000.03. (a) The Legislature finds and declares that Section 1396a(a)(11)(A) of Title 42 of the United States Code provides that California's state plan for medical assistance under the Medicaid program must "provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan."

(b) In furtherance of Section 1396a(a)(11)(A) of Title 42 of the United States Code and Section 7560 of the Government Code, it is the intent of the Legislature to maximize the amount of federal and state funds continually available under agreements identified in Section 1396a(a)(11)(A) of Title 42 of the United States Code and entered into by the State Department of Health Services by making later-appropriated and budgeted funds immediately encumbered and available for expenditure under agreements by operation of law.

(c) Notwithstanding any other provision of law, upon additional funds being appropriated and budgeted for the support of the services identified within the scope of work of an agreement of the type identified in Section 1396a (a)(11)(A) of Title 42 of the United States Code and previously entered into by the State Department of Health Services, the amount of the encumbrance in such an agreement shall be amended, by operation of law, to reflect the newly appropriated and budgeted funds.

(d) Notwithstanding any other provision of law, once an agreement of the type identified in Section 1396a (a)(11)(A) of Title 42 of the United States Code is entered into by the State Department of Health Services, the agreement shall continue in effect indefinitely and need not be amended unless the State Department of Health Services changes the scope of work to be provided under the agreement.

(Added by Stats. 2002, Ch. 1161, Sec. 41. Effective September 30, 2002.)

14000.05. The State Department of Health Services shall consider the special needs and requirements of rural hospitals in California that are financially distressed and in danger of closure. The department may provide technical assistance and other appropriate assistance and relief on Medi-Cal program policies, reimbursement issues, and Medi-Cal operational and procedural problems to financially distressed rural hospitals, when appropriate, in order to preserve the availability of health care services in rural California.

(Added by Stats. 1988, Ch. 999, Sec. 2.)

14000.1. It is the intent of the Legislature that health care services available under this chapter shall be at least equivalent to the level provided in 1970–71.

(Amended by Stats. 1971, Ch. 577.)

14000.2. During the time this chapter is effective and notwithstanding other provisions of the Welfare and Institutions Code and Health and Safety Code, the board of supervisors of each county may prescribe rules which authorize the county hospital to integrate its services with those of other hospitals into a system of community service which offers free choice of hospitals to those requiring hospital care. The intent of this section is to eliminate discrimination or segregation based on economic disability so that the county hospital and other hospitals in the community share in providing services to paying patients and to those who qualify for care in public medical care programs. In prescribing rules under which the county hospital may provide community hospital services described in this section, the board of supervisors shall provide a basis under which patients may be attended by their own personal physicians who are professionally qualified for staff membership in the county hospital.

Notwithstanding any other provisions of law or provisions contained in a county charter, the board of supervisors of any county may transfer the maintenance, operation and management or ownership of the county hospital to the University of California or any other public agency or community nonprofit corporation empowered to operate a hospital facility upon a finding that the community services provided by the hospital could be more efficiently, effectively or economically provided by the transferee than the county. If such transfer be made to the University of California or to any other public agency empowered to operate a hospital facility the transfer of control or ownership may be made with or without the payment of a purchase price by the transferee and otherwise upon such terms and conditions as the parties may mutually agree, but if the transfer be to a community nonprofit corporation, the board of supervisors shall comply with all other provisions of law relating to the sale, lease, or transfer of public property by a county; and provided that in any event the transaction shall include such terms and conditions as the board of supervisors find necessary to insure that the transfer will constitute an ongoing material benefit to the county and its residents.

The intent of this section is to permit the implementation of programs for the consolidation of public hospital services in order to permit the more effective use of existing hospital facilities and retard the spiraling costs of medical care.

(Amended by Stats. 1972, Ch. 709, Sec. 4.)

14000.3. To the extent permitted by federal law, the director may enter into contracts with the Secretary of Health, Education, and Welfare to obtain or provide fiscal intermediary services for all persons who are receiving benefits under this chapter, who are also recipients of benefits under Title XVIII of the Social Security Act.

(Amended by Stats. 1969, Ch. 21.)

14000.4. This chapter shall be known and may be cited as the “Medi-Cal Act.”

(Added by Stats. 1970, Ch. 1030.)

14000.5. On a regional pilot project basis, to the extent authorized by law, the director may enter into contracts with one or more nonprofit organizations to perform the functions of the department’s Office of the Ombudsman. These activities may include outreach, community education and training about health care consumer rights and responsibilities, including the production and distribution of consumer-oriented material, individual consumer assistance, including counseling, advice, assistance, education, advocacy, and referral as appropriate, establishing and operating a database to analyze the nature of the inquiries and requests for assistance, and training of department or county staff. These services may be made available to any person who may be eligible for or is receiving benefits under this chapter. Funds appropriated in the annual Budget Act for the support of the Office of the Ombudsman may be allocated for this purpose.

(Added by Stats. 2002, Ch. 1161, Sec. 42. Effective September 30, 2002.)

14000.6. (a) The Office of Medicare Innovation and Integration is hereby established within the department.

(b) The office shall do all of the following:

(1) Provide focused leadership and expertise on innovative models for Medicare beneficiaries in California, including Medicare-only beneficiaries, and individuals dually eligible for the Medicare and Medi-Cal programs.

(2) Support new and existing models and strategies to benefit Medicare-only beneficiaries in California, in collaboration with local, state, and federal partners and other stakeholders.

(3) Consider and develop strategies for Medicare and Medi-Cal enrollment, benefits, health care delivery systems, and data sharing and reporting, to improve health outcomes, quality, equity, and cost effectiveness.

(4) Develop innovative approaches to integrated models of care and coordinated access to long-term services and supports for Medicare-only beneficiaries and dually eligible beneficiaries.

(Added by Stats. 2021, Ch. 143, Sec. 361. (AB 133) Effective July 27, 2021.)

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.

(Added by Stats. 2013, 1st Ex. Sess., Ch. 4, Sec. 3. (SB 1 1x) Effective September 30, 2013. Section operative January 1, 2014, by its own provisions.)

14000.8. (a) (1) Commencing on January 1, 2026, and each month thereafter, a county with a call center for Medi-Cal applicants or beneficiaries applying for, renewing, or requesting help in obtaining or maintaining Medi-Cal coverage shall collect and submit to the department call-center data metrics, including, but not limited to, total call volume, average call wait times by language, and the average call abandonment rate.

(2) The department shall prepare a report, excluding any personally identifiable information, on call-center data as described in paragraph (1). The department shall post the report on the department's internet website on a quarterly basis no later than 45 calendar days after the conclusion of each quarter. The initial report on call-center data described in paragraph (1) shall be due on May 15, 2026.

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

(Added by Stats. 2024, Ch. 792, Sec. 1. (SB 1289) Effective January 1, 2025.)

14001. Health care as administered under this chapter shall be considered a component of public social services.

(Amended by Stats. 1977, Ch. 1252.)

14001.1. It is the intention of the Legislature, whenever feasible, that the needs of categorically needy persons for health care and related remedial or preventive services be met under the provisions of this chapter.

(Amended by Stats. 1985, Ch. 1354, Sec. 3.)

14001.11. (a) The department shall implement the federal requirements described in Section 1396u-5 of Title 42 of the United States Code.

(b) In each of the several counties of the state, the eligibility and enrollment functions required under Section 1396u-5(a)(2) and (3) of Title 42 of the United States Code, which may include, but are not limited to, determining eligibility and offering enrollment for premium and cost sharing subsidies made available under and in accordance with Section 1395w-114 of Title 42 of the United States Code, shall be a county function and responsibility, subject to the direction, authority, and regulations of the department. The department shall request input from the counties as to the potential cost of implementing these provisions, and shall consider that input in developing the budget.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all county letters, provider bulletins, or similar instructions, with input from the counties. Thereafter, the department may adopt regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of the Government Code.

(d) The department shall seek approval of any amendments to the state plan, necessary to implement this section, for purposes of federal financial participation under Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 et seq.). Notwithstanding any other law and only when all necessary federal approvals have been obtained, this section, with the exception of the Phased-Down State Contribution, as described in subparagraphs (A) to (C), inclusive, of paragraph (1) of subdivision (c) of Section 1396u-5 of Title 42 of the United States Code, shall be implemented only to the extent federal financial participation is available.

(Added by Stats. 2005, Ch. 80, Sec. 20.2. Effective July 19, 2005.)

14002. Health care granted under the provisions of this chapter is held subject to the provisions of any law hereafter enacted amending, repealing, or supplementing in whole or in part the provisions of this chapter, and subject to the rules and regulations of the department. No recipient of health care under this chapter shall have any claim for compensation or otherwise because his service is affected in any way by any such amending, repealing, or supplemental act, or by any such rule or regulation or by any addition, amendment, or repeal of such rules or regulations.

(Amended by Stats. 1969, Ch. 21.)

14002.5. For the purposes of this article, the following definitions shall apply:

(a) "Annuity" means a contract that names an annuitant and gives a person or entity the right to receive periodic payments of a fixed or variable sum for a described period of time, which may include a lump-sum payment or periodic payments upon the death of the annuitant.

(b) "Community spouse" means the spouse of an institutionalized spouse.

(c) "Home and facility care" means the following services that are subject to Medi-Cal reimbursement:

(1) Nursing facility care services.

(2) A level of care in any institution equivalent to that of nursing facility care services.

(3) Home- or community-based care services furnished under a waiver granted pursuant to subsection (c) or (d) of Section 1396n of Title 42 of the United States Code.

(d) “Institutionalized spouse” means any individual to whom all of the following apply:

(1) The individual is in a medical institution or nursing facility or is a person who is receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization pursuant to Chapter 8.75 (commencing with Section 14591), and is likely to meet that requirement for at least 30 consecutive days.

(2) The individual is married to a spouse who is not in a medical institution or nursing facility, or to a spouse who is not receiving services from a Program of All-Inclusive Care for the Elderly organization pursuant to Chapter 8.75 (commencing with Section 14591).

(3) Except for purposes of Sections 14005.7, 14005.12, 14005.16, and 14005.17, an individual who is admitted to a medical institution or nursing facility on or after September 30, 1989, and who applies for Medi-Cal benefits on or after January 1, 1990, or a Medi-Cal recipient who is admitted to a medical institution or nursing facility on or after January 1, 1990.

(e) “Medical institution” has the same meaning as defined in Section 435.1010 of Title 42 of the Code of Federal Regulations.

(f) “Nursing facility” has the same meaning as defined in Section 1250 of the Health and Safety Code.

(Amended by Stats. 2011, Ch. 367, Sec. 7. (AB 574) Effective January 1, 2012.)

14003. The Governor may enter into and execute in behalf of the state all necessary agreements in connection with this chapter as may be required by the United States government.

(Repealed and added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)

14004. If any individual in good faith adheres to the teachings of any bona fide church, sect, denomination, or organization, and in accordance with its principles depends for healing entirely upon prayer or spiritual means, no medical examination shall be required to receive health care authorized by this chapter, but in lieu thereof the certificate of a practitioner of such bona fide sect, denomination, or organization approved and authorized by the department, shall be accepted as to the need of such individual for service. No rule or regulation shall be adopted or continued in force which discriminates against such an individual.

(Amended by Stats. 1969, Ch. 21.)

14005. (a) The health care benefits and services specified in this chapter, to the extent that such services are neither provided under any other federal or state law nor provided nor available under other contractual or legal entitlements of the person, shall be provided under this chapter to any person who is a resident of this state and is made eligible by the provisions of this article. It is the intent of the Legislature that a provider shall look to such other contractual or legal entitlements for payment before submitting a bill for payment under this chapter.

(b) Any applicant for, or recipient of, Medi-Cal benefits who requests medical assistance for home and facility care shall meet the specific eligibility requirements for the receipt of medical assistance for home and facility care set forth in this chapter.

(c) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), and any regulations adopted pursuant to that act, and only to the extent that federal financial participation is available.

(d) To the extent that regulations are necessary to implement this section, the department shall promulgate regulations using the nonemergency regulatory process described in Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of the Government Code.

(e) It is the intent of the Legislature that the provisions of this section shall apply prospectively to any individual to whom the act applies commencing from the date regulations adopted pursuant to this act are filed with the Secretary of State.

(Amended by Stats. 2008, Ch. 379, Sec. 2. Effective January 1, 2009.)

14005.1. Except for adults receiving aid pursuant to Chapter 2 (commencing with Section 11200) and for whom federal financial participation would not be obtainable for their medical costs under Title XIX of the federal Social Security Act, categorically needy persons are eligible for health care services under Section 14005.

Eligibility for health care services under Section 14005 shall continue for four calendar months beginning with the month in which a family becomes ineligible for benefits under the Aid to Families with Dependent Children program, if all of the following apply:

(a) The ineligibility is due wholly or partly to the collection or increased collection of child or spousal support pursuant to Article 7 (commencing with Section 11475) of Chapter 2.

(b) The family has received benefits under the Aid to Families with Dependent Children program in at least three of the six months immediately preceding the month in which ineligibility begins.

(c) Ineligibility occurred after October 1, 1984, and before October 1, 1988.

(Amended by Stats. 1986, Ch. 1089, Sec. 3. Effective September 24, 1986.)

14005.2. Unless otherwise specified in this chapter, the eligibility of a person eligible under the Cuban-Haitian Entrant Program or the Refugee Resettlement Program for health care services under Section 14005 shall be determined by applying the same income and resource methodologies and standards and all other eligibility criteria established pursuant to this chapter that are applied by the department in determining the eligibility of a medically needy family person, except for those criteria that establish categorical relatedness, and only as long as federal funds are available. Victims of trafficking, domestic violence, and other serious crimes, as defined in subdivision (b) of Section 18945, shall be eligible for these services to the same extent as individuals who are admitted to the United States as a refugee under Section 1157 of Title 8 of the United States Code. Services under this subdivision shall be paid from state funds to the extent federal funding is unavailable.

(Amended by Stats. 2006, Ch. 672, Sec. 2. Effective January 1, 2007.)

14005.3. (a) Notwithstanding any other provision of this chapter, any person who:

(1) Was once determined to be disabled in accordance with Section 1614 of Part A of Title XVI of the Social Security Act (Section 1382c, Title 42, United States Code), and

(2) Became ineligible for benefits pursuant to Section 1614 of Part A of Title XVI of the Social Security Act (Section 1382c, Title 42, United States Code) because the person engaged in substantial gainful activity, and

(3) Continues to suffer from the physical or mental impairments which were the basis of the disability determination required under paragraph (1),

shall be considered to be disabled, for the purposes of this chapter, even though such person is engaged in substantial gainful activity. Regardless of whether such person has excess income pursuant to Sections 14005.12 and 14005.13, such person shall be eligible to receive health care benefits and services under this chapter if his or her income does not exceed the maximum income eligibility limits for benefits under Part A of Title XVI of the Social Security Act. Any such person whose income exceeds the maximum income eligibility limits for benefits under Part A of Title XVI of the Social Security Act shall be eligible under Sections 14005.4 and 14052 for health care benefits and services under this chapter, provided, that the income levels for maintenance in Section 14005.12 for such person shall be the maximum income eligibility limits for benefits under Part A of Title XVI of the Social Security Act and provided, that his or her nonexempt income in excess of that maximum is used to pay his or her share of costs.

(b) For purposes of this section, “substantial gainful activity” means work activity considered to be substantial gainful activity under applicable federal regulations adopted pursuant to Section 1614 of Part A of Title XVI of the Social Security Act.

(c) The determination of continued impairments and the need for health care benefits and services shall be supported by medical reports when requested. Such reports shall be provided at the expense of the department.

(Added by Stats. 1979, Ch. 1156.)

14005.4. Unless otherwise specified in this chapter, the eligibility of a state-only Medi-Cal person for health care services under Section 14005 shall be determined by applying the same income and resource methodologies and standards and all other eligibility criteria established pursuant to this chapter that are applied by the department in determining the eligibility of a medically needy family person except for those criteria that establish categorical relatedness.

(Repealed and added by Stats. 1985, Ch. 1354, Sec. 7.)

14005.5. (a) In determining eligibility pursuant to Section 14005.4 or 14005.7, reparation or restitution payments received by victims of the Nazi persecution from the Federal Republic of Germany pursuant to the Federal Law on the Compensation of Victims of the National Socialist Persecution (Federal Compensation Law), as enacted by that government on June 29, 1956, shall not be deemed as available income, nor shall any accumulation of those payments be considered an available resource, to the extent that the funds are not spent and are kept identifiable.

(b) The director shall seek federal waivers from the Secretary of the United States Department of Health and Human Services, in order to ensure federal financial participation. In the event of an initial determination by the Secretary of the United States Department of Health and Human Services that any provision of this section is in conflict with any federal statute or regulation, the department shall take all available and necessary steps to obtain a final determination reversing that decision. In the event that a final determination is made which finds a conflict with federal law, the director shall immediately request the Attorney General to seek judicial review of the determination, and the director shall notify the appropriate policy and fiscal committees of both houses of the Legislature of its request. Notwithstanding the outcome of the director’s efforts to obtain waivers under this subdivision, or a final judicial decision holding that any provision of this section is in conflict with federal law, subdivision (a) shall be implemented on July

1, 1985, or the date upon which waivers are obtained under this subdivision, whichever is earlier. Failure to obtain waivers pursuant to this subdivision shall not affect implementation of subdivision (a).

(Amended by Stats. 1988, Ch. 621, Sec. 1.)

14005.6. (a) The Legislature finds and declares as follows:

(1) Under federal law, minors living at home with their families may not be eligible for the SSI and Medicaid programs.

(2) Under the Federal Budget Reconciliation Act of 1981, however, states may apply for a Section 1915(c) waiver to allow a person to be eligible for SSI and Medicaid when medical and social services provided in the home can be shown to be less costly than services provided in an institution.

(3) Whenever possible, medical and social services should be provided in the least restrictive setting and at the lowest cost to the programs involved.

(4) The State Department of Health Services has already successfully applied for the Section 1915(c) waiver as applied to certain defined populations of developmentally disabled, elderly, and medically acute clients.

(b) The State Director of Health Services shall apply for additional waivers when appropriate to expand the number and types of persons who will be eligible for in-home services.

(Amended by Stats. 2004, Ch. 193, Sec. 237. Effective January 1, 2005.)

14005.60. (a) Commencing January 1, 2014, the department shall provide Medi-Cal benefits for individuals who meet 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) An individual eligible under this section shall not have income that exceeds 133 percent of the federal poverty level as determined, counted, and valued in accordance with the requirements of 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.

(c) (1) Individuals who are eligible under this section shall be required to mandatorily enroll into a Medi-Cal managed care health plan in those counties where a Medi-Cal managed care health plan is available.

(2) (A) Individuals residing in a county where no Medi-Cal managed care health plan is available shall be provided services under the Medi-Cal fee-for-service delivery system subject to subparagraph (B).

(B) If a Medi-Cal managed care health plan becomes available to individuals referenced in subparagraph (A), those individuals shall be enrolled in a Medi-Cal managed care health plan.

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

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

(Added by Stats. 2013, 1st Ex. Sess., Ch. 3, Sec. 9. (AB 1 1x) Effective September 30, 2013.)

14005.61. (a) Except as provided in subdivision (e), individuals who are enrolled in a Low Income Health Program (LIHP) as of December 31, 2013, under California's Bridge to Reform Section 1115(a) Medicaid Demonstration who are at or below 133 percent of the federal poverty level shall be transitioned directly to the Medi-Cal program in accordance with the requirements of this section and pursuant to federal approval.

(b) Except as provided in paragraph (8) of subdivision (c), individuals who are eligible under subdivision (a) shall be required to enroll into Medi-Cal managed care health plans.

(c) Except as provided in subdivision (d), with respect to managed care health plan enrollment, a LIHP enrollee shall be notified by the department at least 60 days prior to January 1, 2014, in accordance with the department's LIHP transition plan of all of the following:

(1) Which Medi-Cal managed care health plan or plans contain his or her existing primary care provider, if the department has this information and the primary care provider is contracted with a Medi-Cal managed care health plan.

(2) That the LIHP enrollee, subject to his or her ability to change as described in paragraph (3), will be assigned to a health plan that includes his or her primary care provider and enrolled effective January 1, 2014. If the enrollee wants to keep his or her primary care provider, no additional action will be required if the primary care provider is contracted with a Medi-Cal managed care health plan.

(3) That the LIHP enrollee may choose any available Medi-Cal managed care health plan and primary care provider in his or her county of residence prior to January 1, 2014, if more than one such plan is available in the county where he or she resides, and he or she will receive all provider and health plan information required to be sent to new enrollees and instructions on how to choose or change his or her health plan and primary care provider.

(4) That in counties with more than one Medi-Cal managed care health plan, if the LIHP enrollee does not affirmatively choose a plan within 30 days of receipt of the notice, he or she shall be enrolled into the Medi-Cal managed care health plan that contains his or her LIHP primary care provider as part of the Medi-Cal managed care contracted primary care network, if the department has this information about the primary care provider, and the primary care provider is contracted with a Medi-Cal managed care health plan. If the primary care provider is contracted with more than one Medi-Cal managed care health plan, then the LIHP enrollee will be assigned to one of the health plans containing his or her primary care provider in accordance with an assignment process established to ensure the linkage.

(5) That if the LIHP enrollee's existing primary care provider is not contracted with any Medi-Cal managed care health plan, then he or she will receive all provider and health plan information required to be sent to new enrollees. If the LIHP enrollee 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.

(6) That the LIHP enrollee does not need to take any action to be transitioned to the Medi-Cal program or to retain his or her primary care provider, if the primary care provider is available pursuant to paragraph (2).

(7) That the LIHP enrollee may choose not to transition to the Medi-Cal program, and what this choice will mean for his or her health care coverage and access to health care services.

(8) That in counties where no Medi-Cal managed care health plans are available, the LIHP enrollee will be transitioned into fee-for-service Medi-Cal, and provided with all information that is required to be sent to new Medi-Cal enrollees including the assistance telephone number for fee-for-service beneficiaries, and that, if a Medi-Cal managed care health plan becomes available in the residence county, he or she will be enrolled in a Medi-Cal managed care health plan according to the enrollment procedures in place at that time.

(d) Individuals who qualify under subdivision (a) who apply and are determined eligible for LIHP after the date identified by the department that is not later than October 1, 2013, will be considered late enrollees. Late enrollees shall be notified in accordance with subdivision (c), except according to a different timeframe, but will transition to Medi-Cal coverage on January 1, 2014. Late enrollees after the date identified in this subdivision shall be transitioned pursuant to the department's LIHP transition plan process.

(e) Individuals who qualify under subdivision (a) and are not denoted as active LIHP enrollees according to the Medi-Cal Eligibility Data System at any point within the date range identified by the department that will start not sooner than December 20, 2013, and continue through December 31, 2013, will not be included in the LIHP transition to the Medi-Cal program. These individuals may apply for Medi-Cal eligibility separately from the LIHP transition process.

(f) In conformity with the department's transition plan, individuals who are enrolled in a LIHP at any point from September 2013 through December 2013, under California's Bridge to Reform Section 1115(a) Medicaid Demonstration and are above 133 percent of the federal poverty level will be provided information regarding how to apply for an eligibility determination for an insurance affordability program, including submission of an application by telephone, by mail, online, or in person.

(g) A Medi-Cal managed care health plan that receives a LIHP enrollee during this transition shall assign the LIHP primary care provider of the enrollee as the Medi-Cal managed care health plan primary care provider of the enrollee, to the extent possible, if the Medi-Cal managed care health plan contracts with that primary care provider, unless the beneficiary has chosen another primary care provider on his or her choice form. A LIHP enrollee who is enrolled into a Medi-Cal managed care plan may work through the Medi-Cal managed care plan to change his or her assigned primary care provider or other provider, after enrollment and subject to provider availability, according to the standard processes that are currently available in Medi-Cal managed care for selecting providers.

(h) The director may, with federal approval, suspend, delay, or otherwise modify the requirement for LIHP program eligibility redeterminations in 2013 to facilitate the process of transitioning LIHP enrollees to other health coverage in 2014.

(i) The county LIHPs and their designees shall work with the department and its designees during the 2013 and 2014 calendar years to facilitate continuity of care and data sharing for the purposes of delivering Medi-Cal services in the 2014 calendar year.

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

(Amended (as added by Stats. 2013, 1st Ex. Sess., Ch. 3, Sec. 10) by Stats. 2013, Ch. 442, Sec. 8. (SB 28) Effective January 1, 2014.)

14005.62. (a) (1) Notwithstanding any other law, for an applicant or beneficiary whose eligibility is not determined using the modified adjusted gross income (MAGI)-based financial methods, as specified in Section 1396a(e)(14) of Title 42 of the United States Code, resources, including property or other assets, shall not be used to determine eligibility under the Medi-Cal program to the extent permitted by federal law. The department shall seek federal authority to disregard all resources as authorized by the flexibilities provided under Section 1396a(r)(2) of Title 42 of the United States Code or other available authorities.

(b) (1) 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 this section by means of county letters, provider bulletins or notices, policy letters, or other similar instructions, without taking regulatory action.

(2) Within two years of implementing the requirements set forth in subdivision (b), the department shall do both of the following:

(A) Adopt, amend, or repeal 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 and this section.

(B) Update its notices and forms to delete any reference to limitations on resources or assets.

(c) No sooner than August 1, 2025, the department shall convene a stakeholder workgroup to provide feedback and assist the department with activities related to the implementation of the version this section to be operative on January 1, 2026, including educational outreach in the form of flyers and factsheets and other public education strategies developed by the department in consultation with interested stakeholders, including, but not limited to, counties and consumer advocates.

(d) This section shall only be implemented to the extent consistent with federal law, upon the department obtaining any necessary federal approvals, and to the extent federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.

(e) This section shall become inoperative on January 1, 2026, and as of that date is repealed.

(Amended by Stats. 2025, Ch. 21, Sec. 58. (AB 116) Effective June 30, 2025. Repealed as of January 1, 2026, by its own provisions. See later operative version added by Sec. 59 of Stats. 2025, Ch. 21.)

14005.62. (a) (1) Notwithstanding any other law, for an applicant or beneficiary whose eligibility is not determined using the modified adjusted gross income (MAGI)-based financial methods, as specified in Section 1396a(e)(14) of Title 42 of the United States Code, the department shall seek federal approval to implement a disregard of one hundred thirty thousand dollars ($130,000) in nonexempt property for a case with one member and sixty five thousand dollars ($65,000) for each additional household member, up to a maximum of 10 members.

(2) This subdivision shall be implemented only after the director determines that systems have been programmed for the disregards specified in paragraph (1) and they communicate that determination in writing to the Department of Finance.

(b) (1) 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 this section by means of county letters, provider bulletins or notices, policy letters, or other similar instructions, without taking regulatory action. Such instructions shall include a list of all exempt property for use until such time that regulations are adopted.

(2) Within two years of implementing the requirements set forth in this subdivision, the department shall do both of the following:

(A) Adopt, amend, or repeal 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 and this section.

(B) Update its notices and forms to reflect the consideration of assets and resources as described in subdivision (a).

(c) Upon operation of subdivision (a), the department shall make available, on a quarterly basis data, the number of Medi-Cal enrollees who lost eligibility due to the asset limit. The department shall consult with stakeholders to determine the appropriate data elements and level of detail, including, but not limited to, the reasons for termination.

(d) This section shall only be implemented to the extent consistent with federal law, upon the department obtaining any necessary federal approvals, and to the extent federal financial participation under the Medi-Cal program is available and not otherwise

jeopardized.

(e) This section shall become operative on January 1, 2026.

(Repealed (in Sec. 58) and added by Stats. 2025, Ch. 21, Sec. 59. (AB 116) Effective June 30, 2025. Operative January 1, 2026, by its own provisions.)

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.

(Added by Stats. 2013, 1st Ex. Sess., Ch. 4, Sec. 11. (SB 1 1x) Effective September 30, 2013.)

14005.64. (a) Effective January 1, 2014, and notwithstanding any other law, when determining eligibility for Medi-Cal benefits, an applicant's or beneficiary's income and resources shall be determined, counted, and valued in accordance with the requirements of Section 1902(e)(14) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(14)), as added by the ACA, which prohibits the use of an assets or resources test for individuals whose income eligibility is determined based on modified adjusted gross income.

(b) When determining the eligibility of applicants and beneficiaries using the MAGI-based financial methods, the 5-percent income disregard required under Section 1902(e)(14)(B)(I) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(14)(B)(I)) shall be applied.

(c) (1) The department shall establish income eligibility thresholds for those Medi-Cal eligibility groups whose eligibility will be determined using MAGI-based financial methods. The income eligibility thresholds shall be developed using the financial methodologies described in Section 1396a(e)(14) of Title 42 of the United States Code and in conformity with Section 1396a(gg) of Title 42 of the United States Code as added by the ACA.

(2) In utilizing state data or the national standard methodology with Survey of Income and Program Participation data to develop the converted modified adjusted gross income standard for Medi-Cal applicants and beneficiaries, the department shall ensure that the financial methodology used for identifying the equivalent income eligibility threshold preserves Medi-Cal eligibility for applicants and beneficiaries to the extent required by federal law. The department shall report to the Legislature on the expected changes in income eligibility thresholds using the chosen methodology for individuals whose income is determined on the basis of a converted dollar amount or federal poverty level percentage. The department shall convene stakeholders, including the Legislature, counties, and consumer advocates regarding the results of the converted standards and shall review with them the information used for the specific calculations before adopting its final methodology for the equivalent income eligibility threshold level.

(3) The income eligibility threshold levels required under this subdivision shall be as follows for the identified coverage groups:

(A) For those pregnant individuals and infants eligible under Sections 435.116 and 435.118 of Title 42 of the Code of Federal Regulations, respectively, 208 percent of the federal poverty level.

(B) For those children one to five years of age, inclusive, eligible under Section 1396a(a)(10)(A)(i)(VI) of Title 42 of the United States Code, 142 percent of the federal poverty level.

(C) For those children 6 to 18 years of age, inclusive, eligible under Section 1396a(a)(10)(A)(i)(VII) of Title 42 of the United States Code, 133 percent of the federal poverty level.

(d) 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 ACA.

(e) For 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 originally enacted and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

(2) “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 ACA.

(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, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(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.

(Amended by Stats. 2022, Ch. 47, Sec. 81. (SB 184) Effective June 30, 2022.)

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

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

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

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

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

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

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

(Amended by Stats. 2014, Ch. 71, Sec. 194. (SB 1304) Effective January 1, 2015.)

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

(Added by Stats. 2013, 1st Ex. Sess., Ch. 4, Sec. 13. (SB 1 1x) Effective September 30, 2013.)

14005.67. The department shall seek any federal waivers necessary to automatically enroll parents in the Medi-Cal program who apply for Medi-Cal benefits and have one or more children who are eligible for Medi-Cal benefits based upon a determined income

level that is at or below the applicable income standard for eligibility under Section 14005.60.

(Added by Stats. 2013, 1st Ex. Sess., Ch. 4, Sec. 14. (SB 1 1x) Effective September 30, 2013.)

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

(Added by Stats. 2013, 1st Ex. Sess., Ch. 4, Sec. 15. (SB 1 1x) Effective September 30, 2013.)

14005.7. (a) Medically needy persons and medically needy family persons are entitled to health care services under Section 14005 providing all eligibility criteria established pursuant to this chapter are met.

(b) Except as otherwise provided in this chapter or in Title XIX of the federal Social Security Act, no medically needy family person, medically needy person or state-only Medi-Cal persons shall be entitled to receive health care services pursuant to Section 14005 during any month in which their spend down of excess income has not been met.

(c) In the case of a medically needy person, monthly income, as determined, defined, counted, and valued, in accordance with Title XIX of the federal Social Security Act, in excess of the amount required for maintenance established pursuant to Section 14005.12, exclusive of any amounts considered exempt as income under Chapter 3 (commencing with Section 12000), less amounts paid for Medicare and other health insurance premiums shall be the spend down of excess income to be met under Section 14005.9.

(d) In the case of a medically needy family person or state-only Medi-Cal person, monthly income, as determined, defined, counted, and valued, in accordance with Title XIX of the federal Social Security Act, in excess of the amount required for maintenance established pursuant to Section 14005.12, exclusive of any amounts considered exempt as income under Chapter 2 (commencing with Section 11200), less amounts paid for Medicare and other health insurance premiums shall be the spend down of excess income to be met under Section 14005.9.

(e) In determining the income of a medically needy person residing in a licensed community care facility, income shall be determined, defined, counted, and valued, in accordance with Title XIX of the federal Social Security Act, any amount paid to the facility for residential care and support that exceeds the amount needed for maintenance shall be deemed unavailable for the purposes of this chapter.

(f) (1) For purposes of this section the following definitions apply:

(A) "SSI" means the federal Supplemental Security Income program established under Title XVI of the federal Social Security Act.

(B) "MNL" means the income standard of the Medi-Cal medically needy program defined in Section 14005.12.

(C) Board and care "personal care services" or "PCS" deduction means the income disregard that is applied to a resident in a licensed community care facility, in lieu of the board and care deduction specified in subdivision (e) of Section 14005.7, when the PCS deduction is greater than the board and care deduction.

(2) (A) For purposes of this section, the SSI recipient retention amount is the amount by which the SSI maximum payment amount to an individual residing in a licensed community care facility exceeds the maximum amount that the state allows community care facilities to charge a resident who is an SSI recipient.

(B) For purposes of this section, the personal and incidental needs deduction for an individual residing in a licensed community care facility is either of the following:

(i) If the deduction specified in subdivision (e) is applicable to the individual, the amount, not to exceed the amount by which the SSI recipient retention amount exceeds twenty dollars ($20), nor to be less than zero, by which the sum of the amount that the individual pays to their licensed community care facility and the SSI recipient retention amount exceed the sum of the individual's MNL, the individual's board and care deduction, and twenty dollars ($20).

(ii) If the deduction specified in paragraph (1) is applicable to the individual, an amount, not to exceed the amount by which the SSI recipient retention amount exceeds twenty dollars ($20), nor to be less than zero, by which the sum of the amount that the individual pays to their community care facility and the SSI recipient retention amount exceed the sum of the individual's MNL, the individual's PCS deduction and twenty dollars ($20).

(3) In determining the countable income of a medically needy individual residing in a licensed community care facility, the individual shall have deducted from their income the amount specified in subparagraph (B) of paragraph (2).

(g) No later than one month after the effective date of subparagraph (B) of paragraph (2) of subdivision (f), the department shall submit to the federal medicaid administrator a state plan amendment seeking approval of the income deduction specified in subdivision (f), and of federal financial participation for the costs resulting from that income deduction.

(h) The deduction prescribed by paragraph (3) of subdivision (f) shall be applied no later than the first day of the fourth month after the month in which the department receives approval for the federal financial participation specified in subdivision (g). Until approval for federal financial participation is received by the department, there shall be no deduction under paragraph (3) of subdivision (f).

(Amended by Stats. 2023, Ch. 42, Sec. 67. (AB 118) Effective July 10, 2023.)

14005.70. (a) The State Department of Health Care Services shall ensure that its contracts with a health care service plan or health insurer to provide Medi-Cal managed care coverage meet all of the following requirements:

(1) A health care service plan or health insurer shall provide coverage in its bridge plan product to its Medi-Cal managed care enrollees and other individuals that meet the requirements in paragraph (2) if the Medi-Cal managed care plan offers a bridge plan product pursuant to Section 100504.5 of the Government Code.

(2) Only the following individuals shall be eligible to enroll in the Medi-Cal managed care plan's bridge plan product if the Medi-Cal managed care plan offers a bridge plan product:

(A) An individual who is determined to be eligible for the Exchange and whose Medi-Cal coverage or Healthy Families coverage was terminated. In implementing this subparagraph, the Exchange shall adopt processes to ensure that individuals have no gap in coverage to the greatest extent possible. The Exchange shall request approval from the federal government to limit enrollment under this subparagraph to individuals with a family income at or below 250 percent of the federal poverty level.

(B) Other members of the modified adjusted gross income household, as defined in Section 100501 of the Government Code, in which there are Medi-Cal or Healthy Families enrollees.

(C) A parent or caretaker relative of a child on Medi-Cal. The Exchange may delay the operative date of this subparagraph until it has the operational capability to implement this subparagraph, but no later than January 1, 2015.

(3) Provide all of the following:

(A) Except as provided in subparagraph (C) of paragraph (2), an individual who is eligible to enroll in a bridge plan product under subparagraph (A) of paragraph (2) shall only be eligible to enroll in a bridge plan product offered by the health care service plan or health insurer through which the individual was enrolled prior to eligibility for a bridge plan product as either a Medi-Cal beneficiary or as a Healthy Families enrollee.

(B) An individual who is eligible to enroll in a bridge plan product under subparagraph (B) of paragraph (2) shall only be eligible to enroll in a bridge plan product offered by the health care service plan or health insurer through which the member of the household was enrolled as a Medi-Cal beneficiary or as a Healthy Families enrollee.

(C) The Exchange shall seek federal approval to allow individuals described in subparagraphs (A) and (B) the option to enroll in a different bridge plan product if the individual's primary care provider is included in the contracted network of the different bridge plan product and either of the following applies to the bridge plan product for which the individual is eligible:

(i) The product is not offered in that individual's service area.

(ii) The product is not offered as a bridge plan product by the Exchange.

(4) The Medi-Cal managed care plan shall only offer a bridge plan product if the bridge plan product premium contribution amount in the silver category for the eligible individual is equal to, or less than, the premium contribution amount for the lowest cost plan in the silver category that would have been available to that individual without the bridge plan product.

(b) The State Department of Health Care Services may enter into a contract with the California Health Benefit Exchange to delegate the implementation of any part of this section to the Exchange.

(c) Notwithstanding subdivision (a) of Section 1399.849 of the Health and Safety Code and subdivision (a) of Section 10965.3 of the Insurance Code, the State Department of Health Care Services may allow a Medi-Cal managed care plan, pursuant to its contract under this section, to limit enrollment into bridge plan products to eligible individuals identified in paragraph (2) of subdivision (a) of

this section based on limitations in contracted network capacity for bridge plan products as provided in Section 1399.857 of the Health and Safety Code or Section 10753.12 of the Insurance Code.

(d) This section shall become inoperative on the October 1 that is five years after the date that federal approval of the bridge plan option occurs, and, as of the second January 1 thereafter, is repealed, unless a later enacted statute that is enacted before that date deletes or extends the dates on which it becomes inoperative and is repealed.

(Added by Stats. 2013, 1st Ex. Sess., Ch. 5, Sec. 14. (SB 3 1x) Effective September 30, 2013. Conditionally inoperative, on date prescribed by its own provisions. Repealed, by its own provisions, on second January 1 after inoperative date.)

14005.73. A person who is otherwise eligible for Medi-Cal benefits under either Section 14005.4 or 14005.7, except for income and resource eligibility, and who is receiving Medi-Cal services for the treatment of multiple sclerosis, shall continue to be eligible to receive benefits only for these services under Medi-Cal, provided that all other conditions of eligibility for the Medi-Cal program are met. These restricted benefits shall continue until such time as the person is eligible for, and receives, third party coverage for these treatments. However, restricted benefits under this section shall not continue for more than two years.

(Added by renumbering Section 14005.75 (as added by Stats. 1985, Ch. 1144, Sec. 1) by Stats. 2015, Ch. 303, Sec. 601. (AB 731) Effective January 1, 2016.)

14005.75. (a) The Legislature finds and declares all of the following:

(1) As a result of federal welfare reform, unprecedented numbers of welfare recipients will be leaving welfare for work, and will face time limits on the receipt of aid.

(2) It is in the interest of the state both to encourage welfare recipients to seek employment and to ensure the continuity of health coverage for these recipients as they move from welfare to work.

(3) California's transitional Medi-Cal program is intended to encourage welfare recipients to seek employment and to ensure continuity of health coverage, but various procedural restrictions limit its effectiveness in achieving those goals.

(b) It is, therefore, the intent of the Legislature to streamline the transitional Medi-Cal program in order to maximize its effectiveness in assisting persons leaving welfare for work.

(Added by Stats. 1997, Ch. 294, Sec. 51. Effective August 18, 1997.)

14005.76. (a) The department shall provide a Medi-Cal beneficiary whose Medi-Cal eligibility is established pursuant to Section 1930 of the federal Social Security Act (42 U.S.C. Sec. 1396u-1) with simple and clear written notice of the availability of the transitional Medi-Cal program and the requirements for that program. This notice shall be provided at the time that Medi-Cal eligibility is conferred to the beneficiary and at least once every six months thereafter.

(b) When a beneficiary loses Medi-Cal eligibility established pursuant to Section 1930 of the federal Social Security Act (42 U.S.C. Sec. 1396u-1) for failure to meet reporting requirements, the department shall provide the beneficiary with the notice described in subdivision (a), and a form with simple and clear instructions on how to complete and return the form to the county. The form shall be used to determine whether the beneficiary is eligible for the transitional Medi-Cal program.

(c) The notice and form described in subdivisions (a) and (b) shall be prepared by the department. The department shall seek input on the notice and form from beneficiaries of aid, beneficiary representatives, and counties.

(d) The department shall review, and if necessary for simplicity and clarity, revise the notice required by subdivision (b) of Section 14005.8 and Section 14005.81. The department shall seek input from beneficiaries, beneficiary representatives, and counties.

(e) Notwithstanding any other provision of law, this section shall become operative nine months after the effective date of this section.

(f) Notwithstanding any other provision of law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation, as provided under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), is available.

(Added by Stats. 1997, Ch. 294, Sec. 52. Effective August 18, 1997.)

14005.8. (a) (1) To the extent required by Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code and regulations adopted pursuant thereto, a family who was receiving aid pursuant to a state plan approved under Part A of Subchapter IV (commencing with Section 601) of Title 42 of the United States Code in at least three of the six months immediately preceding the month in which that family became ineligible for that assistance due to increased hours of employment, income from employment, or the loss of earned income disregards, shall remain eligible for health care services as provided in this chapter during the immediately succeeding six-month period.

(2) The department shall terminate extensions of health care services authorized by paragraph (1) as required under federal law.

(b) The department shall notify persons eligible under subdivision (a) of their right to continued health care services for each six-month period and a description of their reporting requirement, and the circumstances under which the extension may be terminated. The notice shall also include a Medi-Cal card or other evidence of entitlement to those services.

(c) Notwithstanding any other provision of this section, the department, in conformance with federal law, shall offer beneficiaries covered under subdivision (a) the option of remaining eligible for health care services provided in this chapter for an additional extension period of six months. Health services shall be continued in as automatic a manner as permitted by federal law, and without any unnecessary paperwork.

(d) During the initial extension period and any additional six-month extension period, the department, consistent with federal law, may, whenever the department determines it to be cost-effective, elect to pay a family's expenses for premiums, deductibles, coinsurance, or similar costs for health insurance or other health coverage offered by an employer of the caretaker relative or by an employer of the absent parent of the dependent child. If, during the additional six-month extension period, the department elects to pay health premiums and this coverage exists, the beneficiary may be given the opportunity to express his or her preference between continuing the Medi-Cal coverage or obtaining health insurance.

(e) During the additional six-month extension period, the department may impose a premium for the health insurance or other health coverage consistent with Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) if the department determines that the imposition of a premium is cost-effective.

(f) The department shall adopt emergency regulations in order to comply with mandatory provisions of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) for extension of medical assistance. These regulations shall become effective immediately upon filing with the Secretary of State.

(g) This section shall become operative April 1, 1990.

(Amended by Stats. 1998, Ch. 310, Sec. 71. Effective August 19, 1998.)

14005.84. (a) The department shall develop and conduct a community outreach and education campaign to assist persons whose Medi-Cal eligibility is established pursuant to Section 1931 of the federal Social Security Act (42 U.S.C. Sec. 1396u-1), to learn about the availability of the transitional Medi-Cal program.

(b) Any managed care plan, local initiative, or county organized health system contracting with the department to provide services to Medi-Cal enrollees shall include in its evidence of coverage and marketing materials information about the transitional Medi-Cal program and how to apply for program benefits.

(c) To implement this section, the department may develop and execute a contract or may amend any existing or future outreach campaign contract that it has executed. Notwithstanding any other provision of law, any such contract developed and executed, or amended, as required to implement this section shall be exempt from the approval of the Director of General Services and from the Public Contract Code.

(d) Notwithstanding any other provision of law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation, as provided under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), is available.

(Added by Stats. 1997, Ch. 294, Sec. 55. Effective August 18, 1997.)

14005.85. (a) Families who, because of marriage or because separated spouses reunite, lose AFDC eligibility under the chapter because the family no longer meets the need requirement specified in Section 11250 or has increased assets or income, or both, shall be eligible for extended medical benefits as specified under this article for a period not to exceed 12 months.

(b) The department shall seek all federal waivers necessary to implement this section.

(c) This section shall not be implemented until the director has executed a declaration, that shall be retained by the director, that any necessary waivers and federal financial participation have been obtained.

(Amended by Stats. 1996, Ch. 197, Sec. 25. Effective July 22, 1996.)

14005.88. (a) The department shall contract for an independent evaluation, to be completed no later than January 1, 2001, in order to determine the effect of changes made in the transitional Medi-Cal program by the enactment of Sections 14005.76, 14005.82, 14005.83, 14005.84, 14005.87, 14005.89, and the amendment to Section 14005.85 enacted during the first year of the 1997–98 Regular Session of the Legislature, on the employment of welfare recipients and the continuity of their health coverage.

(b) Notwithstanding any other provision of law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation, as provided under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), is available.

(Added by Stats. 1997, Ch. 294, Sec. 56. Effective August 18, 1997.)

14005.89. (a) The department shall monitor participation rates for transitional Medi-Cal and seek input from beneficiaries, beneficiary representatives, and counties, on a regular basis throughout each year to consider changes in transitional Medi-Cal procedures as may be necessary to ensure that participation rates are at levels that would reasonably be expected, given aid caseload developments. Before any such changes are made, the department shall seek any federal waivers, or obtain other federal approval, that may be necessary to implement the changes.

(b) The department shall make the participation rate monitoring data described in subdivision (a) available upon request.

(Added by Stats. 1997, Ch. 294, Sec. 57. Effective August 18, 1997.)

14005.9. (a) The spend down amount of excess income necessary to become eligible for Medi-Cal shall be determined on a monthly basis. No person or family shall be required to incur more than one month's spend down amount of excess income to become eligible for Medi-Cal prior to being certified as specified in Section 14018.

(b) Once the beneficiary has incurred expenses for Medicare and other health insurance deductibles or coinsurance charges and necessary medical and remedial services that are not subject to payment by a third party and that equal or exceed their spend down of excess income to become eligible for Medi-Cal, the individual is entitled to receive health care services pursuant to Section 14005 if all other applicable conditions of eligibility under this chapter are met.

(Amended by Stats. 2023, Ch. 42, Sec. 68. (AB 118) Effective July 10, 2023.)

14005.95. (a) For persons in long-term care, any income deductions, with the exception of other health insurance premiums under Sections 14005.4 and 14005.7, shall not be deducted in the post-eligibility treatment of income determination pursuant to Section 14051.7 to the extent allowable under federal law or regulations.

(b) Once the beneficiary has medical expenses that are not subject to payment by a third party and are equal to or exceed their long-term care patient liability amount, the individual is entitled to receive health care services pursuant to Section 14005 if all other applicable eligibility criteria established pursuant to this chapter are met. Those medical expenses may include, but are not limited to, any of the following:

(1) Medicare health insurance deductibles and coinsurance charges.

(2) Other health insurance deductibles and coinsurance charges.

(3) Necessary medical and remedial services.

(4) Expected expenses for inpatient long-term care in a medical facility.

(Added by Stats. 2023, Ch. 42, Sec. 86. (AB 118) Effective July 10, 2023.)

14005.10. For purposes of facilitating arrangements for health care through prepaid health plans, the department may set standards for determining monthly income, for purposes of eligibility, on the person's average pattern of income and earnings, subject to subsequent adjustment if actual experience deviates substantially from the amount determined by such method.

(Added by renumbering Section 14005.1 by Stats. 1971, Ch. 577.)

14005.11. (a) To the extent required by federal law for qualified beneficiaries enrolled in the federal Medicare Program, the department shall pay the premiums, deductibles, and coinsurance for elderly and disabled persons entitled to benefits under Title XVIII of the federal Social Security Act, whose income does not exceed the federal poverty level and whose resources do not exceed the amount specified in subdivision (a) of Section 14005.62.

(b) The department shall pay, in addition to subdivision (a), applicable additional premiums, deductibles, and coinsurance for drug coverage extended to qualified beneficiaries enrolled in the federal Medicare Program.

(c) The deductible payments required by subdivision (b) may be covered by providing the same drug coverage as offered to categorically needy recipients, as defined in Section 14050.1.

(d) As specified in this section, it is the intent of the Legislature to assist in the payment of Medicare Part B premiums for qualified low-income Medi-Cal beneficiaries who are ineligible for federal sharing or federal contribution for the payment of those premiums.

(e) For a Medi-Cal beneficiary who has a spend down of excess income but who is ineligible for the assistance provided pursuant to subdivision (a), or who is ineligible for any other federally funded assistance for the payment of the beneficiary's Medicare Part B premium, the department shall pay for the beneficiary's Medicare Part B premium in the month following each month that the beneficiary's spend down of excess income has been met.

(f) When a county is informed that an applicant or beneficiary is eligible for benefits under the federal Medicare Program, the county shall determine whether that individual is eligible under the Qualified Medicare Beneficiary program, the Specified Low-Income Medicare Beneficiary program, or the Qualifying Individual program, and shall enroll the applicant or beneficiary in the appropriate program.

(g) (1) The department shall enter into a Medicare Part A buy-in agreement for qualified Medicare beneficiaries with the federal Centers for Medicare and Medicaid Services by submitting a state plan amendment with a proposed effective date in accordance with paragraph (2).

(2) Subject to paragraph (3), the Medicare Part A buy-in agreement described in this subdivision shall be effective on January 1, 2025, or the date the department communicates to the Department of Finance in writing that systems have been programmed for implementation of this subdivision, whichever date is later.

(3) This subdivision shall be implemented only to the extent that any necessary federal approvals are obtained and that federal financial participation is available and is not otherwise jeopardized.

(4) 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, may implement, interpret, or make specific this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, until the time regulations are adopted.

(5) For purposes of this subdivision, “Medicare Part A buy-in agreement” means an agreement authorized by Section 1395v of Title 42 of the United States Code under which the state shall pay Medicare Part A premiums for qualified individuals who are enrolled in both the Medicare Program and the Medi-Cal program.

(h) This section shall become operative on January 1, 2026.

(Amended (as amended by Stats. 2023, Ch. 707, Sec. 1) by Stats. 2025, Ch. 21, Sec. 52. (AB 116) Effective June 30, 2025. Operative January 1, 2026, by its own provisions.)

14005.11. (a) To the extent required by federal law for qualified beneficiaries enrolled in the Medicare Program, the department shall pay the premiums, deductibles, and coinsurance for elderly and disabled persons entitled to benefits under Title XVIII of the federal Social Security Act, whose income does not exceed the federal poverty level.

(b) The department shall pay, in addition to subdivision (a), applicable additional premiums, deductibles, and coinsurance for drug coverage extended to qualified beneficiaries enrolled in the Medicare Program.

(c) The deductible payments required by subdivision (b) may be covered by providing the same drug coverage as offered to categorically needy recipients, as defined in Section 14050.1.

(d) As specified in this section, it is the intent of the Legislature to assist in the payment of Medicare Part B premiums for qualified low-income Medi-Cal beneficiaries who are ineligible for federal sharing or federal contribution for the payment of those premiums.

(e) For a Medi-Cal beneficiary who has a spend down of excess income but who is ineligible for the assistance provided pursuant to subdivision (a), or who is ineligible for any other federally funded assistance for the payment of the beneficiary’s Medicare Part B premium, the department shall pay for the beneficiary’s Medicare Part B premium in the month following each month that the beneficiary’s spend down of excess income has been met.

(f) When a county is informed that an applicant or beneficiary is eligible for benefits under the Medicare Program, the county shall determine whether that individual is eligible under the Qualified Medicare Beneficiary program, the Specified Low-Income Medicare Beneficiary program, or the Qualifying Individual program, and shall enroll the applicant or beneficiary in the appropriate program.

(g) (1) The department shall enter into a Medicare Part A buy-in agreement for qualified Medicare beneficiaries with the federal Centers for Medicare and Medicaid Services by submitting a state plan amendment with a proposed effective date in accordance with paragraph (2).

(2) Subject to paragraph (3), the Medicare Part A buy-in agreement described in this subdivision shall be effective on January 1, 2025, or the date the department communicates to the Department of Finance in writing that systems have been programmed for implementation of this subdivision, whichever date is later.

(3) This subdivision shall be implemented only to the extent that any necessary federal approvals are obtained and that federal financial participation is available and is not otherwise jeopardized.

(4) 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, may implement, interpret, or make specific this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, until the time regulations are adopted.

(5) For purposes of this subdivision, “Medicare Part A buy-in agreement” means an agreement authorized by Section 1395v of Title 42 of the United States Code under which the state shall pay Medicare Part A premiums for qualified individuals who are enrolled in both the Medicare Program and the Medi-Cal program.

(h) This section shall become inoperative on January 1, 2026, and, as of January 1, 2027, is repealed.

(Amended (as amended by Stats. 2023, Ch. 707, Sec. 2) by Stats. 2025, Ch. 21, Sec. 53. (AB 116) Effective June 30, 2025. Inoperative January 1, 2026, by its own provisions. Repealed as of January 1, 2027, by its own provisions. See later operative version, as amended by Sec. 52 of Stats. 2025, Ch. 21.)

14005.12. (a) For the purposes of Sections 14005.4 and 14005.7, the department shall establish the income levels for maintenance need at the lowest levels that reasonably permit medically needy persons to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under Title XIX of the federal Social Security Act. It is the intent of the Legislature that the income levels for maintenance need for medically needy aged, blind, and disabled adults, in particular, shall be based upon amounts that adequately reflect their needs.

(1) Subject to paragraph (2), reductions in the maximum aid payment levels set forth in subdivision (a) of Section 11450 in the 1991–92 fiscal year, and thereafter, shall not result in a reduction in the income levels for maintenance under this section.

(2) (A) The department shall seek any necessary federal authorization for maintaining the income levels for maintenance at the levels in effect June 30, 1991.

(B) If federal authorization is not obtained, medically needy persons shall not be required to pay the difference between the spend down of excess income as determined based on the payment levels in effect on June 30, 1991, under Section 11450, and the spend down of excess income as determined based on the payment levels in effect on July 1, 1991, and thereafter.

(3) Any medically needy person who was eligible for benefits under this chapter as categorically needy for the calendar month immediately preceding the effective date of the reductions in the minimum basic standards of adequate care for the Aid to Families with Dependent Children program as set forth in Section 11452.018 made in the 1995–96 Regular Session of the Legislature shall not be responsible for paying their spend down of excess income if all of the following apply:

(A) The person had eligibility as categorically needy terminated by the reductions in the minimum basic standards of adequate care.

(B) The person, but for the reductions, would be eligible to continue receiving benefits under this chapter as categorically needy.

(C) The person is ineligible to receive benefits without a spend down of excess income as a medically needy person pursuant to paragraph (1) or (2).

(b) In the case of a single individual, the amount of the income level for maintenance per month shall be 80 percent of the highest amount that would ordinarily be paid to a family of two persons, without any income or resources, under subdivision (a) of Section 11450, multiplied by the federal financial participation rate.

(c) In the case of a family of two adults, the income level for maintenance per month shall be the highest amount that would ordinarily be paid to a family of three persons without income or resources under subdivision (a) of Section 11450, multiplied by the federal financial participation rate.

(d) For the purposes of Sections 14005.4 and 14005.7, for a person in a medical institution or nursing facility, or for a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization pursuant to Chapter 8.75 (commencing with Section 14591), the amount considered as required for maintenance per month shall be computed in accordance with, and for those purposes required by, Title XIX of the federal Social Security Act, and regulations adopted pursuant thereto. Those amounts shall be computed pursuant to regulations that include providing for the following purposes:

(1) Personal and incidental needs in the amount of not less than thirty-five dollars ($35) per month while a patient. The department may, by regulation, increase this amount as necessitated by increasing costs of personal and incidental needs. A long-term health care facility shall not charge an individual for the laundry services or periodic hair care specified in Section 14110.4.

(2) The upkeep and maintenance of the home.

(3) The support and care of their minor children, or any disabled relative for whose support they have contributed regularly, if there is no community spouse.

(4) If the person is an institutionalized spouse, for the support and care of their community spouse, minor or dependent children, dependent parents, or dependent siblings of either spouse, provided the individuals are residing with the community spouse.

(5) The community spouse monthly income allowance shall be established at the maximum amount permitted in accordance with Section 1924(d)(1)(B) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396r-5(d)(1)(B)).

(6) The family allowance for each family member residing with the community spouse shall be computed in accordance with the formula established in Section 1924(d)(1)(C) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396r-5(d)(1)(C)).

(e) For the purposes of Sections 14005.4 and 14005.7, with regard to a person in a licensed community care facility, the amount considered as required for maintenance per month shall be computed pursuant to regulations adopted by the department that provide for the support and care of their spouse, minor children, or any disabled relative for whose support they have contributed regularly.

(f) The income levels for maintenance per month, except as specified in subdivisions (b) to (d), inclusive, shall be equal to the highest amounts that would ordinarily be paid to a family of the same size without any income or resources under subdivision (a) of Section 11450, multiplied by the federal financial participation rate.

(g) The "federal financial participation rate," as used in this section, shall mean $133^{1}/_{3}$ percent, or such other rate set forth in Section 1903 of the federal Social Security Act (42 U.S.C. Sec. 1396(b)), or its successor provisions.

(h) The income levels for maintenance per month shall not be decreased to reflect the presence in the household of persons receiving forms of aid other than Medi-Cal.

(i) When family members maintain separate residences, but eligibility is determined as a single unit under Section 14008, the income levels for maintenance per month shall be established for each household in accordance with subdivisions (b) to (h), inclusive. The total of these levels shall be the level for the single eligibility unit.

(j) The income levels for maintenance per month established pursuant to subdivisions (b) to (i), inclusive, shall be calculated on an annual basis, rounded to the next higher multiple of one hundred dollars ($100), and then prorated.

(k) If the conditions described in paragraph (2) of subdivision (b) of Section 14005.12, as added by Section 73 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2025, or the date certified by the department pursuant to paragraph (3) of subdivision (b) of Section 14005.12, as added by Section 73 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

(Amended (as amended by Stats. 2022, Ch. 47, Sec. 72) by Stats. 2023, Ch. 42, Sec. 71. (AB 118) Effective July 10, 2023. Conditionally inoperative on or after January 1, 2025, by its own provisions. Repealed January 1 following the inoperative date. See later operative version amended by Sec. 72 of Stats. 2023, Ch. 42.)

14005.12. (a) For the purposes of Sections 14005.4 and 14005.7, the department shall establish the income levels for maintenance need at the lowest levels that reasonably permit medically needy persons to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under Title XIX of the federal Social Security Act. It is the intent of the Legislature that the income levels for maintenance need for medically needy aged, blind, and disabled adults, in particular, shall be based upon amounts that adequately reflect their needs.

(1) Subject to paragraph (2), reductions in the maximum aid payment levels set forth in subdivision (a) of Section 11450 in the 1991–92 fiscal year, and thereafter, shall not result in a reduction in the income levels for maintenance under this section.

(2) (A) The department shall seek any necessary federal authorization for maintaining the income levels for maintenance at the levels in effect June 30, 1991, and, commencing no sooner than January 1, 2025, as described in subdivision (b).

(B) If federal authorization is not obtained, medically needy persons shall not be required to pay the difference between the spend down of excess income as determined based on the payment levels in effect on June 30, 1991, under Section 11450, and the spend down of excess income as determined based on the payment levels in effect on July 1, 1991, and thereafter.

(3) Any medically needy person who was eligible for benefits under this chapter as categorically needy for the calendar month immediately preceding the effective date of the reductions in the minimum basic standards of adequate care for the Aid to Families with Dependent Children program as set forth in Section 11452.018 made in the 1995–96 Regular Session of the Legislature shall not be responsible for paying their spend down of excess income if all of the following apply:

(A) The person had eligibility as categorically needy terminated by the reductions in the minimum basic standards of adequate care.

(B) The person, but for the reductions, would be eligible to continue receiving benefits under this chapter as categorically needy.

(C) The person is ineligible to receive benefits without a spend down of excess income as a medically needy person pursuant to paragraph (1) or (2).

(b) (1) Effective no sooner than January 1, 2025, and to the extent the department determines the conditions described in paragraph (2) have been met, the amount of the income level for maintenance per month shall be equal to the income limit for Medi-Cal without a spend down of excess income for individuals described in Section 1396a(m)(1)(A) of Title 42 of the United States Code, as that income limit is calculated pursuant to paragraph (3) of subdivision (c) of Section 14005.40.

(2) Implementation of this section is contingent on both of the following conditions:

(A) All necessary federal approvals have been obtained by the department.

(B) The Legislature has appropriated funding to implement this section after a determination that ongoing General Fund resources are available to support the ongoing implementation of this section in the 2024–25 fiscal year and subsequent fiscal years.

(3) The department shall issue a declaration certifying the date that all conditions in paragraph (2) have been met. The department shall post the declaration on its internet website and provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(c) For the purposes of Sections 14005.4 and 14005.7, for a person in a medical institution or nursing facility, or for a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization pursuant to Chapter 8.75 (commencing with Section 14591), the amount considered as required for maintenance per month shall be computed in accordance with, and for those purposes required by, Title XIX of the federal Social Security Act, and regulations adopted pursuant thereto. Those amounts shall be computed pursuant to regulations that include providing for the following purposes:

(1) Personal and incidental needs in the amount of not less than thirty-five dollars ($35) per month while a patient. The department may, by regulation, increase this amount as necessitated by increasing costs of personal and incidental needs. A long-term health care facility shall not charge an individual for the laundry services or periodic hair care specified in Section 14110.4.

(2) The upkeep and maintenance of the home.

(3) The support and care of their minor children, or any disabled relative for whose support they have contributed regularly, if there is no community spouse.

(4) If the person is an institutionalized spouse, for the support and care of their community spouse, minor or dependent children, dependent parents, or dependent siblings of either spouse, provided the individuals are residing with the community spouse.

(5) The community spouse monthly income allowance shall be established at the maximum amount permitted in accordance with Section 1924(d)(1)(B) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396r-5(d)(1)(B)).

(6) The family allowance for each family member residing with the community spouse shall be computed in accordance with the formula established in Section 1924(d)(1)(C) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396r-5(d)(1)(C)).

(d) For the purposes of Sections 14005.4 and 14005.7, with regard to a person in a licensed community care facility, the amount considered as required for maintenance per month shall be computed pursuant to regulations adopted by the department that provide for the support and care of their spouse, minor children, or any disabled relative for whose support they have contributed regularly.

(e) The income levels for maintenance per month shall not be decreased to reflect the presence in the household of persons receiving forms of aid other than Medi-Cal.

(f) When family members maintain separate residences, but eligibility is determined as a single unit under Section 14008, the income levels for maintenance per month shall be established for each household in accordance with subdivisions (b) to (e), inclusive. The total of these levels shall be the level for the single eligibility unit.

(g) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of all-county letters, provider bulletins or notices, policy letters, or other similar instructions, without taking any further regulatory action. Within two calendar years of implementing subdivision (d) of Section 14005.12, the department shall adopt, amend, or repeal any necessary regulations.

(h) This section shall become operative on January 1, 2025, or the date certified by the department pursuant to paragraph (3) of subdivision (b), whichever is later.

(Amended (as added by Stats. 2022, Ch. 47, Sec. 73) by Stats. 2023, Ch. 42, Sec. 72. (AB 118) Effective July 10, 2023. Conditionally operative on or after January 1, 2025, by its own provisions.)

14005.13. (a) Notwithstanding Section 14005.12, when an individual residing in a long-term care facility would incur a long-term care patient liability for services under this chapter due to income that exceeds that allowed for the incidental and personal needs of the individual, a specified portion of the individual's earned income from therapeutic wages shall be exempt. Therapeutic wages are wages earned by the individual under all of the following conditions:

(1) A physician who does not have a financial interest in the long-term care facility in which the individual resides, and who is in charge of the individual's case, prescribes work as therapy for the individual.

(2) The individual must be employed within the same long-term care facility where they reside.

(3) The individual's employment does not displace any existing employees.

(4) The individual has resided in a long-term care facility for a continuous period commencing at least five years prior to the date of the addition of this section as originally adopted during the 1983–84 Regular Session.

(b) The amount of earned income from therapeutic wages that shall be exempt shall be the lesser of 70 percent of the gross therapeutic wages or 70 percent of the maintenance level for a noninstitutionalized person or family of corresponding size as described in subdivision (b), (c), or (e) of Section 14005.12.

(c) The provisions of this section shall be given retroactive effect for the period commencing June 1, 1983.

(d) This section shall not become operative unless and until the necessary waivers are obtained from the United States Department of Health and Human Services.

(e) The director shall adopt regulations implementing this section as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For the purposes of the Administrative Procedure Act, the adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, emergency regulations adopted by the department in order to implement this section shall not be subject to the review and approval of the Office of Administrative Law. These regulations shall become effective immediately upon filing with the Secretary of State.

(f) If the conditions described in paragraph (2) of subdivision (b) of Section 14005.12, as added by Section 73 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2025, or the date certified by the department pursuant to paragraph (3) of subdivision (b) of Section 14005.12, as added by Section 73 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

(Amended (as amended by Stats. 2022, Ch. 47, Sec. 74) by Stats. 2023, Ch. 42, Sec. 73. (AB 118) Effective July 10, 2023. Conditionally operative as prescribed by its own provisions. Conditionally inoperative on or after January 1, 2025, by its own provisions. Repealed January 1 following the inoperative date. See later operative version amended by Sec. 74 of Stats. 2023, Ch. 42.)

14005.13. (a) Notwithstanding Section 14005.12, when an individual residing in a long-term care facility would incur a long-term care patient liability for services under this chapter due to income that exceeds that allowed for the incidental and personal needs of the individual, a specified portion of the individual's earned income from therapeutic wages shall be exempt. Therapeutic wages are wages earned by the individual under all of the following conditions:

(1) A physician who does not have a financial interest in the long-term care facility in which the individual resides, and who is in charge of the individual's case, prescribes work as therapy for the individual.

(2) The individual must be employed within the same long-term care facility where they reside.

(3) The individual's employment does not displace any existing employees.

(4) The individual has resided in a long-term care facility for a continuous period commencing at least five years prior to the date of the addition of this section as originally adopted during the 1983–84 Regular Session.

(b) The amount of earned income from therapeutic wages that shall be exempt shall be the lesser of 70 percent of the gross therapeutic wages or 70 percent of the maintenance level as described in subdivision (b) of Section 14005.12.

(c) The provisions of this section shall be given retroactive effect for the period commencing June 1, 1983.

(d) This section shall not become operative unless and until the necessary waivers are obtained from the United States Department of Health and Human Services.

(e) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of all-county letters, provider bulletins or notices, policy letters, or other similar instructions, without taking any further regulatory action. Within two calendar years of implementing subdivision (d) of Section 14005.12, the department shall adopt, amend, or repeal any necessary regulations.

(f) This section shall become operative on January 1, 2025, or the date certified by the department pursuant to paragraph (3) of subdivision (b) of Section 14005.12, as added by Section 73 of Chapter 47 of the Statutes of 2022, whichever is later.

(Amended (as amended by Stats. 2022, Ch. 738, Sec. 15) by Stats. 2023, Ch. 42, Sec. 74. (AB 118) Effective July 10, 2023. Conditionally operative on or after January 1, 2025, as prescribed by its own provisions.)

14005.14. (a) In addition to the income exemptions specified in subdivision (a) of Section 14005.7, an income exemption shall be allowed each month for the amount actually paid toward the cost of in-home supportive services needed as determined under standards and procedures established by the Director of Social Services, by a person who is eligible for Medi-Cal in accordance with Section 14005. 3 or 14005.7. For the purpose of this section, “in-home supportive services” means those services that are available to recipients of the In-Home Supportive Services Program as defined by the Director of Social Services in regulations adopted pursuant to Article 7 (commencing with Section 12300) of Chapter 3 of Part 3 of Division 9.

(b) The income exemption provided by this section for those persons eligible for Medi-Cal in accordance with Section 14005.7 shall be restricted to those persons who, without in-home supportive services, would require 24-hour-a-day care in a health facility, as defined in Section 1250 of the Health and Safety Code, or a community care facility, as defined under Section 1502 of the Health and Safety Code.

(c) The State Department of Health Services shall seek all federal waivers necessary to allow for federal financial participation. The income exemption authorized by subdivision (b) shall remain in effect during the time period that the federal waivers are pending. If the necessary federal waivers cannot be obtained, the income exemption authorized by subdivision (b) shall continue to be implemented by the department.

(Amended by Stats. 1984, Ch. 364, Sec. 1. Effective July 10, 1984.)

14005.15. Notwithstanding the provisions of Section 14005, Medi-Cal beneficiaries shall obtain family planning services through the Medi-Cal program to the extent they are available through such program.

(Added by Stats. 1973, Ch. 1213.)

14005.16. (a) In determining the eligibility of a married individual pursuant to Section 14005.4 or 14005.7, who resides in a nursing facility, and who is in a Medi-Cal family budget unit separate from that of his or her spouse, the community property interest of the noninstitutionalized spouse in the income of the married individual shall not be considered income available to that individual.

(b) For purposes of this section, there shall be a presumption, rebuttable by either spouse, that each spouse has a community property interest in one-half of the total monthly income of both spouses.

(c) (1) This section shall not become operative unless Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is amended to authorize the consideration of state community property laws in determining eligibility or the federal government authorizes the state to apply community property laws in that determination.

(2) The department shall report to the appropriate committees of the Legislature upon the occurrence of the amendment of federal law or the receipt of federal approval, as specified in paragraph (1).

(Amended (as amended by Stats. 1989, Ch. 1430) by Stats. 1990, Ch. 1329, Sec. 7.5. Effective September 26, 1990. Section conditionally operative by its own provisions.)

14005.17. (a) In determining the eligibility of an institutionalized spouse pursuant to Section 14005.4 or 14005.7, who resides in a medical institution or nursing facility, and who is in a Medi-Cal family budget unit separate from that of his or her spouse, the community property interest of either spouse in the income of the other spouse shall not be considered when determining eligibility for Medi-Cal benefits.

(b) In the case of an institutionalized spouse, income shall be determined in accordance with subsections (b) and (d) of Section 1924 of the federal Social Security Act and regulations adopted pursuant thereto.

(c) (1) This section shall remain operative only until Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is amended to authorize the consideration of state community property law in determining eligibility under this chapter, or the federal government authorizes the consideration of state community property in that determination.

(2) The department shall report to the appropriate committees of the Legislature upon the occurrence of the amendment of federal law or receipt of federal authorization as specified in paragraph (1).

(Added by Stats. 1989, Ch. 1430, Sec. 5.5. Effective October 2, 1989. Conditionally inoperative by its own provisions.)

14005.18. (a) (1) An individual is eligible, to the extent required by federal law, as though the individual was pregnant, for all pregnancy-related and postpartum services for a 60-day period beginning on the last day of pregnancy.

(2) For purposes of paragraph (1), "postpartum services" means those services provided after childbirth, child delivery, or miscarriage.

(b) (1) Notwithstanding subdivision (a), Section 15840, the income eligibility requirements specified in Section 15832, and the annual redetermination requirements described in Section 14005.37, a pregnant individual who is receiving health care coverage under a program identified in subdivision (d) and who is diagnosed with a maternal mental health condition shall remain eligible for the Medi-Cal program under their current eligibility category for a period of one year following the last day of the individual's pregnancy if the individual complies with the requirements specified in subdivision (c) and is otherwise eligible for the Medi-Cal program.

(2) For purposes of this section, "maternal mental health condition" means a mental health condition that occurs during pregnancy or during the postpartum period and, includes, but is not limited to, postpartum depression.

(c) (1) An individual, or a designee of the individual, who seeks to extend Medi-Cal program coverage pursuant to this section shall submit to a county eligibility worker a note from that individual's treating health care provider stating that the health care provider has diagnosed the individual with a maternal mental health condition within 60 days following the last day of the individual's pregnancy.

(2) Notwithstanding paragraph (1), an individual who has had Medi-Cal coverage discontinued within the 60-day period beginning on the last day of pregnancy, but who is diagnosed with a maternal mental health condition more than 60 days following the last day of pregnancy and within the time limit described in subdivision (i) of Section 14005.37, may be reinstated to their previous Medi-Cal eligibility pursuant to subdivision (i) of Section 14005.37 by submitting a note, as described in paragraph (1), from the individual's treating health care provider within the timeframe described in that subdivision.

(d) For purposes of this section, "Medi-Cal program" refers to any of the following programs:

(1) The Medi-Cal Access Program, as described in Chapter 2 (commencing with Section 15810) of Part 3.3.

(2) The Medi-Cal program, as described in this article.

(3) The Perinatal Services Program, as described in Article 4.7 (commencing with Section 14148).

(e) This section does not limit the ability of a qualified individual to apply for and purchase a qualified health plan in Covered California pursuant to Title 22 (commencing with Section 100500) of the Government Code if the qualified individual is otherwise eligible for coverage pursuant to that title.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, provider bulletins, or similar instructions, without taking regulatory action.

(g) Implementation of this section is subject to an appropriation in the annual Budget Act for these purposes.

(h) This section shall become inoperative commencing on the date that Section 14005.185 is implemented. If made inoperative, this section shall become operative again if, and upon the date that, Section 14005.185 is no longer implemented. The department shall determine the implementation status of Section 14005.185 and shall post, on the department's internet website, notice of its determination.

(Amended by Stats. 2021, Ch. 143, Sec. 362. (AB 133) Effective July 27, 2021. Conditionally inoperative or operative as prescribed in subdivision (h).)

14005.185. (a) Notwithstanding Section 15840, the income eligibility requirements specified in Section 15832, and the annual redetermination requirements described in Section 14005.37, a pregnant individual or targeted low-income child who is eligible for and is receiving health care coverage under a Medi-Cal program identified in subdivision (b) shall be eligible for full-scope Medi-Cal benefits for the duration of the pregnancy and for a period of one year following the last day of the individual's pregnancy.

(b) For purposes of this section, "Medi-Cal program" refers to any of the following programs:

(1) The Medi-Cal Access Program, as described in Chapter 2 (commencing with Section 15810) of Part 3.3.

(2) The Medi-Cal program, as described in this article.

(3) The Perinatal Services Program, as described in Article 4.7 (commencing with Section 14148).

(c) The department shall seek any federal approvals, including under Titles XIX and XXI of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), that it determines are necessary to extend coverage for eligible pregnant and postpartum individuals or targeted low-income children as described in this section.

(d) (1) Except as provided in paragraph (2), coverage described in this section shall commence on April 1, 2022, or the effective date or dates reflected in any necessary federal approvals obtained by the department pursuant to subdivision (c), whichever is later.

(2) Notwithstanding paragraph (1), coverage described in this section for populations authorized under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa) shall be effective on the date reflected in any necessary federal approvals obtained by the department pursuant to subdivision (c).

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, provider bulletins, or similar instructions, without taking any further regulatory action.

(f) Implementation of this section is subject to an appropriation in the annual Budget Act, or any other act approved by the Legislature, for the purposes described in this section.

(g) (1) Except as provided in paragraph (2), this section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and not otherwise jeopardized.

(2) With respect to coverage described in the section for populations authorized under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa), the department may implement this section prior to receipt of all necessary federal approvals, so long as the department determines that federal financial participation under the Medi-Cal program is not otherwise jeopardized.

(Added by Stats. 2021, Ch. 143, Sec. 363. (AB 133) Effective July 27, 2021.)

14005.19. The receipt of respite care, as defined in Section 1418.1 of the Health and Safety Code, shall not affect the eligibility of any individual with respect to benefits under this chapter, except as subject to the limitations of subdivision (c) of Section 14124.7.

(Amended by Stats. 2024, Ch. 339, Sec. 3. (SB 1354) Effective January 1, 2025.)

14005.20. (a) The department shall adopt the option made available under Section 1902(a)(10)(A)(ii)(XII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XII)) to pay allowable tuberculosis-related services for persons infected with tuberculosis.

(b) (1) Except as provided in paragraph (2), the income and resources of these persons may not exceed the maximum amount for a disabled person as described in Section 1902(a)(10)(A)(i) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)).

(c) This section shall become operative on January 1, 2026.

(Amended (as amended by Stats. 2023, Ch. 42, Sec. 75) by Stats. 2025, Ch. 21, Sec. 54. (AB 116) Effective June 30, 2025. Operative January 1, 2026, by its own provisions.)

14005.20. (a) The department shall adopt the option made available under Section 1902(a)(10)(A)(ii)(XII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XII)) to pay allowable tuberculosis-related services for persons infected with tuberculosis.

(b) (1) Except as provided in paragraph (2), the income of these persons may not exceed the maximum amount for a disabled person as described in Section 1902(a)(10)(A)(i) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)).

(2) Effective January 1, 2014, the income of individuals eligible under this section may not exceed the maximum amount for a disabled person as described in Section 1902(a)(10)(A)(i) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)), as determined, counted, and valued in accordance with the requirements of Section 14005.64.

(c) The amendments made by the act that added this subdivision shall be implemented only if, and to the extent that, federal financial participation is available and any necessary federal approvals have been obtained.

(d) This section shall become inoperative on January 1, 2026, and, as of January 1, 2027, is repealed.

(Amended (as added by Stats. 2023, Ch. 42, Sec. 76) by Stats. 2025, Ch. 21, Sec. 55. (AB 116) Effective June 30, 2025. Inoperative January 1, 2026, by its own provisions. Repealed as of January 1, 2027, by its own provisions. See later operative version, as amended by Sec. 54 of Stats. 2025, Ch. 21.)

14005.21. (a) Any medically needy aged, blind, or disabled person who was categorically needy under this chapter on the basis of eligibility under Chapter 3 (commencing with Section 12000) or Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title

42 of the United States Code for the month of August 1993, and was discontinued as of September 1, 1993, and who, but for the addition of Section 12200.015, would be eligible to receive benefits without a spend down of excess income in September 1993 under this chapter, shall remain eligible to receive benefits without a spend down of excess income under this chapter as if that person were categorically needy as long as they meet other applicable requirements.

(b) Any medically needy aged, blind, or disabled person who was eligible for benefits under this chapter as categorically needy or medically needy under subdivision (a) for the month of August 1994, shall not be responsible for paying their spend down of excess income if they had that eligibility for benefits without a spend down of excess income interrupted or terminated by the addition of Section 12200.017, and if they, but for Section 12200.017, would be eligible to continue receiving benefits under this chapter without a spend down of excess income.

(c) Any medically needy aged, blind, or disabled person who was eligible for benefits under this chapter as categorically needy, or as medically needy under subdivision (a) or (b), for the calendar month immediately preceding the date that the reductions in maximum aid payments for the state supplementary program established in Chapter 3 (commencing with Section 12000) of Part 3 of Division 9 made in the 1995–96 Regular Session of the Legislature are effective shall not be responsible for paying their spend down of excess income if they had that eligibility for benefits without a spend down of excess income interrupted or terminated by the reductions in maximum aid payments, and if they, but for the reductions, would be eligible to continue receiving benefits under this chapter without a spend down of excess income.

(d) Any medically needy aged, blind, or disabled person who was eligible for benefits under this chapter as categorically needy, or as medically needy under subdivisions (a), (b), or (c) for the calendar month immediately preceding the date that the reductions in maximum aid payments for the state supplementary program established in Chapter 3 (commencing with Section 12000) made in the 1996 portion of the 1995-96 Regular Session of the Legislature are effective shall not be responsible for paying their spend down of excess income if they had that eligibility for benefits without a spend down of excess income interrupted or terminated by the reductions in maximum aid payments, and if they, but for these reductions, would be eligible to continue receiving benefits under this chapter without a spend down of excess income.

(e) The department shall implement this section regardless of the availability of federal financial participation for the spend down of excess income paid from state funds pursuant to subdivisions (a), (b), (c), and (d).

(Amended by Stats. 2023, Ch. 42, Sec. 77. (AB 118) Effective July 10, 2023.)

14005.22. (a) A pregnant individual is eligible for full-scope Medi-Cal benefits under Section 435.116(d)(2) of Title 42 of the Code of Federal Regulations if their income is less than or equal to 109 percent of the federal poverty level, and, effective January 1, 2022, less than or equal to 208 percent of the federal poverty level before the application of the 5-percent income disregard pursuant to subdivision (b) of Section 14005.64, as determined, counted, and valued in accordance with the requirements of 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, and the individual meets all other eligibility requirements.

(b) To the extent permitted by state and federal law, an individual eligible under this section shall be required to enroll in a Medi-Cal managed care health plan in those counties in which a Medi-Cal managed care health plan is available.

(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.

(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.

(Amended by Stats. 2022, Ch. 47, Sec. 76. (SB 184) Effective June 30, 2022.)

14005.23. To the extent federal financial participation is available, the department shall, when determining eligibility for children under Section 1396a(l)(1)(D) of Title 42 of the United States Code, designate a birth date by which all children who have not attained the age of 19 years will meet the age requirement of Section 1396a(l)(1)(D) of Title 42 of the United States Code.

(Added by Stats. 1997, Ch. 626, Sec. 2. Effective January 1, 1998.)

14005.24. The department shall instruct counties, by means of an all county letter or similar instruction, as to the process that is to be used to ensure that each child, physical custody of whom has been voluntarily surrendered pursuant to Section 1255.7 of the Health and Safety Code, shall be determined eligible for benefits under this chapter for, at a minimum, a period of time commencing on the date physical custody is surrendered and ending on the earliest of the following dates:

(a) The last day of the month following the month in which the child was voluntarily surrendered under Section 1255.7 of the Health and Safety Code.

(b) The date the child is reclaimed under Section 1255.7 of the Health and Safety Code.

(c) The date the child ceases to reside in California.

(Amended by Stats. 2005, Ch. 625, Sec. 7. Effective January 1, 2006.)

14005.25. (a) To the extent federal financial participation is available, the department shall exercise the option under Section 1902(e)(12) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(12)) to extend continuous eligibility to children 19 years of age and younger. A child shall remain eligible pursuant to this subdivision from the date of a determination of eligibility for Medi-Cal benefits until the earlier of either:

(1) The end of a 12-month period following the eligibility determination.

(2) The date the individual exceeds the age of 19 years.

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

(c) 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 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.

(Amended (as amended by Stats. 2009, 3rd Ex. Sess., Ch. 24, Sec. 2) by Stats. 2010, Ch. 717, Sec. 143. (SB 853) Effective October 19, 2010.)

14005.255. (a) (1) Notwithstanding Section 14005.25, subject to paragraph (2) and subdivision (d), a child shall be continuously eligible for Medi-Cal up to, five years of age.

(2) A redetermination of Medi-Cal eligibility shall not be conducted before the child reaches five years of age, unless the department or county possesses facts indicating that the family has requested the child's voluntary disenrollment, the child is deceased, the child is no longer a state resident, or the child's original enrollment was based on a state or county error or on fraud, abuse, or perjury attributed to the child or the child's representative.

(b) (1) Implementation of this section is contingent on all of the following conditions:

(A) All necessary federal approvals have been obtained by the department pursuant to subdivision (c).

(B) The Legislature has appropriated funding to implement this section after a determination that ongoing General Fund resources are available to support the ongoing implementation of this section in the 2024–25 fiscal year and subsequent fiscal years.

(C) The department has determined that systems have been programmed to implement this section.

(2) The department shall issue a declaration certifying the date that all conditions in paragraph (1) have been met. The department shall post the declaration on its internet website and provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(c) This section shall be implemented only to the extent that any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, through all-county letters or similar instructions, without taking any further regulatory action.

(e) This section shall become operative on January 1, 2025, or the date certified by the department pursuant to paragraph (2) of subdivision (b), whichever is later.

(Added by Stats. 2022, Ch. 47, Sec. 78. (SB 184) Effective June 30, 2022. Conditionally operative on or after January 1, 2025, by its own provisions.)

14005.26. (a) (1) Except as provided in subdivision (b), the department shall exercise the option pursuant to Section 1902(a)(l0)(A)(ii)(XIV) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIV)) to provide full-scope benefits with no spend down of excess income under this chapter and Chapter 8 (commencing with Section 14200) to optional targeted low-income children pursuant to Section 1905(u)(2)(B) of the federal Social Security Act (42 U.S.C. Sec. 1396d(u)(2)(B)), with family incomes up to and including 200 percent of the federal poverty level. The department shall seek federal approval of a state plan amendment to implement this subdivision.

(2) (A) Pursuant to Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)), the department shall adopt the option to use less restrictive income and resource methodologies to exempt all resources and disregard income at or above

200 percent and up to and including 250 percent of the federal poverty level for the individuals described in paragraph (1). The department shall seek federal approval of a state plan amendment to implement this subdivision.

(B) This paragraph shall be inoperative on January 1, 2014.

(b) Effective January 1, 2014, the federal poverty level percentage income eligibility threshold used pursuant to subdivision (c) of Section 14005.64 to determine eligibility for medical assistance under subdivision (a) shall equal 261 percent of the federal poverty level.

(c) For purposes of carrying out the provisions of this section, the department may adopt the option pursuant to Section 1902(e)(13) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(13)) to rely upon findings of the Managed Risk Medical Insurance Board (MRMIB) regarding one or more components of eligibility.

(d) (1) (A) Except as provided in subparagraph (B) and subparagraph (D) of paragraph (2), the department shall exercise the option pursuant to Section 1916A of the federal Social Security Act (42 U.S.C. Sec. 1396o-1) to impose premiums for individuals described in subdivision (a) whose family income has been determined to be above 150 percent and up to and including 200 percent of the federal poverty level, after application of the income disregard pursuant to paragraph (2) of subdivision (a). The department shall not impose premiums under this subdivision for individuals described in subdivision (a) whose family income has been determined to be at or below 150 percent of the federal poverty level, after application of the income disregard pursuant to paragraph (2) of subdivision (a). The department shall obtain federal approval for the implementation of this subdivision.

(B) Except as provided in subparagraph (D) of paragraph (2), the department shall impose a premium pursuant to subparagraph (A) for individuals whose family income has been determined to be above 160 percent and up to and including 261 percent of the federal poverty level, as determined, counted, and valued in accordance with the requirements of Section 14005.64.

(2) (A) Monthly premiums imposed under this section shall equal thirteen dollars ($13) per child with a maximum contribution of thirty-nine dollars ($39) per family.

(B) Families that pay three months of required premiums in advance shall receive the fourth consecutive month of coverage with no premium required. For purposes of the discount provided by this subparagraph, family contributions paid in the Healthy Families Program for children transitioned to Medi-Cal pursuant to Section 14005.27 shall be credited as Medi-Cal premiums paid.

(C) Families that pay the required premium by an approved means of electronic funds transfer, including credit card payment, shall receive a 25-percent discount from the required premium. If the department and the Managed Risk Medical Insurance Board determine that it is feasible, the department shall treat an authorization for electronic funds transfer or credit card payment to the Healthy Families Program as an authorization for electronic funds transfer or credit card payment to Medi-Cal.

(D) (i) Effective July 1, 2022, to the extent allowable under federal law, and notwithstanding the provisions of this section to the contrary, the department may elect not to impose premiums for an applicable coverage period on individuals whose family income has been determined to be above 160 percent and up to and including 261 percent of the federal poverty level as described in this subdivision.

(ii) If the department elects to not impose premiums for an applicable coverage period pursuant to clause (i) or elects to reinstate such premiums for a subsequent coverage period, the department shall specify that election in the published Medi-Cal Local Assistance Estimate for the impacted state fiscal year or years, subject to appropriation by the annual Budget Act.

(e) This section shall be implemented only to the extent that all necessary federal approvals and waivers described in this section have been obtained and the enhanced rate of federal financial participation under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.) is available for targeted low-income children pursuant to that act.

(f) The department shall not enroll targeted low-income children described in this section in the Medi-Cal program until all necessary federal approvals and waivers have been obtained, and no sooner than January 1, 2013.

(g) (1) (A) Except as provided in subparagraph (B), to the extent the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is not fully operational, for the purposes of implementing this section, for individuals described in subdivision (a) whose family income has been determined to be up to and including 150 percent of the federal poverty level, as determined pursuant to paragraph (2) of subdivision (a), the department shall utilize the budgeting methodology for this population as contained in the November 2011 Medi-Cal Local Assistance Estimate for Medi-Cal county administration costs for eligibility operations.

(B) Effective January 1, 2014, to the extent the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is not fully operational, for purposes of implementing this section for individuals whose family income has been determined to be up to and including 160 percent of the federal poverty level, the department shall utilize the budgeting

methodology for this population as contained in the November 2011 Medi-Cal Local Assistance Estimate for Medi-Cal county administration costs for eligibility operations.

(2) (A) Except as provided in subparagraph (B), for purposes of implementing this section, the department shall include in the Medi-Cal Local Assistance Estimate an amount for Medi-Cal eligibility operations associated with the individuals whose family income is determined to be above 150 percent and up to and including 200 percent of the federal poverty level, after application of the income disregard pursuant to paragraph (2) of subdivision (a). In developing an estimate for this activity, the department shall consider the projected number of final eligibility determinations each county will process and projected county costs. Within 60 days of the passage of the annual Budget Act, the department shall notify each county of their allocation for this activity based upon the amount allotted in the annual Budget Act for this purpose.

(B) Effective January 1, 2014, for purposes of implementing this section, the department shall include in the Medi-Cal Local Assistance Estimate an amount for Medi-Cal eligibility operations associated with the individuals whose family income is determined to be above 160 percent and up to and including 261 percent of the federal poverty level.

(h) When the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is fully operational, the new budget methodology shall be utilized to reimburse counties for eligibility determinations made for individuals pursuant to this section.

(i) Eligibility determinations and annual redeterminations made pursuant to this section shall be performed by county eligibility workers.

(j) In conducting eligibility determinations for individuals pursuant to this section and Section 14005.27, the following reporting and performance standards shall apply to all counties:

(1) Counties shall report to the department, in a manner and for a time period prescribed by the department, in consultation with the County Welfare Directors Association, the number of applications processed on a monthly basis, a breakout of the applications based on income using the federal percentage of poverty levels, the final disposition of each application, including information on the approved Medi-Cal program, if applicable, and the average number of days it took to make the final eligibility determination for applications submitted directly to the county and from the single point of entry (SPE).

(2) Notwithstanding any other law, the following performance standards shall be applied to counties regarding eligibility determinations for individuals eligible pursuant to this section:

(A) For children whose applications are received by the county human services department from the SPE, the following standards shall apply:

(i) Applications for children who are granted accelerated enrollment by the SPE shall be processed according to the timeframes specified in subdivision (d) of Section 14154.

(ii) Applications for children who are not granted accelerated enrollment by the SPE due to the existence of an already active Medi-Cal case shall be processed according to the timeframes specified in subdivision (d) of Section 14154.

(iii) For applications for children who are not described in clause (i) or (ii), 90 percent shall be processed within 10 working days of being received, complete and without client errors.

(iv) If an application described in this section also contains adults, and the adult applicants are required to submit additional information beyond the information provided for the children, the county shall process the eligibility for the child or children without delay, consistent with this section while gathering the necessary information to process eligibility for the adults.

(B) The department, in consultation with the County Welfare Directors Association, shall develop reporting requirements for the counties to provide regular data to the state regarding the timeliness and outcomes of applications processed by the counties that are received from the SPE.

(C) Performance thresholds and corrective action standards as set forth in Section 14154 shall apply.

(D) For applications submitted directly to the county, these applications shall be processed by the counties in accordance with the performance standards established under subdivision (d) of Section 14154.

(3) This subdivision shall be implemented no sooner than January 1, 2013.

(4) Twelve months after implementation of this section pursuant to subdivision (f), the department shall provide enrollment information regarding individuals determined eligible pursuant to subdivision (a) to the fiscal and appropriate policy committees of the Legislature.

(k) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, for purposes of this transition, 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. It is the intent of the Legislature that the department be allowed temporary authority as necessary to implement program changes until completion of the regulatory process.

(2) 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, 2014. 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) To implement this section, the department may enter into and continue contracts with the Healthy Families Program administrative vendor, for the purposes of implementing and maintaining the necessary systems and activities for providing health care coverage to optional targeted low-income children in the Medi-Cal program for purposes of accelerated enrollment application processing by single point of entry, noneligibility-related case maintenance and premium collection, maintenance of the Health-E-App Web portal, call center staffing and operations, certified application assistant services, and reporting capabilities. To further implement this section, the department may also enter into a contract with the Health Care Options Broker of the department for purposes of managed care enrollment activities. The contracts entered into or amended under this section may initially be completed on a noncompetitive bid basis and are exempt from the Public Contract Code. Contracts thereafter shall be entered into or amended on a competitive bid basis and shall be subject to the Public Contract Code.

(m) (1) If at any time the director determines that this section or any part of this section may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), or any amendment or extension of that act, or any additional federal funds that the director, in consultation with the Department of Finance, determines would be advantageous to the state, the director shall give notice to the fiscal and policy committees of the Legislature and to the Department of Finance. After giving notice, this section or any part of this section shall become inoperative on the date that the director executes a declaration stating that the department has determined, in consultation with the Department of Finance, that it is necessary to cease to implement this section or a part or parts thereof, in order to receive federal financial participation, any increase in the federal medical assistance percentage available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, has determined would be advantageous to the state.

(2) The director shall retain the declaration described in paragraph (1), shall provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel, and shall post the declaration on the department's internet website.

(3) In the event that the director makes a determination under paragraph (1) and this section ceases to be implemented, the children shall be enrolled back into the Healthy Families Program.

(Amended by Stats. 2023, Ch. 42, Sec. 78. (AB 118) Effective July 10, 2023. Conditionally inoperative as provided in subd. (m).)

14005.27. (a) Individuals enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code on June 27, 2012, and who are determined eligible to receive benefits pursuant to subdivision (a) of Section 14005.26, or, effective January 1, 2014, subdivision (b) of Section 14005.26, shall be transitioned into Medi-Cal, pursuant to this section.

(b) To the extent necessary and for the purposes of carrying out the provisions of this section, in performing initial eligibility determinations for children enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code, the department shall adopt the option pursuant to Section 1902(e)(13) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(13)) to allow the department or county human services departments to rely upon findings made by the Managed Risk Medical Insurance Board (MRMIB) regarding one or more components of eligibility. The department shall seek federal approval of a state plan amendment to implement this subdivision.

(c) To the extent necessary, the department shall seek federal approval of a state plan amendment or a waiver to provide presumptive eligibility for the optional targeted low-income category of eligibility pursuant to Section 14005.26 for individuals presumptively eligible for or enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code. The presumptive eligibility shall be based upon the most recent information contained in the individual's Healthy Families Program file. The timeframe for the presumptive eligibility shall begin no sooner than January 1, 2013, and shall continue until a determination of Medi-Cal eligibility is made, which determination shall be performed within one year of the individual's Healthy Families Program annual review date.

(d) (1) The California Health and Human Services Agency, in consultation with the Managed Risk Medical Insurance Board, the State Department of Health Care Services, the Department of Managed Health Care, and diverse stakeholders groups, shall provide the

fiscal and policy committees of the Legislature with a strategic plan for the transition of the Healthy Families Program pursuant to this section by no later than October 1, 2012. This strategic plan shall, at a minimum, address all of the following:

(A) State, county, and local administrative components that facilitate a successful subscriber transition such as communication and outreach to subscribers and applicants, eligibility processing, enrollment, communication, and linkage with health plan providers, payments of applicable premiums, and overall systems operation functions.

(B) Methods and processes for diverse stakeholder engagement throughout the entire transition, including all phases of the transition.

(C) State monitoring of managed care health plans' performance and accountability for provision of services, and initial quality indicators for children and adolescents transitioning to Medi-Cal.

(D) Health care and dental delivery system components such as standards for informing and enrollment materials, network adequacy, performance measures and metrics, fiscal solvency, and related factors that ensure timely access to quality health and dental care for children and adolescents transitioning to Medi-Cal.

(E) Inclusion of applicable operational steps, timelines, and key milestones.

(F) A time certain for the transfer of the Healthy Families Advisory Board, as described in Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code, to the State Department of Health Care Services.

(2) The intent of this strategic plan is to serve as an overall guide for the development of each plan for each phase of this transition, pursuant to paragraphs (1) to (8), inclusive, of subdivision (e), to ensure clarity and consistency in approach and subscriber continuity of care. This strategic plan may also be updated by the California Health and Human Services Agency as applicable and provided to the Legislature upon completion.

(e) (1) The department shall transition individuals from the Healthy Families Program to the Medi-Cal program in four phases, as follows:

(A) Phase 1. Individuals enrolled in a Healthy Families Program health plan that is a Medi-Cal managed care health plan shall be enrolled in the same plan no earlier than January 1, 2013, pursuant to the requirements of this section and Section 14011.6, and to the extent the individual is otherwise eligible under this chapter and Chapter 8 (commencing with Section 14200).

(B) Phase 2. Individuals enrolled in a Healthy Families Program managed care health plan that is a subcontractor of a Medi-Cal managed health care plan, to the extent possible, shall be enrolled into a Medi-Cal managed health care plan that includes the individuals' current plan pursuant to the requirements of this section and Section 14011.6, and to the extent the individuals are otherwise eligible under this chapter and Chapter 8 (commencing with Section 14200). The transition of individuals described in this subparagraph shall begin no earlier than April 1, 2013.

(C) Phase 3. Individuals enrolled in a Healthy Families Program plan that is not a Medi-Cal managed care plan and does not contract or subcontract with a Medi-Cal managed care plan shall be enrolled in a Medi-Cal managed care plan in that county. Enrollment shall include consideration of the individuals' primary care providers pursuant to the requirements of this section and Section 14011.6, and to the extent the individuals are otherwise eligible under this chapter and Chapter 8 (commencing with Section 14200). The transition of individuals described in this subparagraph shall begin no earlier than August 1, 2013.

(D) Phase 4.

(i) Individuals residing in a county that is not a Medi-Cal managed care county shall be provided services under the Medi-Cal fee-for-service delivery system, subject to clause (ii). The transition of individuals described in this subparagraph shall begin no earlier than September 1, 2013.

(ii) In the event the department creates a managed health care system in the counties described in clause (i), individuals residing in those counties shall be enrolled in managed health care plans pursuant to this chapter and Chapter 8 (commencing with Section 14200).

(2) For the transition of individuals pursuant to subparagraphs (A), (B), (C), and (D) of paragraph (1), implementation plans shall be developed to ensure state and county systems readiness, health plan network adequacy, and continuity of care with the goal of ensuring there is no disruption of service and there is continued access to coverage for all transitioning individuals. If an individual is not retained with the individual's primary care provider, the implementation plan shall require the managed care plan to report to the department as to how continuity of care is being provided. Transition of individuals described in subparagraphs (A), (B), (C), and (D) of paragraph (1) shall not occur until 90 days after the department has submitted an implementation plan to the fiscal and policy committees of the Legislature. The implementation plans shall include, but not be limited to, information on health and dental plan network adequacy, continuity of care, eligibility and enrollment requirements, consumer protections, and family notifications.

(3) The following requirements shall be in place prior to implementation of Phase 1, and shall be required for all phases of the transition:

(A) Managed care plan performance measures shall be integrated and coordinated with the Healthy Families Program performance standards including, but not limited to, child-only Healthcare Effectiveness Data and Information Set (HEDIS) measures, and measures indicative of performance in serving children and adolescents. These performance measures shall also be in compliance with all performance requirements under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and existing Medi-Cal managed care performance measurements and standards as set forth in this chapter and Chapter 8 (commencing with Section 14200) of Title 22 of the California Code of Regulations, and all-plan letters, including, but not limited to, network adequacy and linguistic services, and shall be met prior to the transition of individuals pursuant to Phase 1.

(B) Medi-Cal managed care health plans shall allow enrollees to remain with their current primary care provider. If an individual does not remain with the current primary care provider, the plan shall report to the department as to how continuity of care is being provided.

(4) (A) As individuals are transitioned pursuant to subparagraphs (A), (B), (C), and (D) of paragraph (1), for individuals residing in all counties except the Counties of Sacramento and Los Angeles, their dental coverage shall transition to fee-for-service dental coverage and may be provided by their current provider if the provider is a Medi-Cal fee-for-service dental provider.

(B) For individuals residing in the County of Sacramento, their dental coverage shall continue to be provided by their current dental managed care plan if their plan is a Medi-Cal dental managed care plan. If their plan is not a Medi-Cal dental managed care plan, they shall select a Medi-Cal dental managed care plan. If they do not choose a Medi-Cal dental managed care plan, they shall be assigned to a plan with preference to a plan with which their current provider is a contracted provider. Any children in the Healthy Families Program transitioned into Medi-Cal dental managed care plans shall also have access to the beneficiary dental exception process, pursuant to Section 14089.09. Further, the Sacramento advisory committee, established pursuant to Section 14089.08, shall be consulted regarding the transition of children in the Healthy Families Program into Medi-Cal dental managed care plans.

(C) (i) For individuals residing in the County of Los Angeles, for purposes of continuity of care, their dental coverage shall continue to be provided by their current dental managed care plan if that plan is a Medi-Cal dental managed care plan. If their plan is not a Medi-Cal dental managed care plan, they may select a Medi-Cal dental managed care plan or choose to move into Medi-Cal fee-for-service dental coverage.

(ii) It is the intent of the Legislature that children transitioning to Medi-Cal under this section have a choice in dental coverage, as provided under existing law.

(5) Dental health plan performance measures and benchmarks shall be in accordance with Section 14459.6.

(6) Medi-Cal managed care health and dental plans shall report to the department, as frequently as specified by the department, specified information pertaining to transition implementation, enrollees, and providers, including, but not limited to, grievances related to access to care, continuity of care requests and outcomes, and changes to provider networks, including provider enrollment and disenrollment changes. The plans shall report this information by county, and in the format requested by the department.

(7) The department may develop supplemental implementation plans to separately account for the transition of individuals from the Healthy Families Program to specific Medi-Cal delivery systems.

(8) The department shall consult with the Legislature and stakeholders, including, but not limited to, consumers, families, consumer advocates, counties, providers, and health and dental plans, in the development of implementation plans described in paragraph (3) for individuals who are transitioned to Medi-Cal in Phase 2, Phase 3, and Phase 4, as described in subparagraphs (B), (C), and (D) of paragraph (1).

(9) (A) The department shall consult and collaborate with the Department of Managed Health Care in assessing Medi-Cal managed care health plan network adequacy in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) for purposes of the developed transition plans pursuant to paragraph (2) for each of the phases.

(B) For purposes of individuals transitioning in Phase 1, as described in subparagraph (A) of paragraph (1), network adequacy shall be assessed as described in this paragraph and findings from this assessment shall be provided to the fiscal and appropriate policy committees of the Legislature 60 days prior to the effective date of implementing this transition.

(10) The department shall provide monthly status reports to the fiscal and policy committees of the Legislature on the transition commencing no later than February 15, 2013. This monthly status transition report shall include, but not be limited to, information on health plan grievances related to access to care, continuity of care requests and outcomes, changes to provider networks, including provider enrollment and disenrollment changes, and eligibility performance standards pursuant to subdivision (n). A final comprehensive report shall be provided within 90 days after completion of the last phase of transition.

(f) (1) The department and MRMIB shall work collaboratively in the development of notices for individuals transitioned pursuant to paragraph (1) of subdivision (e).

(2) The state shall provide written notice to individuals enrolled in the Healthy Families Program of their transition to the Medi-Cal program at least 60 days prior to the transition of individuals in Phase 1, as described in subparagraph (A) of paragraph (1) of subdivision (e), and at least 90 days prior to transition of individuals in Phases 2, 3, and 4, as described in subparagraphs (B), (C), and (D) of paragraph (1) of subdivision (e).

(3) Notices developed pursuant to this subdivision shall ensure individuals are informed regarding the transition, including, but not limited to, how individuals' systems of care may change, when the changes will occur, and whom they can contact for assistance when choosing a Medi-Cal managed care plan, if applicable, including a toll-free telephone number, and with problems they may encounter. The department shall consult with stakeholders regarding notices developed pursuant to this subdivision. These notices shall be developed using plain language, and written translation of the notices shall be available for those who are limited English proficient or non-English speaking in all Medi-Cal threshold languages.

(4) The department shall designate department liaisons responsible for the coordination of the Healthy Families Program and may establish a children's-focused section for this purpose and to facilitate the provision of health care services for children enrolled in Medi-Cal.

(5) The department shall provide a process for ongoing stakeholder consultation and make information publicly available, including the achievement of benchmarks, enrollment data, utilization data, and quality measures.

(g) (1) In order to aid the transition of Healthy Families Program enrollees, MRMIB, on the effective date of the act that added this section and continuing through the completion of the transition of Healthy Families Program enrollees to the Medi-Cal program, shall begin requesting and collecting from health plans contracting with MRMIB pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code, information about each health plan's provider network, including, but not limited to, the primary care and all specialty care providers assigned to individuals enrolled in the health plan. MRMIB shall obtain this information in a manner that coincides with the transition activities described in subdivision (d), and shall provide all of the collected information to the department within 60 days of the department's request for this information to ensure timely transitions of Healthy Families Program enrollees.

(2) The department shall analyze the existing Healthy Families Program delivery system network and the Medi-Cal fee-for-service provider networks, including, but not limited to, Medi-Cal dental providers, to determine overlaps of the provider networks in each county for which there are no Medi-Cal managed care plans or dental managed care plans. To the extent there is a lack of existing Medi-Cal fee-for-service providers available to serve the Healthy Families Program enrollees, the department shall work with the Healthy Families Program provider community to encourage participation of those providers in the Medi-Cal program, and develop a streamlined process to enroll them as Medi-Cal providers.

(3) (A) MRMIB, within 60 days of a request by the department, shall provide the department any data, information, or record concerning the Healthy Families Program as is necessary to implement the transition of enrollment required pursuant to this section.

(B) Notwithstanding any other law, all of the following shall apply:

(i) The term "data, information, or record" shall include, but is not limited to, personal information as defined in Section 1798.3 of the Civil Code.

(ii) Any data, information, or record shall be exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code) and any other law, to the same extent that it was exempt from disclosure or privileged prior to the provision of the data, information, or record to the department.

(iii) The provision of this data, information, or record to the department shall not constitute a waiver of any evidentiary privilege or exemption from disclosure.

(iv) The department shall keep all data, information, or records provided by MRMIB confidential to the full extent permitted by law, including, but not limited to, the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code), and consistent with MRMIB's contractual obligations to keep the data, information, or records confidential.

(h) This section shall be implemented only to the extent that all necessary federal approvals and waivers have been obtained and the enhanced rate of federal financial participation under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.) is available for targeted low-income children pursuant to that act.

(i) (1) (A) Except as provided in subparagraph (B), the department shall exercise the option pursuant to Section 1916A of the federal Social Security Act (42 U.S.C. Sec. 1396o-1) to impose premiums for individuals described in subdivision (a) of Section 14005.26 whose family income has been determined to be above 150 percent and up to and including 200 percent of the federal poverty level, after application of the income disregard pursuant to paragraph (2) of subdivision (a) of Section 14005.26. The department shall not impose premiums under this subdivision for individuals described in subdivision (a) of Section 14005.26 whose family income has been determined to be at or below 150 percent of the federal poverty level, after application of the income disregard pursuant to paragraph (2) of subdivision (a) of Section 14005.26. The department shall obtain federal approval for the implementation of this subdivision.

(B) Effective January 1, 2014, the family income range for the imposition of premiums pursuant to subparagraph (A) for individuals described in subdivision (a) or (b) of Section 14005.26 shall be above 160 percent and shall go up to and include 261 percent of the federal poverty level as determined, counted, and valued in accordance with the requirements of Section 14005.64. The department shall not impose premiums for eligible individuals whose family income has been determined to be at or below 160 percent of the federal poverty level.

(2) All premiums imposed under this section shall equal the family contributions described in paragraph (2) of subdivision (d) of Section 12693.43 of the Insurance Code and shall be reduced in conformity with subdivisions (e) and (f) of Section 12693.43 of the Insurance Code.

(j) The department shall not enroll targeted low-income children described in this section in the Medi-Cal program until all necessary federal approvals and waivers have been obtained, or no sooner than January 1, 2013.

(k) (1) (A) Except as provided in subparagraph (B), to the extent the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is not fully operational, for the purposes of implementing this section, for individuals described in subdivision (a) whose family income has been determined to be at or below 150 percent of the federal poverty level, after application of the disregard pursuant to paragraph (2) of subdivision (a) of Section 14005.26, the department shall utilize the budgeting methodology for this population as contained in the November 2011 Medi-Cal Local Assistance Estimate for Medi-Cal county administration costs for eligibility operations.

(B) Effective January 1, 2014, the federal poverty level percentage used under subparagraph (A) for individuals described in subdivision (a) shall equal 160 percent of the federal poverty level as determined, counted, and valued in accordance with the requirements of Section 14005.64.

(2) (A) Except as provided in subparagraph (B), for purposes of implementing this section, the department shall include in the Medi-Cal Local Assistance Estimate an amount for Medi-Cal eligibility operations associated with the transfer of Healthy Families Program enrollees eligible pursuant to subdivision (a) of Section 14005.26 and whose family income is determined to be above 150 percent and up to and including 200 percent of the federal poverty level, after application of the income disregard pursuant to paragraph (2) of subdivision (a) of Section 14005.26. In developing an estimate for this activity, the department shall consider the projected number of final eligibility determinations each county will process and projected county costs. Within 60 days of the passage of the annual Budget Act, the department shall notify each county of their allocation for this activity based upon the amount allotted in the annual Budget Act for this purpose.

(B) Effective January 1, 2014, for purposes of implementing this section, the department shall include in the Medi-Cal Local Assistance Estimate an amount for Medi-Cal eligibility operations associated with the transfer of Healthy Families Program enrollees eligible pursuant to subdivision (a) or (b) of Section 14005.26 and whose family income is determined to be above 160 percent and up to and including 261 percent of the federal poverty level.

(l) When the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is fully operational, the new budget methodology shall be utilized to reimburse counties for eligibility determinations made for individuals pursuant to this section.

(m) Except as provided in subdivision (b), eligibility determinations and annual redeterminations made pursuant to this section shall be performed by county eligibility workers.

(n) In conducting the eligibility determinations for individuals pursuant to this section and Section 14005.26, the following reporting and performance standards shall apply to all counties:

(1) Counties shall report to the department, in a manner and for a time period determined by the department, in consultation with the County Welfare Directors Association, the number of applications processed on a monthly basis, a breakout of the applications based on income using the federal percentage of poverty levels, the final disposition of each application, including information on the approved Medi-Cal program, if applicable, and the average number of days it took to make the final eligibility determination for applications submitted directly to the county and from the single point of entry (SPE).

(2) Notwithstanding any other law, the following performance standards shall be applied to counties for eligibility determinations for individuals eligible pursuant to this section:

(A) For children whose applications are received by the county human services department from the SPE, the following standards shall apply:

(i) Applications for children who are granted accelerated enrollment by the SPE shall be processed according to the timeframes specified in subdivision (d) of Section 14154.

(ii) Applications for children who are not granted accelerated enrollment by the SPE due to the existence of an already active Medi-Cal case shall be processed according to the timeframes specified in subdivision (d) of Section 14154.

(iii) For applications for children who are not described in clause (i) or (ii), 90 percent shall be processed within 10 working days of being received, complete and without client errors.

(iv) If an application described in this section also contains adults, and the adult applicants are required to submit additional information beyond the information provided for the children, the county shall process the eligibility for the child or children without delay, consistent with this section while gathering the necessary information to process eligibility for the adults.

(B) The department, in consultation with the County Welfare Directors Association, shall develop reporting requirements for the counties to provide regular data to the state regarding the timeliness and outcomes of applications processed by the counties that are received from the SPE.

(C) Performance thresholds and corrective action standards as set forth in Section 14154 shall apply.

(D) For applications received directly by the county, these applications shall be processed by the counties in accordance with the performance standards established under subdivision (d) of Section 14154.

(3) This subdivision shall be implemented no sooner than January 1, 2013.

(4) Twelve months after implementation of this section pursuant to subdivision (e), the department shall provide enrollment information regarding individuals determined eligible pursuant to subdivision (a) to the fiscal and appropriate policy committees of the Legislature.

(o) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, for purposes of this transition, 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. It is the intent of the Legislature that the department be allowed temporary authority as necessary to implement program changes until completion of the regulatory process.

(2) 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, 2014. 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.

(p) To implement this section, the department may enter into and continue contracts with the Healthy Families Program administrative vendor, for the purposes of implementing and maintaining the necessary systems and activities for providing health care coverage to optional targeted low-income children in the Medi-Cal program for purposes of accelerated enrollment application processing by single point of entry, noneligibility-related case maintenance and premium collection, maintenance of the Health-E-App web portal, call center staffing and operations, certified application assistant services, and reporting capabilities. To further implement this section, the department may also enter into a contract with the Health Care Options Broker of the department for purposes of managed care enrollment activities. The contracts entered into or amended under this section may initially be completed on a noncompetitive bid basis and are exempt from the Public Contract Code. Contracts thereafter shall be entered into or amended on a competitive bid basis and shall be subject to the Public Contract Code.

(q) (1) If at any time the director determines that this section or any part of this section may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), or any amendment or extension of that act, or any additional federal funds that the director, in consultation with the Department of Finance, determines would be advantageous to the state, the director shall give notice to the fiscal and policy committees of the Legislature and to the Department of Finance. After giving notice, this section or any part of this section shall become inoperative on the date that the director executes a declaration stating that the department has determined, in consultation with the Department of Finance, that it is

necessary to cease to implement this section or a part or parts thereof in order to receive federal financial participation, any increase in the federal medical assistance percentage available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, has determined would be advantageous to the state.

(2) The director shall retain the declaration described in paragraph (1), shall provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel, and shall post the declaration on the department's internet website.

(3) In the event that the director makes a determination under paragraph (1) and this section ceases to be implemented, the children shall be enrolled back into the Healthy Families Program.

(Amended by Stats. 2021, Ch. 615, Sec. 440. (AB 474) Effective January 1, 2022. Operative January 1, 2023, pursuant to Sec. 463 of Stats. 2021, Ch. 615. Conditionally inoperative as provided in subd. (q).)

14005.271. (a) The Healthy Families Advisory Board established by former Section 12693.90 of the Insurance Code is hereby renamed the Medi-Cal Children's Health Advisory Panel.

(b) The Medi-Cal Children's Health Advisory Panel shall be an independent, statewide advisory board that shall advise the State Department of Health Care Services on matters relevant to all children enrolled in Medi-Cal and their families, including, but not limited to, emerging trends in the care of children, quality measurements, communications between the State Department of Health Care Services and Medi-Cal families, provider network issues, and Medi-Cal enrollment issues.

(c) The membership of the advisory panel shall be composed of the following 15 members:

(1) One member who is a licensed, practicing dentist.

(2) One physician and surgeon who is board certified in the area of family practice medicine.

(3) One physician and surgeon who is board certified in pediatrics.

(4) One representative from a licensed nonprofit primary care clinic.

(5) One representative from the mental health provider community.

(6) One representative of the substance abuse provider community.

(7) One representative of the county public health provider community.

(8) One representative from a licensed hospital that is on the disproportionate share list maintained by the State Department of Health Care Services.

(9) A current or former foster youth; an attorney, social worker, probation officer, or court appointed special advocate who currently represents one or more foster youth; a foster care service provider; or a child welfare advocate.

(10) Three members, each of whom is either a Medi-Cal enrollee who has received Medi-Cal benefits or services in relation to a pregnancy, including, but not limited to, benefits or services received through the Medi-Cal Access Program, or is a parent, foster parent, relative caregiver, or legal guardian of a Medi-Cal enrollee who is 21 years of age or younger.

(11) One representative from the health plan community.

(12) One representative from the business community.

(13) One representative from the education community.

(d) The advisory panel shall elect, from among its members, its chair. In order to coordinate the activities of the advisory panel with other advisory bodies whose scope includes children enrolled in Medi-Cal, the chair shall keep apprised of relevant Medi-Cal stakeholder meetings by communicating with State Department of Health Care Services staff assisting the advisory panel.

(e) The advisory panel members shall be appointed by the State Department of Health Care Services, or in the case of vacancies of three months or greater, by the chair.

(f) A member of the advisory panel appointed on or after January 1, 2018, shall serve a term of three years, commencing upon the expiration of the predecessor member's term, except that a member appointed to fill a vacancy caused by any reason other than expiration of the predecessor member's term shall serve the remainder of the unexpired term.

(g) Members of the advisory panel appointed prior to January 1, 2018, shall, by lot, designate five members of the panel who shall end their terms on December 31, 2018, five members who shall end their terms on December 31, 2019, and five members who shall end their terms on December 31, 2020.

(h) An advisory panel member may be removed by the State Department of Health Care Services, in consultation with the chair, if the removal is determined to be necessary by the Director of Health Care Services. The chair may recommend removal of a member of the advisory panel for cause if the member obstructs the function of the advisory panel. For the purpose of this subdivision, "obstruction of the function of the advisory panel" includes, but is not limited to, the failure of a member to attend two consecutive meetings of the advisory panel.

(i) The chair shall immediately notify the State Department of Health Care Services upon the occurrence of a vacancy on the advisory panel. For the purposes of this subdivision, a vacancy shall not exist solely because a panel member ceases to meet the qualifications of the provision pursuant to which the member was appointed.

(j) The advisory panel's powers and duties include, but are not limited to, both of the following:

(1) To advise the Director of Health Care Services on all policies, regulations, and operations of the Medi-Cal program related to providing health care services to children.

(2) To meet at least quarterly, unless deemed unnecessary by the chair.

(k) The State Department of Health Care Services' powers and duties shall include, but not be limited to, all of the following:

(1) To provide general support and staff assistance to the advisory panel.

(2) To convene and attend meetings of the advisory panel at least quarterly, unless deemed unnecessary by the chair, at locations that are easily accessible to the public and advisory panel members, are of sufficient duration for presentation, discussion, and public comment on each agenda item, and are in accordance with the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

(3) To reimburse the members of the advisory panel for all necessary travel expenses associated with the activities of the advisory panel, and to provide a stipend of one hundred dollars ($100) per meeting attended to each panel member who is a Medi-Cal enrollee or a parent, foster parent, relative caregiver, or legal guardian of a Medi-Cal enrollee.

(4) To maintain an Internet Web page on the department's Internet Web site dedicated to the advisory panel that shall include, but not be limited to, all of the following:

(A) The purpose and scope of the advisory panel.

(B) The current membership of the advisory panel.

(C) A list of past and future meetings.

(D) Agendas and other materials made available for past and future meetings.

(E) Recommendations submitted to the department by the advisory panel.

(F) The department's responses to recommendations submitted by the advisory panel.

(G) Contact information for department staff assisting the advisory panel.

(5) To inform advisory panel members when new information is posted to the Internet Web page dedicated to the advisory panel.

(6) Notwithstanding Section 10231.5 of the Government Code, to submit on or before January 1, 2018, a report to the Legislature on the advisory panel's accomplishments, effectiveness, efficiency, and any recommendations for statutory changes needed to improve the ability of the advisory panel to fulfill its purpose. The report shall be submitted in compliance with Section 9795 of the Government Code.

(l) The Legislature does not intend the addition of this section to result in a new panel, but rather a continuation of the prior panel established by former Section 12693.90 of the Insurance Code. New panel members shall not be appointed until a vacancy occurs.

(Amended by Stats. 2017, Ch. 280, Sec. 1. (SB 220) Effective January 1, 2018.)

14005.275. The department shall ensure coordination of covered services across all delivery systems of care in order to minimize disruption in services for children transitioning from the Healthy Families Program to Medi-Cal pursuant to Chapter 28 of the Statutes of 2012.

(Added by Stats. 2013, Ch. 23, Sec. 54.5. (AB 82) Effective June 27, 2013.)

14005.277. In order to assist the California Health Benefit Exchange, established pursuant to Title 22 (commencing with Section 100500) of the Government Code, to conduct outreach to individuals potentially eligible for an insurance affordability program, as defined in Section 15926, the department shall provide the California Health Benefit Exchange, or its designee, with the names, addresses, email addresses, telephone numbers, or other contact information, and written and spoken languages of individuals who are not enrolled in Medi-Cal but are the parents or caretakers of children enrolled in the Healthy Families Program or the Medi-Cal program pursuant to Section 14005.27.

(Added by Stats. 2013, Ch. 448, Sec. 3. (SB 800) Effective January 1, 2014.)

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 until his or her 26th birthday if he or she was in foster care on his or her 18th birthday, or such higher age the state has elected under Title IV-E of the federal Social Security Act (42 U.S.C. Sec. 670 et seq.). In addition, the department shall implement the federal option to provide Medi-Cal benefits to individuals who were in foster care and enrolled in Medicaid in any state.

(1) A foster care adolescent who was in foster care in this state on his or her 18th birthday, or such higher age the state has elected under Title IV-E of the federal Social Security Act (42 U.S.C. Sec. 670 et seq.), 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) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 1, 2017, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

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

(Amended by Stats. 2014, Ch. 831, Sec. 4. (SB 508) Effective January 1, 2015.)

14005.285. (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, the department may 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 any necessary regulations are adopted. The department shall adopt regulations by July 1, 2017, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of this section, and notwithstanding Section 10231.5 of the

Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

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

(Added by Stats. 2014, Ch. 831, Sec. 5. (SB 508) Effective January 1, 2015.)

14005.287. (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)(I) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(I)) to extend Medi-Cal benefits to individuals under 21 years of age placed in foster homes or private institutions for whom a public agency is assuming full or partial financial responsibility.

(b) Pursuant to Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)), all of the income considered when determining an individual's eligibility under this section shall be disregarded.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 1, 2017, 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.

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

(Added by Stats. 2014, Ch. 831, Sec. 6. (SB 508) Effective January 1, 2015.)

14005.288. (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)(VIII) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(VIII)) to extend Medi-Cal benefits to individuals under 21 years of age for whom an adoption agreement, other than an agreement under Title IV–E of the federal Social Security Act (42 U.S.C. Sec. 671 et seq.), between the state and the adoptive parent or parents is in effect.

(b) Pursuant to Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)), all of the income considered when determining an individual's eligibility under this section shall be disregarded.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 1, 2017, 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.

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

(Added by Stats. 2014, Ch. 831, Sec. 7. (SB 508) Effective January 1, 2015.)

14005.29. To the extent that federal matching funds are available, disabled persons who are otherwise eligible for benefits under this chapter, except for income due to employment, shall continue to be eligible to receive benefits for conditions excluded from coverage by a private insurer, provided those persons' incomes do not exceed 200 percent of the income level for maintenance established pursuant to Section 14005.12.

(Added by Stats. 1989, Ch. 883, Sec. 1.)

14005.30. (a) 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 with family incomes that do not exceed 109 percent of the federal poverty level.

(b) (1) Except as provided for in paragraph (3), when determining eligibility under this section, an applicant's or beneficiary's income and resources shall be determined, counted, and valued in accordance with the requirements of Section 1396a(e)(14) of Title 42 of the United States Code, as added by the ACA.

(2) When determining eligibility under this section, an applicant's or beneficiary's assets shall not be considered and deprivation shall not be a requirement for eligibility.

(3) The department shall seek federal approval to use the determination of eligibility for the CalWORKs program as a determination of eligibility for Medi-Cal benefits under this section. The department's use of the CalWORKs eligibility determination to determine eligibility for Medi-Cal benefits under this section shall be consistent, and in conformity, with the terms of the federal approval.

(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 and in which new income limits for the program established by this section are adopted by the department.

(d) The MAGI-based income eligibility standard applied under this section shall conform with the maintenance of effort requirements of Sections 1396a(e)(14) and 1396a(gg) of Title 42 of the United States Code, as added by the ACA.

(e) For 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 originally enacted and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

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

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 1, 2018, 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. Commencing six months after the effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(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.

(Amended by Stats. 2017, Ch. 52, Sec. 21. (SB 97) Effective July 10, 2017.)

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

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

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

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

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

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

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

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

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

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

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

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

(Repealed (in Sec. 6) and added by Stats. 2013, 1st Ex. Sess., Ch. 4, Sec. 7. (SB 1 1x) Effective September 30, 2013. Section operative January 1, 2014, by its own provisions.)

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 spend down of excess income.

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

(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, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

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

(Amended by Stats. 2023, Ch. 42, Sec. 79. (AB 118) Effective July 10, 2023.)

14005.33. (a) If a Medi-Cal beneficiary's Medi-Cal eligibility worker is changed, notice shall be sent to the beneficiary within 10 days of the change. This notice shall include the worker's name, address, and telephone number, and the beneficiary's Medi-Cal case number, and hours during which the county's Medi-Cal eligibility workers may be contacted by the beneficiary.

(b) This section shall be implemented on or before July 1, 2001.

(Added by Stats. 2000, Ch. 1088, Sec. 3. Effective January 1, 2001.)

14005.34. (a) For an individual whose cash aid was terminated pursuant to Chapter 2 (commencing with Section 11200), but whose Medi-Cal eligibility was continued either pursuant to subdivision (a) of Section 14005.31 or pursuant to a transfer of eligibility under Section 14005.32, the Medi-Cal beneficiary's annual reaffirmation date under Section 14012 shall be no earlier than 12 months from the date on which the most recent annual CalWORKs cash aid eligibility determination was conducted, or, if no such determination was conducted, 12 months from the date cash aid was granted.

(b) 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 U.S.C. Sec. 1396 and following) is available.

(c) 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.

(Added by Stats. 2000, Ch. 1088, Sec. 4. Effective January 1, 2001.)

14005.35. The department, in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers, shall study the feasibility of adopting a mechanism whereby, to the extent federal financial participation is available, a Medi-Cal managed care plan shall be notified whenever the eligibility of a Medi-Cal beneficiary enrolled in that plan is being redetermined, including notice of the date upon which any forms must be submitted to the county by the beneficiary.

(Amended by Stats. 2001, Ch. 159, Sec. 195. Effective January 1, 2002.)

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) (1) 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.

(2) When a managed care plan obtains a beneficiary's updated contact information, the managed care plan shall ask the beneficiary for approval to provide the beneficiary's updated contact information to the appropriate county. If the managed care plan does not obtain approval from the beneficiary to provide the appropriate county with the updated contact information, the county shall attempt to verify that the information that 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 contact shall first be attempted using the method of contact identified by the beneficiary as the preferred method of contact, if a method has been identified.

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

(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.

(Amended (as amended by Stats. 2013, 1st Ex. Sess., Ch. 3, Sec. 5) by Stats. 2013, Ch. 442, Sec. 5. (SB 28) Effective January 1, 2014.)

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 the county receives information about changes in a beneficiary's circumstances that may affect eligibility for Medi-Cal 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 and a beneficiary's Medi-Cal 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. For the purposes of this subdivision, for a beneficiary who is subject to the use of MAGI-based financial methods, the determination of whether the beneficiary is eligible for Medi-Cal benefits under any basis shall include, but is not limited to, a determination of eligibility for Medi-Cal benefits on a basis that is exempt from the use of MAGI-based financial methods only if either of the following occurs:

(1) The county assesses the beneficiary as being potentially eligible under a program that is exempt from the use of MAGI-based financial methods, including, but not limited to, on the basis of age, blindness, disability, or the need for long-term care services and supports.

(2) The beneficiary requests that the county determine whether the beneficiary is eligible for Medi-Cal benefits on a basis that is exempt from the use of MAGI-based financial methods.

(e) (1) For purposes of acquiring information necessary to conduct the eligibility redeterminations described in 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 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 their immediate family members, which are open, or were closed within the last 90 days, information accessed through any databases accessed 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 county or to the county via the department.

(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 the information it is based on.

(B) That the 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 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 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, at least 60 days before the beneficiary's annual redetermination date, 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 include all of the following:

(A) The requirement that the beneficiary 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 telephone 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 after the prepopulated form is mailed to the beneficiary to collect the necessary information if the beneficiary has not responded to the request for additional information or has provided an incomplete response.

(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 the beneficiary's 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 incomplete, the county shall follow the procedures set forth in paragraph (3) of subdivision (g) to work with the beneficiary to complete the information.

(5) (A) The form 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.

(g) (1) In the case of a redetermination due to change in circumstances, if a county cannot obtain sufficient information to redetermine eligibility pursuant to subdivision (e), the county shall send to the beneficiary a form that states the information needed to redetermine 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 only request information for nonapplicants necessary to make an eligibility 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. The beneficiary is not required to sign or return the form. The form shall include a telephone number to call in order to obtain more information. Future revisions to the form shall be developed by the department in consultation with the counties, representatives of consumers, and eligibility workers. A Medi-Cal beneficiary shall have 30 days from the date the form is mailed pursuant to this subdivision to respond.

(2) 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 marked as undeliverable shall result in an immediate notice of action terminating Medi-Cal eligibility.

(3) During the 30-day period after the date of mailing of a form to the Medi-Cal beneficiary pursuant to this subdivision, the county shall attempt to contact the beneficiary by telephone, in writing, or other commonly available electronic means, in counties where such electronic communication is available, to request the necessary information if the beneficiary has not responded to the request for additional information or has provided an incomplete response. If the beneficiary does not supply the necessary information to the county within the 30-day limit, a 10-day notice of termination of Medi-Cal eligibility shall be sent.

(h) Beneficiaries shall be required to report any change in circumstances that may affect their eligibility within 10 calendar days following the date the change occurred.

(i) If, within 90 days of a Medi-Cal beneficiary's eligibility termination date or a change in eligibility status due to the beneficiary's failure to provide needed information, the discontinued beneficiary submits to the county a signed and completed form or otherwise provides the needed information to the county, eligibility shall be redetermined in a timely manner by the county without requiring a new application. The beneficiary shall be entitled to request a Medi-Cal eligibility determination for any of the three months

immediately prior to the month in which the beneficiary provided the needed information to the county, in accordance with Section 14019.

(j) If the information available to the county pursuant to the redetermination procedures of 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.

(k) The department shall, with the counties and representatives of consumers, including those with disabilities, and Medi-Cal eligibility workers, develop a timeframe for redetermination of Medi-Cal eligibility based upon disability, including ex parte review, the redetermination forms described in 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.

(l) 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.

(m) 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.

(n) In the case of a redetermination due to a change in circumstances, if a county determines that the beneficiary remains eligible for Medi-Cal benefits, the county shall begin a new 12-month eligibility period.

(o) 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 insurance affordability programs, and, 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.

(p) 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.

(q) The requirements to provide information in subdivisions (e) and (g), and to report changes in circumstances in subdivision (h), 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 website identified by the department, telephone, mail, in person, and other commonly available electronic means as authorized by the department.

(r) 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.

(s) 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.

(t) When contacting a beneficiary under paragraphs (2) and (4) of subdivision (f), and paragraph (3) of subdivision (g), a county shall first attempt to use the method of contact identified by the beneficiary as the preferred method of contact, if a method has been identified.

(u) The department shall seek federal approval to extend the annual redetermination date under this section for a three-month period for those Medi-Cal beneficiaries whose annual redeterminations are scheduled to occur between January 1, 2014, and March 31, 2014.

(v) 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. The department shall adopt regulations by July 1, 2017, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(w) 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.

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

(Amended by Stats. 2022, Ch. 47, Sec. 80. (SB 184) Effective June 30, 2022.)

14005.38. (a) The principal and interest of a 529 savings plan shall be excluded from consideration for purposes of any asset or resources test to determine eligibility for Medi-Cal benefits with respect to an applicant or beneficiary whose eligibility is not determined using MAGI-based financial methods.

(b) The qualified distributions from a 529 savings account shall be excluded from consideration for purposes of any income test to determine eligibility for Medi-Cal benefits with respect to an applicant or beneficiary.

(c) The following definitions shall apply for purposes of this section:

(1) “529 savings plan” means a qualified tuition program that satisfies the requirements of Section 529 of the Internal Revenue Code.

(2) “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 originally enacted and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

(d) The department shall seek any necessary approvals from the federal Centers for Medicare and Medicaid Services to implement this section. The department shall implement this section only in a manner that is consistent with federal Medicaid law and regulations, and only to the extent that the necessary approvals are obtained and federal financial participation is not jeopardized.

(Added by Stats. 2018, Ch. 121, Sec. 2. (AB 1785) Effective January 1, 2019.)

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

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

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 1, 2017, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

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

(Amended (as amended by Stats. 2013, 1st Ex. Sess., Ch. 4, Sec. 10) by Stats. 2013, Ch. 442, Sec. 7. (SB 28) Effective January 1, 2014.)

14005.40. (a) To the extent federal financial participation is available, the department shall exercise its option under Section 1902(a)(10)(A)(ii)(X) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(X)), to implement a program for aged and disabled persons as described in Section 1902(m) of the federal Social Security Act (42 U.S.C. Sec. 1396a(m)(1)).

(b) To the extent federal financial participation is available, the blind shall be included within the definition of disabled for the purposes of the program established in this section.

(c) An individual shall satisfy the financial eligibility requirement of this program if all of the following conditions are met:

(1) Countable income, as determined in accordance with Section 1902(m) of the federal Social Security Act (42 U.S.C. Sec. 1396a(m)), does not exceed an income level equal to 100 percent of the applicable federal poverty level.

(2) (A) Until the time that the department obtains federal approval for the income disregard described in paragraph (3), countable income shall include an additional two hundred thirty dollars ($230) for an individual or, in the case of a couple, three hundred ten dollars ($310).

(B) Upon receipt of federal approval for, and implementation of, paragraph (3), this paragraph shall become inoperative. The director shall execute a declaration, which shall be retained by the director, stating that federal approval for paragraph (3) has been obtained and the date that paragraph (3) shall be implemented. The director shall post the declaration on the department’s internet website.

(3) (A) Pursuant to Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)), all countable income over 100 percent of the federal poverty level, up to 138 percent of the federal poverty level, shall be disregarded, after taking all other disregards, deductions, and exclusions into account for those persons eligible pursuant to this section.

(B) The department shall seek federal approval to implement this paragraph.

(4) (A) For the purposes of calculating countable income under this section, an income exemption shall be applied as necessary to adjust the Supplemental Security Income/State Supplementary Program for the Aged, Blind, and Disabled (SSI/SSP) payment level as used in this section so that it is the same as the SSI/SSP payment level that was in place on May 1, 2009.

(B) This additional income exemption shall cease to be implemented when the SSI/SSP payment levels increase beyond those in effect on May 1, 2009.

(C) The income level determined pursuant to paragraphs (1) and (2) shall not be less than the SSI/SSP payment level the individual receives or would receive as a disabled or blind individual or, in the case of a couple, the SSI/SSP payment level the couple receives or would receive as a disabled or blind couple.

(5) Countable resources, as determined in accordance with subdivision (a) of Section 14005.62, do not exceed the maximum levels established in that section.

(d) The financial eligibility requirements provided in subdivision (c) may be adjusted upwards to reflect the cost of living in California, contingent upon appropriation in the annual Budget Act.

(e) (1) 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 regulations are adopted.

(2) The department shall adopt regulations by January 1, 2030, 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. The department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations are adopted.

(f) 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 level described in subdivision (c).

(g) (1) For purposes of this section, the following definitions apply:

(A) “SSI” means the federal Supplemental Security Income program established under Title XVI of the federal Social Security Act.

(B) “Income level” means the applicable income level specified in subdivision (c).

(C) The board and care “personal care services” or “PCS” deduction refers to an income disregard that is applied to a resident in a licensed community care facility in lieu of the board and care deduction (equal to the amount by which the basic board and care rate exceeds the income level in subparagraph (B)) when the PCS deduction is greater than the board and care deduction.

(2) (A) For purposes of this section, the SSI recipient retention amount is the amount by which the SSI maximum payment amount to an individual residing in a licensed community care facility exceeds the maximum amount that the state allows community care facilities to charge a resident who is an SSI recipient.

(B) For the purposes of this section, the personal and incidental needs deduction for an individual residing in a licensed community care facility is one of the following:

(i) If the board and care deduction is applicable to the individual, the amount, not to exceed the amount by which the SSI recipient retention amount exceeds twenty dollars ($20), nor to be less than zero, by which the sum of the amount that the individual pays to the individual’s licensed community care facility and the SSI recipient retention amount exceed the sum of the individual’s income level, the individual’s board and care deduction, and twenty dollars ($20).

(ii) If the PCS deduction specified in paragraph (1) of subdivision (g) is applicable to the individual, an amount, not to exceed the amount by which the SSI recipient retention amount exceeds twenty dollars ($20), nor to be less than zero, by which the sum of the amount that the individual pays to the individual’s community care facility and the SSI recipient retention amount exceed the sum of the individual’s income level, the individual’s PCS deduction, and twenty dollars ($20).

(3) In determining the countable income under this section of an individual residing in a licensed community care facility, the individual shall have deducted from the individual’s income the amount specified in subparagraph (B) of paragraph (2).

(h) No later than one month after the effective date of subdivision (g), the department shall submit to the federal Medicaid program administrator a state plan amendment seeking approval of the income deduction specified in paragraph (3) of subdivision (g), and of federal financial participation for the costs resulting from that income deduction.

(i) The deduction prescribed by paragraph (3) of subdivision (g) shall be applied no later than the first day of the fourth month after the month in which the department receives approval for the federal financial participation specified in subdivision (h). Until approval for federal financial participation is received, there shall be no deduction under paragraph (3) of subdivision (g).

(j) This section shall be implemented only if, and to the extent that, any necessary federal approvals have been obtained.

(k) Paragraph (3) of subdivision (c) shall be implemented after the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of paragraph (3) of subdivision (c), but no sooner than January 1, 2020.

(l) This section shall become operative on January 1, 2026.

(Amended (as amended by Stats. 2023, Ch. 42, Sec. 80) by Stats. 2025, Ch. 21, Sec. 56. (AB 116) Effective June 30, 2025. Operative January 1, 2026, by its own provisions.)

14005.40. (a) To the extent federal financial participation is available, the department shall exercise its option under Section 1902(a)(10)(A)(ii)(X) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(X)), to implement a program for aged and disabled persons as described in Section 1902(m) of the federal Social Security Act (42 U.S.C. Sec. 1396a(m)(1)).

(b) To the extent federal financial participation is available, the blind shall be included within the definition of disabled for the purposes of the program established in this section.

(c) An individual shall satisfy the financial eligibility requirement of this program if all of the following conditions are met:

(1) Countable income, as determined in accordance with Section 1902(m) of the federal Social Security Act (42 U.S.C. Sec. 1396a(m)), does not exceed an income level equal to 100 percent of the applicable federal poverty level.

(2) (A) Until the time that the department obtains federal approval for the income disregard described in paragraph (3), countable income shall include an additional two hundred thirty dollars ($230) for an individual or, in the case of a couple, three hundred ten dollars ($310).

(B) Upon receipt of federal approval for, and implementation of, paragraph (3), this paragraph shall become inoperative. The director shall execute a declaration, which shall be retained by the director, stating that federal approval for paragraph (3) has been obtained and the date that paragraph (3) shall be implemented. The director shall post the declaration on the department's internet website.

(3) (A) Pursuant to Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)), all countable income over 100 percent of the federal poverty level, up to 138 percent of the federal poverty level, shall be disregarded, after taking all other disregards, deductions, and exclusions into account for those persons eligible pursuant to this section.

(B) The department shall seek federal approval to implement this paragraph.

(4) (A) For the purposes of calculating countable income under this section, an income exemption shall be applied as necessary to adjust the Supplemental Security Income/State Supplementary Program for the Aged, Blind, and Disabled (SSI/SSP) payment level as used in this section so that it is the same as the SSI/SSP payment level that was in place on May 1, 2009.

(B) This additional income exemption shall cease to be implemented when the SSI/SSP payment levels increase beyond those in effect on May 1, 2009.

(C) The income level determined pursuant to paragraphs (1) and (2) shall not be less than the SSI/SSP payment level the individual receives or would receive as a disabled or blind individual or, in the case of a couple, the SSI/SSP payment level the couple receives or would receive as a disabled or blind couple.

(5) Countable resources, including property or other assets, shall not be considered in determining eligibility.

(d) The financial eligibility requirements provided in subdivision (c) may be adjusted upwards to reflect the cost of living in California, contingent upon appropriation in the annual Budget Act.

(e) (1) 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 regulations are adopted.

(2) The department shall adopt regulations by July 1, 2023, 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. The department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations are adopted.

(f) 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 level described in subdivision (c).

(g) (1) For purposes of this section, the following definitions apply:

(A) “SSI” means the federal Supplemental Security Income program established under Title XVI of the federal Social Security Act.

(B) “Income level” means the applicable income level specified in subdivision (c).

(C) The board and care “personal care services” or “PCS” deduction refers to an income disregard that is applied to a resident in a licensed community care facility in lieu of the board and care deduction (equal to the amount by which the basic board and care rate exceeds the income level in subparagraph (B)) when the PCS deduction is greater than the board and care deduction.

(2) (A) For purposes of this section, the SSI recipient retention amount is the amount by which the SSI maximum payment amount to an individual residing in a licensed community care facility exceeds the maximum amount that the state allows community care facilities to charge a resident who is an SSI recipient.

(B) For the purposes of this section, the personal and incidental needs deduction for an individual residing in a licensed community care facility is one of the following:

(i) If the board and care deduction is applicable to the individual, the amount, not to exceed the amount by which the SSI recipient retention amount exceeds twenty dollars ($20), nor to be less than zero, by which the sum of the amount that the individual pays to the individual’s licensed community care facility and the SSI recipient retention amount exceed the sum of the individual’s income level, the individual’s board and care deduction, and twenty dollars ($20).

(ii) If the PCS deduction specified in paragraph (1) of subdivision (g) is applicable to the individual, an amount, not to exceed the amount by which the SSI recipient retention amount exceeds twenty dollars ($20), nor to be less than zero, by which the sum of the amount that the individual pays to the individual’s community care facility and the SSI recipient retention amount exceed the sum of the individual’s income level, the individual’s PCS deduction, and twenty dollars ($20).

(3) In determining the countable income under this section of an individual residing in a licensed community care facility, the individual shall have deducted from the individual’s income the amount specified in subparagraph (B) of paragraph (2).

(h) No later than one month after the effective date of subdivision (g), the department shall submit to the federal Medicaid program administrator a state plan amendment seeking approval of the income deduction specified in paragraph (3) of subdivision (g), and of federal financial participation for the costs resulting from that income deduction.

(i) The deduction prescribed by paragraph (3) of subdivision (g) shall be applied no later than the first day of the fourth month after the month in which the department receives approval for the federal financial participation specified in subdivision (h). Until approval for federal financial participation is received, there shall be no deduction under paragraph (3) of subdivision (g).

(j) This section shall be implemented only if, and to the extent that, any necessary federal approvals have been obtained.

(k) Paragraph (3) of subdivision (c) shall be implemented after the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of paragraph (3) of subdivision (c), but no sooner than January 1, 2020.

(l) This section shall become inoperative on January 1, 2026, and, as of January 1, 2027, is repealed.

(Amended (as added by Stats. 2023, Ch. 42, Sec. 81) by Stats. 2025, Ch. 21, Sec. 57. (AB 116) Effective June 30, 2025. Inoperative January 1, 2026, by its own provisions. Repealed as of January 1, 2027, by its own provisions. See later operative version, as amended by Sec. 56 of Stats. 2025, Ch. 21.)

14005.401. (a) The department shall seek a Medicaid state plan amendment or waiver to implement an income disregard that would allow an aged, blind, or disabled individual who becomes ineligible for benefits under the Medi-Cal program pursuant to Section 14005.40 because of the state’s payment of the individual’s Medicare Part B premiums to remain eligible for the Medi-Cal program under Section 14005.40 if their income and resources otherwise meet all eligibility requirements.

(b) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted.

(2) The department shall adopt regulations by January 1, 2030, 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 be implemented only if, and to the extent that, federal financial participation is available and necessary federal approvals have been obtained.

(d) This section shall become operative on January 1, 2026.

(Amended (as amended by Stats. 2023, Ch. 42, Sec. 82) by Stats. 2025, Ch. 21, Sec. 60. (AB 116) Effective June 30, 2025. Operative January 1, 2026, by its own provisions.)

14005.401. (a) The department shall seek a Medicaid state plan amendment or waiver to implement an income disregard that would allow an aged, blind, or disabled individual who becomes ineligible for benefits under the Medi-Cal program pursuant to Section 14005.40 because of the state's payment of the individual's Medicare Part B premiums to remain eligible for the Medi-Cal program under Section 14005.40 if their income otherwise meets all eligibility requirements.

(b) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted.

(2) The department shall adopt regulations by July 1, 2021, 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.

(3) Commencing six months after the effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

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

(d) This section shall become inoperative on January 1, 2026, and, as of January 1, 2027, is repealed.

(Amended (as added by Stats. 2023, Ch. 42, Sec. 83) by Stats. 2025, Ch. 21, Sec. 61. (AB 116) Effective June 30, 2025. Inoperative January 1, 2026, by its own provisions. Repealed as of January 1, 2027, by its own provisions. See later operative version, as amended by Sec. 60 of Stats. 2025, Ch. 21.)

14005.41. (a) Notwithstanding any other law, the department shall deem to have met the income documentation requirements for participation in the Medi-Cal program, without a spend down of excess income, any child who is less than six years of age and who has been determined to be eligible for free meals through a federally funded program using the National School Lunch Program application provided for pursuant to Chapter 13 (commencing with Section 1751) of Title 42 of the United States Code.

(b) Notwithstanding any other law, with regard to any child who is enrolled in and attending public school in the State of California, the department shall accept documentation of enrollment for free meals under the National School Lunch Program as sufficient documentation of California residency for that child for the purposes of the Medi-Cal program.

(c) (1) (A) Notwithstanding any other law, each county shall participate in a statewide pilot project to determine Medi-Cal program eligibility for any child under six years of age and currently enrolled in school in the State of California who is eligible for free meals under the National School Lunch Program upon receipt of proof of participation in the National School Lunch Program and a signed Medi-Cal application, which may be the supplemented application, described in subdivision (i). Counties shall notify the parent or guardian of the results of the eligibility determination.

(B) Notwithstanding any other law, each county shall participate in a statewide pilot project to use the procedure described in this subdivision to determine Medi-Cal eligibility without a spend down of excess income, and, if eligible, shall enroll in the Medi-Cal program, any child six years of age or older currently enrolled in school in the State of California who is eligible for free meals under the National School Lunch Program, upon receipt of proof of participation in the National School Lunch Program and a signed Medi-Cal application, which may be the supplemented application, described in subdivision (i). If the county determines from the supplemented application described in subdivision (i) that the child meets the eligibility requirements for participation in the Medi-Cal program, the county shall notify the parent or guardian that the child has been found eligible for the Medi-Cal program. If the county is unable to determine from the information on the application as described in subdivision (i) whether the child is eligible, the county shall contact the family to seek any additional information regarding income, household composition, or deductions that the department, in consultation with the county welfare departments, may determine to be necessary to complete the Medi-Cal application. If the county determines that the child does

not meet the income eligibility requirements for participation in the full-scope no-cost Medi-Cal program, the county shall notify the parent or guardian of the determination and shall forward the school lunch application and any supplemental forms as described in subdivision (i) to the Healthy Families Program. If an applicant is determined to be ineligible for the full-scope no-cost Medi-Cal program and for the Healthy Families Program, the school lunch application and any supplemental forms as described in subdivision (i) shall be forwarded to a county- or local-sponsored health insurance program, as applicable, if the parent or guardian has provided consent. For purposes of this section, a county- or local-sponsored health insurance program includes a county agency, a local initiative, a county-organized health system, or other local entity that provides health care coverage to children who do not qualify for the full-scope no-cost Medi-Cal program or for the Healthy Families Program.

(2) Each county shall ask the parent or guardian of each child identified in subparagraph (A) of paragraph (1) and the parent or guardian of each child whom the county determines to meet the income eligibility requirements for participation in the Medi-Cal program under subparagraph (B) of paragraph (1) to provide additional documentation as required by current law necessary for retention of eligibility in the Medi-Cal program. If a parent or guardian does not provide the documentation required for retention of full-scope Medi-Cal program eligibility, the county shall continue the child's enrollment in the Medi-Cal program, but only for the limited scope of Medi-Cal program benefits as described in Section 14007.5. If applicable, the county shall also forward the school lunch application and any supplemental forms as described in subdivision (i), for applicants who are determined to be ineligible for the full-scope no-cost Medi-Cal program and for the Healthy Families Program, to a county- or local-sponsored health insurance program if the parent or guardian has provided consent.

(d) Nothing in this section shall be construed as preventing the department from verifying eligibility through the Income Eligibility Verification System match mandated by Section 1137 of the federal Social Security Act (42 U.S.C. Sec. 1320b-7) or from requesting additional information or documentation required by federal law.

(e) Each county shall include its cost of implementing this section in its annual Medi-Cal administrative budget requests submitted to the department.

(f) For purposes of this section, the Medi-Cal program application date shall be the date on which the school lunch application information is received by the local agency determining eligibility under the Medi-Cal program.

(g) (1) This section shall be implemented only if, and to the extent that, federal financial participation is available for the services provided and only for the period of time the free National School Lunch Program utilizes a gross income standard at or below 133 percent of the federal poverty level. This section shall be implemented in a manner consistent with any federal approval.

(2) Notwithstanding paragraph (1), if the department determines that one or more state plan amendments are necessary to ensure full federal financial participation in the provisions of this section, the department shall prepare and submit requests for the state plan amendments to the federal government, after which this section shall not be implemented until the department receives approval of all necessary state plan amendments.

(h) (1) Notwithstanding subdivision (g), not later than March 1, 2003, the department, in consultation with the State Department of Education and representatives of the school districts, county superintendents of schools, local agencies that administer the Medi-Cal program, consumer advocates, and other stakeholders, shall develop and distribute the policies and procedures, including any all-county letters, necessary to implement Section 49557.2 of the Education Code and this section.

(2) The policies and procedures required to be developed and distributed pursuant to subdivision (a) shall include, at a minimum, both of the following:

(A) Processes for the school districts, county superintendents of schools, and local agencies that administer the Medi-Cal program to use in forwarding and processing free school lunch application information pursuant to Section 49557.2 of the Education Code, and in following up with the applicants to obtain any necessary documentation required by federal law.

(B) Instructions for implementing the eligibility provisions of this chapter.

(3) The policies and procedures required to be developed pursuant to subdivision (a) shall specify all of the following:

(A) The information on the school lunch application may be used to initiate a Medi-Cal program application only when the applicant has provided their consent pursuant to Section 49557.2 of the Education Code.

(B) The date of the Medi-Cal program application shall be the date on which the school lunch application was received by the local agency that determines eligibility under the Medi-Cal program.

(C) The county, in determining eligibility for the Medi-Cal program, shall request additional documentation only as required by federal law, and shall enroll any child whose parent or guardian does not provide the necessary documentation for full-scope benefits under the Medi-Cal program in the Medi-Cal program with limited scope benefits, as described in Section 14007.5.

(i) To the extent federal financial participation is available, and to the extent administratively feasible, the department shall utilize the free National School Lunch Program application developed under Section 49557.2 of the Education Code, if supplemented as

needed by simplified forms and disclosures, including Medi-Cal rights and responsibility notices and privacy notices, as a Medi-Cal application for children described in this section.

(j) 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.

(k) The department shall review the effectiveness of the statewide pilot project and make recommendations regarding appropriate ways to expand the use of the approaches contained in this section.

(l) In order to expedite health coverage for children who have been determined eligible for free meals under the National School Lunch Program, the department, at its discretion, may choose to implement this section in whole or in part by exercising the option described in Section 1396r-1a of Title 42 of the United States Code to allow information provided on the National School Lunch Program application referred to, and supplemented as described, in paragraph (1) of subdivision (a) of Section 49557.2 of the Education Code to serve as a basis for a preliminary eligibility determination by a qualified entity designated by the department.

(m) County- and local-sponsored health program agencies are authorized to use the supplemental application described in subdivision (i) and received pursuant to subdivision (c) to make an eligibility determination for those respective programs, and shall request additional information only as needed to complete the eligibility process.

(n) A county may, at its option, and with the consent of the parent or guardian as provided in paragraph (3) of subdivision (a) of Section 49557.2 of the Education Code, notify the school of the names and contact information of children who are in jeopardy of losing accelerated Medi-Cal coverage because a child's parent or guardian has not provided required followup information to the county. This notice shall be limited to the names and contact information, and shall not specify what information is missing. This shall be done for the sole purpose of enabling the school, at its option, to conduct outreach activities to encourage or assist those parents or guardians to complete and submit the required followup information.

(Amended by Stats. 2023, Ch. 42, Sec. 84. (AB 118) Effective July 10, 2023.)

14005.42. (a) The department shall provide full-scope benefits under this chapter, without spend down of excess income, to all individuals on behalf of whom kinship guardians are receiving aid under any of the Kinship Guardian Assistance Payment Programs pursuant to Article 4.5 (commencing with Section 11360) of Chapter 2.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department and the State Department of Social Services may implement, without taking regulatory action, this section by means of all county letters or similar instruction. Thereafter, as needed, the departments 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) To the extent that federal financial participation is not available, the cost of benefits provided under this section shall be covered only by state funds.

(d) The department and the State Department of Social Services shall work cooperatively to develop procedures that maximize the availability of federal financial participation for the cost of benefits provided under this section. The procedures shall include conforming the application and eligibility determination process for this population to meet the requirements of federal Medicaid law.

(Amended by Stats. 2023, Ch. 42, Sec. 85. (AB 118) Effective July 10, 2023.)

14005.50. (a) To the extent that federal financial participation is available, the department shall exercise the option made available under Section 1902(a)(10)(A)(ii)(I) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(I)) to extend full-scope Medi-Cal benefits to individuals who are ineligible for full-scope Medi-Cal benefits under a program listed in subdivision (c) as a result of the July 1, 2009, reduction in the SSI/SSP program maximum aid payments pursuant to Section 12200.019, or any subsequent reductions in maximum aid payments.

(b) The programs authorized under this section shall utilize the income and resource standards and methodologies of the SSI/SSP program and in addition an income disregard shall be applied as necessary to adjust the income standard to that which was in place for the affected program on May 1, 2009.

(c) (1) The SSI/SSP program under Title XVI of the federal Social Security Act.

(2) The Pickle program under the Pickle Amendment to Title XIX of the federal Social Security Act (Public Law 94-566).

(3) The Disabled Adult Child program under Section 1634 of the federal Social Security Act (42 U.S.C. Sec. 1383c).

(4) The Disabled Widow or Widower program under Section 1634 of the federal Social Security Act (42 U.S.C. Sec. 1383c).

(d) Notwithstanding subdivision (b), for the purposes of this section, for blind individuals who meet the criteria for blindness as set forth in Section 1614(a)(2) of the federal Social Security Act (42 U.S.C. Sec. 1382c(a)(2)), but who have not been determined to be

disabled in accordance with Section 1614(a)(3) of that Act (42 U.S.C. Sec. 1382c(a)(3)), the income and resource standards and methodologies applied in determining eligibility under this section shall be identical to that of the Aged and Disabled Federal Poverty Level program under Section 14005.40.

(e) The department shall implement an expedited application process to determine the Medi-Cal eligibility under this section for individuals who, based on excess income, are denied eligibility for the SSI/SSP program by the Social Security Administration. The department shall use its best efforts to identify these individuals from information provided by the Social Security Administration. The department shall also allow these individuals to self-identify by producing a copy of the notice of action that they received from the Social Security Administration informing them that their application for eligibility for the SSI/SSP program was denied based on excess income.

(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 an all-county letter or similar instruction without taking regulatory action.

(g) This section shall cease to be implemented when the SSI/SSP program payment levels increase beyond those in effect on May 1, 2009.

(h) Nothing in this section shall be read as entitling any individual to Medi-Cal benefits before his or her Medi-Cal eligibility determination has been completed.

(i) This section shall not change the procedures for redetermining a beneficiary's eligibility for Medi-Cal benefits.

(j) The department shall seek any approvals from the federal Centers for Medicare and Medicaid Services necessary to obtain federal financial participation and to expeditiously implement this section.

(Added by Stats. 2009, 4th Ex. Sess., Ch. 5, Sec. 31. Effective July 28, 2009.)

14006. (a) This section applies to medically needy persons, medically needy family persons, and state-only Medi-Cal persons.

(b) For the purposes of this section, the term "principal residence" means the home, including a multiple-dwelling unit, in which the individual resides or formerly resided. The home will continue to be considered the principal residence if any of the following is applicable:

(1) During any absence, the individual intends to return to the home.

(2) The individual lives in a nursing facility or a medical institution and intends to return home.

(3) The individual's spouse or a dependent relative of the individual continues to reside in the home during the individual's absence.

(4) The individual does not have the right, authority, power, or legal capacity to liquidate the property, but a bona fide effort is being made to attain the right, authority, power, or legal capacity to liquidate the property.

(5) The property cannot readily be converted to cash but a bona fide effort is being made to sell the property, in which case the state shall, subject to notice and an opportunity for a hearing, have a lien against the property, to the extent permitted by federal law, for the cost of medical services.

The lien shall be recorded, and from the date of recording, shall have the force, effect, and priority of a judgment lien.

(6) If it is a multiple-dwelling unit, one unit of which is occupied by the applicant or recipient, any unit not occupied by the applicant or recipient is producing income for the individual or family reasonably consistent with its value.

(7) It is inhabited by any sibling or child of the recipient who has continuously resided in the property since at least one year prior to the date the owner entered a nursing facility, or in a medical institution.

For purposes of this subdivision, "bona fide effort" means that the property shall be listed with a licensed real estate broker at the value determined to be the fair market value by a qualified real estate appraiser and the applicant or recipient provides evidence that a continuous effort is being made to sell the property, offers at fair market value are accepted, and all offers are reported.

(c) For purposes of determining eligibility under this part, resources shall be determined, defined, counted, and valued in accordance with the federal law governing resources under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.). Resources exempt under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) shall not be considered in determining eligibility. A community spouse may retain nonexempt resources to the maximum extent permitted under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.). Medically needy individuals and families may retain nonexempt resources to the extent permitted under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.). In addition, the principal residence as defined in subdivision (b) shall be exempt.

(d) The director, to meet the requirements of the federal Social Security Act and to ensure the highest percentage of federal financial participation in the program provided by this chapter, may decrease or increase the amounts set forth herein.

(e) (1) If the holdings are in the form of real property, the value shall be the assessed value, determined under the most recent county property tax assessment, less the unpaid amount of any encumbrance of record.

(2) If the real property other than the home is not producing income reasonably consistent with its value, the applicant or recipient shall be allowed reasonable time to begin producing such income from the property. If the property cannot produce reasonable income or be sold based on the market value, the applicant or recipient shall be allowed to submit evidence from a qualified real estate appraiser that indicates the value for which the property can be adequately utilized or sold. If the applicant or recipient provides evidence that the only method of adequately utilizing the property is sale, and the property has not been sold at market value during a reasonable period of time, the property shall be considered to be adequately utilized provided it is listed with a licensed real estate broker at the value determined to be the fair market value by a qualified real estate appraiser and the applicant or recipient provides evidence that a bona fide and continuous effort is being made to sell the property.

(3) If federal requirements permit a person to whom this subdivision applies to own an automobile of greater value than is permitted in determining eligibility for aid under Chapter 3 (commencing with Section 12000), the department shall adopt regulations authorizing that higher allowance.

(f) Any mortgage or note secured by a deed of trust shall be deemed real property if its value does not exceed six thousand dollars ($6,000) and it is obtained by the applicant or recipient, or in combination with their spouse, through the sale of such real property.

(g) If the holdings consist of money on deposit, the value shall be the actual amount thereof. If the holdings are in any other form of personal property or investment, except life insurance, the value shall be the conversion value as of the date of application or the anniversary date of such application. If the holdings are in the form of life insurance, the value shall be the cash value as of the policy anniversary nearest the date of such application.

(h) The value of property holdings shall be determined as of the date of application and, if the person is found eligible, this determination shall establish the amount of such holdings to be considered during the ensuing 12 months except a new determination to govern during the succeeding 12 months shall be made on the first anniversary date of the application or such alternate date as may be established following the acquisition of additional holdings as provided in the following paragraph and on each succeeding anniversary date thereafter.

(i) If any person shall by gift, inheritance, or other manner, acquire additional holdings during any such interval, other than from their own earnings, they shall immediately report such acquisition, and the anniversary date shall become the date of such acquisition.

(j) If any provision of this section does not comply with federal requirements, the provision shall become inoperative to the extent that it is not in compliance with federal requirements pursuant to Section 11003.

(k) This section shall become inoperative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain inoperative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.

(Amended by Stats. 2023, Ch. 42, Sec. 87. (AB 118) Effective July 10, 2023. Conditionally inoperative on or after January 1, 2024, by its own provisions. Superseded on January 1, 2026; see amendment by Stats. 2025, Ch. 21.)

14006. (a) This section applies to medically needy persons, medically needy family persons, and state-only Medi-Cal persons.

(b) For the purposes of this section, the term “principal residence” means the home, including a multiple-dwelling unit, in which the individual resides or formerly resided. The home will continue to be considered the principal residence if any of the following is applicable:

(1) During any absence, the individual intends to return to the home.

(2) The individual lives in a nursing facility or a medical institution and intends to return home.

(3) The individual’s spouse or a dependent relative of the individual continues to reside in the home during the individual’s absence.

(4) The individual does not have the right, authority, power, or legal capacity to liquidate the property, but a bona fide effort is being made to attain the right, authority, power, or legal capacity to liquidate the property.

(5) The property cannot readily be converted to cash but a bona fide effort is being made to sell the property, in which case the state shall, subject to notice and an opportunity for a hearing, have a lien against the property, to the extent permitted by federal law, for the cost of medical services.

The lien shall be recorded, and from the date of recording, shall have the force, effect, and priority of a judgment lien.

(6) If it is a multiple-dwelling unit, one unit of which is occupied by the applicant or recipient, any unit not occupied by the applicant or recipient is producing income for the individual or family reasonably consistent with its value.

(7) It is inhabited by any sibling or child of the recipient who has continuously resided in the property since at least one year prior to the date the owner entered a nursing facility, or in a medical institution.

For purposes of this subdivision, “bona fide effort” means that the property shall be listed with a licensed real estate broker at the value determined to be the fair market value by a qualified real estate appraiser and the applicant or recipient provides evidence that a continuous effort is being made to sell the property, offers at fair market value are accepted, and all offers are reported.

(c) For purposes of determining eligibility under this part, countable resources shall be determined in accordance with subdivision (a) of Section 14005.62. Resources exempt under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) shall not be considered in determining eligibility. A community spouse may retain nonexempt resources to the maximum extent permitted under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.). Medically needy individuals and families may retain nonexempt resources to the extent permitted under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.). In addition, the principal residence as defined in subdivision (b) shall be exempt.

(d) The director, to meet the requirements of the federal Social Security Act and to ensure the highest percentage of federal financial participation in the program provided by this chapter, may decrease or increase the amounts set forth herein.

(e) (1) If the holdings are in the form of real property, the value shall be the assessed value, determined under the most recent county property tax assessment, less the unpaid amount of any encumbrance of record.

(2) If the real property other than the home is not producing income reasonably consistent with its value, the applicant or recipient shall be allowed reasonable time to begin producing such income from the property. If the property cannot produce reasonable income or be sold based on the market value, the applicant or recipient shall be allowed to submit evidence from a qualified real estate appraiser that indicates the value for which the property can be adequately utilized or sold. If the applicant or recipient provides evidence that the only method of adequately utilizing the property is sale, and the property has not been sold at market value during a reasonable period of time, the property shall be considered to be adequately utilized provided it is listed with a licensed real estate broker at the value determined to be the fair market value by a qualified real estate appraiser and the applicant or recipient provides evidence that a bona fide and continuous effort is being made to sell the property.

(3) If federal requirements permit a person to whom this subdivision applies to own an automobile of greater value than is permitted in determining eligibility for aid under Chapter 3 (commencing with Section 12000), the department shall adopt regulations authorizing that higher allowance.

(f) Any mortgage or note secured by a deed of trust shall be deemed real property if its value does not exceed six thousand dollars ($6,000) and it is obtained by the applicant or recipient, or in combination with their spouse, through the sale of such real property.

(g) If the holdings consist of money on deposit, the value shall be the actual amount thereof. If the holdings are in any other form of personal property or investment, except life insurance, the value shall be the conversion value as of the date of application or the anniversary date of such application. If the holdings are in the form of life insurance, the value shall be the cash value as of the policy anniversary nearest the date of such application.

(h) The value of property holdings shall be determined as of the date of application and, if the person is found eligible, this determination shall establish the amount of such holdings to be considered during the ensuing 12 months except a new determination to govern during the succeeding 12 months shall be made on the first anniversary date of the application or such alternate date as may be established following the acquisition of additional holdings as provided in the following paragraph and on each succeeding anniversary date thereafter.

(i) If any person shall by gift, inheritance, or other manner, acquire additional holdings during any such interval, other than from their own earnings, they shall immediately report such acquisition, and the anniversary date shall become the date of such acquisition.

(j) If any provision of this section does not comply with federal requirements, the provision shall become inoperative to the extent that it is not in compliance with federal requirements pursuant to Section 11003.

(k) This section shall become operative on January 1, 2026.

(Amended by Stats. 2025, Ch. 21, Sec. 62. (AB 116) Effective June 30, 2025. Operative January 1, 2026, by its own provisions.)

14006.01. (a) This section applies to any individual who is residing in a continuing care retirement community, as defined in paragraph (10) of subdivision (c) of Section 1771 of the Health and Safety Code, pursuant to a continuing care contract, as defined in paragraph (8) of subdivision (c) of Section 1771 of the Health and Safety Code, or pursuant to a life care contract, as defined in subdivision (l) of Section 1771 of the Health and Safety Code, that collects an entrance fee from its residents upon admission.

(b) In determining an individual’s eligibility for Medi-Cal benefits, the individual’s entrance fee shall be considered a resource available to the individual if all of the following apply:

(1) The individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care if other resources or income of the individual are insufficient to pay for care.

(2) The individual is eligible for a refund of any remaining entrance fee when they die or terminate their contract with, and leave, the continuing care retirement community.

(3) The entrance fee does not confer an ownership interest in the continuing care retirement community.

(c) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), and any regulations adopted pursuant to that act, and only to the extent required by federal law, and only to the extent that federal financial participation is available.

(d) To the extent that regulations are necessary to implement this section, the department shall promulgate regulations using the nonemergency regulatory process described in Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of the Government Code.

(e) It is the intent of the Legislature that the provisions of this section shall apply prospectively to any individual to whom the act applies commencing from the date regulations adopted pursuant to this act are filed with the Secretary of State.

(f) This section shall become inoperative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain inoperative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.

(Amended by Stats. 2023, Ch. 42, Sec. 88. (AB 118) Effective July 10, 2023. Conditionally inoperative on or after January 1, 2024, by its own provisions. Superseded on January 1, 2026; see amendment by Stats. 2025, Ch. 21.)

14006.01. (a) This section applies to any individual who is residing in a continuing care retirement community, as defined in paragraph (10) of subdivision (c) of Section 1771 of the Health and Safety Code, pursuant to a continuing care contract, as defined in paragraph (8) of subdivision (c) of Section 1771 of the Health and Safety Code, or pursuant to a life care contract, as defined in subdivision (l) of Section 1771 of the Health and Safety Code, that collects an entrance fee from its residents upon admission.

(b) In determining an individual's eligibility for Medi-Cal benefits, the individual's entrance fee shall be considered a resource available to the individual if all of the following apply:

(1) The individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care if other resources or income of the individual are insufficient to pay for care.

(2) The individual is eligible for a refund of any remaining entrance fee when they die or terminate their contract with, and leave, the continuing care retirement community.

(3) The entrance fee does not confer an ownership interest in the continuing care retirement community.

(c) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), and any regulations adopted pursuant to that act, and only to the extent required by federal law, and only to the extent that federal financial participation is available.

(d) To the extent that regulations are necessary to implement this section, the department shall promulgate regulations using the nonemergency regulatory process described in Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of the Government Code.

(e) It is the intent of the Legislature that the provisions of this section shall apply prospectively to any individual to whom the act applies commencing from the date regulations adopted pursuant to this act are filed with the Secretary of State.

(f) This section shall become operative on January 1, 2026.

(Amended by Stats. 2025, Ch. 21, Sec. 63. (AB 116) Effective June 30, 2025. Operative January 1, 2026, by its own provisions.)

14006.15. (a) For the purposes of this section, "equity interest" means the lesser of the following:

(1) The assessed value of the principal residence determined under the most recent tax assessment, less any encumbrances of record.

(2) The appraised value of the principal residence determined by a qualified real estate appraiser who has been retained by the applicant or beneficiary, less any encumbrances of record.

(b) Notwithstanding subdivisions (b) and (c) of Section 14006, and except as provided in subdivision (c), an individual is not eligible for medical assistance for home and facility care if their equity interest in the principal residence exceeds seven hundred fifty thousand dollars ($750,000). No later than December 31, 2011, and each year thereafter, this amount shall be increased based on the percentage increase in the consumer price index for all urban consumers (all items, United States city average), rounded to the nearest one thousand dollars ($1,000).

(c) This section does not apply to an individual if any of the following circumstances exist:

(1) The spouse of the individual or the individual's child, who is under 21 years of age, or who is blind or who is disabled, as defined in paragraph (3) of subsection (a) of Section 1382c of Title 42 of the United States Code, is lawfully residing in the individual's home.

(2) The individual was determined eligible for medical assistance for home and facility care based on an application filed before January 1, 2006.

(3) The department determines that ineligibility for medical assistance for home and facility care would result in demonstrated hardship on the individual. For purposes of this section, demonstrated hardship shall include, but need not be limited to, any of the following circumstances:

(A) The individual was receiving home and facility care prior to January 1, 2006.

(B) The individual has been determined to be eligible for medical assistance for home and facility care based on an application filed on or after January 1, 2006, and before the date that regulations adopted pursuant to this section are certified with the Secretary of State.

(C) The individual purchased and received benefits under a long-term care insurance policy certified by the department's California Partnership for Long-Term Care Program, established by Division 12 (commencing with Section 22000).

(D) The individual's equity interest in the principal residence exceeds the equity interest limit as provided in subdivision (b), but would not exceed the equity interest limit under that subdivision if it had been increased by using the quarterly House Price Index (HPI) for California, published by the Office of Federal Housing Enterprise Oversight (OFHEO).

(E) The applicant or beneficiary has been denied a home equity loan by at least three lending institutions, or is ineligible for any one Federal Housing Administration (FHA) approved loan or reverse mortgage.

(F) The applicant or beneficiary, with good cause, is unable to provide verification of the equity value.

(G) The applicant or beneficiary meets the criteria set forth in subdivision (b) of Section 14015.1.

(d) To the extent that federal financial participation is unavailable to cover the costs associated with subparagraph (C) of paragraph (3) of subdivision (c), state general funds shall be used.

(e) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act, and except for subparagraph (C) of paragraph (3) of subdivision (c), and subdivision (d), only to the extent that federal financial participation is available.

(f) To the extent that regulations are necessary to implement this section, the department shall promulgate regulations using the nonemergency regulatory process described in Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of the Government Code.

(g) It is the intent of the Legislature that the provisions of this section shall apply prospectively to any individual to whom the act applies commencing from the date regulations adopted pursuant to this act are filed with the Secretary of State.

(h) This section shall become inoperative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain inoperative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.

(Amended by Stats. 2023, Ch. 42, Sec. 90. (AB 118) Effective July 10, 2023. Conditionally inoperative on or after January 1, 2024, by its own provisions. Superseded on January 1, 2026; see amendment by Stats. 2025, Ch. 21.)

14006.15. (a) For the purposes of this section, "equity interest" means the lesser of the following:

(1) The assessed value of the principal residence determined under the most recent tax assessment, less any encumbrances of record.

(2) The appraised value of the principal residence determined by a qualified real estate appraiser who has been retained by the applicant or beneficiary, less any encumbrances of record.

(b) Notwithstanding subdivisions (b) and (c) of Section 14006, and except as provided in subdivision (c), an individual is not eligible for medical assistance for home and facility care if their equity interest in the principal residence exceeds seven hundred fifty thousand dollars ($750,000). No later than December 31, 2011, and each year thereafter, this amount shall be increased based on the percentage increase in the consumer price index for all urban consumers (all items, United States city average), rounded to the nearest one thousand dollars ($1,000).

(c) This section does not apply to an individual if any of the following circumstances exist:

(1) The spouse of the individual or the individual's child, who is under 21 years of age, or who is blind or who is disabled, as defined in paragraph (3) of subsection (a) of Section 1382c of Title 42 of the United States Code, is lawfully residing in the individual's home.

(2) The individual was determined eligible for medical assistance for home and facility care based on an application filed before January 1, 2006.

(3) The department determines that ineligibility for medical assistance for home and facility care would result in demonstrated hardship on the individual. For purposes of this section, demonstrated hardship shall include, but need not be limited to, any of the following circumstances:

(A) The individual was receiving home and facility care prior to January 1, 2006.

(B) The individual has been determined to be eligible for medical assistance for home and facility care based on an application filed on or after January 1, 2006, and before the date that regulations adopted pursuant to this section are certified with the Secretary of State.

(C) The individual purchased and received benefits under a long-term care insurance policy certified by the department's California Partnership for Long-Term Care Program, established by Division 12 (commencing with Section 22000).

(D) The individual's equity interest in the principal residence exceeds the equity interest limit as provided in subdivision (b), but would not exceed the equity interest limit under that subdivision if it had been increased by using the quarterly House Price Index (HPI) for California, published by the Office of Federal Housing Enterprise Oversight (OFHEO).

(E) The applicant or beneficiary has been denied a home equity loan by at least three lending institutions, or is ineligible for any one Federal Housing Administration (FHA) approved loan or reverse mortgage.

(F) The applicant or beneficiary, with good cause, is unable to provide verification of the equity value.

(G) The applicant or beneficiary meets the criteria set forth in subdivision (b) of Section 14015.1.

(d) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act, and only to the extent that federal financial participation is available.

(e) To the extent that regulations are necessary to implement this section, the department shall promulgate regulations using the nonemergency regulatory process described in Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of the Government Code.

(f) It is the intent of the Legislature that the provisions of this section shall apply prospectively to any individual to whom the act applies commencing from the date regulations adopted pursuant to this act are filed with the Secretary of State.

(g) This section shall become operative on January 1, 2026.

(Amended by Stats. 2025, Ch. 21, Sec. 65. (AB 116) Effective June 30, 2025. Operative January 1, 2026, by its own provisions.)

14006.2. (a) In determining the eligibility of a married individual, pursuant to Section 14005.4 or 14005.7, who, in accordance with Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and regulations adopted pursuant thereto, is considered to be living separately from their spouse, the individual shall be considered to have made a transfer of resources for full and adequate consideration under Section 14006 or 14015 by reason of either of the following:

(1) Having entered into a written agreement with their spouse dividing their nonexempt community property into equal shares of separate property. Property so agreed to be separate property shall be considered by the department to be the separate property of the spouse who, pursuant to the agreement, is the owner of the property. Only in cases in which separate property owned by one spouse is actually made available to the other spouse, may the department count the separate property in the eligibility determination of the nonowner spouse.

(2) Having transferred to their spouse all of their interest in a home, whether the transfer was made before or after the individual became a resident in a nursing facility in accordance with and to the extent permitted by Title XIX of the federal Social Security Act and regulations promulgated pursuant thereto.

(b) The department shall furnish to all Medi-Cal applicants a clear and simple statement in writing advising them that (1) in the case of an individual who is an inpatient in a nursing facility, if the individual or the individual's conservator transferred to the individual's spouse all of the interest in a home, the individual shall not be considered ineligible for Medi-Cal by reason of the transfer; and that (2) if the individual and the individual's spouse execute a written interspousal agreement that divides and transmutes nonexempt community property into equal shares of separate property, the separate property of the individual's spouse shall not be considered available to the individual and need not be spent by the spouse for the individual's care in a nursing facility or other medical institution. The statement provided for in this subdivision shall also be furnished to each individual admitted to a nursing facility, along with, but separately from, the statement required under Section 72527 of Title 22 of the California Code of Regulations.

(c) In order to qualify for Medi-Cal benefits pursuant to Section 14005.4 or 14005.7, a married individual who resides in a nursing facility, and who is in a Medi-Cal budget unit separate from that of their spouse, shall be required to expend their other resources for their own benefit, so that the amount that remains does not exceed the limit established pursuant to subdivision (c) of Section 14006. In the event that the married individual expends their resources for expenses associated with or for improvements to property, those expenditures shall be considered to be for their own benefit only to the extent that the expenditures are proportionate to the ownership interest the individual has in the property. For purposes of this section, the term "their other resources" shall be limited to the following:

(1) All of their separate property that would not have been exempt under applicable Medi-Cal laws and regulations at the time when they entered a nursing facility, or at the date of execution of the agreement referred to in this section, whichever is earlier. For purposes of this paragraph, the mere change of residence from one facility to another shall not be deemed to be a new entry.

(2) One-half of all the community property, or the proceeds from the sale or exchange of that property, that would not have been exempt at the time described in paragraph (1).

(d) For purposes of subdivision (c), in the absence of an agreement such as that referred to in subdivision (a), there shall be a presumption, rebuttable by either spouse, that all property owned by either spouse was community property.

(e) The statement furnished pursuant to subdivision (b) shall advise all persons entering a long-term care facility, and all Medi-Cal applicants that only their half of the community property shall be taken into account in determining their eligibility for Medi-Cal, whether or not they execute the written interspousal agreement referred to in the statement.

(f) This section shall not apply to an institutionalized spouse.

(g) This section shall apply to the full extent to an institutionalized spouse if Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is amended to authorize the consideration of state community property law in determining eligibility under this chapter, or the federal government authorizes the state to apply community property laws in making that determination.

(h) (1) Subdivision (f) shall become inoperative if the federal government amends Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) to allow state community property laws to be considered for Medi-Cal eligibility purposes, or the federal government authorizes the state to apply community property laws in making that determination.

(2) The department shall report to the appropriate committees of the Legislature upon the occurrence of the amendment of federal law or receipt of federal authorization as specified in paragraph (1).

(i) This section shall become inoperative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain inoperative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.

(Amended by Stats. 2023, Ch. 42, Sec. 91. (AB 118) Effective July 10, 2023. Conditionally inoperative on or after January 1, 2024, by its own provisions. Superseded on January 1, 2026; see amendment by Stats. 2025, Ch. 21.)

14006.2. (a) In determining the eligibility of a married individual, pursuant to Section 14005.4 or 14005.7, who, in accordance with Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and regulations adopted pursuant thereto, is considered to be living separately from their spouse, the individual shall be considered to have made a transfer of resources for full and adequate consideration under Section 14006 or 14015 by reason of either of the following:

(1) Having entered into a written agreement with their spouse dividing their nonexempt community property into equal shares of separate property. Property so agreed to be separate property shall be considered by the department to be the separate property of the spouse who, pursuant to the agreement, is the owner of the property. Only in cases in which separate property owned by one spouse is actually made available to the other spouse, may the department count the separate property in the eligibility determination of the nonowner spouse.

(2) Having transferred to their spouse all of their interest in a home, whether the transfer was made before or after the individual became a resident in a nursing facility in accordance with and to the extent permitted by Title XIX of the federal Social Security Act and regulations promulgated pursuant thereto.

(b) The department shall furnish to all Medi-Cal applicants a clear and simple statement in writing advising them that (1) in the case of an individual who is an inpatient in a nursing facility, if the individual or the individual's conservator transferred to the individual's spouse all of the interest in a home, the individual shall not be considered ineligible for Medi-Cal by reason of the transfer; and that (2) if the individual and the individual's spouse execute a written interspousal agreement that divides and transmutes nonexempt community property into equal shares of separate property, the separate property of the individual's spouse shall not be considered available to the individual and need not be spent by the spouse for the individual's care in a nursing facility or other medical institution. The statement provided for in this subdivision shall also be furnished to each individual admitted to a nursing facility, along with, but separately from, the statement required under Section 72527 of Title 22 of the California Code of Regulations.

(c) In order to qualify for Medi-Cal benefits pursuant to Section 14005.4 or 14005.7, a married individual who resides in a nursing facility, and who is in a Medi-Cal budget unit separate from that of their spouse, shall be required to expend their other resources for their own benefit, so that the amount that remains does not exceed the maximum levels established pursuant to subdivision (a) of Section 14005.62. In the event that the married individual expends their resources for expenses associated with or for improvements to property, those expenditures shall be considered to be for their own benefit only to the extent that the expenditures are proportionate to the ownership interest the individual has in the property. For purposes of this section, the term "their other resources" shall be limited to the following:

(1) All of their separate property that would not have been exempt under applicable Medi-Cal laws and regulations at the time when they entered a nursing facility, or at the date of execution of the agreement referred to in this section, whichever is earlier. For purposes of this paragraph, the mere change of residence from one facility to another shall not be deemed to be a new entry.

(2) One-half of all the community property, or the proceeds from the sale or exchange of that property, that would not have been exempt at the time described in paragraph (1).

(d) For purposes of subdivision (c), in the absence of an agreement such as that referred to in subdivision (a), there shall be a presumption, rebuttable by either spouse, that all property owned by either spouse was community property.

(e) The statement furnished pursuant to subdivision (b) shall advise all persons entering a long-term care facility, and all Medi-Cal applicants that only their half of the community property shall be taken into account in determining their eligibility for Medi-Cal, whether or not they execute the written interspousal agreement referred to in the statement.

(f) This section shall not apply to an institutionalized spouse.

(g) This section shall apply to the full extent to an institutionalized spouse if Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is amended to authorize the consideration of state community property law in determining eligibility under this chapter, or the federal government authorizes the state to apply community property laws in making that determination.

(h) (1) Subdivision (f) shall become inoperative if the federal government amends Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) to allow state community property laws to be considered for Medi-Cal eligibility purposes, or the federal government authorizes the state to apply community property laws in making that determination.

(2) The department shall report to the appropriate committees of the Legislature upon the occurrence of the amendment of federal law or receipt of federal authorization as specified in paragraph (1).

(i) This section shall become operative on January 1, 2026.

(Amended by Stats. 2025, Ch. 21, Sec. 66. (AB 116) Effective June 30, 2025. Operative January 1, 2026, by its own provisions.)

14006.3. (a) The department, at the time of application or the assessment pursuant to Section 14006.6, and any nursing facility enrolled as a provider in the Medi-Cal program, before admitting any person, shall provide a clear and simple statement, in writing, in a form and language specified by the department, to that person, and that person's spouse, legal representative, or agent, if any, that explains the resource and income requirements of the Medi-Cal program, including, but not limited to, certain exempt resources, certain protections against spousal impoverishment, and certain circumstances under which an interest in a home may be transferred without affecting Medi-Cal eligibility.

(b) This section shall become operative on January 1, 2026.

(Amended (as amended by Stats. 2023, Ch. 42, Sec. 92) by Stats. 2025, Ch. 21, Sec. 67. (AB 116) Effective June 30, 2025. Operative January 1, 2026, by its own provisions.)

14006.3. (a) The department, at the time of application or the assessment pursuant to former Section 14006.6, and any nursing facility enrolled as a provider in the Medi-Cal program, before admitting any person, shall provide a clear and simple statement, in writing, in a form and language specified by the department, to that person, and that person's spouse, legal representative, or agent,

if any, that explains the income requirements of the Medi-Cal program, including, but not limited to, certain protections against spousal impoverishment.

(b) This section shall become inoperative on January 1, 2026, and, as of January 1, 2027, is repealed.

(Amended (as added by Stats. 2023, Ch. 42, Sec. 93) by Stats. 2025, Ch. 21, Sec. 68. (AB 116) Effective June 30, 2025. Inoperative January 1, 2026, by its own provisions. Repealed as of January 1, 2027, by its own provisions. See later operative version, as amended by Sec. 67 of Stats. 2025, Ch. 21.)

14006.4. (a) The statement required by Sections 14006.2 and 14006.3 shall be in the following form:

"NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY

If you or your spouse is in or is entering a nursing facility, read this important message!

You or your spouse do not have to use all your resources, such as savings, before Medi-Cal might help pay for all or some of the costs of a nursing facility.

You should be aware of the following to take advantage of these provisions of the law:

UNMARRIED RESIDENT

An unmarried resident is financially eligible for Medi-Cal benefits if they have less than (insert amount of individual's resource allowance) in available resources. A home is an exempt resource and is not considered against the resource limit, as long as the resident states on the Medi-Cal application that they intend to return home. Clothes, household furnishings, irrevocable burial plans, burial plots, and an automobile are examples of other exempt resources.

If an unmarried resident is financially eligible for Medi-Cal reimbursement, they are allowed to keep from their monthly income a personal allowance of (insert amount of personal needs allowance) plus the amount of health insurance premiums paid monthly. The remainder of the monthly income is paid to the nursing facility as a monthly deductible called the "Medi-Cal long-term care patient liability."

MARRIED RESIDENT

If one spouse lives in a nursing facility, and the other spouse does not live in a nursing facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than (insert amount of Community Spouse Resource Allowance plus individual's resource allowance) in available assets. The couple's home will not be counted against this (insert amount of Community Spouse Resource Allowance plus individual's resource allowance), as long as one spouse or a dependent relative, or both, lives in the home, or the spouse in the nursing facility states on the Medi-Cal application that they intend to return to the couple's home to live.

If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least their individual monthly income or (insert amount of Minimum Monthly Maintenance Needs Allowance), whichever is greater. Of the couple's remaining monthly income, the spouse in the nursing facility is allowed to keep a personal allowance of (insert amount of personal needs allowance) plus the amount of health insurance premiums paid monthly. The remaining money, if any, generally must be paid to the nursing facility as the Medi-Cal long-term care patient liability. The Medi-Cal program will pay remaining nursing facility costs.

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge that will allow the at-home spouse to retain additional resources or income. Such an order can allow the couple to retain more than (insert amount of Community Spouse Resource Allowance plus individual's resource allowance) in available resources, if the income that could be generated by the retained resources would not cause the total monthly income available to the at-home spouse to exceed (insert amount of Monthly Maintenance Needs Allowance). Such an order also can allow the at-home spouse to retain more than (insert amount of Monthly Maintenance Needs Allowance) in monthly income, if the extra income is necessary "due to exceptional circumstances resulting in significant financial duress."

An at-home spouse also may obtain a court order to increase the amount of income and resources that they are allowed to retain, or to transfer property from the spouse in the nursing facility to the at-home spouse. You should contact a knowledgeable attorney for further information regarding court orders.

The paragraphs above do not apply if both spouses live in a nursing facility and neither previously has been granted Medi-Cal eligibility. In this situation, the spouses may be able to hasten Medi-Cal eligibility by entering into an agreement that divides their community property. The advice of a knowledgeable attorney should be obtained prior to the signing of this type of agreement.

Note: For married couples, the resource limit ((insert amount of Community Spouse Resource Allowance plus individual's resource allowance) in (insert current year)) and income limit ((insert amount of Minimum Monthly Maintenance Needs Allowance) in (insert current year)) generally increase a slight amount on January 1 of every year.

TRANSFER OF HOME FOR BOTH A MARRIED AND AN UNMARRIED RESIDENT

A transfer of a property interest in a resident's home will not cause ineligibility for Medi-Cal reimbursement if either of the following conditions is met:

(a) At the time of transfer, the recipient of the property interest states in writing that the resident would have been allowed to return to the home at the time of the transfer, if the resident's medical condition allowed them to leave the nursing facility. This provision shall only apply if the home has been considered an exempt resource because of the resident's intent to return home.

(b) The home is transferred to one of the following individuals:

(1) The resident's spouse.

(2) The resident's minor or disabled child.

(3) A sibling of the resident who has an equity interest in the home, and who resided in the resident's home for at least one year immediately before the resident began living in institutions.

(4) A child of the resident who resided in the resident's home at least two years before the resident began living in institutions, and who provided care to the resident that permitted the resident to remain at home longer.

This is only a brief description of the Medi-Cal eligibility rules, for more detailed information, you should call your county welfare department. You will probably want to consult with the local branch of the state long-term care ombudsman, an attorney, or a legal services program for seniors in your area.

I have read the above notice and have received a copy.

Dated: _____ Signature: _____"

(c) The statement required by subdivision (a) shall be printed in at least 10-point type, shall be clearly separate from any other document or writing, and shall be signed by the person to be admitted and that person's spouse, and legal representative, if any.

(d) Any nursing facility that willfully fails to comply with this section shall be subject to a class "B" citation, as defined by Section 1424 of the Health and Safety Code.

(e) The department may revise this statement as necessary to maintain its consistency with state and federal law.

(f) This section shall become operative on January 1, 2026.

(Amended (as amended by Stats. 2023, Ch. 42, Sec. 94) by Stats. 2025, Ch. 21, Sec. 69. (AB 116) Effective June 30, 2025. Operative January 1, 2026, by its own provisions.)

14006.4. (a) The statement required by Section 14006.3 shall be in the following form:

"NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY

If you or your spouse is in or is entering a nursing facility, read this important message!

You or your spouse do not have to use all your resources, such as savings, before Medi-Cal might help pay for all or some of the costs of a nursing facility.

You should be aware of the following to take advantage of these provisions of the law:

UNMARRIED RESIDENT

An unmarried resident is financially eligible for Medi-Cal benefits if they meet income requirements. Resources, including property and assets, are not considered in determining Medi-Cal eligibility.

If an unmarried resident is financially eligible for Medi-Cal reimbursement, they are allowed to keep from their monthly income a personal allowance of (insert amount of personal needs allowance) plus the amount of health insurance premiums paid monthly. The remainder of the monthly income is paid to the nursing facility as a monthly deductible called the "Medi-Cal share of cost."

MARRIED RESIDENT

If one spouse lives in a nursing facility, and the other spouse does not live in a nursing facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together meets income requirements. Resources, including property and assets, are not considered in determining Medi-Cal eligibility.

If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least their individual monthly income or (insert amount of Minimum Monthly Maintenance Needs Allowance), whichever is greater. Of the couple's remaining monthly income, the spouse in the nursing facility is allowed to keep a personal allowance of (insert amount of personal needs allowance) plus the amount of health insurance premiums paid monthly. The remaining money, if any, generally must be paid to the nursing facility as the Medi-Cal share of cost. The Medi-Cal program will pay remaining nursing facility costs.

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge that will allow the at-home spouse to retain additional income. That order may allow the at-home spouse to retain more than (insert amount of Monthly Maintenance Needs Allowance) in monthly income, if the extra income is necessary "due to exceptional circumstances resulting in significant financial duress."

An at-home spouse also may obtain a court order to increase the amount of income that they are allowed to retain. You should contact a knowledgeable attorney for further information regarding court orders.

Note: For married couples, the income limit ((insert amount of Minimum Monthly Maintenance Needs Allowance) in (insert current year)) generally increase a slight amount on January 1 of every year.

This is only a brief description of the Medi-Cal eligibility rules, for more detailed information, you should call your county welfare department. You will probably want to consult with the local branch of the state long-term care ombudsman, an attorney, or a legal services program for seniors in your area.

I have read the above notice and have received a copy.

Dated: _____ Signature: _____"

(b) The statement required by subdivision (a) shall be printed in at least 10-point type, shall be clearly separate from any other document or writing, and shall be signed by the person to be admitted and that person's spouse, and legal representative, if any.

(c) Any nursing facility that willfully fails to comply with this section shall be subject to a class "B" citation, as defined by Section 1424 of the Health and Safety Code.

(d) The department may revise this statement as necessary to maintain its consistency with state and federal law.

(e) This section shall become inoperative on January 1, 2026, and, as of January 1, 2027, is repealed.

(Amended (as added by Stats. 2023, Ch. 42, Sec. 95) by Stats. 2025, Ch. 21, Sec. 70. (AB 116) Effective June 30, 2025. Inoperative January 1, 2026, by its own provisions. Repealed as of January 1, 2027, by its own provisions. See later operative version, as amended by Sec. 69 of Stats. 2025, Ch. 21.)

14006.41. (a) To be eligible for medical assistance for home and facility care, an individual shall disclose at the time of the individual's application or redetermination a description of any interest that he or she or his or her spouse has in an annuity, which is known to the individual or his or her spouse, regardless of whether the annuity is irrevocable or is treated as income or as a resource.

(b) At the time of the individual's application or redetermination, the department shall inform the individual and his or her spouse that, by virtue of its provision of medical assistance for home and facility care to the individual, the state will, by operation of law, become a remainder beneficiary of certain annuities, as described in Section 14009.6.

(c) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act, and only to the extent that federal financial participation is available.

(d) To the extent that regulations are necessary to implement this section, the department shall promulgate regulations using the nonemergency regulatory process described in Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of the Government Code.

(e) It is the intent of the Legislature that the provisions of this section shall apply prospectively to any individual to whom the act applies commencing from the date regulations adopted pursuant to this act are filed with the Secretary of State.

(Added by Stats. 2008, Ch. 379, Sec. 5. Effective January 1, 2009.)

14006.5. (a) The department shall include training regarding the treatment of separate and community income and resources in determining eligibility for Medi-Cal benefits, as part of the ongoing training offered to county welfare departments.

(b) Commencing January 1, 2026, the department shall also include training regarding the applicability of the lookback period outlined in Section 14015, which only applies to people seeking home- and facility-based care as described in subdivision (c) of Section 1396p of Title 42 of the United States Code, as part of the ongoing training offered to county welfare departments.

(Amended (as amended by Stats. 2023, Ch. 42, Sec. 96) by Stats. 2025, Ch. 21, Sec. 71. (AB 116) Effective June 30, 2025. See same-numbered section added by Stats. 2023, Ch. 42.)

14006.5. (a) The department shall include training on the treatment of separate and community income in determining eligibility for Medi-Cal benefits, as part of the ongoing training offered to county welfare departments.

(b) This section shall become operative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain

operative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.

(Added by Stats. 2023, Ch. 42, Sec. 97. (AB 118) Effective July 10, 2023. Conditionally operative on or after January 1, 2024, by its own provisions. See same-numbered section amended by Stats. 2025, Ch. 21.)

14006.6. (a) To the extent required by Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and regulations adopted pursuant thereto, upon the request of either an institutionalized spouse or a community spouse, and upon receipt of relevant documentation of resources, the department shall promptly assess and document the total value of the couple's resources to the extent either the institutionalized spouse or the community spouse has an ownership interest. Upon completion of the assessment and documentation, the department shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment.

(b) If the assessment is not part of an application for Medi-Cal, the department may, as a condition of providing the assessment, require payment of a fee not to exceed the reasonable expenses of providing and documenting the assessment.

(c) For purposes of completing the assessment, resources shall be determined, defined, counted, and valued in accordance with subdivision (c) of Section 14006.

(d) At the time of providing the copy of the assessment to the couple, the department shall include a notice indicating that either spouse will have a right to a fair hearing to the extent required by federal law.

(e) (1) This section shall remain operative only until Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is amended to authorize the consideration of state community property law in determining eligibility under this chapter, or the federal government authorizes the state to apply community property laws in making that determination.

(2) The department shall report to the appropriate committees of the Legislature upon the occurrence of the amendment of federal law or the receipt of federal authorization to apply community property law, as specified in paragraph (1).

(f) This section shall become inoperative on the later of either January 1, 2024, or the date on which the determination of the Director of Health Care Services is communicated in writing to the Department of Finance pursuant to paragraph (2) of subdivision (b) of Section 14005.62, and subject to implementation of Section 14005.62 pursuant to subdivision (d) of that section, and shall remain inoperative for time periods in which the department has obtained the necessary federal approvals to implement paragraph (2) of subdivision (b) of Section 14005.62 for the applicable population.

(Amended by Stats. 2023, Ch. 42, Sec. 98. (AB 118) Effective July 10, 2023. Conditionally inoperative as provided in subdivisions (e) and (f). Superseded on January 1, 2026; see amendment by Stats. 2025, Ch. 21.)

14006.6. (a) To the extent required by Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and regulations adopted pursuant thereto, upon the request of either an institutionalized spouse or a community spouse, and upon receipt of relevant documentation of resources, the department shall promptly assess and document the total value of the couple's resources to the extent either the institutionalized spouse or the community spouse has an ownership interest. Upon completion of the assessment and documentation, the department shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment.

(b) If the assessment is not part of an application for Medi-Cal, the department may, as a condition of providing the assessment, require payment of a fee not to exceed the reasonable expenses of providing and documenting the assessment.

(c) For purposes of completing the assessment, resources shall be determined, defined, counted, and valued in accordance with subdivision (c) of Section 14006, and subject to the maximum resource levels specified in subdivision (a) of Section 14005.62.

(d) At the time of providing the copy of the assessment to the couple, the department shall include a notice indicating that either spouse will have a right to a fair hearing to the extent required by federal law.

(e) (1) This section shall remain operative only until Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is amended to authorize the consideration of state community property law in determining eligibility under this chapter, or the federal government authorizes the state to apply community property laws in making that determination.

(2) The department shall report to the appropriate committees of the Legislature upon the occurrence of the amendment of federal law or the receipt of federal authorization to apply community property law, as specified in paragraph (1).

(f) This section shall become operative on January 1, 2026.

(Amended by Stats. 2025, Ch. 21, Sec. 72. (AB 116) Effective June 30, 2025. Operative January 1, 2026, by its own provisions.)

14006.7. (a) At the time of application for Medi-Cal benefits, the department shall provide to any applicant who is aged, blind, or disabled, other than an individual applying for, or receiving, aid under Chapter 2 (commencing with Section 11200), Article 5 (commencing with Section 12200) of Chapter 3, or Article 7 (commencing with Section 12300) of Chapter 3, and to the applicant's

spouse, legal representative, or agent, if any, a clear and simple statement, in writing, in a form and language specified by the department, that explains the circumstances under which an interest in a home may be transferred for less than fair market value without affecting Medi-Cal eligibility.

(b) The statement required by subdivision (a) shall be in the following form:

"NOTICE REGARDING TRANSFER OF A HOME FOR BOTH A MARRIED AND AN UNMARRIED APPLICANT/BENEFICIARY

A transfer of property interest for less than fair market value in a Medi-Cal beneficiary's home will not cause ineligibility for Medi-Cal benefits if at the time of the transfer, the home would have been considered an exempt resource.

This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. You will probably want to consult with an attorney, your local legal services program for seniors, or the local branch of the long-term care ombudsman program.

I have read the above notice and have received a copy.

Dated: _____ Signature: _____"

(c) The statement required by subdivision (a) shall be printed in at least 12-point type, shall be clearly separate from any other document or writing, and may be signed by the applicant, the applicant's spouse, legal representative, or agent, if any. Failure to sign this form shall not result in ineligibility for medical assistance.

(d) The department may revise this statement as necessary to maintain its consistency with state and federal law.

(e) In the case of an applicant applying for Medi-Cal reimbursement for nursing facility care, the statements required under Sections 14006.2 and 14006.3 shall apply, and the statement required by subdivision (a) shall not be provided.

(Added by Stats. 2002, Ch. 556, Sec. 1. Effective January 1, 2003.)

14007. No period of residence in this state shall be required as a condition of eligibility under this chapter, but an individual who does not reside in this state shall not be eligible.

(Amended by Stats. 1969, Ch. 21.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(j) A denial of a determination of residency may be appealed in the same manner as any other denial of eligibility. The administrative law judge shall receive any proof of residency offered by the individual and may inquire into any facts relevant to the question of residency. A determination of residency shall not be granted unless a preponderance of the credible evidence supports that the individual is a resident of this state under Section 14007.15.

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

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

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

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

(Amended by Stats. 2014, Ch. 71, Sec. 195. (SB 1304) Effective January 1, 2015.)

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

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

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

(3) The individual is incapable of indicating intent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) Been judicially determined to be legally incompetent.

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

(j) To the extent otherwise required by Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall adopt emergency regulations implementing this section no later than July 1, 2015. The department may thereafter readopt the emergency regulations pursuant to that chapter. The adoption and readoption, by the department, of regulations implementing this section shall be deemed to be an emergency and necessary to avoid serious harm to

the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

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

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

(Added by Stats. 2013, 1st Ex. Sess., Ch. 4, Sec. 18. (SB 1 1x) Effective September 30, 2013. Section operative January 1, 2014, by its own provisions.)

14007.2. (a) Any individual who is otherwise eligible for Medi-Cal services, but who does not meet the documentation requirements described in subdivision (e) of Section 14011.2, shall be eligible only for the scope of services made available to persons who are not citizens or nationals of the United States under subdivision (d) of Section 14007.5, and Sections 14007.65, 14007.7, and 14007.8.

(b) To the extent that federal financial participation is available to fund services described under subdivision (a), the department shall file all necessary state plan amendments or waivers to obtain that funding.

(Amended by Stats. 2021, Ch. 296, Sec. 71. (AB 1096) Effective January 1, 2022.)

14007.4. Any children under the jurisdiction of the county welfare department, who are dependent children in relative placement, foster home placement, or group home placement, and any child in custody pending the filing of a petition for placement, who are receiving or are eligible to receive services from the county welfare department, shall be deemed to have met the residence requirements for services under this chapter, and no further verification of residence shall be required.

This section shall be implemented only to the extent that full federal financial participation is made available.

(Added by Stats. 1986, Ch. 630, Sec. 1.)

14007.45. (a) To the extent federal financial participation is available, the department shall exercise the option provided in Section 1920A of the federal Social Security Act (42 U.S.C. Sec. 1396r-1a) to the extent necessary to implement a program for accelerated eligibility for children who are in the process of entering the foster care system.

(b) The department shall designate county foster care workers, public health nurses, or other staff who are involved in the children's removal from the home as a qualified entity capable of making an eligibility determination under Section 1920A of the federal Social Security Act (42 U.S.C. Sec. 1396r-1a).

(c) The qualified entity shall have access to the Medi-Cal Eligibility Data System to determine whether the child for whom the petition of dependency was filed is eligible for Medi-Cal. If the child is not currently eligible for Medi-Cal, the qualified entity shall have the authority to enter the child's information into the Medi-Cal Eligibility Data System to ensure timely issuance of either a Medi-Cal card or Medi-Cal Benefits Identification Card thereby ensuring immediate proof of or access to proof of Medi-Cal eligibility.

(d) The department shall seek any state plan amendments necessary to implement this section. Once federal approval of all necessary state plan amendments is received, implementation shall begin on the first day of the month that follows the full calendar month after the month federal approval is received.

(e) In the event that the state plan amendment necessary to implement this section is disapproved by the federal government, the department shall instruct counties on all available procedures for expediting eligibility applications for children described in subdivision (a) and for immediately issuing sufficient proof of eligibility to ensure that eligibility of children entering the foster care system can be immediately confirmed by providers.

(f) If the federal waiver described in Section 12693.755 of the Insurance Code for covering parents under the State Children's Health Insurance Program is approved, and if the option under Section 1920A of the federal Social Security Act (42 U.S.C. Sec. 1396r-1a) is exercised to extend accelerated eligibility to all children as part of implementation of that waiver, and if the state plan amendment for implementation of this section is disapproved, then the department shall have discretion to determine whether and under what circumstances foster care workers who complete the application form described in subdivision (e) shall submit that form to the qualified entity for accelerated eligibility rather than to the county Medi-Cal eligibility worker.

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

(h) 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 any regulatory action, 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.

(Added by Stats. 2001, Ch. 171, Sec. 32.5. Effective August 10, 2001.)

14007.5. (a) Persons who are not citizens or nationals of the United States shall be eligible for Medi-Cal, whether federally funded or state-funded, only to the same extent as permitted under federal law and regulations for receipt of federal financial participation under Title XIX of the federal Social Security Act, except as otherwise provided in this section and elsewhere in this chapter.

(b) In accordance with Section 1903(v)(1) of the federal Social Security Act (42 U.S.C. Sec. 1396b(v)(1)), a person who is not a citizen or a national of the United States shall only be eligible for the full scope of Medi-Cal benefits if the person has an immigration status described in Section 1641(b) of Title 8 of the United States Code. For purposes of this section, persons who are not citizens or nationals of the United States and who are "permanently residing in the United States under color of law" shall be interpreted to include all persons who are not citizens or nationals of the United States residing in the United States with the knowledge and permission of the United States Department of Homeland Security and whose departure the United States Department of Homeland Security does not contemplate enforcing and with respect to whom federal financial participation is not available under Title XIX of the federal Social Security Act.

(c) A person who has an immigration status described in Section 1641(b) of Title 8 of the United States Code, but who is subject to the limitation described in Section 1613(a) of Title 8 of the United States Code, or a person who is otherwise permanently residing in the United States under color of law, shall be eligible for the full scope, except as described in subdivision (l), of Medi-Cal benefits.

(d) Any person who is not a citizen or national of the United States who is otherwise eligible for Medi-Cal services, but who does not meet the requirements under subdivision (b) or (c), shall only be eligible for care and services that are necessary for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law, except as described in Sections 14007.65, 14007.7, and 14007.8. For purposes of this section, the term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(1) Placing the patient's health in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction to any bodily organ or part. It is the intent of this section to entitle eligible individuals to inpatient and outpatient services that are necessary for the treatment of the emergency medical condition in the same manner as administered by the department through regulations and provisions of federal law.

(e) (1) No sooner than July 1, 2027, except for individuals under 19 years of age, individuals over 59 years of age, and pregnant women, all individuals described in subdivisions (c) and (d) shall be required to pay a monthly premium as a condition of eligibility for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(2) Monthly premiums imposed under this subdivision shall be thirty dollars ($30) per beneficiary.

(3) An individual required to pay premiums pursuant to this subdivision, after no more than 90 days of nonpayment of the monthly premium, is only eligible for medically necessary pregnancy-related services, and care and services necessary for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law. All outstanding premium balances shall be paid in full as a condition of continued eligibility for the full scope of Medi-Cal benefits.

(f) Pursuant to Section 14001.2, each county department shall require that each applicant for, or beneficiary of, Medi-Cal, including a child, shall provide their social security number account number, or numbers, if they have more than one social security number.

(g) (1) In order to be eligible for benefits under subdivision (b) or (c), an applicant or beneficiary shall present United States Citizenship and Immigration Services registration documentation or other proof of satisfactory immigration status from the United States Citizenship and Immigration Services.

(2) Any person who meets all other program requirements but who lacks documentation of United States Citizenship and Immigration Services registration or other proof of satisfactory immigration status shall be provided a reasonable opportunity to submit the evidence. For purposes of this paragraph, "reasonable opportunity" means 30 days or the time it actually takes the county to process the Medi-Cal application, whichever is longer.

(3) During the reasonable opportunity period under paragraph (2), the county department shall process the applicant's application for medical assistance in a manner that conforms to its normal processing procedures and timeframes.

(h) (1) The county department shall grant only the Medi-Cal benefits set forth in subdivision (d) of this section or in Section 14007.65, 14007.7, or 14007.8 to any individual who, after 30 calendar days or the time it actually takes the county to process the Medi-Cal application, whichever is longer, has failed to submit documents constituting reasonable evidence indicating a satisfactory immigration status for Medi-Cal purposes, or who is reported by the United States Citizenship and Immigration Services to lack a satisfactory immigration status for Medi-Cal purposes.

(2) If a person who is not a citizen or national of the United States has been receiving Medi-Cal benefits based on eligibility established prior to the effective date of this section and that individual, upon redetermination of eligibility for benefits, fails to submit documents constituting reasonable evidence indicating a satisfactory immigration status for Medi-Cal purposes, the county department shall discontinue the Medi-Cal benefits, except for the care and services set forth in subdivision (d) of this section or in Section 14007.65, 14007.7, or 14007.8. The county department shall provide adequate notice to the individual of any adverse action and shall accord the individual an opportunity for a fair hearing if the individual requests one.

(i) To the extent permitted by federal law and regulations, a person who is not a citizen or national of the United States applying for services under subdivisions (b) and (c) shall be granted eligibility for the scope of services to which they would otherwise be entitled if, at the time the county department makes the determination about their eligibility, the person meets either of the following requirements:

(1) The person has not had a reasonable opportunity to submit documents constituting reasonable evidence indicating satisfactory immigration status.

(2) The person has provided documents constituting reasonable evidence indicating a satisfactory immigration status, but the county department has not received timely verification of the person's immigration status from the United States Citizenship and Immigration Services.

(3) The verification process shall protect the privacy of all participants. A person's immigration status shall be subject to verification by the United States Citizenship and Immigration Services, to the extent required for receipt of federal financial participation in the Medi-Cal program.

(j) If a person does not declare status as a lawful permanent resident or person permanently residing under color of law, or as a person legalized under Section 210, 210A, or 245A of the federal Immigration and Nationality Act (Public Law 82-414), Medi-Cal coverage under subdivision (d) of this section or in Section 14007.65, 14007.7, or 14007.8 shall be provided to the individual if they are otherwise eligible.

(k) If a person subject to this section is not fluent in English, the county department shall provide an understandable explanation of the requirements of this section in a language in which the person is fluent.

(l) No sooner than July 1, 2026, all individuals described in subdivisions (c) and (d) who are 19 years of age or older shall not be eligible for dental services set forth in this chapter, except for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law.

(m) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement, interpret, or make specific this section, in whole or in part, by means of plan or county letter, information notices, plan or provider bulletins, or other similar instructions, without taking any further regulatory action.

(n) Subdivisions (e) and (l) shall be implemented only after the director determines, and communicates in writing to the Department of Finance, that systems have been programmed for implementation.

(Amended by Stats. 2025, Ch. 21, Sec. 73. (AB 116) Effective June 30, 2025.)

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

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

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

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

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

(Repealed (in Sec. 19) and added by Stats. 2013, 1st Ex. Sess., Ch. 4, Sec. 20. (SB 1 1x) Effective September 30, 2013. Section operative January 1, 2014, by its own provisions.)

14007.65. (a) Persons who are not citizens or nationals of the United States who were receiving long-term care services under the authority of subdivision (f) of Section 1 of Chapter 1441 of the Statutes of 1988 on the day prior to the effective date of this section shall continue to receive those long-term care services.

(b) On or after the effective date of this section, any applicant who is not lawfully present in the United States, who is otherwise eligible for Medi-Cal services, but who does not meet the requirements under subdivision (b) of Section 14007.5, would be eligible to receive federally reimbursable long-term care services pursuant to the Medicaid program provided for pursuant to Title 19 of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), shall be eligible to receive long-term care services to the extent that funding is made available for this purpose in the annual Budget Act. In no event shall expenditures for this program exceed the amount necessary to serve 110 percent of the 1999–2000 estimated eligible population without further authorization by the Legislature.

(Amended by Stats. 2025, Ch. 21, Sec. 74. (AB 116) Effective June 30, 2025.)

14007.7. Any person who is not a citizen or national of the United States who is otherwise eligible for Medi-Cal services, but who does not meet the requirements under subdivision (b) or (c) of Section 14007.5, shall be eligible for medically necessary pregnancy-related services.

(Amended by Stats. 2021, Ch. 296, Sec. 74. (AB 1096) Effective January 1, 2022.)

14007.705. (a) Through its courts and statutes, and under its Constitution, California protects a woman's right to reproductive privacy. California reaffirms these protections and specifically its Supreme Court decision in People v. Belous (1969) 71 Cal.2d 954, 966-68.

(b) The State Department of Health Services and the Managed Risk Medical Insurance Board may accept or use moneys under Title XXI of the federal Social Security Act (known as the State Children's Health Insurance Program or S-CHIP), as interpreted in Section 457.10 of Title 42 of the Code of Federal Regulations, to fund services for women pursuant to Section 14007.7 (Medi-Cal) and Part 6.3 (commencing with Section 12695) (Access for Infants and Mothers (AIM)) of Division 2 of the Insurance Code only when, during the period of coverage, the woman is the beneficiary. The scope of services covered under Medi-Cal and AIM, as defined in statutes, regulations, and state plans, is not altered by this section or the state plan amendment submitted pursuant to this section.

(c) California's S-CHIP plan and any amendments submitted and implemented pursuant to this section shall be consistent with subdivisions (a) and (b).

(d) This section is a declaration of existing law.

(Added by Stats. 2005, Ch. 23, Sec. 2. Effective January 1, 2006.)

14007.71. (a) The department shall adopt the option made available under Section 1396a(a)(10)(A)(ii)(XVIII) of Title 42 of the United States Code, to provide medical assistance during the period in which an individual described in subdivision (c) of Section 104162 of the Health and Safety Code requires treatment for breast or cervical cancer. In addition, to assist in the delivery of timely and continuing breast cancer and cervical cancer treatment, a state benefits identification card shall be issued by the department within four working days of the date in which the individual submits application information that demonstrates to the provider, as described in subdivision (c) of Section 104162 of the Health and Safety Code, that the individual meets the federal criteria described in Section 1902a(aa) of the federal Social Security Act (Section 1396a(aa) of Title 42 of the United States Code).

(b) Notwithstanding any other provision of law, an individual who meets the definition of the term defined in Section 1641 of Title 8 of the United States Code shall not be determined ineligible for services under this section solely on the basis of the individual's date of entry into the United States.

(c) The department shall file all necessary state plan amendments to implement the requirements of 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 shall implement this section, and Article 1.3 (commencing with Section 104150) and Article 1.5 (commencing with Section 104160) of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code, by means of an all-county letter or similar instruction, without taking any further regulatory action. Thereafter, the department shall adopt regulations to implement this section 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.

(e) Notwithstanding any other provision of law, the department shall make eligibility determinations and redeterminations necessary for applicants and beneficiaries to obtain services pursuant to this section as provided under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(f) Except for those individuals described in subdivision (b) and notwithstanding any other provision of law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation, as provided under Title XIX of the federal Social Security Act (42 U.S.C. Section 1396a, et seq.), is available.

(g) The department shall implement this section on January 1, 2002, if a state plan amendment adopting the option described in subdivision (a), has been approved by the federal Centers for Medicare and Medicaid Services, or at the time state plan amendment is approved, if a later date.

(Amended by Stats. 2021, Ch. 296, Sec. 75. (AB 1096) Effective January 1, 2022.)

14007.8. (a) (1) An individual who is 25 years of age or younger, and who does not have satisfactory immigration status or is unable to establish satisfactory immigration status as required by Section 14011.2, shall be eligible for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(2) (A) After the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of this subparagraph, but no sooner than May 1, 2022, an individual who is 50 years of age or older, and who does not have satisfactory immigration status or is unable to establish satisfactory immigration status as required by Section 14011.2, shall be eligible for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(B) After the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of this subparagraph, but no later than January 1, 2024, an individual who is 26 to 49 years of age, inclusive, and who does not have satisfactory immigration status as required by Section 14011.2, shall be eligible for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(b) No sooner than January 1, 2026, an individual who is 19 years of age or older, who does not have satisfactory immigration status as required by Section 14011.2, who is otherwise eligible for Medi-Cal services pursuant to subdivision (d) of Section 14007.5, who applies for Medi-Cal on or after January 1, 2026, shall only be eligible for medically necessary pregnancy-related services, and care and services necessary for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law.

(c) (1) No sooner than January 1, 2026, if an individual described in subdivision (a) who is 19 years of age or older loses eligibility for full-scope Medi-Cal on or after January 1, 2026, the individual shall only be eligible for medically necessary pregnancy-related services, and care and services necessary for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law.

(2) No sooner than January 1, 2026, notwithstanding paragraph (1), if an individual described in subdivision (a) who is 19 years of age or older loses eligibility for full-scope Medi-Cal while pregnant, the individual shall remain eligible for full-scope Medi-Cal throughout the pregnancy and for 12 months after the pregnancy ends.

(3) Notwithstanding subdivision (b), an individual who is 19 years of age or older, who does not have satisfactory immigration status as required by Section 14011.2, who was enrolled in full-scope Medi-Cal and was not pregnant, but loses coverage for full-scope Medi-Cal, shall be eligible to reenroll in full-scope Medi-Cal within three months from the date of disenrollment for full-scope Medi-Cal, pregnancy-only Medi-Cal, or postpartum Medi-Cal. Repayment of outstanding premium balances prior to the initiation of the three-month cure period shall be a condition of reenrollment under this subdivision for individuals disenrolled from Medi-Cal due to nonpayment of premiums.

(d) The department shall provide monthly updates to the appropriate policy and fiscal committees of the Legislature on the status of the implementation of this section.

(e) To the extent permitted by state and federal law, an individual eligible for full-scope Medi-Cal pursuant to subdivision (a) shall be required to enroll in a Medi-Cal managed care health plan. Enrollment in a Medi-Cal managed care health plan shall not preclude a beneficiary from being enrolled in any other children's Medi-Cal specialty program that they would otherwise be eligible for.

(f) (1) The department shall maximize federal financial participation in implementing this section to the extent allowable. For purposes of implementing this section, the department shall claim federal financial participation to the extent that the department determines it is available.

(2) To the extent that federal financial participation is unavailable, the department shall implement this section using state funds appropriated for this purpose.

(g) This section shall be implemented only to the extent it is in compliance with Section 1621(d) of Title 8 of the United States Code.

(h) (1) 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 any necessary 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.

(2) Notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(i) In implementing this section, the department may contract, as necessary, on a bid or nonbid basis. This subdivision establishes an accelerated process for issuing contracts pursuant to this section. Those contracts, and any other contracts entered into pursuant to this subdivision, may be on a noncompetitive bid basis and shall be exempt from both of the following:

(1) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part.

(2) Review or approval of contracts by the Department of General Services.

(j) (1) No sooner than July 1, 2026, except for individuals under 19 years of age, individuals over 59 years of age, and pregnant women, all individuals described in subdivision (a) shall be required to pay a monthly premium as a condition of eligibility for Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(2) Monthly premiums imposed under this section shall be thirty dollars ($30) per beneficiary.

(3) An individual described in paragraph (1), after no more than 90 days of nonpayment of the monthly premium, will only be eligible for medically necessary pregnancy-related services, and care and services necessary for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law. All outstanding premium balances shall be paid in full as a condition of continued eligibility for full-scope Medi-Cal coverage.

(k) No sooner than July 1, 2026, and notwithstanding subdivision (a) and paragraph (2) of subdivision (c), an individual who is 19 years of age or older, who is eligible for Medi-Cal benefits pursuant to subdivision (a), shall not be eligible for dental services set forth in this chapter, except for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law.

(l) Subdivisions (b), (c), (j), and (k) shall be implemented only after the director determines, and communicates in writing to the Department of Finance, that systems have been programmed for implementation.

(Amended by Stats. 2025, Ch. 21, Sec. 75. (AB 116) Effective June 30, 2025.)

14007.9. (a) (1) The department shall adopt the option made available under Section 1902(a)(10)(A)(ii)(XIII) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIII)). In order to be eligible for benefits under this section, an individual shall be required to meet all of the following requirements:

(A) The individual's net countable income is less than 250 percent of the federal poverty level for one person or, if the deeming of spousal income applies to the individual, the individual's net countable income is less than 250 percent of the federal poverty level for two persons.

(B) The individual is disabled under Title II of the federal Social Security Act (42 U.S.C. Sec. 401 et seq.), Title XVI of the federal Social Security Act (42 U.S.C. Sec. 1381 et seq.), or Section 1902(v) of the federal Social Security Act (42 U.S.C. Sec. 1396a(v)). An individual shall be determined to be eligible under this section without regard to their ability to engage in, or actual engagement in, substantial gainful activity, as defined in Section 223(d)(4) of the federal Social Security Act (42 U.S.C. Sec. 423(d)(4)).

(C) The individual's countable resources shall not exceed the maximum levels established in subdivision (a) of Section 14005.62. The determination of countable resources shall follow the methodology used under Title XVI of the federal Social Security Act (42 U.S.C. Sec. 1381 et seq.), as applicable.

(2) To the extent federal financial participation is available, an individual otherwise eligible under this section, but who is temporarily unemployed, may elect to remain on Medi-Cal under this section for up to 26 weeks, provided the individual continues to pay premiums during the temporary period of unemployment, for coverage periods in which premiums are imposed.

(b) (1) Countable income shall be determined under Section 1612 of the federal Social Security Act (42 U.S.C. Sec. 1382a), except that the individual's disability income, including all federal and state disability benefits and private disability insurance, shall be exempted. Resources excluded under Section 1613 of the federal Social Security Act (42 U.S.C. Sec. 1382b) shall be disregarded.

(2) Resources in the form of employer or individual retirement arrangements authorized under the Internal Revenue Code shall be exempted as authorized by Section 1902(r) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)).

(3) (A) For the purposes of calculating countable income under this section, an income exemption shall be applied as necessary to adjust the income standard so that it is the same as the income standard that was in place on May 1, 2009.

(B) This additional income exemption shall cease to be implemented when the SSI/SSP program payment levels increase beyond those in effect on May 1, 2009.

(C) 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 paragraph by means of an all-county letter or similar instruction without taking regulatory action.

(4) Retained earned income of an eligible individual who is receiving health care benefits under this section shall be considered an exempt resource when held in a separately identifiable account and not commingled with other resources, as authorized by Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)).

(5) Social security disability income that converts to social security retirement income upon the retirement of an individual, including any increases in the amount of that income, shall be exempt. The department shall submit a state plan amendment for this specific exemption, and the exemption shall be implemented only if, and to the extent that, the state plan amendment is approved.

(c) All resources exempted pursuant to paragraph (2) of subdivision (b) for an individual who is receiving health care benefits under this section shall continue to be exempt under any other Medi-Cal program that is subject to Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)) under which the beneficiary later becomes eligible for medical assistance where that eligibility is based on age, blindness, or disability. The department shall submit a state plan amendment for this specific exemption, and the exemption shall be implemented only if, and to the extent that, the state plan amendment is approved.

(d) After an individual is determined eligible for Medi-Cal benefits under this section, the individual's countable income, as determined under Section 1612 of the federal Social Security Act (42 U.S.C. Sec. 1382a), shall be used to determine the amount of the individual's required premium payment, as described in subdivision (f), when applicable. Disability income and converted retirement income made exempt under paragraphs (1) and (5), respectively, of subdivision (b) for eligibility purposes shall be considered countable income for purposes of determining the amount of the required premium payment.

(e) Medi-Cal benefits provided under this chapter pursuant to this section shall be available in the same amount, duration, and scope as those benefits are available for persons who are eligible for Medi-Cal benefits as categorically needy persons and as specified in Section 14007.5.

(f) Individuals eligible for Medi-Cal benefits under this section shall be subject to the payment of premiums determined under this subdivision, except as provided in subdivision (k). Each individual shall pay a monthly premium that is equal to 5 percent of their individual countable income, as described in subdivision (d), or if the deeming of spousal income of an ineligible spouse applies, a monthly premium that is equal to 5 percent of the total countable income of both spouses, except that the minimum premium payment per eligible individual shall be twenty dollars ($20) per month, and the maximum premium payment per eligible individual shall be two hundred fifty dollars ($250) per month.

(g) In order to implement the collection of premiums under this section, the department may develop and execute a contract with a public or private entity to collect premiums, or may amend any existing or future premium-collection contract that it has executed. Notwithstanding any other law, any contract developed and executed or amended pursuant to this subdivision is exempt from the approval of the Director of General Services and from the Public Contract Code.

(h) Notwithstanding the rulemaking provisions of 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 any regulatory action, this section by means of an all-county letter or similar instruction. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(i) Notwithstanding any other law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation is available pursuant to Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and only to the extent that the department seeks and obtains approval of all necessary Medicaid state plan amendments.

(j) If any provision of this section, or its application, is held invalid by a final judicial determination, it shall cease to be implemented. A determination of invalidity shall not affect other provisions or applications of this section that can be given effect without the implementation of the invalid provision or application.

(k) (1) Effective July 1, 2022, to the extent allowable under federal law, and notwithstanding the provisions of this section to the contrary, the department may elect not to impose premiums on individuals eligible under this section for an applicable coverage period.

(2) If the department elects to not impose premiums for an applicable coverage period pursuant to paragraph (1) or elects to reinstate such premiums for a subsequent coverage period, the department shall specify that election in the published Medi-Cal Local Assistance Estimate for the impacted state fiscal year or years, subject to appropriation by the annual Budget Act.

(l) This section shall become operative on January 1, 2026.

(Amended (as amended by Stats. 2023, Ch. 42, Sec. 101) by Stats. 2025, Ch. 21, Sec. 78. (AB 116) Effective June 30, 2025. Operative January 1, 2026, by its own provisions.)

14007.9. (a) (1) The department shall adopt the option made available under Section 1902(a)(10)(A)(ii)(XIII) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIII)). In order to be eligible for benefits under this section, an individual shall be required to meet all of the following requirements:

(A) The individual's net countable income is less than 250 percent of the federal poverty level for one person or, if the deeming of spousal income applies to the individual, the individual's net countable income is less than 250 percent of the federal poverty level for two persons.

(B) The individual is disabled under Title II of the federal Social Security Act (42 U.S.C. Sec. 401 et seq.), Title XVI of the federal Social Security Act (42 U.S.C. Sec. 1381 et seq.), or Section 1902(v) of the federal Social Security Act (42 U.S.C. Sec. 1396a(v)). An individual shall be determined to be eligible under this section without regard to their ability to engage in, or actual engagement in, substantial gainful activity, as defined in Section 223(d)(4) of the federal Social Security Act (42 U.S.C. Sec. 423(d)(4)).

(C) Resources that are not counted as income shall not be included in determinations of eligibility.

(2) To the extent federal financial participation is available, an individual otherwise eligible under this section, but who is temporarily unemployed, may elect to remain on Medi-Cal under this section for up to 26 weeks, provided the individual continues to pay premiums during the temporary period of unemployment, for coverage periods in which premiums are imposed.

(b) Countable income shall be determined under Section 1612 of the federal Social Security Act (42 U.S.C. Sec. 1382a), except that the individual's disability income, including all federal and state disability benefits and private disability insurance, shall be exempted.

(1) For the purposes of calculating countable income under this section, an income exemption shall be applied as necessary to adjust the income standard so that it is the same as the income standard that was in place on May 1, 2009.

(2) This additional income exemption shall cease to be implemented when the SSI/SSP program payment levels increase beyond those in effect on May 1, 2009.

(3) 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 paragraph by means of an all-county letter or similar instruction without taking regulatory action.

(4) Social security disability income that converts to social security retirement income upon the retirement of an individual, including any increases in the amount of that income, shall be exempt. The department shall submit a state plan amendment for this specific exemption, and the exemption shall be implemented only if, and to the extent that, the state plan amendment is approved.

(c) After an individual is determined eligible for Medi-Cal benefits under this section, the individual's countable income, as determined under Section 1612 of the federal Social Security Act (42 U.S.C. Sec. 1382a), shall be used to determine the amount of the individual's required premium payment, as described in subdivision (f), when applicable. Disability income and converted retirement income made exempt under paragraphs (1) and (3), respectively, of subdivision (b) for eligibility purposes shall be considered countable income for purposes of determining the amount of the required premium payment.

(d) Medi-Cal benefits provided under this chapter pursuant to this section shall be available in the same amount, duration, and scope as those benefits are available for persons who are eligible for Medi-Cal benefits as categorically needy persons and as specified in Section 14007.5.

(e) (1) Individuals eligible for Medi-Cal benefits under this section shall be subject to the payment of premiums determined under this subdivision, except as provided in subdivision (m). Each individual shall pay a monthly premium that is equal to 5 percent of their individual countable income, as described in subdivision (c), or if the deeming of spousal income of an ineligible spouse applies, a monthly premium that is equal to 5 percent of the total countable income of both spouses, except that the minimum premium payment per eligible individual shall be twenty dollars ($20) per month, and the maximum premium payment per eligible individual shall be two hundred fifty dollars ($250) per month.

(2) The amendments made to this subdivision by Chapter 282 of the Statutes of 2009 shall be implemented no later than 90 days after the operative date specified in paragraph (2) of subdivision (j).

(f) In order to implement the collection of premiums under this section, the department may develop and execute a contract with a public or private entity to collect premiums, or may amend any existing or future premium-collection contract that it has executed.

Notwithstanding any other law, any contract developed and executed or amended pursuant to this subdivision is exempt from the approval of the Director of General Services and from the Public Contract Code.

(g) Notwithstanding the rulemaking provisions of 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 any regulatory action, this section by means of an all-county letter or similar instruction. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(h) Notwithstanding any other law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation is available pursuant to Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and only to the extent that the department seeks and obtains approval of all necessary Medicaid state plan amendments.

(i) If any provision of this section, or its application, is held invalid by a final judicial determination, it shall cease to be implemented. A determination of invalidity shall not affect other provisions or applications of this section that can be given effect without the implementation of the invalid provision or application.

(j) (1) Except as provided in paragraph (2), the amendments made to this section by Chapter 282 of the Statutes of 2009 shall not become operative until 30 days after the date that the increase in the state's federal medical assistance percentage (FMAP) pursuant to the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5) is no longer available under that act or any extension of that act.

(2) The amendments made to this section by Chapter 282 of the Statutes of 2009 contained in subdivisions (c) and (e) shall not become operative until 30 days after the date that the director executes a declaration stating that the implementation of subdivisions (c) and (e) will not jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148) or any amendment or extension of that act, any increase in the FMAP available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, determines would be advantageous to the state.

(3) If at any time the director determines that the statement in the declaration executed pursuant to paragraph (2) may no longer be accurate, the director shall give notice to the Joint Legislative Budget Committee and to the Department of Finance. After giving notice, the amendments made to this section by Chapter 282 of the Statutes of 2009 contained in subdivisions (c) and (e) shall become inoperative on the date that the director executes a declaration stating that the department has determined, in consultation with the Department of Finance, that it is necessary to cease to implement subdivisions (c) and (e) in order to receive federal financial participation, any increase in the FMAP available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, has determined would be advantageous to the state, in which case, subdivision (c) of this section, as stated by Section 32 of Chapter 5 of the Fourth Extraordinary Session of the Statutes of 2009, shall be operative.

(4) The director shall post a declaration made pursuant to paragraph (2) or (3) on the department's internet website and the director shall send the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(k) 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 subdivision (j) by means of all-county letters or similar instruction, without taking regulatory action.

(l) (1) Effective July 1, 2022, to the extent allowable under federal law, and notwithstanding the provisions of this section to the contrary, the department may elect not to impose premiums on individuals eligible under this section for an applicable coverage period.

(2) If the department elects to not impose premiums for an applicable coverage period pursuant to paragraph (1) or elects to reinstate such premiums for a subsequent coverage period, the department shall specify that election in the published Medi-Cal Local Assistance Estimate for the impacted state fiscal year or years, subject to appropriation by the annual Budget Act.

(m) This section shall become inoperative on January 1, 2026, and, as of January 1, 2027, is repealed.

(Amended (as added by Stats. 2023, Ch. 42, Sec. 102) by Stats. 2025, Ch. 21, Sec. 79. (AB 116) Effective June 30, 2025. Inoperative January 1, 2026, by its own provisions. Repealed as of January 1, 2027, by its own provisions. See later operative version, as amended by Sec. 78 of Stats. 2025, Ch. 21.)

14007.95. The department shall report to the Governor and the Legislature any information the department gathers from the California Health Improvement Project, or from any other public or private sources, that may explain the low participation rates in the optional program provided pursuant to Section 14007.9 and any recommendations from the department on actions the state may take to increase participation by eligible persons in a manner that is cost effective for the state and beneficial for the participants.

(Added by Stats. 2002, Ch. 1088, Sec. 7. Effective January 1, 2003.)

14008. (a) No relative, other than the spouse, shall be held to be financially responsible for the cost of health care received by an adult eligible under this chapter, except as provided in subdivisions (b) and (c).

(b) Except as provided in Section 14010, no relative, other than the parent or parents of a child under the age of 18 years, or a child over the age of 18 years if a parent claims the child as a dependent in order to receive a tax credit or deduction for purposes of state or federal income taxation, shall be held to be financially responsible for the cost of health care or related services received by such child, otherwise eligible under this chapter.

(c) To the extent permitted by federal law, the parent or parents shall have such financial responsibility for any child 18 years of age or older but under the age of 21 years who is living in the home of the parent or parents.

(Amended by Stats. 1982, Ch. 1594, Sec. 25. Effective September 30, 1982.)

14008.6. (a) As a condition of eligibility for medical services provided under this chapter or Chapter 8 (commencing with Section 14200), each applicant or beneficiary shall do all of the following:

(1) Assign to the state any rights to medical support and to payments for medical care from a third party that an individual may have on his or her own behalf or on behalf of any other family member for whom that individual has the legal authority to assign those rights, and is applying for or receiving medical services. Receipt of medical services under this chapter or Chapter 8 (commencing with Section 14200) shall operate as an assignment by operation of law. If those rights are assigned pursuant to this subdivision, the assignee may become an assignee of record by the local child support agency or other public official filing with the court clerk an affidavit showing that an assignment has been made or that there has been an assignment by operation of law. This procedure does not limit any other means by which the assignee may become an assignee of record.

(2) Cooperate, as defined by subdivision (b) of Section 11477, with the local child support agency in establishing the paternity of a child born out of wedlock with respect to whom medical services are requested or claimed, and for whom that individual can legally assign the rights described in paragraph (1), and in obtaining any medical support, as provided in Section 17400 of the Family Code, and payments, as described in paragraph (1), due any person for whom medical services are requested or obtained.

(3) Cooperate with the state in identifying and providing information to assist the state in pursuing any third party who may be liable to pay for care and services available under the Medi-Cal program.

(b) The local child support agency shall verify that the applicant or recipient refused to offer reasonable cooperation prior to determining that the applicant or recipient is ineligible. The granting of medical services shall not be delayed or denied if the applicant is otherwise eligible, if the applicant completes the necessary forms and agrees to cooperate with the district attorney in securing medical support and determining paternity, where applicable.

(c) An applicant or beneficiary shall be considered to be cooperating with the local child support agency and shall be eligible for medical services, if otherwise eligible, if the applicant or beneficiary cooperates to the best of his or her ability or has good cause for refusal to cooperate with the requirements in paragraphs (2) and (3) of subdivision (a), as defined by Section 11477.04. The county welfare department shall make the determination of whether good cause for refusal to cooperate exists.

(d) The county welfare department and the local child support agency shall ensure that all applicants for or beneficiaries of medical services under this chapter or Chapter 8 (commencing with Section 14200) are properly notified of the conditions imposed by this section.

(Amended by Stats. 2001, Ch. 159, Sec. 196. Effective January 1, 2002.)

14008.7. If the applicant or beneficiary does not cooperate in the manner described in subdivisions (b) and (c) of Section 14008.6 to establish paternity and medical support orders against the noncustodial parents of each of the children for whom Medi-Cal services are requested or received, without good cause, as described in Section 11477.04, the applicant or beneficiary shall be ineligible for aid under this chapter or Chapter 8 (commencing with Section 14200). An applicant's or beneficiary's refusal to cooperate shall not effect the eligibility of the child or children. If otherwise eligible, the child or children may be granted Medi-Cal or continue to receive Medi-Cal.

(Added by Stats. 1997, Ch. 599, Sec. 64. Effective January 1, 1998.)

14009. (a) Any applicant for, or beneficiary of Medi-Cal, or person acting on behalf of an applicant or beneficiary shall be informed as to the provisions of eligibility and, in writing, of their responsibility for reporting facts material to a correct determination of eligibility and spend down of excess income.

(b) Any applicant for, or beneficiary of Medi-Cal, or person acting on behalf of an applicant or beneficiary shall be responsible for reporting accurately and completely within their competence those facts required of them pursuant to subdivision (a) and to report promptly any changes in those facts.

(c) If, because of a failure to report facts in accordance with subdivision (b), the beneficiary received health care to which they were not entitled, they shall be liable to repay any overpayment. The amount of overpayment shall be based on the amount of excess income or resources and computed in accordance with overpayment regulations promulgated by the director.

(d) No liability for overpayment shall result from circumstances where there is a failure on the part of an applicant or beneficiary to perform an act constituting a condition of eligibility, if the failure is caused by an error made by the department or a county welfare department, or where the beneficiary reported facts in accordance with subdivision (b) but a county welfare department failed to act on those facts.

(e) When the department determines that an overpayment has occurred, the department shall seek to recover the full amount of the overpayment by appropriate action under state law against the income or resources of the beneficiary or the income and resources of any person who is financially responsible for the cost of their health care pursuant to Section 14008.

(f) The department shall advise the beneficiary of the overpayment, the amount they are liable to repay, and of their entitlement to a hearing on the propriety of the action pursuant to Chapter 7 (commencing with Section 10950) of Part 2.

(g) No civil or criminal action may be commenced against any person based on alleged unlawful application for or receipt of health care services, where the case record of the person has been destroyed after the expiration of the retention period provided pursuant to Section 10851.

(Amended by Stats. 2023, Ch. 42, Sec. 103. (AB 118) Effective July 10, 2023.)

14009.5. (a) It is the intent of the Legislature, with the amendments made to this section by the act that added subdivision (g), to do all of the following:

(1) Limit Medi-Cal estate recovery only for those services required to be collected under federal law.

(2) Limit the definition of “estate” to include only the real and personal property and other assets required to be collected under federal law.

(3) Require the State Department of Health Care Services to implement the option in the State Medicaid Manual to waive its claim, as a substantial hardship, when the estate subject to recovery is a homestead of modest value, subject to federal approval.

(4) Prohibit recovery from the estate of a deceased Medi-Cal member who is survived by a spouse or registered domestic partner.

(5) Ensure that Medi-Cal members can easily and timely receive information about how much their estate may owe Medi-Cal when they die.

(b) Notwithstanding any other provision of this chapter, the department shall claim against the estate of the decedent, or against any recipient of the property of that decedent by distribution, an amount equal to the payments for the health care services received or the value of the property received by any recipient from the decedent by distribution, whichever is less, only in either of the following circumstances:

(1) Against the real property of a Medi-Cal member of any age who meets the criteria in Section 1396p(a)(1)(B) of Title 42 of the United States Code and who was or is an inpatient in a nursing facility in accordance with Section 1396p(b)(1)(A) of Title 42 of the United States Code.

(2) (A) The decedent was 55 years of age or older when the individual received health care services.

(B) The department shall not claim under this paragraph when there is any of the following:

(i) A surviving spouse or surviving registered domestic partner.

(ii) A surviving child who is under 21 years of age.

(iii) A surviving child who is blind or disabled, within the meaning of Section 1614 of the federal Social Security Act (42 U.S.C. Sec. 1382c).

(c) (1) The department shall waive its claim, in whole or in part, if it determines that enforcement of the claim would result in substantial hardship to other dependents, heirs, or survivors of the individual against whose estate the claim exists.

(2) In determining the existence of substantial hardship, in addition to other factors considered by the department consistent with federal law and guidance, the department shall, subject to federal approval, waive its claim when the estate subject to recovery is a homestead of modest value.

(3) The department shall notify individuals of the waiver provision and the opportunity for a hearing to establish that a waiver should be granted.

(d) If the department proposes and accepts a voluntary postdeath lien, the voluntary postdeath lien shall accrue interest at the rate equal to the annual average rate earned on investments in the Surplus Money Investment Fund in the calendar year preceding the year in which the decedent died or simple interest at 7 percent per annum, whichever is lower.

(e) (1) The department shall provide a current or former member, or his or her authorized representative designated under Section 14014.5, upon request, a copy of the amount of Medi-Cal expenses that may be recoverable under this section through the date of the request. The information may be requested once per calendar year for a fee to cover the department's reasonable administrative costs, not to exceed five dollars ($5) if the current or former member meets either of the following descriptions:

(A) An individual who is 55 years of age or older when the individual received health care services.

(B) A permanently institutionalized individual who is an inpatient in a nursing facility, intermediate care facility for the intellectually disabled, or other medical institution.

(2) The department shall permit a member to request the information described in paragraph (1) through the Internet, by telephone, by mail, or through other commonly available electronic means. Upon receipt of the request for information described in paragraph (1), the department shall work with the member to ensure that the member submits documentation necessary to identify the individual and process the member's request.

(3) The department shall conspicuously post on its Internet Web site a description of the methods by which a request under this subdivision may be made, including, but not limited to, the department's telephone number and any addresses that may be used for this purpose. The department shall also include this information in its pamphlet for the Medi-Cal Estate Recovery Program and any other notices the department distributes to members specifically regarding estate recovery.

(4) Upon receiving a request for the information described in paragraph (1) and all necessary supporting documentation, the department shall provide the information requested within 90 days after receipt of the request.

(f) The following definitions shall govern the construction of this section:

(1) "Decedent" means a member who has received health care under this chapter or Chapter 8 (commencing with Section 14200) and who has died leaving property to others through distribution.

(2) "Dependents" includes, but is not limited to, immediate family or blood relatives of the decedent.

(3) "Estate" means all real and personal property and other assets in the individual's probate estate that are required to be subject to a claim for recovery pursuant to Section 1396p(b)(4)(A) of Title 42 of the United States Code.

(4) "Health care services" means only those services required to be recovered under Section 1396p(b)(1)(B)(i) of Title 42 of the United States Code.

(5) "Homestead of modest value" means a home whose fair market value is 50 percent or less of the average price of homes in the county where the homestead is located, as of the date of the decedent's death.

(g) The amendments made to this section by the act that added this subdivision shall apply only to individuals who die on or after January 1, 2017.

(Amended by Stats. 2016, Ch. 30, Sec. 22. (SB 833) Effective June 27, 2016.)

14009.6. (a) As a result of providing medical assistance for home and facility care to an individual, the state shall, by operation of law, become a remainder beneficiary, to the extent required by Section 1917(e) of the federal Social Security Act (42 U.S.C. Sec. 1396p(e)), of annuities purchased in whole or in part by the individual or the individual's spouse in which the individual or the individual's spouse is an annuitant, except as provided in Section 14009.7, unless the individual or the individual's spouse notifies the department in writing that they prohibit the state from acquiring a remainder interest in their annuity, in which case subdivision (d) shall apply.

(b) This section shall only apply to the following annuities:

(1) Those purchased on or after February 8, 2006.

(2) Those purchased before February 8, 2006, and subjected to a transaction that occurred on or after February 8, 2006.

(A) For the purposes of this paragraph, "transaction" includes, but is not limited to, any action taken by the individual or the individual's spouse that changes the course of payments to be made by the annuity or the treatment of the income or principal of the annuity.

(B) For the purpose of this paragraph, “transaction” shall not include any of the following:

(i) Routine changes and automatic events that do not require any action or decision on or after February 8, 2006.

(ii) Changes that occur based on the terms of the annuity that existed prior to February 8, 2006, and that do not require a decision, election, or action to take effect.

(iii) Changes that are beyond the control of the individual or the individual’s spouse.

(c) Any provision in any annuity subject to this section that has the effect of restricting the right of the state to become a remainder beneficiary is void.

(d) If an individual or the individual’s spouse notifies the department in writing that they prohibit the state from acquiring a remainder interest in their annuity, the purchase of the annuity shall be treated as the transfer of an asset for less than fair market value that is subject to Section 14015.

(e) (1) When the state becomes aware of an annuity in which it has acquired a remainder interest, the department shall notify the issuer of the annuity of the state’s acquisition of its remainder beneficiary interest.

(2) The issuer of the annuity shall, upon notification by the department, immediately inform the department of the amount of income and principal being withdrawn from the annuity as of the date of the individual’s disclosure of the annuity.

(3) The issuer of the annuity shall, upon request by the department or any agent of the department, immediately disclose to the department the amount of income and principal being withdrawn from the annuity.

(4) The issuer of the annuity shall immediately notify the department if there is any change in either of the following:

(A) The amount of income or principal being withdrawn from that annuity.

(B) The named beneficiaries of the annuity.

(f) Any moneys received by the state pursuant to this section shall be deposited into the General Fund.

(g) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act, and only to the extent that federal financial participation is available.

(h) To the extent that regulations are necessary to implement this section, the department shall promulgate regulations using the nonemergency regulatory process described in Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of the Government Code.

(i) It is the intent of the Legislature that the provisions of this section shall apply prospectively to any individual to whom the act applies commencing from the date regulations adopted pursuant to this act are filed with the Secretary of State.

(j) This section shall become operative on January 1, 2026.

(Amended (as amended by Stats. 2023, Ch. 42, Sec. 104) by Stats. 2025, Ch. 21, Sec. 80. (AB 116) Effective June 30, 2025. Operative January 1, 2026, by its own provisions.)

14009.6. (a) As a result of providing medical assistance for home and facility care to an individual, the state shall, by operation of law, become a remainder beneficiary, to the extent required by Section 1917(e) of the federal Social Security Act (42 U.S.C. Sec. 1396p(e)), of annuities purchased in whole or in part by the individual or the individual’s spouse in which the individual or the individual’s spouse is an annuitant, except as provided in Section 14009.7, unless the individual or the individual’s spouse notifies the department in writing that they prohibit the state from acquiring a remainder interest in their annuity.

(b) This section shall only apply to the following annuities:

(1) Those purchased on or after February 8, 2006.

(2) Those purchased before February 8, 2006, and subjected to a transaction that occurred on or after February 8, 2006.

(A) For the purposes of this paragraph, “transaction” includes, but is not limited to, any action taken by the individual or the individual’s spouse that changes the course of payments to be made by the annuity or the treatment of the income or principal of the annuity.

(B) For the purpose of this paragraph, “transaction” shall not include any of the following:

(i) Routine changes and automatic events that do not require any action or decision on or after February 8, 2006.

(ii) Changes that occur based on the terms of the annuity that existed prior to February 8, 2006, and that do not require a decision, election, or action to take effect.

(iii) Changes that are beyond the control of the individual or the individual's spouse.

(c) Any provision in any annuity subject to this section that has the effect of restricting the right of the state to become a remainder beneficiary is void.

(d) (1) When the state becomes aware of an annuity in which it has acquired a remainder interest, the department shall notify the issuer of the annuity of the state's acquisition of its remainder beneficiary interest.

(2) The issuer of the annuity shall, upon notification by the department, immediately inform the department of the amount of income and principal being withdrawn from the annuity as of the date of the individual's disclosure of the annuity.

(3) The issuer of the annuity shall, upon request by the department or any agent of the department, immediately disclose to the department the amount of income and principal being withdrawn from the annuity.

(4) The issuer of the annuity shall immediately notify the department if there is any change in either of the following:

(A) The amount of income or principal being withdrawn from that annuity.

(B) The named beneficiaries of the annuity.

(e) Any moneys received by the state pursuant to this section shall be deposited into the General Fund.

(f) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act, and only to the extent that federal financial participation is available.

(g) To the extent that regulations are necessary to implement this section, the department shall promulgate regulations using the nonemergency regulatory process described in Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of the Government Code.

(h) It is the intent of the Legislature that the provisions of this section shall apply prospectively to any individual to whom the act applies commencing from the date regulations adopted pursuant to this act are filed with the Secretary of State.

(i) This section shall become inoperative on January 1, 2026, and, as of January 1, 2027, is repealed.

(Amended (as added by Stats. 2023, Ch. 42, Sec. 105) by Stats. 2025, Ch. 21, Sec. 81. (AB 116) Effective June 30, 2025. Inoperative January 1, 2026, by its own provisions. Repealed as of January 1, 2027, by its own provisions. See later operative version, as amended by Sec. 80 of Stats. 2025, Ch. 21.)

14009.7. (a) If an annuity is considered part or all of the community spouse resource allowance allowed under subdivision (c) of Section 14006, the state shall only become a remainder beneficiary of that portion of the annuity that is not a part of that community spouse resource allowance.

(b) The state shall not become a remainder beneficiary of an annuity that is any of the following:

(1) Purchased by a community spouse with resources of the community spouse during the continuous period in which the individual is receiving medical assistance for home and facility care and after the month in which the individual is determined eligible for these benefits.

(2) Contained in a retirement plan qualified under Title 26 of the United States Code, established by an employer or an individual, including, but not limited to, an Individual Retirement Annuity or Account (IRA), Roth IRA, or Keogh fund.

(3) An annuity that is all of the following:

(A) The annuity is irrevocable and nonassignable.

(B) The annuity is actuarially sound.

(C) The annuity provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made from the annuity.

(c) The individual or the community spouse, or both, shall bear the burden of demonstrating that the requirements of this section that limit the state's right to become a remainder beneficiary, as described in Section 14009.6, are met.

(d) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act, and only to the extent that federal financial participation is available.

(e) To the extent that regulations are necessary to implement this section, the department shall promulgate regulations using the nonemergency regulatory process described in Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of the Government Code.

(f) It is the intent of the Legislature that the provisions of this section shall apply prospectively to any individual to whom the act applies commencing from the date regulations adopted pursuant to this act are filed with the Secretary of State.

(g) This section shall become operative on January 1, 2026.

(Amended (as amended by Stats. 2023, Ch. 42, Sec. 106) by Stats. 2025, Ch. 21, Sec. 82. (AB 116) Effective June 30, 2025. Operative January 1, 2026, by its own provisions.)

14009.7. (a) The state shall not become a remainder beneficiary of an annuity that is any of the following:

(1) Purchased by a community spouse with resources of the community spouse before or during the continuous period in which the individual is receiving medical assistance for home and facility care and after the month in which the individual is determined eligible for these benefits.

(2) Contained in a retirement plan qualified under Title 26 of the United States Code, established by an employer or an individual, including, but not limited to, an Individual Retirement Annuity or Account (IRA), Roth IRA, or Keogh fund.

(3) An annuity that is all of the following:

(A) The annuity is irrevocable and nonassignable.

(B) The annuity is actuarially sound.

(C) The annuity provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made from the annuity.

(b) The individual or the community spouse, or both, shall bear the burden of demonstrating that the requirements of this section that limit the state's right to become a remainder beneficiary, as described in Section 14009.6, are met.

(c) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act, and only to the extent that federal financial participation is available.

(d) To the extent that regulations are necessary to implement this section, the department shall promulgate regulations using the nonemergency regulatory process described in Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of the Government Code.

(e) It is the intent of the Legislature that the provisions of this section shall apply prospectively to any individual to whom the act applies commencing from the date regulations adopted pursuant to this act are filed with the Secretary of State.

(f) This section shall become inoperative on January 1, 2026, and, as of January 1, 2027, is repealed.

(Amended (as added by Stats. 2023, Ch. 42, Sec. 107) by Stats. 2025, Ch. 21, Sec. 83. (AB 116) Effective June 30, 2025. Inoperative January 1, 2026, by its own provisions. Repealed as of January 1, 2027, by its own provisions. See later operative version, as amended by Sec. 82 of Stats. 2025, Ch. 21.)

14010. (a) Notwithstanding any other provision of law, the parent or parents of a person under 21 years of age shall not be held financially responsible, nor shall financial contribution be requested or required of such parent or parents for health care or related services to which the person may consent under any express provision of law, including, but not limited to, Sections 6924, 6925, 6926, 6927, 6928, and 6929 of the Family Code, and including, but not limited to, maternity home care, social service counseling, and other services related to pregnancy of the person which are provided by a licensed maternity home.

Federal financial participation in providing such services shall not be claimed to the extent that the exemption from financial responsibility provided by this section is inconsistent with federal law.

(b) Notwithstanding the provisions of subdivision (a), the parent or parents of a person under 21 years of age, who is living in the home of the parent or parents, shall be held financially responsible for health care or related services to which the person under 21 years of age may consent pursuant to paragraph (1) of subdivision (e) of Section 7050 of the Family Code, but excluding health care and or related services to which a person may consent under Sections 6924, 6925, 6926, 6927, 6928, and 6929 of the Family Code.

(Amended by Stats. 1992, Ch. 163, Sec. 154. Effective January 1, 1993. Operative January 1, 1994, by Sec. 161 of Ch. 163.)

14011. (a) An applicant who is not a recipient of aid under Chapter 2 (commencing with Section 11200) or Chapter 3 (commencing with Section 12000) shall be required to file an affirmation setting forth facts about their annual income and other resources and

qualifications for eligibility as may be required by the department. Those statements shall be on forms prescribed by the department.

(b) To the extent permitted by federal law, eligibility for medical assistance for applicants shall not be granted until the applicant or designated representative provides independent documentation verifying statements of the following:

(1) Gross income by type and source.

(2) Income amounts withheld for taxes.

(3) Health care benefits available through employment, retirement, military service, work related injuries or settlements from prior injuries.

(4) Employee retirement contributions, and other employee benefit contributions, deductible expenses for maintenance or improvement of income-producing property and status and value of property owned, other than property exempt under Section 14006. The director may prescribe those items of exempt property that the director deems should be verified as to status and value in order to reasonably assure a correct designation of those items as exempt.

(c) The verification requirements of subdivision (b) apply to income, income deductions and property both of applicants for medical assistance, excluding applicants for public assistance, and to persons whose income, income deductions, expenses or property holdings must be considered in determining the applicant's eligibility and spend down of excess income.

(d) A determination of eligibility and spend down of excess income may be extended beyond otherwise prescribed timeframes if, in the county department's judgment, and subject to standards of the director, the applicant or designated representative has good cause for failure to provide the required verification and continues to make a good faith effort to provide verification.

(e) To the extent permitted by federal law, in addition to the other verification requirements of this section, a county department may require verification of any other applicant statements, or conduct a full and complete investigation of the statements, whenever a verification or investigation is warranted in the judgment of the county department.

(f) If documentation is unavailable, as defined in regulations promulgated by the department, the applicant's signed statement as to the value or amount shall be deemed to constitute verification.

(g) This section shall become operative on January 1, 2026.

(Amended (as amended by Stats. 2023, Ch. 42, Sec. 108) by Stats. 2025, Ch. 21, Sec. 84. (AB 116) Effective June 30, 2025. Operative January 1, 2026, by its own provisions.)

14011. (a) An applicant who is not a recipient of aid under Chapter 2 (commencing with Section 11200) or Chapter 3 (commencing with Section 12000) shall be required to file an affirmation setting forth facts about their annual income and qualifications for eligibility as may be required by the department. Those statements shall be on forms prescribed by the department.

(b) To the extent permitted by federal law, eligibility for medical assistance for applicants shall not be granted until the applicant or designated representative provides independent documentation verifying statements of all of the following:

(1) Gross income by type and source.

(2) Income amounts withheld for taxes.

(3) Health care benefits available through employment, retirement, military service, work-related injuries or settlements from prior injuries.

(c) The verification requirements of subdivision (b) apply to income and income deductions of applicants for medical assistance, excluding applicants for public assistance, and to persons whose income, income deductions, or expenses must be considered in determining the applicant's eligibility and spend down of excess income.

(d) A determination of eligibility and spend down of excess income may be extended beyond otherwise prescribed timeframes if, in the county department's judgment, and subject to standards of the director, the applicant or designated representative has good cause for failure to provide the required verification and continues to make a good faith effort to provide verification.

(e) To the extent permitted by federal law, in addition to the other verification requirements of this section, a county department may require verification of any other applicant statements, or conduct a full and complete investigation of the statements, whenever a verification or investigation is warranted in the judgment of the county department.

(f) If documentation is unavailable, as defined in regulations promulgated by the department, the applicant's signed statement as to the value or amount shall be deemed to constitute verification.

(g) This section shall become inoperative on January 1, 2026, and, as of January 1, 2027, is repealed.

(Amended (as added by Stats. 2023, Ch. 42, Sec. 109) by Stats. 2025, Ch. 21, Sec. 85. (AB 116) Effective June 30, 2025. Inoperative January 1, 2026, by its own provisions. Repealed as of January 1, 2027, by its own provisions. See later operative version, as amended by Sec. 84 of Stats.

2025, Ch. 21.)

14011.1. (a) The department shall, not later than July 1, 1998, create and implement a simplified application package for the following Medi-Cal applicants, as described under Section 1902(l)(3) of the federal Social Security Act (42 U.S.C. Sec. 1396a(l)(3)):

(1) Children.

(2) Pregnant women and infants.

(b) In developing the application package described in this section, the department shall seek input from the Managed Risk Medical Insurance Board and persons with expertise, including beneficiary representatives, counties, and beneficiaries.

(c) The department shall permit an applicant to whom subdivision (a) applies to apply for benefits by mailing in the simplified application package. The package shall include, but not be limited to, the following items, as they now exist or may be changed from time to time:

(1) An application for cash aid, CalFresh, and Medi-Cal.

(2) A statement of citizenship, alienage, and immigration status.

(3) A statement of facts.

(4) Important information for persons requesting Medi-Cal.

(5) The Child Health and Disability Prevention Program brochure.

(d) The department shall not require an applicant who submits a simplified application pursuant to subdivision (c) to complete a face-to-face interview, except for good cause, a suspicion of fraud, or to complete the application process. Every application package shall contain a notification of the applicant's right to complete a face-to-face interview.

(e) The department shall implement this section only to the extent that its provisions are not violative of the requirements of federal law, and only to the extent that federal financial participation is not jeopardized.

(Amended by Stats. 2011, Ch. 227, Sec. 60. (AB 1400) Effective January 1, 2012.)

14011.10. (a) Except as provided in Sections 14053.7, 14053.8, and 14184.800, benefits provided under this chapter to an individual who is an inmate of a public institution shall be suspended in accordance with Section 1396d(a)(31)(A) of Title 42 of the United States Code as provided in subdivisions (c), (d), and (e).

(b) A county welfare department shall notify the department within 10 days of receiving information that an individual on Medi-Cal in the county is or will be an inmate of a public institution.

(c) Until October 1, 2020, if an individual is a Medi-Cal beneficiary on the date they become an inmate of a public institution, their benefits under this chapter and under Chapter 8 (commencing with Section 14200) shall be suspended effective the date they become an inmate of a public institution. The suspension shall end on the date they are no longer an inmate of a public institution or one year from the date they become an inmate of a public institution, whichever is sooner.

(d) Commencing October 1, 2020, and through December 31, 2022, inclusive, if an individual is a Medi-Cal beneficiary on the date they become an inmate of a public institution, their benefits under this chapter and under Chapter 8 (commencing with Section 14200) shall be suspended effective the date they become an inmate of a public institution. The suspension shall end according to the following:

(1) For an individual who is not defined as a juvenile under Section 1396a(nn)(1)(A) or 1396a(nn)(1)(B) of Title 42 of the United States Code, the suspension shall end on the date the individual is no longer an inmate of a public institution or one year from the date the individual becomes an inmate of a public institution, whichever is sooner.

(2) For an individual who is defined as a juvenile under Section 1396a(nn)(1)(A) or 1396a(nn)(1)(B) of Title 42 of the United States Code, the suspension shall end in accordance with Section 1396a(a)(84) of Title 42 of the United States Code, or one year from the date the individual becomes an inmate of a public institution, whichever is later.

(e) (1) Commencing January 1, 2023, if an individual is a Medi-Cal beneficiary on the date they become an inmate of a public institution, their benefits under this chapter and under Chapter 8 (commencing with Section 14200) shall be suspended effective the date they become an inmate of a public institution.

(2) For an individual who is defined as a juvenile under Section 1396a(nn)(1)(A) or 1396a(nn)(1)(B) of Title 42 of the United States Code, and for an individual who is not defined as a juvenile under these sections to the extent permissible under federal law, the

suspension shall end on the date the individual is no longer an inmate of a public institution, if otherwise eligible.

(f) The department, in consultation with stakeholders, including the County Welfare Directors Association of California and advocates, shall develop and implement a redetermination of eligibility, to the extent required by federal law, pursuant to Section 14005.37, for individuals referenced in paragraph (2) of subdivision (d) and subdivision (e) whose eligibility is suspended pursuant to this section.

(g) This section does not create a state-funded benefit or program. Health care services under this chapter and Chapter 8 (commencing with Section 14200) shall not be available to inmates of public institutions whose Medi-Cal benefits have been suspended under this section.

(h) This section shall be implemented only if and to the extent allowed by federal law. This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approval of state plan amendments or other federal approvals have been obtained.

(i) This section shall be implemented on January 1, 2010, or the date when all necessary federal approvals are obtained, whichever is later.

(j) By January 1, 2010, or the date when all necessary federal approvals are obtained, whichever is later, the department, in consultation with the Chief Probation Officers of California and the County Welfare Directors Association of California, shall establish the protocols and procedures necessary to implement this section, including any needed changes to the protocols and procedures previously established to implement Section 14029.5.

(k) The department shall determine whether federal financial participation will be jeopardized by implementing this section and shall implement this section only if and to the extent that federal financial participation is not jeopardized.

(l) 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.

(m) Notwithstanding any other law, commencing no sooner than July 1, 2021, the department, in consultation with representatives of county welfare departments, the Statewide Automated Welfare System and other interested stakeholders, shall initiate the planning process to prioritize the automation of Medi-Cal suspensions for incarcerated individuals into the California Healthcare Eligibility, Enrollment, and Retention System, as set forth in this section. This change shall be reflected in both the California Healthcare Eligibility, Enrollment, and Retention System 24-Month Roadmap Initiatives and the County Eligibility Worker Dashboard.

(Amended by Stats. 2022, Ch. 47, Sec. 85. (SB 184) Effective June 30, 2022.)

14011.15. (a) The department shall, not later than July 1, 2000, create and implement a simplified application package for children, families, and adults applying for Medi-Cal benefits. This simplified application package shall include a simplified supplemental resource form.

(b) In developing the application package described in subdivision (a), the department shall seek input from persons with expertise, including beneficiary representatives, counties, and beneficiaries.

(c) The department shall allow an applicant to apply for benefits by mailing in the simplified application package.

(d) The simplified application package shall utilize at a minimum, all of the following documentation standards:

(1) Proof of income shall be documented by the most recent paystub or a copy of the last year's federal income tax return.

(2) Self-declaration of pregnancy.

(3) A simplified supplemental resource form, if applicable.

(e) The department shall not require an applicant who submits a simplified application pursuant to this section to complete a face-to-face interview, except for good cause, a suspicion of fraud, or in order to complete the application process. A county shall conduct random monitoring of the mail-in application process to ensure appropriate enrollment. Every application package shall contain a notification of the applicant's right to complete a face-to-face interview.

(f) The department shall implement this section only to the extent that its provisions are not in violation of the requirements of federal law, and only to the extent that federal financial participation is available.

(g) 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.

(Amended by Stats. 2003, 1st Ex. Sess., Ch. 9, Sec. 5. Effective May 5, 2003.)

14011.2. (a) The department shall require that each applicant for or beneficiary of Medi-Cal, including a child, who is not a recipient of aid under the provisions of Chapter 2 (commencing with Section 11200) or Chapter 3 (commencing with Section 12000) shall provide their social security account number, or numbers, if they have more than one such number.

(b) The requirement for a social security account number shall be a condition of eligibility only for the applicant who is seeking or the beneficiary who is receiving (1) full-scope medical benefits or (2), pursuant to Section 14007.5, restricted medical benefits (emergency and pregnancy-related services only), and, in either case, who declares, as required in subdivision (d), that they are a citizen or national of the United States, and, if they are not a citizen or national of the United States, that they have satisfactory immigration status.

(c) The requirement for a social security account number shall not be a condition of eligibility for the applicant who is seeking or the beneficiary who is receiving, pursuant to Section 14007.5, restricted medical benefits (emergency and pregnancy-related services only), and who has not made the declaration, as required in subdivision (d), that they are not a citizen or national of the United States, and, if they are not a citizen or national of the United States, that they do not have satisfactory immigration status.

(d) Every applicant or beneficiary or, in the case of a child, by the child's caretaker relative or legal guardian on their behalf shall declare, under penalty of perjury, that they are, or are not, any of the following:

(1) A citizen of the United States.

(2) A national of the United States.

(3) A person who has satisfactory immigration status.

(e) (1) Notwithstanding Section 50301.1 of Title 22 of the California Code of Regulations, an individual who declares to be a citizen or national of the United States in accordance with Section 1903(i)(22) of the federal Social Security Act (42 U.S.C. Sec. 1396b(i)(22)) shall present satisfactory documentary evidence of citizenship or nationality in compliance with Section 1903(x) (42 U.S.C. Sec. 1396b(x) of the federal Social Security Act). Except as otherwise provided in Section 14007.2 and in paragraph (7), no services shall be available under this chapter for an individual who fails to comply with the documentation requirements of this section.

(2) (A) The documentation required pursuant to paragraph (1) shall be provided once by each individual, as follows:

(i) During the initial application process for applicants.

(ii) During the redetermination process for existing beneficiaries.

(B) If the documentation is obtained from a beneficiary, the county shall maintain a copy of the documentation in the case file of the beneficiary, and shall not request this documentation again.

(C) If electronic verification is used, a record of the documentation shall be maintained in the case record and shall not be requested again.

(D) Once the required documentation has been obtained by the county, the beneficiary shall not be required to provide it again, even if they are transferring to or applying in a new county.

(3) To the extent that federal financial participation is available, the department shall provide for exceptions or alternatives to the documentation requirements imposed by this subdivision as a means of providing individuals with increased flexibility and ability to provide satisfactory documentary evidence within a reasonable period of time. These exceptions or alternatives may include, but shall not be limited to, using an expanded list of acceptable documents, relying on electronic data matches for birth certificates, relying on a sworn affidavit of citizenship with respect to an individual who can demonstrate good cause for their inability or other failure to provide the required documentation, and relying on other information that may be available electronically.

(4) (A) To the extent that federal financial participation is available, the department shall rely on the eligibility determinations for the CalWORKs program or the Aid to Families with Dependent Children-Foster Care program as meeting the requirements of this section.

(B) To the extent that federal financial participation is available, an individual shall be deemed to have met the documentation requirements of this subdivision if the individual has been determined to be eligible for supplemental security income pursuant to Title XVI of the Social Security Act (42 U.S.C. Sec. 1601 et seq.).

(5) The following provisions shall apply to the extent that federal financial participation is available:

(A) If an individual cooperates in the effort to obtain and present the documentation required under this subdivision, the individual shall be given as much time as is allowed by federal law and policy to present that documentation.

(B) During the time period described in subparagraph (A), an applicant shall receive the scope of Medi-Cal benefits for which the applicant is otherwise eligible.

(6) To the extent that federal financial participation is available, the county shall do all of the following to assist an individual in obtaining and presenting the documentation required under this subdivision:

(A) For an applicant who does not present the required documentation at the time of application, the county, during the time period described in subparagraph (A) of paragraph (5), shall assist the applicant in obtaining that documentation.

(B) For a current beneficiary who has not yet documented their citizenship, the county shall do the following:

(i) If, at the time of annual redetermination, the beneficiary returns the annual redetermination form and, but for the failure to present the required documentation, continued eligibility could be established, the county shall do the following:

(I) Review county eligibility files and records, and the Medi-Cal Eligibility Data System, to access those documents. This review shall include a review of any CalWORKs or CalFresh files that may exist for the beneficiary.

(II) Attempt to reach the beneficiary by telephone to advise the beneficiary as to the need to obtain and present the required documentation.

(III) If the beneficiary fails to respond to the telephone contact or present the required documents, send a second form to the beneficiary that highlights the documentation being requested and informs the beneficiary to contact the county. The form shall be written in a simple, clear, consumer-friendly manner, and shall explain why the documentation is necessary.

(IV) If the beneficiary fails to contact the county, the county shall make another attempt to reach the beneficiary by telephone to advise the beneficiary of the need to obtain and present the required documentation.

(ii) Document in the case file any efforts made to contact and advise the beneficiary as to the need to obtain and present the required documentation.

(C) If a beneficiary fails to present the required documentation after the process required under clause (i), the county shall send a 10-day notice of action to indicate that the beneficiary's benefits are reduced to those made available under Section 14007.2.

(7) To the extent federal financial participation is available, and only to the extent any necessary federal approvals have been obtained, the department may, in its discretion, elect the option referenced in Section 1396a(a)(46)(B)(ii) of Title 42 of the United States Code to satisfy the requirements of paragraph (1). This paragraph shall become operative on January 1, 2010, or when all necessary agreements with the Commissioner of Social Security are in place, whichever is later. The department may implement this paragraph earlier than January 1, 2010, only to the extent allowed by federal law or guidance.

(8) (A) Any benefits provided in accordance with subparagraph (B) of paragraph (5) shall terminate if any of the following occurs:

(i) The individual does not obtain and present the required documentation within the time period provided in subparagraph (A) of paragraph (5).

(ii) The documentation is received by the county and the county has made a final determination of eligibility.

(B) The termination of Medi-Cal benefits under this paragraph shall occur without the necessity of further review or determination by the department. This shall not affect an individual's right to a hearing with respect to the denial of the application or termination of eligibility resulting from the annual eligibility redetermination.

(9) 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 subdivision by means of an all-county letter or similar instruction without taking regulatory action. Within three years from the date that this subdivision becomes effective, 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.

(10) The department shall notify and consult with advocates, providers, counties, and health plans in implementing, interpreting, or making specific this subdivision.

(11) The department shall file all necessary state plan amendments to implement the requirements of this subdivision. Upon filing any state plan amendment, the department shall provide the appropriate fiscal committees of the Legislature with a copy of the

state plan amendment.

(12) If any part of this subdivision is in conflict with or does not comply with federal law, the subdivision shall be implemented only to the extent that federal law permits. Any part that is in conflict with or does not comply with federal law shall be severable from the remaining portions of this subdivision.

(Amended by Stats. 2021, Ch. 296, Sec. 76. (AB 1096) Effective January 1, 2022.)

14011.25. To the extent federal financial participation is available, the department shall take all steps necessary to comply with the terms and conditions of the State Child Health Insurance Program waiver described in Section 12693.755 of the Insurance Code extending eligibility under the Healthy Families Program to parents and certain other adults. The department shall seek any state plan amendments or other waivers under Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 et seq.) necessary to implement this section.

(Added by renumbering Section 14011.2 (as added by Stats. 2001, Ch. 171, Sec. 34) by Stats. 2015, Ch. 303, Sec. 603. (AB 731) Effective January 1, 2016.)

14011.3. (a) To the same extent as required by federal law, a person who is not a citizen or national of the United States whose entry into the United States has been sponsored by an individual who, or organization that, executed an affidavit of support or similar agreement with respect to the person shall be ineligible for the Medi-Cal program for a period of five years after the person's entry into the United States unless the sponsoring person dies or the sponsoring organization ceases to exist.

(b) Subdivision (a) shall not apply with respect to any person who is not a citizen or national of the United States who is:

(1) Admitted to the United States as a result of the application, prior to April 1, 1980, of Section 1153(a)(7) of Title 8 of the United States Code.

(2) Admitted to the United States as a result of the application, after March 31, 1980, of Section 1157(c) of Title 8 of the United States Code.

(3) Paroled into the United States under Section 1182(d)(5) of Title 8 of the United States Code.

(4) Granted political asylum by the United States Attorney General under Section 1158 of Title 8 of the United States Code.

(5) A Cuban or Haitian entrant, as defined in Section 501(e) of the Refugee Education Assistance Act of 1980 (Public Law 96-422).

(c) This section shall become operative on the effective date of federal law that prohibits providing Medi-Cal assistance to a sponsored person, as defined in subdivision (a), and shall remain operative only as long as federal law remains in effect. The director shall determine the operative dates of this section pursuant to this subdivision and shall execute a declaration, that shall be retained by the director, that sets forth the operative date or termination date.

(Amended by Stats. 2021, Ch. 296, Sec. 77. (AB 1096) Effective January 1, 2022. Operation (or resumed operation) of this section is subject to conditions prescribed in subd. (c). After initial operation, this section may become inoperative as provided in subd. (c).)

14011.4. The department shall, subject to the requirements of federal law, and not later than six months after the effective date of this section, develop a simple referral form to be used as proof of birth, in order to initiate Medi-Cal enrollment and the establishment of benefits for newborns who are eligible for one year of automatic continuous Medi-Cal eligible benefits pursuant to Section 1902(e)(4) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(4)). In developing the referral form, the department shall seek input from beneficiary representatives and health care providers serving pregnant women receiving, or eligible for, Medi-Cal benefits. The infant's parent or guardian, or, with the knowledge and written consent of the infant's parent or guardian, a health care provider or other hospital worker, may submit the referral form by mail or facsimile. Upon receipt of the form, the department shall, subject to the requirements of federal law, assign a Medi-Cal number to the newborn and issue a Medi-Cal card.

(Added by Stats. 1997, Ch. 294, Sec. 58. Effective August 18, 1997.)

14011.5. The department shall be responsible for establishing the necessary systems for the identification, review and approval, disbursement, and reimbursement systems for those health services provided to the medically indigent population eligible for federal reimbursement under the Refugee/Cuban Haitian Entrant Program.

(Added by Stats. 1982, Ch. 1594, Sec. 27. Effective September 30, 1982.)

14011.6. (a) To the extent federal financial participation is available, the department shall exercise the option provided in Section 1920a of the federal Social Security Act (42 U.S.C. Sec. 1396r-1a) to implement a program for accelerated enrollment of children.

(b) The department shall designate the single point of entry, as defined in subdivision (c), as the qualified entity for determining eligibility under this section.

(c) For purposes of this section, “single point of entry” means the centralized processing entity that accepts and screens applications for benefits under the Medi-Cal Program for the purpose of forwarding them to the appropriate counties.

(d) The department shall implement this section only if, and to the extent that, federal financial participation is available.

(e) The department shall seek federal approval of any state plan amendments necessary to implement this section. When federal approval of the state plan amendment or amendments is received, the department shall commence implementation of this section on the first day of the second month following the month in which federal approval of the state plan amendment or amendments is received, or on July 1, 2002, whichever is later.

(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, without taking any regulatory action, implement this section by means of all-county letters. 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) Upon the receipt of an application for a child who has coverage pursuant to the accelerated enrollment program, a county shall determine whether the child is eligible for Medi-Cal benefits. If the county determines that the child does not meet the eligibility requirements for participation in the Medi-Cal program, the county shall report this finding to the Medical Eligibility Data System so that accelerated enrollment coverage benefits are discontinued. The information to be reported shall consist of the minimum data elements necessary to discontinue that coverage for the child. This subdivision shall become operative on July 1, 2002, or the date that the program for accelerated enrollment coverage for children takes effect, whichever is later.

(Amended by Stats. 2007, Ch. 188, Sec. 35. Effective August 24, 2007.)

14011.65. (a) To the extent allowed under federal law and only if federal financial participation is available under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.), the state shall administer the Medi-Cal to Healthy Families Accelerated Enrollment program, to provide any child who meets the criteria set forth in subdivision (b) with temporary health benefits for the period described in paragraph (2) of subdivision (b), as established under Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.

(b) (1) Any child who meets all of the following requirements, shall be eligible for temporary health benefits under this section:

(A) The child, or their parent or guardian, submits an application for the Medi-Cal program directly to the county.

(B) The child’s income, as determined on the basis of the application described in subparagraph (A), is within the income limits established by the Healthy Families Program.

(C) The child is under 19 years of age at the time of the application.

(D) The county determines, on the basis of the application described in subparagraph (A), that the child is eligible for full scope Medi-Cal with a spend down of excess income.

(E) The child is not receiving Medi-Cal benefits at the time that the application is submitted.

(F) The child, or their parent or guardian, gives, or has given consent for the application to be shared with the Healthy Families Program for purposes of determining the child’s Healthy Families Program eligibility.

(2) The period of accelerated eligibility provided for under this section begins on the first day of the month that the county finds that the child meets all of the criteria described in paragraph (1) and concludes on the last day of the month that the child either is fully enrolled in, or has been determined ineligible for, the Healthy Families Program.

(3) For any child who meets the requirements for temporary health benefits under this section, the county shall forward to the Healthy Families Program sufficient information from the child’s application to determine eligibility for the Healthy Families Program. To the extent possible, submission of that information to the Healthy Families Program shall be accomplished using an electronic process developed for use in the Medi-Cal-to-Healthy Families Bridge Benefits Program. The department shall give the Healthy Families Program a daily electronic file of all children provided temporary health benefits pursuant to this section.

(4) The temporary health benefits provided under this section shall be identical to the benefits provided to children who receive full-scope Medi-Cal benefits without a spend down of excess income and shall only be made available through a Medi-Cal provider.

(c) The department, in consultation with the Managed Risk Medical Insurance Board and representatives of the local agencies that administer the Medi-Cal program, consumer advocates, and other stakeholders, shall develop and distribute the policies and procedures, including any all-county letters, necessary to implement 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 shall implement this section by means of all-county letters or similar instructions, without taking any further regulatory action. Thereafter, the department may adopt regulations, as necessary, to implement this section 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.

(e) The department shall seek approval of any amendments to the state plan necessary to implement this section, in accordance with Title XIX (42 U.S.C. Sec. 1396 et seq.) of the Social Security Act. Notwithstanding any other law, only when all necessary federal approvals have been obtained shall this section be implemented.

(f) Under no circumstances shall this section be implemented unless the state has sought and obtained approval of any amendments to its state plan, as described in Section 12693.50 of the Insurance Code, necessary to implement this section and obtain funding under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.) for the provision of benefits provided under this section. Notwithstanding any other law, and only when all necessary federal approvals have been obtained by the state, this section shall be implemented only to the extent federal financial participation under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.) is available to fund benefits provided under this section.

(g) The department shall commence implementation of this section on the first day of the third month following the month in which federal approval of the state plan amendment or amendments described in subdivision (f), and subdivision (b) of Section 12693.50 of the Insurance Code is received, or on August 1, 2006, whichever is later.

(h) This section shall cease to be implemented on the date that the director executes a declaration, pursuant to subdivision (h) of Section 14011.65, stating that implementation of Section 14011.65a has commenced. Implementation of this section shall resume on the date that Section 14011.65a becomes inoperative, pursuant to subdivision (h) of that section.

(Amended by Stats. 2023, Ch. 42, Sec. 110. (AB 118) Effective July 10, 2023. As provided in subdivision (h), this section is not implemented during implementation of Section 14011.65a.)

14011.65a. (a) To the extent allowed under federal law under Title XIX (42) U.S.C. 1396 et seq.) and Title XXI (42 U.S.C. 1397aa et seq.) of the Social Security Act, and only if federal financial participation is available under Title XXI (42 U.S.C. 1397aa et seq.) of the Social Security Act, the state shall administer the Medi-Cal to Healthy Families Presumptive Eligibility Program, to provide any child who meets the criteria set forth in subdivision (b) with presumptive eligibility benefits for the period described in paragraph (4) of subdivision (b).

(b) (1) On the basis of an initial screen performed by the county when an application for Medi-Cal or Healthy Families Program eligibility is filed, any child who meets all of the following requirements, shall be eligible for presumptive eligibility benefits under this section:

(A) The child, or his or her parent or guardian, submits an application for the Medi-Cal program or the Healthy Families Program directly to the county.

(B) The child's income, as screened by the county on the basis of the application described in subparagraph (A), is not within the income levels necessary to establish no share-of-cost Medi-Cal eligibility.

(C) The child's income, as screened by the county on the basis of the application described in subparagraph (A), is within the income limits established by the Healthy Families Program.

(D) The child is under 19 years of age at the time of the application.

(E) The child is not receiving no-cost Medi-Cal or Healthy Families benefits at the time that the application is submitted.

(2) When the county performs the initial screen and determines that the child meets the criteria described in paragraph (1), the county shall establish presumptive eligibility for Healthy Families for that child. Once presumptive eligibility has been established, the county shall continue to determine child's eligibility for Medi-Cal on the basis of the filed application.

(3) When the county completes the Medi-Cal eligibility determination process and determines a child ineligible for no-cost Medi-Cal and the child appears to be income eligible for the Healthy Families Program, the county shall find the child presumptively eligible for the Healthy Families Program and comply with the standards set forth in paragraph (5) if either of the following conditions are met:

(A) The county determined the child eligible for Medi-Cal with a share of cost.

(B) The child is not income eligible for a poverty level program and the county did not establish no-cost Medi-Cal eligibility because the child did not complete or failed to pass the resource standard or establish disability or deprivation.

(4) The period of presumptive eligibility provided for under this section begins on the first day of the month that the county finds that the child meets all of the criteria described in paragraph (1) or (3), and concludes on the last day of the month of the child's effective date of coverage in the Healthy Families Program, or determination of ineligibility for the Healthy Families Program.

(5) (A) For any child who meets the requirements for presumptive eligibility benefits under this section, the county shall forward to the Healthy Families Program the child's application, to determine eligibility for the Healthy Families Program. The submission of the application to the Healthy Families Program shall be accomplished using an electronic format, specified by the department provided that the department has implemented the automated interfaces necessary to accomplish electronic submission of applications from the county to the Healthy Families Program without requiring duplicative data entry by the county. If all of the eligibility criteria set forth in paragraph (1) of subdivision (b) are established at the time of application, the application to Healthy Families Program shall be forwarded in accordance with the timeframes established by the department.

(B) The department shall give the Healthy Families Program a daily electronic file of all children provided presumptive eligibility benefits pursuant to this section.

(6) The presumptive eligibility benefits provided under this section shall be identical to the benefits provided to children who receive full-scope Medi-Cal benefits without a share of cost and shall only be made available through a Medi-Cal provider.

(c) The department, in consultation with the Managed Risk Medical Insurance Board and representatives of the local agencies that administer the Medi-Cal program, consumer advocates, and other stakeholders, shall develop and distribute the policies and procedures, including any all-county letters, necessary to implement 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 shall implement this section by means of all-county letters or similar instructions, without taking any further regulatory action. Thereafter, the department may adopt regulations, as necessary, to implement this section 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.

(e) The department shall seek approval of any amendments to the state plan necessary to implement this section, in accordance with Title XIX (42 U.S.C. Sec. 1396 et seq.) of the Social Security Act. Notwithstanding any other provision of law, only when all necessary federal approvals have been obtained shall this section be implemented.

(f) Under no circumstances shall this section be implemented unless the state has sought and obtained approval of any amendments to its state plan, as described in Section 12693.50 of the Insurance Code, necessary to implement this section and obtain funding under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.) for the provision of benefits provided under this section. Notwithstanding any other provision of law, and only when all necessary federal approvals have been obtained by the state, this section shall be implemented only to the extent federal financial participation under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.) is available to fund benefits provided under this section.

(g) The department shall commence implementation of this section on the first day of the third month following the month in which federal approval of the state plan amendment or amendments described in subdivision (f), and subdivision (b) of Section 12693.50 of the Insurance Code is received, or on August 1, 2007, whichever is later.

(h) Upon implementation of the Medi-Cal to Healthy Families Presumptive Eligibility Program pursuant to this section, the director shall execute a declaration, which shall be retained by the director, stating that implementation of this section has commenced. This section shall become inoperative three years after the date that the director executes the declaration, and shall be repealed on January 1 of the year following the date upon which this section becomes inoperative.

(Added by Stats. 2006, Ch. 328, Sec. 7. Effective January 1, 2007. Inoperative on date prescribed in subd. (h). Repealed on January 1 after inoperative date, by its own provisions.)

14011.65b. (a) To the extent federal financial participation is available, the department shall exercise the option provided in Section 1920a of the federal Social Security Act (42 U.S.C. Sec. 1396r-1a) to implement a program of presumptive eligibility for any child who meets both of the following criteria:

(1) He or she has been receiving, but is no longer eligible for, benefits under the Healthy Families Program.

(2) He or she appears to be income-eligible for full-scope Medi-Cal without a share of cost.

(b) The department shall designate the Managed Risk Medical Insurance Board or any agent designated by the Managed Risk Medical Insurance Board, including, but not limited to, the single point of entry defined in subdivision (c) of Section 14011.6, as the qualified entity for determining eligibility under this section.

(c) The presumptive eligibility benefits provided under this section shall be identical to the benefits provided to children who receive full-scope Medi-Cal benefits without a share of cost, and shall only be made available through a Medi-Cal provider.

(d) The department shall commence implementation of this section on July 1, 2007, or after all necessary federal approvals are obtained, whichever date is later. Upon implementation of the presumptive eligibility program described in this section, the Director of Health Care Services shall executive a declaration, which shall be retained by the director, stating that implementation of the program has commenced.

(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, initially implement this section by means of all-county letters. Thereafter, the department shall adopt any necessary 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.

(f) Upon the receipt of a timely and complete Medi-Cal application for a child who has coverage pursuant to the presumptive eligibility program authorized under this section, a county shall determine whether the child is eligible for Medi-Cal benefits. If the county determines that the child does not meet the eligibility requirements for participation in the Medi-Cal program, the county shall timely report this finding to the Medical Eligibility Data System so that presumptive eligibility benefits are discontinued.

(Added by Stats. 2007, Ch. 188, Sec. 36. Effective August 24, 2007.)

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

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

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

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

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

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

(c) Qualified hospitals may only make presumptive eligibility determinations based upon income for children, pregnant people, parents and other caretaker relatives, and other adults, whose income is calculated using the applicable MAGI-based income standard or for individuals who are 65 years of age or older, blind, or disabled whose income is not calculated using the applicable MAGI-based income standard for which federal approval is obtained pursuant to subdivision (g).

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

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

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 1, 2017, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(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.

(Amended by Stats. 2023, Ch. 372, Sec. 1. (AB 1481) Effective January 1, 2024.)

14011.7. (a) To the extent allowed under federal law and only if federal financial participation is available, the department shall exercise the option provided in Section 1396r-1a of Title 42 of the United States Code and the option provided in Section 1397gg(e)(1)(D) of Title 42 of the United States Code to implement a program for preenrollment of children into the Medi-Cal program. Upon

the exercise of both of the federal options described in this subdivision, the department shall implement the Children's Presumptive Eligibility Program for the preenrollment of children into the Medi-Cal program.

(b) (1) Before July 1, 2003, the department shall develop an electronic application to serve as the application for the Children's Presumptive Eligibility Program, to the extent allowed under federal law.

(2) The department may, at its option, also use the electronic application developed pursuant to paragraph (1), as a means to enroll newborns into the Medi-Cal program as is authorized under Section 1396a(e)(4) of Title 42 of the United States Code. Providers may submit newborn enrollments through the electronic application on behalf of patients without a patient's signature.

(c) (1) The department may designate, as necessary, Medi-Cal providers as qualified entities who are authorized to determine eligibility for preenrollment into the Medi-Cal program as authorized under this section.

(2) The provider shall assist the parent or guardian of the child seeking eligibility for preenrollment into the Medi-Cal program in completing the electronic application.

(d) The electronic application developed pursuant to subdivision (b) may only be filed when the child is in need of Medi-Cal.

(e) (1) The electronic application developed pursuant to subdivision (b) shall request all information necessary for a provider to make an immediate determination as to whether a child meets the eligibility requirements for preenrollment into the Medi-Cal program pursuant to the federal options described in Section 1396r-1a or 1397gg(e)(1)(D) of Title 42 of the United States Code.

(2) (A) If the electronic application indicates that the child is seeking eligibility for no cost full-scope Medi-Cal benefits, the department shall mail to the child's parent or guardian a followup application for Medi-Cal program eligibility. The parent or guardian of the child shall be advised to complete and submit to the appropriate entity the followup application.

(B) The followup application, at a minimum, shall include all notices and forms necessary for the Medi-Cal program eligibility determination under state and federal law, including, but not limited to, any information and documentation that is required for the joint application package described in Section 14011.1.

(C) The date of application for the Medi-Cal program is the date the completed followup application is submitted with the appropriate entity by the parent or guardian.

(3) Upon making a determination pursuant to paragraph (1) that a child is eligible, the provider shall inform the child's parent or guardian of both of the following:

(A) That the child has been determined to be eligible for preenrollment into the Medi-Cal program.

(B) That if the child has been determined to be eligible for preenrollment into the Medi-Cal program, the period of preenrollment eligibility will end on the last day of the month following the month in which the determination of preenrollment eligibility is made, unless the parent or guardian completes and returns to the appropriate entity the followup application described in paragraph (2) on or before that date.

(4) If the followup application described in paragraph (2) is submitted on or before the last day of the month following the month in which a determination is made that the child is eligible for preenrollment into the Medi-Cal program, the period of preenrollment eligibility shall continue until the completion of the determination process for the applicable program or programs.

(f) The department shall seek approval of any amendments to the state plan, necessary to implement this section, for purposes of funding under Title XIX (42 U.S.C. 1396 et seq.) and Title XXI (42 U.S.C. 1397aa et seq.) of the Social Security Act. Notwithstanding any other provision of law and only when all necessary federal approvals have been obtained, this section shall be implemented only to the extent federal financial participation is available.

(g) To implement this section, the department may contract with public or private entities, or utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary, only if services provided under the program are specifically identified and reimbursed in a manner that appropriately claims federal financial reimbursement. Contracts, including the Medi-Cal fiscal intermediary contracts and contract amendments, any system change pursuant to a change order, and any project or systems development notice shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, and any policies, procedures, or regulations authorized by these laws.

(h) 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 any further regulatory action. Thereafter, the department shall adopt regulations, as necessary, to implement this section 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.

(Amended by Stats. 2023, Ch. 42, Sec. 111. (AB 118) Effective July 10, 2023.)

14011.75. (a) The department shall conduct, or contract for the conducting of, a feasibility study report of technological requirements for modifying the electronic application authorized pursuant to Section 14011.7, known as the CHDP Gateway, to allow a person applying on behalf of a child the option to simultaneously preenroll and apply for enrollment in the Medi-Cal program or the Healthy Families Program over the Internet without submitting a followup paper application pursuant to the criteria set forth in subdivision (c).

(b) The results of the feasibility study report shall be provided to the fiscal and health policy committees of the Legislature on or before March 1, 2008.

(c) (1) The modifications to the CHDP Gateway that shall be the subject of the feasibility study report of technological requirements under subdivision (a) shall allow an optional electronic application for enrollment to be submitted at the time of applying for preenrollment, so long as written consent to exercise the option is obtained.

(2) The optional electronic application developed for the purposes of this section shall comply with all of the following:

(A) Be the simplest permitted by federal law to achieve the purposes of this section, except that nothing in this section shall allow self-certification of income.

(B) Be adequate to constitute an application for medical assistance.

(C) Request only the information that is necessary to provide the child with continuing preliminary benefits within the meaning of subdivision (b) of Section 14011.8 until a final eligibility determination is made pursuant to the federal options described in Section 1396r-1a or Section 1397ee(1)(D) of Title 42 of the United States Code and to the extent federal financial participation is allowed.

(d) The department shall consult with representatives of consumers, counties, and medical providers in developing the policies and procedures for the modifications to the CHDP Gateway that shall be the subject of the feasibility study report of technological requirements under this section.

(Added by Stats. 2006, Ch. 332, Sec. 1. Effective January 1, 2007.)

14011.78. (a) The department may contract with public or private entities, or utilize existing health care service provider payment mechanisms, including the Medi-Cal program's fiscal intermediary, in order to implement subdivision (b) of Section 12693.26 and subdivision (e) of Section 12696.05 of the Insurance Code, only if services provided under those sections are specifically identified and reimbursed in a manner that appropriately claims federal financial reimbursement.

(b) Contracts under this section, including the Medi-Cal fiscal intermediary contract, and including any contract amendment, any system change pursuant to a change order, and any project or systems development notice, shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, and any policies, procedures, or regulations authorized by these laws.

(Added by Stats. 2011, Ch. 29, Sec. 8. (AB 102) Effective June 29, 2011.)

14011.8. (a) Benefits provided to an individual pursuant to a preliminary determination as described in Section 1396r-1, 1396r-1a, or 1396r-1b of Title 42 of the United States Code shall end, without the necessity for any further review or determination by the department, on or before the last day of the month following the month in which the preliminary determination was made, unless an application for medical assistance under the state plan is filed on or before that date.

(b) If an application for medical assistance is filed on or before the last day of the month following the month in which the preliminary determination was made, preliminary benefits shall continue until the regular eligibility determination based on the application has been completed. The application shall be treated in all respects as an initial application for benefits and the following shall apply:

(1) In the case of an applicant who is found eligible for medical assistance, benefits shall be granted in an amount and under those conditions, including imposition of a spend down of excess income, as have been found applicable pursuant to the regular eligibility determination.

(2) In the case of all other applicants, provision of preliminary benefits shall end on the day that the regular eligibility determination is made.

(c) Notwithstanding any other law, medical assistance pursuant to a preliminary determination as described in Section 1396r-1, 1396r-1a, or 1396r-1b of Title 42 of the United States Code shall be provided only if and to the extent federal financial participation is available.

(Amended by Stats. 2023, Ch. 42, Sec. 112. (AB 118) Effective July 10, 2023.)

14011.9. (a) On or before October 1, 2002, the department shall issue instructions to counties via an all-county letter or similar instructions to establish an automated system for tracking the status of applications received by county welfare departments from the centralized processing entity that accepts and screens applications for benefits under the Medi-Cal program for the purpose of forwarding these applications to the appropriate counties. Except for reporting denials of applications on behalf of children enrolled in accelerated Medi-Cal coverage pursuant to subdivision (g) of Section 14011.6, the department shall not institute a process to require county welfare departments to routinely manually report to the Medi-Cal Eligibility Data System (MEDS) regarding the status of applications for Medi-Cal coverage prior to the development of an interface between that county's automated eligibility determination system and the MEDS system for the purposes of implementing this section. It is the intent of the Legislature that the Health Human Services Data Center and the counties complete the automation changes necessary to implement the automated tracking system on or before July 1, 2003.

(b) This section shall be implemented only to the extent that federal financial participation is not jeopardized.

(c) Nothing in this section shall be construed as prohibiting the department from requiring a county to report on the status of an individual application or to manually generate a report on a statistically valid sampling of applications pursuant to federally required monitoring activities.

(Added by Stats. 2002, Ch. 1161, Sec. 47. Effective September 30, 2002.)

14012. (a) The Legislature finds and declares that the goal of the Medi-Cal program is to provide comprehensive health care to low-income Californians who cannot afford the cost of health care.

(b) (1) The department may seek waivers of federal Medicaid requirements in furtherance of this goal, including, but not limited to, demonstration projects that aim to either increase the number of Medi-Cal beneficiaries or enhance the medical assistance provided to beneficiaries.

(2) A waiver proposed by the department, which offers nonmedical benefits to Medi-Cal beneficiaries, including, but not limited to, employment or housing assistance, shall offer these benefits on a voluntary basis, and not as a condition of receiving medical assistance.

(c) Prior to applying for a federal waiver or an extension of a federal waiver, the department shall provide a public notice and comment period pursuant to Section 431.408 of Title 42 of the Code of Federal Regulations, effective April 27, 2012, and any other subsequently developed federal requirements.

(Added by Stats. 2018, Ch. 692, Sec. 1. (SB 1108) Effective January 1, 2019.)

14012.5. (a) By July 1, 2007, the department shall implement a process that allows applicants and beneficiaries to self-certify the amount and nature of assets and income without the need to submit income or asset documentation.

(b) The process shall apply to applicants and beneficiaries in the program described in Section 14005.30, the federal poverty level programs for infants, children and pregnant women, the Medically-Indigent and Medically-Needy Programs for children and families, and other similar programs designated by the department, in order to preserve family unity or simplify administration. The process shall not apply to applicants or beneficiaries whose eligibility is based on their status as aged, blind, or based upon a disability determination unless, to the extent possible, they are members of families in which a child, parent, or spouse of that person is also a Medi-Cal applicant or beneficiary.

(c) The department shall implement the process of self-certification in two phases. The first phase shall be implemented in two counties as established in subdivision (d), and consistent with requirements set forth in this section. The second phase shall be implemented statewide as established in subdivision (h) and subject to the conditions set forth in this section.

(d) The department shall implement the first phase in two counties that have a combined Medi-Cal population of approximately 10 percent of the total statewide Medi-Cal population for the programs described in subdivision (b) as being eligible for the self-certification process. The department shall select the two counties for the initial phase of implementation by considering the following factors:

(1) The county's demonstrated record of completing eligibility determinations and redeterminations accurately and on a timely basis.

(2) The county's demonstrated record of accurately, quickly and successfully implementing programs.

(e) Each county shall agree to meet all federal requirements for income, resource, and other verifications, and to perform determinations and verifications in a timely manner.

(f) Following a two-year implementation of the first phase, the department shall promptly provide the fiscal and policy committees of the Legislature with an evaluation of the self-certification process and its impacts on the Medi-Cal program, including its impact on

enrolling and retaining eligible persons, simplifying the program, assuring program and fiscal integrity, administrative costs, and its overall cost-benefit to the state.

(g) The director may modify or terminate the first phase of implementation not sooner than 90 days after providing notification to the Chair of the Joint Legislative Budget Committee. This notification shall articulate the specific reasons for the modification or termination and shall include all relevant data elements which are applicable to document the reasons provided for said modifications or termination. Upon the request of the Chair of the Joint Legislative Budget Committee, the director shall promptly provide any additional clarifying information regarding the first phase of implementation as requested.

(h) Following two years of operation in two counties and submission of the evaluation to the Legislature, the director, in consultation with the Department of Finance, shall determine whether to implement the self-certification process statewide. This determination shall be based on the outcomes of the evaluation, including the ability to increase enrollment of eligible children and families, and to maintain the overall integrity of the Medi-Cal program. Statewide implementation shall be contingent on a specific appropriation being provided for this purpose in the Budget Act or subsequent legislation.

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

(j) 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 any further regulatory action. Thereafter, the department shall adopt regulations, as necessary, to implement this section 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.

(k) The department, in consultation with the Department of Finance, counties, and other interested stakeholders, shall determine which types of assets and income are appropriate for self-certification under this section.

(l) Nothing in this section shall be read to preclude a county from requesting documentation from any applicant or beneficiary regarding any income or asset where a question arises about such income or asset during the county's determination or redetermination of eligibility following receipt of the application or annual redetermination form.

(m) Nothing in this section shall change the ability of the department to self-certify income, assets, or other program information to the extent allowed under state or federal law, waiver, or the state plan.

(n) (1) This section shall not be implemented if the voters approve Proposition 86, the tobacco tax initiative, at the statewide general election on November 7, 2006.

(2) Notwithstanding paragraph (1) if Proposition 86 is approved by the voters at the statewide general election on November 7, 2006, this section shall be implemented during the pendency of any legal action concerning the validity of the proposition.

(Added by Stats. 2006, Ch. 328, Sec. 8. Effective January 1, 2007.)

14013. The department shall establish a system for investigation of a sufficient sample of applications and affirmations as shall be deemed necessary to assure the validity of such applications.

(Added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)

14013.3. (a) When determining whether an individual is eligible for Medi-Cal benefits, the department shall verify the accuracy of the information identified in this section that is provided as a part of the application or redetermination process in conformity with this section.

(b) Before requesting additional verification from an applicant or beneficiary for information they provide as part of the application or redetermination process, the department shall obtain information about an individual that is available electronically from other state and federal agencies and programs in determining an individual's eligibility for Medi-Cal benefits or for potential eligibility for an insurance affordability program offered through the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code. Needed information shall be obtained from the following sources, including any other source the department determines is useful:

(1) Information related to wages, net earnings from self-employment, unearned income, and resources from any of the following:

(A) The State Wage Information Collection Agency.

(B) The federal Internal Revenue Service.

(C) The federal Social Security Administration.

(D) The Employment Development Department.

(E) The state administered supplementary payment program under Section 1382e of Title 42 of the United States Code.

(F) Any state program administered under a plan approved under Titles I, X, XIV, or XVI of the federal Social Security Act.

(2) Information related to eligibility or enrollment from any of the following:

(A) The CalFresh program pursuant to Chapter 10 (commencing with Section 18900) of Part 6.

(B) The CalWORKs program.

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

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

(E) The electronic service established in accordance with Section 435.949 of Title 42 of the Code of Federal Regulations.

(c) (1) If the income information obtained by the department pursuant to subdivision (b) is reasonably compatible with the information provided by or on behalf of the individual, the department shall accept the information provided by or on behalf of the individual as being accurate.

(2) If the income information obtained by the department is not reasonably compatible with the information provided by or on behalf of the individual, the department shall require that the individual provide additional information that reasonably explains the discrepancy.

(3) For the purposes of this subdivision, income information obtained by the department is reasonably compatible with information provided by or on behalf of an individual if any of the following conditions are met:

(A) Both state that the individual's income is above the applicable income standard or other relevant income threshold for eligibility.

(B) Both state that the individual's income is at or below the applicable income standard or other relevant income threshold for eligibility.

(C) The information provided by or on behalf of the individual states that the individual's income is above, and the information obtained by the department states that the individual's income is at or below, the applicable income standard or other relevant income threshold for eligibility.

(4) If subparagraph (C) of paragraph (3) applies, the individual shall be informed that the income information provided by them was higher than the information that was electronically verified and that they may request a reconciliation of the difference. This paragraph shall be implemented no later than January 1, 2015.

(d) (1) The department shall accept the attestation of the individual regarding whether they are pregnant unless the department has information that is not reasonably compatible with the attestation.

(2) If the information obtained by the department is not reasonably compatible with the information provided by or on behalf of the individual under paragraph (1), the department shall require that the individual provide additional information that reasonably explains the discrepancy.

(e) If any information not described in subdivision (c) or (d) that is needed for an eligibility determination or redetermination and is obtained by the department is not reasonably compatible with the information provided by or on behalf of the individual, the department shall require that the individual provide additional information that reasonably explains the discrepancy.

(f) The department shall develop, and update as it is modified, a verification plan describing the verification policies and procedures adopted by the department to verify eligibility information. If the department determines that any state or federal agencies or programs not previously identified in the verification plan are useful in determining an individual's eligibility for Medi-Cal benefits or for potential eligibility, for an insurance affordability program offered through the California Health Benefit Exchange, the department shall update the verification plan to identify those additional agencies or programs. The development and modification of the verification plan shall be undertaken in consultation with representatives from county human services departments, legal aid advocates, and the Legislature. This verification plan shall conform to all federal requirements and shall be posted on the department's internet website.

(g) 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.

(h) 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.

(i) This section shall become operative on January 1, 2026.

(Amended (as amended by Stats. 2023, Ch. 42, Sec. 113) by Stats. 2025, Ch. 21, Sec. 86. (AB 116) Effective June 30, 2025. Operative January 1, 2026, by its own provisions.)

14013.3. (a) When determining whether an individual is eligible for Medi-Cal benefits, the department shall verify the accuracy of the information identified in this section that is provided as a part of the application or redetermination process in conformity with this section.

(b) Before requesting additional verification from an applicant or beneficiary for information they provide as part of the application or redetermination process, the department shall obtain information about an individual that is available electronically from other state and federal agencies and programs in determining an individual's eligibility for Medi-Cal benefits or for potential eligibility for an insurance affordability program offered through the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code. Needed information shall be obtained from the following sources, including any other source the department determines is useful:

(1) Information related to wages, net earnings from self-employment, and unearned income from any of the following:

(A) The State Wage Information Collection Agency.

(B) The federal Internal Revenue Service.

(C) The federal Social Security Administration.

(D) The Employment Development Department.

(E) The state administered supplementary payment program under Section 1382e of Title 42 of the United States Code.

(F) Any state program administered under a plan approved under Titles I, X, XIV, or XVI of the federal Social Security Act.

(2) Information related to eligibility or enrollment from any of the following:

(A) The CalFresh program pursuant to Chapter 10 (commencing with Section 18900) of Part 6.

(B) The CalWORKs program.

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

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

(E) The electronic service established in accordance with Section 435.949 of Title 42 of the Code of Federal Regulations.

(c) (1) If the income information obtained by the department pursuant to subdivision (b) is reasonably compatible with the information provided by or on behalf of the individual, the department shall accept the information provided by or on behalf of the individual as being accurate.

(2) If the income information obtained by the department is not reasonably compatible with the information provided by or on behalf of the individual, the department shall require that the individual provide additional information that reasonably explains the discrepancy.

(3) For the purposes of this subdivision, income information obtained by the department is reasonably compatible with information provided by or on behalf of an individual if any of the following conditions are met:

(A) Both state that the individual's income is above the applicable income standard or other relevant income threshold for eligibility.

(B) Both state that the individual's income is at or below the applicable income standard or other relevant income threshold for eligibility.

(C) The information provided by or on behalf of the individual states that the individual's income is above, and the information obtained by the department states that the individual's income is at or below, the applicable income standard or other relevant income threshold for eligibility.

(4) If subparagraph (C) of paragraph (3) applies, the individual shall be informed that the income information provided by them was higher than the information that was electronically verified and that they may request a reconciliation of the difference. This paragraph shall be implemented no later than January 1, 2015.

(d) (1) The department shall accept the attestation of the individual regarding whether they are pregnant unless the department has information that is not reasonably compatible with the attestation.

(2) If the information obtained by the department is not reasonably compatible with the information provided by or on behalf of the individual under paragraph (1), the department shall require that the individual provide additional information that reasonably explains the discrepancy.

(e) If any information not described in subdivision (c) or (d) that is needed for an eligibility determination or redetermination and is obtained by the department is not reasonably compatible with the information provided by or on behalf of the individual, the department shall require that the individual provide additional information that reasonably explains the discrepancy.

(f) The department shall develop, and update as it is modified, a verification plan describing the verification policies and procedures adopted by the department to verify eligibility information. If the department determines that any state or federal agencies or programs not previously identified in the verification plan are useful in determining an individual's eligibility for Medi-Cal benefits or for potential eligibility, for an insurance affordability program offered through the California Health Benefit Exchange, the department shall update the verification plan to identify those additional agencies or programs. The development and modification of the verification plan shall be undertaken in consultation with representatives from county human services departments, legal aid advocates, and the Legislature. This verification plan shall conform to all federal requirements and shall be posted on the department's internet website.

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

(h) 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.

(i) This section shall become inoperative on January 1, 2026, and, as of January 1, 2027, is repealed.

(Amended (as added by Stats. 2023, Ch. 42, Sec. 114) by Stats. 2025, Ch. 21, Sec. 87. (AB 116) Effective June 30, 2025. Inoperative January 1, 2026, by its own provisions. Repealed as of January 1, 2027, by its own provisions. See later operative version, as amended by Sec. 86 of Stats. 2025, Ch. 21.)

14013.5. (a) Pursuant to, and only to the extent required by, Section 1940 of the federal Social Security Act (42 U.S.C. Sec. 1396w) and subject to the provisions of this section, the department shall implement an asset verification program for the purpose of determining or redetermining the eligibility of an applicant for, or recipient of, Medi-Cal benefits on the basis of being aged, blind, or disabled.

(b) (1) Any applicant or recipient described in subdivision (a), and any other person whose resources are required by law to be disclosed to determine the eligibility of the applicant or recipient, shall provide authorization for the department to obtain from any financial institution any financial record held by the institution with respect to the applicant or recipient, and any other person, as applicable, whenever the department determines the record is needed in connection with a determination with respect to the eligibility for, or the amount or extent of, the medical assistance.

(2) The department's obtaining of financial records pursuant to this section shall be subject to the cost reimbursement requirements of Section 1115(a) of the federal Right to Financial Privacy Act of 1978 (12 U.S.C. Sec. 3415(a)) and shall be at no cost to the applicant, recipient, or any other person.

(3) An authorization under this subdivision shall not be required for any applicant or recipient whose assets have been verified by the federal Social Security Administration.

(4) An authorization under this subdivision shall only be required for those applicants and recipients as required by federal law and federal guidance.

(c) As used in this section:

(1) “Financial institution” has the same meaning as defined in Section 1101(1) of the federal Right to Financial Privacy Act of 1978 (12 U.S.C. Sec. 3401(1)).

(2) “Financial record” has the same meaning as defined in Section 1101(2) of the federal Right to Financial Privacy Act of 1978 (12 U.S.C. Sec. 3401(2)).

(3) “Any other person” shall mean the spouse of an applicant or recipient, a parent of an unemancipated minor, or any other person whose resources are required by federal law to be disclosed to determine the eligibility of the applicant or recipient.

(d) An authorization provided to the department under subdivision (b) shall remain effective until the earlier of:

(1) The rendering of a final adverse decision on the applicant’s application for medical assistance.

(2) The cessation of the recipient’s eligibility for the medical assistance.

(3) The express revocation by the applicant or recipient, or other required person, as applicable, of the authorization, in a written notification to the department.

(e) (1) An authorization obtained by the department under subdivision (b) shall be considered as meeting the requirements of Section 1103(a) of the federal Right to Financial Privacy Act of 1978 (12 U.S.C. Sec. 3403(a)) and, notwithstanding Section 1104(a) of the federal Right to Financial Privacy Act of 1978 (12 U.S.C. Sec. 3404(a)), need not be furnished to the financial institution.

(2) The certification requirements of Section 1103(b) of the federal Right to Financial Privacy Act of 1978 (12 U.S.C. Sec. 3403(b)) shall not apply to requests by the department or its designee pursuant to an authorization provided under subdivision (b).

(3) A request by the department or its designee pursuant to an authorization provided under subdivision (b) shall be deemed to meet the requirements of Section 1104(a)(3) of the federal Right to Financial Privacy Act of 1978 (12 U.S.C. Sec. 3404(a)(3)) and of Section 1102 of the act (12 U.S.C. Sec. 3402), relating to a reasonable description of financial records.

(f) If an applicant for, or recipient of, medical assistance, or other required person, as applicable, refuses to provide, or revokes, any authorization made by the applicant or recipient, or other required person, as applicable, for the department to obtain from any financial institution any financial record, the department may, on that basis, determine that the applicant or recipient is ineligible for medical assistance.

(g) The department shall provide the applicant or recipient with notice of the asset verification requirement of this section, including privacy protections and the duration and scope of the authorization, prior to the applicant or recipient being requested to provide the authorization required by subdivision (b).

(h) The department shall, in coordination with the counties and advocates, develop criteria regarding how and when the authorization required under subdivision (b) will be required, how and when verification will be required, what standards will be used, and the content of the notice to the applicants and recipients described in subdivision (g) concerning the authorization.

(i) Notwithstanding the rulemaking provisions of 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 any regulatory action, this section by means of an all-county letter or similar instruction. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(j) To implement this section, the department may contract with public or private entities that shall be subject to the same requirements and limitations on use and disclosure of information as would apply if the department were to implement this section directly. In order to demonstrate good faith efforts to meet federal implementation requirements of Section 1940 of the federal Social Security Act (42 U.S.C. Sec. 1396w) and to avoid any withholding of federal financial participation, the Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Therefore, contracts under this section shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part. Contracts under this section shall be exempt from the requirements of Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of the Government Code.

(Added by Stats. 2009, 4th Ex. Sess., Ch. 5, Sec. 34. Effective July 28, 2009.)

14014. (a) Any person receiving health care for which he or she was not eligible on the basis of false declarations as to his or her eligibility or any person making false declarations as to eligibility on behalf of any other person receiving health care for which that other person was not eligible shall be liable for repayment and shall be guilty of a misdemeanor or felony depending on the amount paid on his or her behalf for which he or she was not eligible, as specified in Section 487 of the Penal Code.

(b) (1) Any person who willfully and knowingly counsels or encourages any individual to make false statements or otherwise causes false statements to be made on an application, in order to receive health care services to which the applicant is not entitled, shall be liable to the Medi-Cal program for damages incurred for the cost of services rendered to the applicant.

(2) Paragraph (1) shall be implemented to the extent permitted by federal law and to the extent that implementation of paragraph (1) does not affect the availability of federal financial participation.

(Amended by Stats. 1996, Ch. 837, Sec. 1. Effective January 1, 1997.)

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

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

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

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

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

(2) Be effective until the applicant or beneficiary cancels or modifies the authorization or appoints a new authorized representative, or the authorized representative informs the agency that he or she is no longer acting in that capacity or there is a change in the legal authority on which the authority was based. The notice shall conform to all federal requirements.

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

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

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

(1) “Authorized representative” means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Added by Stats. 2013, 1st Ex. Sess., Ch. 4, Sec. 23. (SB 1 1x) Effective September 30, 2013.)

14015. (a) (1) The providing of health care under this chapter shall not impose any limitation or restriction upon the person's right to sell, exchange or change the form of property holdings nor shall the care provided constitute any encumbrance on the holdings. However, the transfer or gift of assets, including income and resources, for less than fair market value shall, pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act, result in a period of ineligibility for medical assistance for home and facility care, which may include partial months of ineligibility, applied in accordance with federal law.

(2) Any items, including notes, loans, life estates, or annuities that are held and distributed in a manner that is not in conformity with the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and regulations adopted pursuant to that act, shall be treated as a transferred asset and may result in a period of ineligibility as described in paragraph (1), as required by Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act.

(b) Pursuant to Section 1917 (c)(2)(C)(ii) of the federal Social Security Act (42 U.S.C. Sec. 1396p(c)(2)(C)(ii)), a satisfactory showing that assets transferred exclusively for a purpose other than to qualify for medical assistance shall not result in ineligibility for Medi-Cal and shall include, but not be limited to, the following:

(1) Assets that would have been considered exempt for purposes of establishing eligibility pursuant to federal or state laws at the time of transfer.

(2) Property with a net market value that, when the property is transferred, if included in the property reserve, would not result in ineligibility.

(3) Assets for which adequate consideration is received.

(4) Property upon which foreclosure or repossession was imminent at the time of transfer, provided there is no evidence of collusion.

(5) Assets transferred in return for an enforceable contract for life care that does not include complete medical care.

(6) Assets transferred without adequate consideration, provided that the applicant or beneficiary provides convincing evidence to overcome the presumption that the transfer was for the purpose of establishing eligibility or reducing the spend down of excess income.

(c) In administering this section, it shall be presumed that assets transferred by the applicant or beneficiary prior to the look-back period established by the department preceding the date of initial application were not transferred to establish eligibility or reduce the spend down of excess income. These assets shall not be considered in determining eligibility.

(d) Any item of durable medical equipment that is purchased for a recipient pursuant to this chapter exclusively with Medi-Cal program funds shall be returned to the department when the department determines that the item is no longer medically necessary for the recipient. Items of durable medical equipment shall include, but are not limited to, wheelchairs and special hospital beds.

(e) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act, and only to the extent that federal financial participation is available.

(f) (1) 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 regulations are adopted.

(2) The department shall adopt regulations by January 1, 2030, 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. The department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations are adopted.

(g) It is the intent of the Legislature that the provisions of this section shall apply prospectively to any individual to whom the act applies commencing from the date regulations adopted pursuant to this section are filed with the Secretary of State. Transfers or gifts of assets prior to the implementation of this section are exempt, to the extent allowed under federal law and regulations.

(h) This section shall become operative on January 1, 2026.

(Amended by Stats. 2025, Ch. 21, Sec. 88. (AB 116) Effective June 30, 2025. Operative January 1, 2026, by its own provisions.)

14015.1. (a) The department shall consider, at initial application or redetermination, whether an undue hardship, as described in subdivision (b), exists prior to finding that an applicant or recipient is subject to a period of ineligibility for medical assistance for home and facility care pursuant to this article. No person shall be subject to a period of ineligibility for medical assistance for home and facility care at the time of the initial application or redetermination if the department determines that an undue hardship exists.

(b) An undue hardship shall be found to exist under any of the following circumstances:

(1) The individual has been determined eligible for medical assistance for home and facility care based on an application filed on or after January 1, 2006, and before the date that regulations adopted pursuant or relating to this section have been certified with the Secretary of State.

(2) The deprivation of medical assistance for home and facility care would cause an endangerment to the life or health of the individual.

(3) The denial of medical assistance for home and facility care would result in the eviction of the individual from a nursing home.

(4) The individual is otherwise eligible for the Medi-Cal program and unable to obtain home and facility care without Medi-Cal.

(5) The denial of medical assistance for home and facility care would cause the individual to be unable to remain at home or in the community and would hasten or cause the individual’s entry into a medical or long-term care institution.

(6) The individual would be deprived of food, clothing, shelter, or other necessities of life.

(c) The department shall establish regulations, procedures, and forms that ensure all of the following:

(1) The department or county provides a notice of the undue hardship process, at the initial request and the annual redetermination, to any individual who requests medical assistance for home and facility care. The notice shall inform the individual that undue hardship shall be considered before a request for medical assistance for home and facility care is denied.

(2) A timely and simplified process is established to determine whether an undue hardship exists and an exception will be granted.

(3) If the issue of undue hardship is considered and found not to apply, the department shall provide the individual with a notice of action that states the reasons for the adverse determination. The notice of action shall specify how that adverse determination can

be appealed. Upon the request of the applicant or beneficiary, or person acting on his or her behalf, undue hardship notices shall be provided to the home and facility care administrator in accordance with regulations promulgated by the department.

(d) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act, and only to the extent that federal financial participation is available.

(e) To the extent that regulations are necessary to implement this section, the department shall promulgate regulations using the nonemergency regulatory process described in Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of the Government Code.

(f) It is the intent of the Legislature that the provisions of this section shall apply prospectively to any individual to whom the act applies commencing from the date regulations adopted pursuant to this act are filed with the Secretary of State.

(Added by Stats. 2008, Ch. 379, Sec. 9. Effective January 1, 2009.)

14015.12. (a) For the purposes of this section, the following definitions shall apply:

(1) “Opposite-sex spouse” means a person of the opposite sex who is legally married to an applicant for, or recipient of, home and facility care.

(2) “Registered domestic partner” means a person that meets the requirements of Section 297 of the Family Code and with whom the applicant for, or recipient of, home and facility care shares the common residence.

(3) “Same-sex spouse” means a person of the same sex who is legally married to an applicant for, or recipient of, home and facility care.

(b) In addition to the requirements of Section 14015.1, the department shall consider, at initial application or redetermination, whether an undue hardship, as described in subdivision (c), exists prior to finding that an applicant or recipient is subject to a period of ineligibility for medical assistance for home and facility care pursuant to this article. No person shall be subject to a period of ineligibility for medical assistance for home and facility care at the time of the initial application or redetermination if the department determines that an undue hardship exists.

(c) An undue hardship shall be found to exist under any of the following circumstances:

(1) The applicant for, or recipient of, home and facility care transferred all or any portion of their ownership interest in the shared principal residence to their same-sex spouse or registered domestic partner.

(2) (A) Subject to the requirements of subparagraph (B), the applicant for, or recipient of, home and facility care transferred their ownership interest in resources other than the shared principal residence to their same-sex spouse or registered domestic partner and the value of those resources does not exceed the value of resources that the individual could transfer to their same-sex spouse or registered domestic partner and does not exceed the community spouse resource allowance that would be available to that person if they were an opposite-sex spouse. When considering whether an undue hardship exists under this paragraph, the Medi-Cal eligibility determination rules applicable to resource evaluations for an applicant for, or recipient of, home and facility care and their opposite-sex spouse shall be used to determine the resources available to an applicant for, or recipient of, home and facility care and their same-sex spouse or registered domestic partner.

(B) If the value of the resources transferred exceeds the limit specified in subparagraph (A), the amount of resources transferred that meet the limit shall be subject to the undue hardship exception specified in subparagraph (A) and the amount of resources transferred in excess of the limit shall not be subject to an undue hardship exception under this section and shall be considered a transfer of assets for less than fair market value.

(3) (A) Subject to the requirements of subparagraph (B), the applicant for, or recipient of, home and facility care transferred their income or right to receive income to their same-sex spouse or registered domestic partner and the amount of the transferred income does not exceed the amount of income that the individual could transfer to their same-sex spouse or registered domestic partner and does not exceed the maximum monthly spousal income allowance that would be available to that person if they were an opposite-sex spouse. When considering whether an undue hardship exists under this paragraph, the Medi-Cal eligibility determination rules applicable to income evaluations for an applicant for, or recipient of, home and facility care and their opposite-sex spouse shall be used to determine the income available to an applicant for, or recipient of, home and facility care and their same-sex spouse or registered domestic partner.

(B) If the amount of income transferred exceeds the limit specified in subparagraph (A), the amount of income transferred that meets the limit shall be subject to the undue hardship exception specified in subparagraph (A) and the amount of income transferred in excess of the limit shall not be subject to an undue hardship exception under this section and shall continue to be included in the applicant’s or recipient’s spend down of excess income. To the extent that the excess income transferred was

the applicant's or recipient's right to receive a future income stream and that transfer can be revoked, the applicant or recipient shall revoke the transfer. To the extent that the transferred income stream cannot be revoked, that future income stream shall be considered a transfer of assets for less than fair market value.

(d) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act.

(e) (1) The department shall submit a state plan amendment or seek other federal approval before implementing the undue hardship circumstances identified in this section. The department shall request, in the state plan amendment or other federal approval request, that the effective date of approval be retroactive to January 1, 2012.

(2) This section shall be implemented only if, and to the extent that, a state plan amendment is approved or other federal approval is obtained and federal financial participation is available.

(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.

(Amended by Stats. 2023, Ch. 42, Sec. 116. (AB 118) Effective July 10, 2023.)

14015.2. (a) In accordance with Section 1917(c)(2)(D) of the federal Social Security Act (42 U.S.C. Sec. 1396p(c)(2)(D)), any of the following may request a fair hearing on the issue of undue hardship:

(1) An individual requesting or receiving medical assistance for home and facility care.

(2) A personal representative of an individual requesting or receiving medical assistance for home and facility care.

(3) The facility in which the individual requesting or receiving medical assistance for home and facility care is residing, with the consent of that individual or the personal representative of that individual.

(b) An individual with a pending undue hardship appeal who is subject to a period of ineligibility pursuant to this article shall receive medical assistance for home and facility care for a maximum of 30 bed-hold days.

(c) This section does not alter or limit the right of applicants or recipients to obtain a state hearing in accordance with Chapter 7 (commencing with Section 10950) of Part 2.

(d) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), and any regulations adopted pursuant to that act, and only to the extent that federal financial participation is available.

(e) To the extent that regulations are necessary to implement this section, the department shall promulgate regulations using the nonemergency regulatory process described in Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of the Government Code.

(f) It is the intent of the Legislature that the provisions of this section shall apply prospectively to any individual to whom the act applies commencing from the date regulations adopted pursuant to this act are filed with the Secretary of State.

(Added by Stats. 2008, Ch. 379, Sec. 10. Effective January 1, 2009.)

14015.5. (a) Notwithstanding any other 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 is able to 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 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, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(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.

(Amended by Stats. 2015, Ch. 18, Sec. 36. (SB 75) Effective June 24, 2015.)

14015.7. (a) (1) Notwithstanding any other provision of 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 transferral. The workflow transfer protocol and transferral 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 transfer 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 transfer 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 provision of 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’s 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 provision of 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 paragraph (3), initially determining 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 transferral 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, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(e) 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) The state shall be responsible for providing the administrative funding to the counties for work associated with this section. Funding shall be subject to the annual state budget process.

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

(Added by Stats. 2013, 1st Ex. Sess., Ch. 3, Sec. 17. (AB 1 1x) Effective September 30, 2013. Section operative October 1, 2013, by its own provisions.)

14015.8. (a) The department, any other government agency that is determining eligibility for, or enrollment in, the Medi-Cal program or any other program administered by the department, or collecting protected health information for those purposes, and the

California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code, shall share information with each other as necessary to enable them to perform their respective statutory and regulatory duties under state and federal law. This information shall include, but not be limited to, personal information, as defined in subdivision (a) of Section 1798.3 of the Civil Code, and protected health information, as defined in Parts 160 and 164 of Title 45 of the Code of Federal Regulations, regarding individual beneficiaries and applicants.

(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 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 any necessary regulations are adopted. The department shall adopt regulations by July 1, 2017, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(Amended (as added by Stats. 2013, 1st Ex. Sess., Ch. 3, Sec. 18) by Stats. 2013, Ch. 442, Sec. 10. (SB 28) Effective January 1, 2014.)

14016. (a) The county in which the person resides, except as specified in subdivision (d), shall determine the eligibility of each person pursuant to Sections 14005.1, 14005.4, and 14005.7 and Article 4.4 (commencing with Section 14140), except that the department may contract with the federal Social Security Administration for the determination of Medi-Cal eligibility of persons eligible under Title XVI of the Social Security Act. Upon termination of such assistance, the county shall determine whether the person remains eligible for Medi-Cal coverage under one of these sections.

(b) The department shall institute an eligibility quality control program, to verify the eligibility determination of a sample of persons in each county granted Medi-Cal eligibility under Section 14005.4, 14005.7, or 14005.8 or Article 4. 4 (commencing with Section 14140).

(c) A review period shall be defined as one year and shall coincide with the federal fiscal year. The department shall draw a random sample of cases for each period. The random sample shall be drawn to ensure a minimum number of cases reviewed in each county in each review period according to the following:

(1) All cases shall be sampled in any county with less than 50 Medi-Cal cases.

(2) Fifty cases in any county with greater than 0.01 percent and less than or equal to .50 percent of the Medi-Cal cases.

(3) Seventy-five cases in any county with greater than .50 percent and less than or equal to 1 percent of the Medi-Cal cases.

(4) One hundred cases in any county with greater than 1 percent and less than or equal to 3 percent of the Medi-Cal cases.

(5) One hundred twenty-five cases in any county with greater than 3 percent and less than or equal to 10 percent of the Medi-Cal cases.

(6) Six hundred fifty cases in any county with greater than 10 percent of the Medi-Cal cases.

(d) When family members maintain separate residences, but eligibility is determined as a single unit because of the provisions of Section 14008, the county in which the parent or parents reside shall determine the eligibility for the entire unit.

(e) In administering the provisions of law and regulations related to eligibility determination the director shall impose such fiscal penalties as provided by this section to assure adequate county administrative performance.

(f) The director shall hold counties financially liable for payments made on behalf of ineligible persons or persons with an incorrect spend down of excess income. When a sample case is found to include an ineligible person or a person with an understated spend down of excess income, written notification shall be sent to the county department that describes the error and requests a written response within two weeks. The county shall indicate whether it agrees or disagrees with the findings. If the county disagrees, the department shall reevaluate the error findings, taking into consideration any additional facts contained in the county's response. The department shall again notify the county of the department's findings. If the county continues to disagree with the error findings, the county may appeal to the Chief of the Medi-Cal Policy Division, requesting that the department review the case and render a final decision. The director may reduce or waive the fiscal liability of a county if the department is unable to meet the minimum sample required, as defined in subdivision (c), or if an individual county experienced a natural disaster, job actions, or other occurrences that impacted the findings in an individual county as determined by the director.

(g) The department shall utilize the methodology detailed in this subdivision to establish counties' fiscal penalties. The department shall determine each county's case error rate for each review period by dividing the number of completed case reviews in that county found in error by the number of case reviews in that county. State caused errors shall be determined by the department and shall not be included in this calculation. Case error rates shall be arrayed from highest to lowest. From this array, the department shall determine the percentage of counties liable as follows:

(1) The 60 percent of counties with the highest case error rates shall be liable if the state's dollar error rate exceeds the federal standard by 0.01 percent to 1 percent.

(2) The 70 percent of counties with the highest case error rates shall be liable if the state's dollar error rate exceeds the federal standard by greater than 1 percent and less than or equal to 2 percent.

(3) The 80 percent of counties with the highest case error rates shall be liable if the state's dollar error rate exceeds the federal standard by greater than 2 percent and less than or equal to 3 percent.

(4) The 90 percent of counties with the highest case error rates shall be liable if the state's dollar error rate exceeds the federal standard by greater than 3 percent and less than or equal to 4 percent.

(5) All counties shall be liable if the state's dollar error rate exceeds the federal standard by greater than 4 percent.

As used herein, "the state's dollar error rate" means the Medicaid dollar error rate reported to the department by the United States Department of Health and Human Services, less any portion of this error rate attributable to state caused errors. The term "federal standard" means the Medicaid dollar error rate standard to which the state is held accountable.

For each county determined liable, the department shall calculate a penalty multiple that shall be the product of a liable county's case error rate multiplied by the liable county's percentage of statewide Medi-Cal cases. Each county's fiscal penalty shall be the product of a county's penalty multiple divided by the sum of all penalty multiples, multiplied times the penalty bank. The penalty bank includes only quality control federal fiscal sanctions, federal withholds, federal disallowances, and any associated General Fund expenditures, minus the value of any state assumed errors and the General Fund share of the value of client caused errors. The case error rate and penalty multiple shall be adjusted by excluding client errors for the purpose of determining the associated General Fund expenditures.

If, after the department has assessed penalties to counties, the federal government reduces or eliminates any quality control federal fiscal sanction, federal withhold or federal disallowance, the department shall reduce or eliminate the corresponding fiscal penalty assessment including any associated General Fund expenditures to liable counties.

(h) When a county welfare department contravenes state eligibility processing regulations and written instructions in a way that produces increased program benefits or administrative expenses but doesn't result in an increase in the eligibility dollar error rate, the director shall recoup from that county the additional administrative or program benefit costs above those that would have been incurred had that county not contravened the established state eligibility processing regulations and written instructions. This section shall not be construed to interfere with the rights of counties to out-station eligibility staff.

Notwithstanding the number of counties determined liable for fiscal penalties under this section, individual county corrective action plans as prescribed by the department shall be required from all counties that exceed a 15 percent case error rate.

(i) Any penalties imposed under this system shall be collected through direct repayment from liable counties rather than through any reduction in funds otherwise due to counties.

(Amended by Stats. 2023, Ch. 42, Sec. 117. (AB 118) Effective July 10, 2023.)

14016.1. If a patient at a health facility operated by the county either directly or through contract is received in a comatose condition or suffering from amnesia and dies before he is able to cooperate in providing information necessary to a determination of Medi-Cal eligibility, the patient shall be presumed eligible. However, such presumption may be rebutted by the department. All costs incurred in providing care to such patient under such presumption shall be reimbursable to the extent permitted by federal statutes and regulations. If such a patient subsequently is determined ineligible, the department shall make reasonable efforts to recover the costs of care incurred during the period of presumptive eligibility and shall have the right to seek restitution in a civil action.

(Added by Stats. 1978, Ch. 101.)

14016.2. If a person who is incapable of acting on his own behalf and who would otherwise be eligible is discontinued from Medi-Cal eligibility because the guardian or authorized representative of the person fails or refuses to provide information needed to determine eligibility, then anyone with knowledge of the person's need for Medi-Cal coverage may apply for retroactive eligibility for any of the three preceding months on behalf of the person. If the necessary information becomes available within three months of the application the county department shall act on the application to determine the person's eligibility for the retroactive period.

The provisions of this section shall become inoperative to the extent that they are found to conflict with federal requirements governing federal reimbursements of state Medicaid costs.

(Added by Stats. 1979, Ch. 985.)

14016.3. The department shall provide technical assistance to counties in order to maximize the identification of private health care coverage as defined by Section 10020. A county agency shall receive reimbursement for the administrative costs for properly completing a form which identifies such private health care coverage only in those cases where the agency does not receive such

reimbursement from the department or the State Department of Social Services. The administrative costs for properly completing the form shall be determined by the department.

(Added by Stats. 1981, Ch. 102, Sec. 105. Effective June 28, 1981.)

14016.4. The department may enter into an agreement with a county to have the county detect and recover the value of any Medi-Cal benefits which have been improperly received or obtained by any person. Counties shall receive an incentive amount not to exceed 30 percent of the amount remaining after reasonable county costs of the recovery have been deducted from the amount recovered. As the single state agency for state plan purposes, the department is responsible for and has authority to impose procedural requirements necessary for federal compliance.

The administrative costs for the implementation of this section shall be controlled by the department. The department shall establish and maintain a plan whereby costs for counties' administration of beneficiary collections will be effectively controlled. The plan shall establish standards and performance criteria, including workload, productivity, and support services standards, to which counties shall adhere.

(Amended by Stats. 1986, Ch. 1052, Sec. 3. Effective September 24, 1986.)

14016.5. (a) At the time of determining or redetermining the eligibility of a Medi-Cal program or Aid to Families with Dependent Children (AFDC) program applicant or beneficiary who resides in an area served by a managed health care plan or pilot program in which beneficiaries may enroll, each applicant or beneficiary shall be informed of the managed care and fee-for-service options available regarding methods of receiving Medi-Cal benefits.

(b) The information described in subdivision (a) shall include all of the following elements:

(1) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in the fee-for-service sector.

(2) Each beneficiary or eligible applicant shall be provided with the name, address, telephone number, and specialty, if any, of each primary care provider, and each clinic participating in each prepaid managed health care plan, pilot project, or fee-for-service case management provider option. This information shall be provided under geographic area designations, in alphabetical order by the name of the primary care provider and clinic. The name, address, and telephone number of each specialist participating in each prepaid managed health care plan, pilot project, or fee-for-service case management provider option shall be made available by contacting either the health care options contractor or the prepaid managed health care plan, pilot project, or fee-for-service case management provider.

(3) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in a managed care option, if his or her treating provider is a primary care provider or clinic contracting with any of the prepaid managed health care plans, pilot projects, or fee-for-service case management provider options available, has available capacity, and agrees to continue to treat that beneficiary or applicant.

(4) In areas specified by the director, each beneficiary or eligible applicant shall be informed that if he or she fails to make a choice, or does not certify that he or she has an established relationship with a primary care provider or clinic, he or she shall be assigned to, and enrolled in, a prepaid managed health care plan, pilot project, or fee-for-service case management provider.

(c) No later than 30 days following the date a Medi-Cal or AFDC beneficiary or applicant is determined eligible, the beneficiary or applicant shall indicate his or her choice in writing, as a condition of coverage for Medi-Cal benefits, of either of the following health care options:

(1) To obtain benefits by receiving a Medi-Cal card, which may be used to obtain services from individual providers, that the beneficiary would locate, that choose to provide services to Medi-Cal beneficiaries.

The department may require each beneficiary or eligible applicant, as a condition for electing this option, to sign a statement certifying that he or she has an established patient-provider relationship, or in the case of a dependent, the parent or guardian shall make that certification. This certification shall not require the acknowledgment or guarantee of acceptance, by any indicated Medi-Cal provider or health facility, of any beneficiary making a certification under this section.

(2) (A) To obtain benefits by enrolling in a prepaid managed health care plan, pilot program, or fee-for-service case management provider that has agreed to make Medi-Cal services readily available to enrolled Medi-Cal beneficiaries.

(B) At the time the beneficiary or eligible applicant selects a prepaid managed health care plan, pilot project, or fee-for-service case management provider, the department shall, when applicable, encourage the beneficiary or eligible applicant to also indicate, in writing, his or her choice of primary care provider or clinic contracting with the selected prepaid managed health care plan, pilot project, or fee-for-service case management provider.

(d) (1) In areas specified by the director, a Medi-Cal or AFDC beneficiary or eligible applicant who does not make a choice, or who does not certify that he or she has an established relationship with a primary care provider or clinic, shall be assigned to and enrolled in an appropriate Medi-Cal managed care plan, pilot project, or fee-for-service case management provider providing service within the area in which the beneficiary resides.

(2) If it is not possible to enroll the beneficiary under a Medi-Cal managed care plan, pilot project, or a fee-for-service case management provider because of a lack of capacity or availability of participating contractors, the beneficiary shall be provided with a Medi-Cal card and informed about fee-for-service primary care providers who do all of the following:

(A) The providers agree to accept Medi-Cal patients.

(B) The providers provide information about the provider's willingness to accept Medi-Cal patients as described in Section 14016.6.

(C) The providers provide services within the area in which the beneficiary resides.

(e) If a beneficiary or eligible applicant does not choose a primary care provider or clinic, or does not select any primary care provider who is available, the managed health care plan, pilot project, or fee-for-service case management provider that was selected by or assigned to the beneficiary shall ensure that the beneficiary selects a primary care provider or clinic within 30 days after enrollment or is assigned to a primary care provider within 40 days after enrollment.

(f) (1) The managed care plan shall have a valid Medi-Cal contract, adequate capacity, and appropriate staffing to provide health care services to the beneficiary.

(2) The department shall establish standards for all of the following:

(A) The maximum distances a beneficiary is required to travel to obtain primary care services from the managed care plan, fee-for-service case management provider, or pilot project in which the beneficiary is enrolled.

(B) The conditions under which a primary care service site shall be accessible by public transportation.

(C) The conditions under which a managed care plan, fee-for-service case management provider, or pilot project shall provide nonmedical transportation to a primary care service site.

(3) In developing the standards required by paragraph (2), the department shall take into account, on a geographic basis, the means of transportation used and distances typically traveled by Medi-Cal beneficiaries to obtain fee-for-service primary care services and the experience of managed care plans in delivering services to Medi-Cal enrollees. The department shall also consider the provider's ability to render culturally and linguistically appropriate services.

(g) To the extent possible, the arrangements for carrying out subdivision (d) shall provide for the equitable distribution of Medi-Cal beneficiaries among participating managed care plans, fee-for-service case management providers, and pilot projects.

(h) If, under the provisions of subdivision (d), a Medi-Cal beneficiary or applicant does not make a choice or does not certify that he or she has an established relationship with a primary care provider or clinic, the person may, at the option of the department, be provided with a Medi-Cal card or be assigned to and enrolled in a managed care plan providing service within the area in which the beneficiary resides.

(i) Any Medi-Cal or AFDC beneficiary who is dissatisfied with the provider or managed care plan, pilot project, or fee-for-service case management provider shall be allowed to select or be assigned to another provider or managed care plan, pilot project, or fee-for-service case management provider.

(j) The department or its contractor shall notify a managed care plan, pilot project, or fee-for-service case management provider when it has been selected by or assigned to a beneficiary. The managed care plan, pilot project, or fee-for-service case management provider that has been selected by, or assigned to, a beneficiary, shall notify the primary care provider or clinic that it has been selected or assigned. The managed care plan, pilot project, or fee-for-service case management provider shall also notify the beneficiary of the managed care plan, pilot project, or fee-for-service case management provider or clinic selected or assigned.

(k) (1) The department shall ensure that Medi-Cal beneficiaries eligible under Title XVI of the federal Social Security Act are provided with information about options available regarding methods of receiving Medi-Cal benefits as described in subdivision (c).

(2) (A) The director may waive the requirements of subdivisions (c) and (d) until a means is established to directly provide the information described in subdivision (a) to beneficiaries who are eligible for the federal Supplemental Security Income for the Aged, Blind, and Disabled Program (Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code).

(B) The director may elect not to apply the requirements of subdivisions (c) and (d) to beneficiaries whose eligibility under the Supplemental Security Income program is established before January 1, 1994.

(l) In areas where there is no prepaid managed health care plan or pilot program that has contracted with the department to provide services to Medi-Cal beneficiaries, and where no other enrollment requirements have been established by the department, no explicit choice need be made, and the beneficiary or eligible applicant shall receive a Medi-Cal card.

(m) The following definitions contained in this subdivision shall control the construction of this section, unless the context requires otherwise:

(1) “Applicant,” “beneficiary,” and “eligible applicant,” in the case of a family group, mean any person with legal authority to make a choice on behalf of dependent family members.

(2) “Fee-for-service case management provider” means a provider enrolled and certified to participate in the Medi-Cal fee-for-service case management program the department may elect to develop in selected areas of the state with the assistance of and in cooperation with California physician providers and other interested provider groups.

(3) “Managed health care plan” and “managed care plan” mean a person or entity operating under a Medi-Cal contract with the department under this chapter or Chapter 8 (commencing with Section 14200) to provide, or arrange for, health care services for Medi-Cal beneficiaries as an alternative to the Medi-Cal fee-for-service program that has a contractual responsibility to manage health care provided to Medi-Cal beneficiaries covered by the contract.

(n) (1) Whenever a county welfare department notifies a public assistance recipient or Medi-Cal beneficiary that the recipient or beneficiary is losing Medi-Cal eligibility, the county shall include, in the notice to the recipient or beneficiary, notification that the loss of eligibility shall also result in the recipient’s or beneficiary’s disenrollment from Medi-Cal managed health care or dental plans, if enrolled.

(2) Whenever the department or the county welfare department processes a change in a public assistance recipient’s or Medi-Cal beneficiary’s residence or aid code that will result in the recipient’s or beneficiary’s disenrollment from the managed health care or dental plan in which he or she is currently enrolled, a written notice shall be given to the recipient or beneficiary.

(o) This section shall be implemented in a manner consistent with any federal waiver required to be obtained by the department in order to implement this section.

(p) (1) If the functionality is available in the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), individuals or their authorized representatives may select Medi-Cal managed care plans via CalHEERS.

(A) Any person that assists a Medi-Cal beneficiary who is eligible for the program based on modified adjusted gross income (MAGI) to select a Medi-Cal managed care plan via CalHEERS shall complete a training program that includes all of the following:

(i) The right to select a plan, to designate a plan at a later date, to have plan choice materials sent by mail, and that if the person does not select a plan, one will be selected for them.

(ii) All plan enrollment options and requirements with regard to MAGI Medi-Cal eligibility.

(iii) Any applicable timeframes in which the plan choice must be designated and the mechanism for designating plan choice.

(iv) How to use provider directories, how to identify which providers are in a particular plan network, and the applicable characteristics of primary care and specialty care providers and providers of other services, such as languages spoken, whether they are accepting new patients, and office locations.

(v) To the extent applicable, how to access Medi-Cal services prior to plan enrollment, including the right to retroactive Medi-Cal benefits.

(B) Any person that assists a Medi-Cal beneficiary who is not eligible for Medi-Cal on the basis of MAGI to select a Medi-Cal managed care plan shall complete a training program that includes all of the following:

(i) All of the information included in the training program described in subparagraph (A).

(ii) The enrollment options and requirements with regard to each Medi-Cal eligibility category, including whether enrollment is mandatory, how to obtain medical exemptions and continuity of care, waiver programs, carved-out services, and the California Children’s Services Program, as applicable.

(2) The department shall consult with a group of stakeholders through either a group currently in existence or convened for this purpose that includes representatives of plans, providers, consumer advocates, counties, eligibility workers, CalHEERS, the California Health Benefit Exchange (Exchange), and the Legislature to review process, timelines, scripts, training curricula, monitoring and oversight plans, and plan marketing and informational materials.

(3) In developing materials, scripts, and processes, the department and the Exchange shall consult with or test the materials, scripts, and processes with stakeholders that have expertise in health plan selection, and in assisting populations of diverse demographic characteristics such as race, ethnicity, language spoken, geographic region, sexual orientation, and gender identity or preference.

(4) The department, CalHEERS, the Exchange, and counties may adopt the recommendations of the advisory body convened in paragraph (2) and specify the reasons if the recommendations are not adopted.

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

(Repealed (in Sec. 19) and added by Stats. 2013, 1st Ex. Sess., Ch. 3, Sec. 20. (AB 1 1x) Effective September 30, 2013. Section operative January 1, 2014, by its own provisions.)

14016.51. Upon the availability of federal funding, the department shall modify the Medi-Cal program mail-in application form, and other appropriate materials, and the single point-of-entry application form, to allow applicants in counties served by managed care plans to contact the enrollment contractor by using the Health Care Options toll-free telephone number to request and receive enrollment materials before a Medi-Cal eligibility determination has been made.

(Amended by Stats. 2005, Ch. 22, Sec. 225. Effective January 1, 2006.)

14016.55. (a) It is the intent of the Legislature that Medi-Cal beneficiaries who are required to enroll in a Medi-Cal managed care health plan make an informed choice that is not the result of confusion, lack of information, or understanding of the choices available to them.

(b) It is the intent of the Legislature that the department strive to increase the level of choice of Medi-Cal beneficiaries required to enroll in a Medi-Cal managed care health plan and that default rates be no greater than 20 percent in any participating county.

(c) In any county in which conversion to managed care plan enrollment has taken place and where the default rate, as defined in subdivision (e), is 20 percent or higher in two consecutive months occurring after conversion upon the effective date of this section, the department shall conduct a one-time survey of beneficiaries aimed at determining the reasons why beneficiaries fail to enroll into a managed care plan when required to do so by the department or its health care options contractor.

(d) The department shall submit the results of the survey to the appropriate legislative policy and budget committees within six months of completion, and implement a plan of correction intended to reduce the rate of beneficiary default. The plan of correction may include, but not be limited to, culturally appropriate outreach and education activities, including the use of community based organization.

(e) For purposes of this section, “default rate” refers to the rate of Medi-Cal beneficiaries defaulting into managed care health plan enrollment by virtue of their failure to make an election, as provided for in Section 14016.5.

(Added by Stats. 1998, Ch. 310, Sec. 78. Effective August 19, 1998.)

14016.6. The State Department of Health Care Services shall develop a program to implement subdivision (p) of Section 14016.5 and to provide information and assistance to enable Medi-Cal beneficiaries to understand and successfully use the services of the Medi-Cal managed care plans in which they enroll. The program shall include, but not be limited to, the following components:

(a) (1) Development of a method to inform beneficiaries and applicants of all of the following:

(A) Their choices for receiving Medi-Cal benefits including the use of fee-for-service sector managed health care plans, or pilot programs.

(B) The availability of staff and information resources to Medi-Cal managed health care plan enrollees described in subdivision (f).

(2) (A) Marketing and informational materials, including printed materials, films, and exhibits, to be provided to Medi-Cal beneficiaries and applicants when choosing methods of receiving health care benefits.

(B) The department shall not be responsible for the costs of developing material required by subparagraph (A).

(C) (i) The department may prescribe the format and edit the informational materials for factual accuracy, objectivity, and comprehensibility.

(ii) The department, the California Health Benefit Exchange (Exchange), the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), and entities or persons designated pursuant to subdivision (g) shall use the edited materials in informing beneficiaries and applicants of their choices for receiving Medi-Cal benefits.

(b) Provision of information that is necessary to implement this program in a manner that fairly and objectively explains to beneficiaries and applicants their choices for methods of receiving Medi-Cal benefits, including information prepared by the department.

(c) Provision of information about providers who will provide services to Medi-Cal beneficiaries. This may be information about provider referral services of a local provider professional organization. The information shall be made available to Medi-Cal beneficiaries and applicants at the same time the beneficiary or applicant is being informed of the options available for receiving care.

(d) Training of individuals, including county human services staff, to carry out the program.

(e) Monitoring the implementation of the program at any location, including online at the Exchange or at counties, where choices are made available in order to assure that beneficiaries and applicants may make a well-informed choice, without duress.

(f) Staff and information resources dedicated to directly assist Medi-Cal managed health care plan enrollees to understand how to effectively use the services of, and resolve problems or complaints involving, their managed health care plans.

(g) Notwithstanding any other law, the department, in consultation with the Exchange, may authorize specific persons or entities, including counties, to provide information to beneficiaries concerning their health care options for receiving Medi-Cal benefits and assistance with enrollment. This subdivision shall apply in all geographic areas designated by the director. This subdivision shall be implemented in a manner consistent with federal law.

(h) 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.

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

(Amended (as added by Stats. 2013, 1st Ex. Sess., Ch. 3, Sec. 22) by Stats. 2013, Ch. 442, Sec. 11. (SB 28) Effective January 1, 2014.)

14016.7. (a) Managed care contracts entered into by the department under the act adding this section shall include all of the following:

(1) Contractor requirements concerning eligibility and coverage verification.

(2) Utilization controls.

(3) Claims processing.

(b) The contract requirements shall include all of the following:

(1) Standards for prompt response to provider requests for information.

(2) Twenty-four hour response to emergency service authorization requests.

(3) Use of commonly accepted billing forms.

(Added by Stats. 1991, Ch. 95, Sec. 4. Effective June 30, 1991.)

14016.8. (a) The Legislature finds and declares that the right of every patient to receive basic information necessary to give full and informed consent is a fundamental tenet of good public health policy and has long been the established law of this state. Some hospitals and other providers do not provide a full range of reproductive health services and may prohibit or otherwise not provide sterilization, infertility treatments, abortion, or contraceptive services, including emergency contraception. It is the intent of the Legislature that every patient be given full and complete information about the health care services available to allow patients to make well informed health care decisions.

(b) On or before July 1, 2001, the department shall:

(1) Ensure that all Medi-Cal beneficiaries receive the following statement by the methods described in paragraphs (2) to (6), inclusive:

“Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency

contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor or clinic, or call the Medi-Cal managed care plan at (insert the plan's membership services number or other appropriate number that individuals can call for information) to ensure that you can obtain the health care services that you need."

(2) Require that each Medi-Cal managed care plan provide the statement described in paragraph (1), in at least 12-point boldface type at the beginning of each provider directory.

(3) Require that each Medi-Cal managed care plan place the statement described in paragraph (1) in a prominent location on any provider directory posted on the plan's website, if any, and include this statement in a conspicuous place in the plan's evidence of coverage and disclosure forms, if any.

(4) Require that the statement described in paragraph (1) be included in the health care option activities described in Sections 14016.5, 14087.305, subdivision (e) of Section 14089, and paragraph (2) of subdivision (f) of Section 14408.

(5) Require each county organized health system to provide to Medi-Cal beneficiaries the statement described in paragraph (1). This statement shall be provided in writing in at least 12-point boldface type prior to enrollment, prior to selection of a primary care provider, and on an annual basis.

(6) Ensure that the statement described in paragraph (1) is provided to any other Medi-Cal managed care beneficiary who would not receive the statement under the provisions of paragraphs (2) to (5), inclusive. This statement shall be provided in writing in at least 12-point boldface type prior to enrollment, prior to selection of a primary care provider, and on an annual basis.

(c) The requirement to provide the statement described in paragraph (1) of subdivision (b) shall apply to Medi-Cal managed care programs, including, but not limited to, the following programs:

(1) In areas where the department is contracting with persons or entities that are contracting with, or governed, owned, or operated by, either a county board of supervisors or a county special commission, or a county health authority, operating under Article 2.8 (commencing with Section 14087.5) or Article 7 (commencing with Section 14490) of Chapter 8, or Chapter 3 (commencing with Section 101675) of Part 4 of Division 101 of the Health and Safety Code.

(2) In areas specified by the director for expansion of the Medi-Cal managed care program under Section 14087.3, including where the department is contracting with prepaid health plans, including prepaid health plans that are contracting with, governed, owned, or operated by a county board of supervisors, a county special commission or county health authority authorized by Sections 14018.7, 14087.31, 14087.316, 14087.35, 14087.36, 14087.38, and 14087.9605.

(3) Where the department has entered into contracts with prepaid health plans or primary care case management providers pursuant to Article 2.9 (commencing with Section 14088) and Chapter 8 (commencing with Section 14200).

(4) Where the department or the California Medical Assistance Commission has entered into contracts with any persons or entities pursuant to Section 14087.47, Article 2.91 (commencing with Section 14089), or Article 2.97 (commencing with Section 14093).

(d) A Medi-Cal managed care plan shall not be required to provide the statement described in paragraph (1) of subdivision (b) in a service area in which none of the hospitals, health facilities, clinics, medical groups, or independent practice associations with which it contracts limit or restrict any of the reproductive services described in the statement.

(e) This section shall not apply to specialized health care service plans.

(Added by Stats. 2000, Ch. 347, Sec. 4. Effective January 1, 2001.)

14016.9. Where determined to be cost effective, the department shall utilize the earnings clearance system to verify the eligibility of persons who have applied for or are receiving benefits pursuant to Sections 14005.4 and 14005.7.

(Amended by Stats. 1985, Ch. 1354, Sec. 11.)

14016.10. The department shall implement the federal requirement under Section 4603 of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101–508) which provides for the continuity of Medi-Cal coverage during pregnancy and the post partum period for pregnant women who were certified as Medi-Cal eligible.

(Added by Stats. 1991, Ch. 1062, Sec. 1. Effective October 14, 1991.)

14017. On a regional pilot project basis, the department may issue an identification card to a person eligible for Medi-Cal program benefits under Section 14005.1, 14005.4, or 14005.7 who is certified, but is not in possession of a valid California driver's license or identification card issued by the Department of Motor Vehicles. The identification card shall contain his or her picture, social security number, identifying characteristics, and signature. This provision shall not apply to:

(a) Persons age 12 and under.

(b) Recipients of aid under Title XVI of the Social Security Act.

(c) Persons in long-term institutional status.

(Amended by Stats. 1982, Ch. 327, Sec. 224. Effective June 30, 1982.)

14017.1. The Joint Legislative Audit Committee shall conduct an audit of one or more county eligibility departments.

(Amended by Stats. 2001, Ch. 745, Sec. 247. Effective October 12, 2001.)

14017.5. The department shall not issue identification cards to Medi-Cal recipients on a statewide basis until (1) a pilot project has been completed which indicates that the General Fund savings from reduced unauthorized use of Medi-Cal cards more than offsets the costs of issuing the identification cards, and (2) the Legislature has specifically appropriated the funds necessary to issue identification cards to Medi-Cal beneficiaries.

If identification cards are issued by the department on a pilot project or statewide basis, the department shall notify providers that current Medi-Cal beneficiaries have been issued identification cards in accordance with Section 14017. At that time, it shall be the responsibility of the provider prior to rendering nonemergency Medi-Cal reimbursable services to persons presenting themselves as Medi-Cal beneficiaries to verify the person's identity by matching the name and signature on their identification card issued by the department or their valid California driver's license or California identification card issued by the Department of Motor Vehicles, against a signature executed at the time of service and further by visually verifying their likeness to the photograph on the identification card or driver's license. If the provider complies in good faith, he or she shall not be held responsible by having payments withheld by the state.

(Amended by Stats. 1982, Ch. 1014, Sec. 1.)

14017.6. For the purposes of this chapter, all references to "the Medi-Cal card," identified in Section 14017.8, shall be deemed to also be a reference to the benefits identification card, identified in Section 14017.7.

(Added by Stats. 2001, Ch. 171, Sec. 36. Effective August 10, 2001.)

14017.7. (a) In addition to the issuance of Medi-Cal cards, pursuant to Section 14017.8, the department may issue a benefits identification card for the purpose of identifying an individual who has been determined eligible for health care benefits under this chapter or health care benefits under another health care program administered by the department, including, but not limited to, the Medi-Cal Access Program as described in Chapter 2 (commencing with Section 15810) of Part 3.3, or both.

(b) The department may also issue a benefits identification card for the purpose of identifying an individual who has been determined eligible to receive health care services from a Medi-Cal provider under the Healthy Families Program under Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code, if children are enrolled back into that program pursuant to subdivision (m) of Section 14005.26 or subdivision (q) of Section 14005.27.

(c) In no event shall a benefits identification card be issued to an individual described in subdivision (a) or (b) unless appropriate and adequate safeguards have been implemented to ensure all of the following:

(1) If the individual has been determined eligible for health care benefits under another health care program administered by the department or a program identified in subdivision (b), that health care program pays for any and all health care benefits delivered to the individual by that health care program.

(2) State funds appropriated to or federal Medicaid financial participation claimed by the Medi-Cal program shall only be used for the delivery of health care benefits authorized pursuant to this chapter.

(d) The individual described in subdivision (a) or (b) may present the benefits identification card to obtain health care benefits for which that individual has been determined eligible under this chapter, or health care benefits under another health care program administered by the department or a program identified in subdivision (b), or all of them.

(e) Where applicable, all laws, regulations, restrictions, conditions, and terms of participation regarding the possession, billing, and use of Medi-Cal cards shall also apply to a benefits identification card.

(f) For the purposes of this section, "benefits" includes medically necessary services, goods, supplies, or merchandise.

(Amended by Stats. 2023, Ch. 266, Sec. 1. (AB 614) Effective January 1, 2024.)

14017.8. Each person eligible under Section 14005.1 and each person eligible under Section 14005.4 or 14005.7 who is certified eligible shall be provided, by the department, with a Medi-Cal card certifying his or her status, identification number, expiration date and his or her entitlements, insofar as these do not require specific prior authorization. The department shall determine the form of the Medi-Cal card. The cards shall be for a term as determined by the department and, unless canceled for cause, shall entitle

individuals to care and service as indicated. Cause for cancellation shall exist when the person dies, loses state residence, is found to be ineligible, or has been issued a new Medi-Cal card.

(Added by Stats. 1985, Ch. 1354, Sec. 12.)

14018. (a) (1) The Medi-Cal card shall be authorization for payment for health care services rendered, during and subsequent to the month of application of a person eligible under Section 14005.1, or a person eligible under Section 14005.4 or 14005.7 who is certified by the department.

(2) The Medi-Cal card shall be signed and dated in the space provided on the card by the beneficiary upon receipt of the card and prior to presentation of the card for any service. This paragraph shall not apply to either of the following:

(A) Persons 17 years of age and under.

(B) Persons in long-term care.

(b) Notwithstanding subdivision (a), any person with a Medi-Cal card who receives medical assistance for home and facility care may be ineligible for payment for periods of time, including partial months of ineligibility, as determined pursuant to Section 14015 and in accordance with Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(c) This section shall be implemented pursuant to the requirements of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and any regulations adopted pursuant to that act, and only to the extent that federal financial participation is available.

(d) To the extent that regulations are necessary to implement this section, the department shall promulgate regulations using the nonemergency regulatory process described in Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of the Government Code.

(e) It is the intent of the Legislature that the provisions of this section shall apply prospectively to any individual to whom the act applies commencing from the date regulations adopted pursuant to this act are filed with the Secretary of State.

(Amended by Stats. 2008, Ch. 379, Sec. 11. Effective January 1, 2009.)

14018.1. The department shall prospectively notify a Medi-Cal managed care plan of the date of the regularly scheduled annual redetermination of a Medi-Cal beneficiary in a disabled aid category, who is enrolled in that plan and where eligibility redetermination is the responsibility of the department. Nothing in this section shall provide a beneficiary with additional Medi-Cal coverage due to the department's failure to provide this notice.

(Added by Stats. 2001, Ch. 742, Sec. 1. Effective January 1, 2002.)

14018.2. (a) Reimbursement shall not be denied to any qualified health care provider for care rendered to an eligible Medi-Cal beneficiary for the sole reason that a proof of eligibility label does not accompany the bill.

Proof of eligibility labels may, however, continue to be used as such and shall be made available to an eligible Medi-Cal beneficiary through the local office which has determined the person's eligibility or through the department. The provider may submit machine-reproduced copies of the beneficiary Medi-Cal card for billing purposes as long as the copy is made from the original unaltered Medi-Cal card under circumstances controlled by the provider, for example, on the premises of the provider with copying equipment controlled by the provider.

(b) It shall remain the responsibility of a Medi-Cal beneficiary to provide information and evidence of Medi-Cal eligibility, restrictions on the eligibility, and non-Medi-Cal health coverage, to that person's health care providers, if this information is requested by those providers prior to rendering services to that beneficiary.

(c) It shall be the responsibility of the provider prior to rendering Medi-Cal reimbursable services to persons presenting themselves as Medi-Cal beneficiaries to make a good faith effort to verify the person's identity, if the person is not known to the provider, by matching the name and signature on his or her Medi-Cal card against the signature on a valid California driver's license, or California identification card issued by the Department of Motor Vehicles, or another type of picture identification card or other credible document of identification. When the provider verifies the beneficiary's identity with a signed Medi-Cal card and one of the documents described above, the state will deem this to be a good faith effort. If the provider does not make a good faith effort of reasonable identification prior to rendering Medi-Cal reimbursable services and renders services to a presenting person who is ineligible for those Medi-Cal services, payment for those services may later be disallowed.

This provision shall not apply to:

(1) Persons 17 years of age and under.

(2) Persons in long-term care.

(3) Persons receiving emergency services.

(d) Notwithstanding subdivision (b) of this section, county welfare departments may provide Medi-Cal eligibility information to other governmental agencies and their designated agents as necessary for proper administration of the Medi-Cal program.

(e) If a hospital obtains proof of Medi-Cal eligibility for a patient subsequent to the date of service, it shall be the responsibility of the hospital to provide all information regarding that person's Medi-Cal eligibility to all hospital-based providers, ambulance transportation services providers, providers that provide ambulance transportation services through the "911" emergency response system, and other hospital-based providers of professional services that bill separately for all services associated with the person's treatment in the hospital rendered during the same time period for which the hospital is submitting a claim. The hospital may inform the provider that the person's Medi-Cal eligibility is pending, before a final determination is made on the patient's Medi-Cal application, to satisfy the requirements of this subdivision. If the provider or the provider's agent obtains this information from the hospital, the requirement has been satisfied.

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

(1) "Hospital-based provider" means an anesthesiologist, radiologist, pathologist, emergency room physician, or other physician or a group of physicians providing medical services at the hospital.

(2) "Hospital-based professional services" means services performed for a patient while at a hospital, related to the patient's hospital stay, and known to the hospital, including, but not limited to, diagnostic, laboratory, therapeutic, and radiologic services.

(Amended by Stats. 2009, Ch. 511, Sec. 1. (AB 1142) Effective January 1, 2010.)

14018.4. (a) Reimbursement shall not be denied to any hospital, licensed primary care clinic, or long-term health care facility as defined in Section 1326 of the Health and Safety Code for care rendered to an eligible Medi-Cal beneficiary for the sole reason that a proof of eligibility label does not accompany the bill, so long as the claim includes other appropriate documentation of eligibility.

(b) The director shall require county welfare departments to issue, upon the request of a hospital, licensed primary care clinic, or long-term health care facility as defined in Section 1326 of the Health and Safety Code providing care to an eligible Medi-Cal beneficiary, replacement Medi-Cal proof of eligibility labels or other appropriate documentation of eligibility to the requester, if all of the following conditions are met:

(1) The hospital, licensed primary care clinic, or long-term health care facility as defined in Section 1326 of the Health and Safety Code attempted to obtain a label from the beneficiary at the time the service was provided.

(2) The hospital, licensed primary care clinic, or long-term health care facility as defined in Section 1326 of the Health and Safety Code made a subsequent attempt to obtain a label or other appropriate documentation from the beneficiary.

(c) Notwithstanding subdivision (a), the director shall require that the replacement proof of eligibility label or other appropriate documentation of eligibility provided pursuant to subdivision (b) accompany the bill of the hospital, the licensed primary care clinic, or the long-term health care facility as defined in Section 1326 of the Health and Safety Code.

(d) This section shall remain in effect only until both the Secretary of the Senate and the Chief Clerk of the Assembly have received certification by registered mail from the Director of Health Services, that the automated eligibility verification system required by Section 14042 is operative for all counties and has been demonstrated to be accurate for each county at the 97-percent level as required by Section 14042 and as of that date is repealed.

(Amended by Stats. 1987, Ch. 1161, Sec. 3. Repealed as of date prescribed by its own provisions.)

14018.5. Notwithstanding any other provision of law, Section 3275 of the Civil Code does not apply to Medi-Cal reimbursement or prior authorization.

(Added by Stats. 1999, Ch. 146, Sec. 36. Effective July 22, 1999.)

14018.7. (a) Notwithstanding any other provision of law, neither a member of the governing body of the commission nor a member of any advisory panel to the governing body shall be deemed to be interested in a contract entered into by the commission within the meaning of Article 4 (commencing with Section 1090) of Chapter 1 of Division 4 of Title 1 of the Government Code if all of the following apply:

(1) The board of supervisors or the governing body appointed the individual to represent the interests of physicians, health care practitioners, hospitals, pharmacies, or other health care organizations.

(2) The contract authorizes the individual or the organization the individual represents to provide services under the local initiative.

(3) The contract contains substantially the same terms and conditions as contracts entered into with other individuals or organizations that the individual was appointed to represent.

(4) The individual does not influence or attempt to influence any advisory panel, the governing body, or any member of the governing body to enter into the contract.

(5) The individual discloses the interest to the governing body and the advisory panel, if applicable, and abstains from voting on the contract.

(6) The governing body and the advisory panel, if applicable, notes the disclosure and abstention in its official records and authorizes the contract in good faith by a vote of its membership sufficient for that purpose without counting the vote of the individual.

(b) (1) For purposes of this section, “commission” means a nonprofit corporation established in Kern County to operate the local health plan and other health care programs owned by, or operated in, Kern County.

(2) The commission shall be considered a public entity for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code.

(c) For purposes of this section, “governing body” means the board of directors of the nonprofit corporation established in Kern County, and “board of supervisors” means the Kern County Board of Supervisors.

(d) The commission may enter into agreements under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code.

(Amended by Stats. 2004, Ch. 228, Sec. 10.3. Effective August 16, 2004.)

14019. Notwithstanding the provisions of Section 14018, except as provided in Sections 14019.1 and 14019.6, a Medi-Cal card shall be authorization for payment for health care services rendered, under conditions prescribed by the director and to the extent required by federal law, during any of the three months immediately prior to the month in which application was made, and for which such person would have otherwise been eligible.

(Amended by Stats. 1982, Ch. 328, Sec. 13. Effective June 30, 1982.)

14019.3. (a) A beneficiary or any person on behalf of a beneficiary who has paid for medically necessary health care services, otherwise covered by the Medi-Cal program, received by the beneficiary shall be entitled to a return from a provider or directly from the department of any part of the payment that meets all of the following:

(1) Was rendered during the 90-day period prior to application for, his or her Medi-Cal card, or after application for but prior to the issuance of, his or her Medi-Cal card, for which the card authorizes payment under Section 14018 or 14019, or was charged to the beneficiary as excess copayment during the period after issuance of his or her Medi-Cal card.

(2) Is not payable by a third party under contractual or other legal entitlement.

(3) Was not used to satisfy his or her paid or obligated liability for health care services or to establish eligibility.

(b) To the extent permitted by federal law, whether or not a facility actually evicts a beneficiary, a beneficiary who may validly be evicted pursuant to Section 1439.7 of the Health and Safety Code, and who has received and paid for health care services otherwise covered by the Medi-Cal program shall not be entitled to the return from a provider of any part of the payment for which service was rendered during any period prior to the date upon which knowledge is acquired by a provider of the application of a beneficiary for Medi-Cal or the date of application for Medi-Cal, whichever is later.

(c) Upon presentation of the Medi-Cal card or other proof of eligibility, a provider shall submit a Medi-Cal claim for reimbursement, subject to the rules and regulations of the Medi-Cal program.

(d) Notwithstanding subdivision (c), payment received from the state in accordance with Medi-Cal fee structures shall constitute payment in full, except that a provider, after making a full refund to the department of any Medi-Cal payments received for services, may recover all provider fees to the extent that any other contractual entitlement, including, but not limited to, a private group or indemnification insurance program, is obligated to pay the charges for the care provided a beneficiary.

(e) A provider shall return any and all payments made by a beneficiary, or any person on behalf of a beneficiary, other than a third party obligated to pay charges by reason of a beneficiary’s other contractual or legal entitlement for Medi-Cal program covered services upon receipt of Medi-Cal payment.

(f) To the extent permitted by federal law, the department shall waive overpayments made to a pharmacy provider that would otherwise be reimbursable to the department for prescription drugs returned to a pharmacy provider from a nursing facility upon discontinuation of the drug therapy or death of a beneficiary.

(g) The department shall ensure payment to a beneficiary from a provider. A provider shall be notified in writing by the department when a beneficiary has submitted a claim to the department for reimbursement of services provided during the periods specified in paragraph (1) of subdivision (a). If a provider is not currently enrolled in the Medi-Cal program, the department shall assist in that enrollment. Enrollment in the Medi-Cal program may be made retroactive to the date the service was rendered.

(h) If a provider fails or refuses to reimburse a beneficiary for services provided during the periods specified in paragraph (1) of subdivision (a), within 90 days of receipt by the department of a written request by a beneficiary or a representative of a beneficiary, the department may take enforcement action that may include, but shall not be limited to, any or all of the following:

(1) Withholding of future provider payments.

(2) Suspension of a provider from participation in the Medi-Cal program.

(3) Recoupment of funds from a provider.

(i) If a provider fails or refuses to reimburse a beneficiary within 90 days after receipt by the department of a written request from a beneficiary or a representative of a beneficiary, the department shall directly reimburse a beneficiary for medically necessary health care expenses incurred during the periods specified in paragraph (1) of subdivision (a). The department shall reimburse a beneficiary only to the extent that federal financial participation is available and only when the claim meets all of the following criteria:

(1) The service was a covered benefit under the Medi-Cal program.

(2) The provider was an enrolled Medi-Cal provider at the time the service was rendered.

(3) The service was ordered by a health care provider, within the scope of his or her practice.

(4) The beneficiary is eligible for reimbursement, as specified in subdivision (a).

(5) The reimbursement shall be the amount paid by the beneficiary, not to exceed the rate established for that service under the Medi-Cal program.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of the Government Code, this section may be implemented with a provider bulletin or similar notification, without any further regulatory action.

(Amended by Stats. 2003, Ch. 230, Sec. 58. Effective August 11, 2003.)

14019.4. (a) A provider of health care services who obtains a label or copy from the Medi-Cal card or other proof of eligibility pursuant to this chapter shall not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient, or a person other than the department or a third-party payor who provides a contractual or legal entitlement to health care services.

(b) Whenever a service or set of services rendered to a Medi-Cal beneficiary results in the submission of a claim in excess of five hundred dollars ($500), and the beneficiary has given the provider proof of eligibility to receive the service or services, the provider shall issue the beneficiary a receipt to document that appropriate proof of eligibility has been provided. The form and content of those receipts shall be determined by the provider but shall be sufficient to comply with the intent of this subdivision. Nursing facilities and all categories of intermediate care facilities for the developmentally disabled are exempt from the requirements of this subdivision.

(c) In addition to being subject to applicable sanctions set forth in law or regulation, a provider of health care services who obtains a label from, or copy of, the Medi-Cal card or other proof of eligibility pursuant to this chapter, and who subsequently pursues reimbursement or payment for the cost of covered services from the beneficiary or fails to cease collection efforts against the beneficiary for covered services as required by subdivision (d), may be subject to a penalty, payable to the department, not to exceed three times the amount payable by the Medi-Cal program. In implementing this subdivision, mitigating circumstances, which include, but are not limited to, clerical error and good faith mistake, shall be considered when assessing the penalty. Providers subject to penalties under this subdivision shall have the right to appeal the assessed penalty, consistent with department procedures.

(d) When a Medi-Cal provider receives proof of a patient's Medi-Cal eligibility and that provider has previously referred an unpaid bill for services rendered to the patient to a debt collector, the Medi-Cal provider shall promptly notify the debt collector of the patient's Medi-Cal coverage, instruct the debt collector to cease collection efforts on the unpaid bill for the covered services, and notify the patient accordingly.

(e) If a patient provides proof of Medi-Cal eligibility to a debt collector, and the debt collector fails to notify the provider of this proof, the provider shall not be responsible for ensuring that collection efforts against the patient cease pursuant to subdivision (d) until either the patient or the debt collector provides the provider with proof of the patient's Medi-Cal eligibility.

(f) A Medi-Cal provider or debt collector shall be deemed to be in violation of subdivision (a) of Section 1785.25 of the Civil Code if more than 30 days after receiving proof of Medi-Cal coverage the provider or debt collector does either of the following:

(1) Furnishes information regarding the rendering of the Medi-Cal covered services to a consumer credit reporting agency.

(2) Fails to provide corrections of, or instructions to delete, as appropriate, information regarding Medi-Cal covered services previously furnished by that Medi-Cal provider or debt collector to a consumer reporting agency.

(g) This section shall not apply to the Medi-Cal spend down of excess income owed by a Medi-Cal beneficiary, unless the beneficiary's spend down of excess income has been met for the month in which services were rendered.

(h) For purposes of this section, "debt collector" includes any person who regularly engages in debt collection, as defined by Section 1788.2 of the Civil Code, but does not include the original Medi-Cal provider.

(Amended by Stats. 2023, Ch. 42, Sec. 118. (AB 118) Effective July 10, 2023.)

14019.5. Nothing in this chapter shall be construed as imposing any control over the management of any medical or health care facility, except that each such facility shall be required to comply with reasonable standards for certification to participate in the program provided by this chapter.

(Amended by Stats. 1971, Ch. 577.)

14019.6. Notwithstanding any other provision of law, no person, whose property reserve exceeds the property limit, may establish eligibility for any of the three months immediately prior to the month in which application was made, by spenddown of such excess property.

(Added by Stats. 1982, Ch. 328, Sec. 15. Effective June 30, 1982.)

14019.7. (a) Notwithstanding Section 14019.4 and if permitted by federal law, a relative of a skilled nursing facility resident who is a beneficiary under this chapter may pay an additional amount to the facility to enable the resident to obtain requested noncovered services, such as a private room, telephone, or television, or for bed hold days that exceed a period paid for under the state plan.

(b) The additional charge for requested noncovered services shall not exceed the amount charged to private pay residents. The additional charge for bed hold days shall not exceed the rate paid for by the Medi-Cal program for a covered bed hold day. The additional charge for a private room shall not exceed the difference between the private pay rate for a semiprivate room and a private room.

(c) Prior to accepting supplemental payment for holding a bed for a resident in a facility, a facility shall disclose to the relative the resident's right under federal law to be readmitted without charge upon the first availability of a bed in a semiprivate room in that facility, other state and federal laws regarding bed hold rights, the average number of bed vacancies at that facility for the past month, and the current number of bed vacancies. Written information regarding bed vacancies shall be provided to the relative at the first available opportunity.

(d) The ability of a resident's relative to pay an additional amount for noncovered services shall not be a condition of admission.

(Added by Stats. 2004, Ch. 661, Sec. 2. Effective January 1, 2005.)

14020. All sections of this chapter shall remain in operation during such times as grants-in-aid are provided or made available to the state on the basis of a state plan approved by the federal government for medical assistance pursuant to provisions of the Federal Social Security Act, as amended.

(Amended by Stats. 1969, Ch. 21.)

14021. Notwithstanding any other provision of this chapter, health care shall include the following mental health and substance use disorder services:

(a) Mental health services provided by a county or a city.

(b) Mental health services provided in a community mental health service or in a community mental health center organized under the federal Community Mental Health Centers Act of 1963. No amount shall be paid for that portion of the total costs of care and services in a federally funded community mental health center which may be compensated by the United States government under the federal Community Mental Health Centers Act of 1963. No amount shall be paid to a community mental health service or a federally funded community mental health center unless the community mental health service or the federally funded community mental health center participates in a county or city mental health performance contract pursuant to Section 5650.

(c) Drug Medi-Cal outpatient substance use disorder services under the jurisdiction of the department provided by a county provider certified under this chapter or a private provider certified under this chapter which has an approved contract with the county or with the department to provide covered substance use disorder services.

(d) Inpatient hospital services in an institution for mental diseases to persons of all ages, provided that the institution for mental diseases is certified as a psychiatric hospital under Title XVIII of the federal Social Security Act and regulations issued thereunder.

Notwithstanding Section 14157, no money in the State Health Care Deposit Fund shall be expended for the purposes of this section unless the Legislature specifically appropriates money for the purposes of this section.

The amendment of this subdivision enacted at the 1972 Regular Session of the Legislature does not constitute a change in, but is declaratory of, the preexisting law.

(e) (1) Other diagnostic, screening, preventive, or remedial rehabilitative services for the maximum restoration of an individual to the best possible functional level.

(2) Paragraph (1) includes any medical or remedial services provided in a facility, home, or other setting, that are recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.

(Amended by Stats. 2012, Ch. 36, Sec. 72. (SB 1014) Effective June 27, 2012. Operative July 1, 2012, by Sec. 83 of Ch. 36.)

14021.2. (a) The department shall develop a proposal for the United States Secretary of Health and Human Services for selection as a participating state in the time-limited demonstration program pursuant to Section 223 of the federal Protecting Access to Medicare Act of 2014 (Public Law 113-93) in order to improve mental health services furnished by certified community behavioral health clinics to Medi-Cal beneficiaries.

(b) The department shall use the funds appropriated in the act that added this section to pay any costs that will support the development of a competitive proposal, including, but not limited to, establishing actuarially sound rates and providing technical assistance to counties.

(c) If the state is selected as a participating state in the time-limited demonstration program described in subdivision (a), the department, by March 1, 2017, shall provide an update to the Legislature that includes, to the extent it is available, the following information:

(1) The names of the participating counties.

(2) The estimated amount of additional funding each county is expected to receive under the demonstration program.

(3) The proposed uses of the additional funds and the county funds no longer required to be used as the federal match.

(4) A description of the improved partnerships between certified community behavioral health clinics and veterans organizations, primary care providers, health plans, educational agencies, and other organizations that the demonstration program includes.

(5) Other identified benefits from the demonstration program funding and planning process, and recommendations on any components of the demonstration program that could be extended to other counties.

(Amended by Stats. 2016, Ch. 283, Sec. 2. (AB 168) Effective January 1, 2017.)

14021.3. The state plan for medical assistance under Medicaid pursuant to Section 1915(g) of Title 19 of the federal Social Security Act, as amended by Public Law 99-272 (42 U.S.C. Section 1396n(g)), shall include targeted case management services as a benefit under the specialty mental health services Medi-Cal program.

(Amended (as added by Stats. 1987, Ch. 1385, Sec. 1) by Stats. 2012, Ch. 34, Sec. 222. (SB 1009) Effective June 27, 2012. Operative July 1, 2012, by Sec. 254 of Ch. 34.)

14021.30. (a) It is the intent of the Legislature to transfer to the State Department of Health Care Services, no later than July 1, 2012, the administration of the Drug Medi-Cal program from the State Department of Alcohol and Drug Programs. It is further the intent of the Legislature that this transfer should happen efficiently and effectively, with no unintended interruptions in service delivery. This transfer is intended to do all of the following:

(1) Improve access to alcohol and drug treatment services, including a focus on recovery and rehabilitation services.

(2) More effectively integrate the financing of services, including the receipt of federal funds.

(3) Improve state accountability and outcomes.

(4) Provide focused, high-level leadership for behavioral health services.

(b) Effective July 1, 2012, the administrative functions for the Drug Medi-Cal program that were previously performed by the State Department of Alcohol and Drug Programs are transferred to the department.

(c) Notwithstanding subdivision (b), the department and the State Department of Alcohol and Drug Programs may conduct transition activities prior to July 1, 2012, that are necessary to ensure the efficient and effective transfer of Drug Medi-Cal program functions by that date in accordance with the transition plan described in Section 14021.31.

(d) After July 1, 2012, and through the quarter ending June 30, 2014, the department shall provide quarterly updates to the Legislature, key stakeholders, and the public on the steps foreseen, planned, and completed for the Drug Medi-Cal transfer, noting areas of concern, delay, or disruption, as the program fully transitions to the State Department of Health Care Services. These updates shall include information on continuity of care for beneficiaries and any access issues to care that arise as a result of or within the Drug Medi-Cal transfer. The State Department of Health Care Services shall convene meetings with interested stakeholders, including legislative representatives, either in preparation for or at the release of these quarterly updates. The first of these quarterly updates shall be released no later than October 1, 2012.

(Amended by Stats. 2012, Ch. 36, Sec. 73. (SB 1014) Effective June 27, 2012. Operative July 1, 2012, by Sec. 83 of Ch. 36.)

14021.31. The department, in collaboration with the State Department of Alcohol and Drug Programs, shall develop an administrative and programmatic transition plan to guide the transfer of the Drug Medi-Cal program to the department effective July 1, 2012.

(a) Commencing no later than July 15, 2011, the department, together with the State Department of Alcohol and Drug Programs, shall convene stakeholders to receive input from consumers, family members, providers, counties, and representatives of the Legislature concerning the transfer of the administration of Drug Medi-Cal functions currently performed by the State Department of Alcohol and Drug Programs to the department. This consultation shall inform the creation of an administrative and programmatic transition plan that shall include, but is not limited to, the following components:

(1) Plans for how to review monthly billing from counties to monitor and prevent any disruptions of service to Drug Medi-Cal beneficiaries during and immediately after the transition, and a description of how the department intends to approach the longer-term development of measures for access and quality of service.

(2) A detailed description of the Drug Medi-Cal administrative functions currently performed by the State Department of Alcohol and Drug Programs.

(3) Explanations of the operational steps, timelines, and key milestones for determining when and how each of these functions will be transferred. These explanations shall also be developed for the transition of position and staff serving the Drug Medi-Cal program and how these will relate to and align with positions for the Medi-Cal program at the department. The department shall consult with the Department of Human Resources in developing this aspect of the transition plan.

(4) A list of any planned or proposed changes or efficiencies in how the functions will be performed, including the anticipated fiscal and programmatic impacts of the changes.

(5) A detailed organization chart that reflects the planned staffing at the department, taking into account the requirements of subparagraphs (A) to (C), inclusive, and includes focused, high-level leadership for behavioral health issues.

(6) A description of how stakeholders were included in the initial planning process to formulate the transition plan, and a description of how their feedback will be taken into consideration after transition activities are underway.

(b) The department, together with the State Department of Alcohol and Drug Programs, shall convene and consult with stakeholders at least once following production of a draft of the transition plan and before submission of that plan to the Legislature. Continued consultation with stakeholders shall occur in accordance with the requirement in subparagraph (F) of paragraph (1).

(Amended by Stats. 2018, Ch. 903, Sec. 22. (SB 1504) Effective January 1, 2019.)

14021.33. A regulation or order concerning the Drug Medi-Cal Treatment Program adopted by the State Department of Alcohol and Drug Programs pursuant to former Chapter 3.4 (commencing with Section 11758.40) of Part 1 of Division 10.5 of the Health and Safety Code, as in effect preceding the effective date of the act that added this section, shall remain in effect and shall be fully enforceable, unless and until the readoption, amendment, or repeal of the regulation or order by the department, or until it expires by its own terms.

(Added by Stats. 2012, Ch. 36, Sec. 74. (SB 1014) Effective June 27, 2012. Operative July 1, 2012, by Sec. 83 of Ch. 36.)

14021.35. (a) The department shall prepare and submit amendments to the Medicaid state plan and apply for any necessary waivers in order to obtain federal financial participation to implement Drug Medi-Cal Treatment Program provisions contained in Section 14124.24.

(b) Upon federal approval for federal financial assistance, the department, in consultation with the State Department of Alcohol and Drug Programs, shall define the Drug Medi-Cal services, as needed, shall establish the standards under which those services qualify as Drug Medi-Cal reimbursable services, and shall develop appropriate rates of reimbursement for those services, subject to utilization controls.

(Amended by Stats. 2012, Ch. 36, Sec. 75. (SB 1014) Effective June 27, 2012. Operative July 1, 2012, by Sec. 83 of Ch. 36.)

14021.4. (a) California's plan for federal Medi-Cal grants for medical assistance programs, pursuant to Subchapter XIX (commencing with Section 1396) of Title 42 of the United States Code, shall accomplish the following objectives:

(1) Expansion of the location and type of therapeutic services offered to persons with mental illnesses under Medi-Cal by the category of "other diagnostic, screening, preventative, and rehabilitative services" that is available to states under the federal Social Security Act and its implementing regulations (42 U.S.C. Sec. 1396d(a)(13); 42 C.F.R. 440.130).

(2) Expansion of federal financial participation in the costs of specialty mental health services provided by local mental health plans or under contract with the mental health plans.

(3) Expansion of the location where reimbursable specialty mental health services can be provided, including home, school, and community-based sites.

(4) Expansion of federal financial participation for services that meet the rehabilitation needs of persons with mental illnesses, including, but not limited to, medication management, functional rehabilitation assessments of clients, and rehabilitative services that include remedial services directed at restoration to the highest possible functional level for persons with mental illnesses and maximum reduction of symptoms of mental illness.

(5) Improvement of fiscal systems and accountability structures for specialty mental health services, costs, and rates, with the goal of achieving federal fiscal requirements.

(b) The department's state plan revision shall be completed with review and comments by the County Behavioral Health Directors Association of California and other appropriate groups.

(c) Services under the rehabilitative option shall be limited to specialty mental health plans certified to provide Medi-Cal under this option.

(d) It is the intent of the Legislature that the rehabilitation option of the state Medicaid plan be implemented to expand and provide flexibility to treatment services and to increase the federal participation without increasing the costs to the General Fund.

(e) The department shall review and revise the quality assurance standards and guidelines required by Section 14725 to ensure that quality services are delivered to the eligible population. Any reviews shall include, but not be limited to, appropriate use of mental health professionals, including psychiatrists, in the treatment and rehabilitation of clients under this model. The existing quality assurance standards and guidelines shall remain in effect until the adoption of the new quality assurance standards and guidelines.

(f) Consistent with services offered to persons with mental illnesses under the Medi-Cal program, as required by this section, it is the intent of the Legislature for the department to include care and treatment of persons with mental illnesses who are eligible for the Medi-Cal program in facilities with a bed capacity of 16 beds or less.

(Amended by Stats. 2015, Ch. 455, Sec. 51. (SB 804) Effective January 1, 2016.)

14021.5. (a) Notwithstanding any other provision of law, rates for reimbursing specialty mental health and substance use disorder services allowable under the Medi-Cal program and rendered to Medi-Cal beneficiaries shall continue to be based on the upper limits allowable under federal law and regulations for services provided prior to July 1, 1980, on the lower of reasonable cost and customary charges for services provided July 1, 1980, through June 30, 1982, and on the lowest of reasonable cost, customary charges, and rates paid by the Medi-Cal program for services provided July 1, 1982, through June 30, 1984.

(b) The Legislature hereby states and declares that this section does not constitute a change in, but is declaratory of, existing law and that rates for reimbursing specialty mental health and substance use disorder services to Medi-Cal beneficiaries under the Medi-Cal program in previous fiscal years were based upon the lower of reasonable costs or customary charges.

(c) The department shall promulgate emergency regulations relating to claims submission and establishing rates and a ratesetting methodology for determining reimbursement of specialty mental health and substance use disorder services allowable under the Medi-Cal program and rendered to Medi-Cal beneficiaries. The methodology and rates shall reflect the most recently completed cost reports and shall be effective commencing July 1, 1984.

(d) Notwithstanding any other law, rates for reimbursing specialty mental health services allowable under the Medi-Cal program and rendered to Medi-Cal beneficiaries shall be effective from July 1 through June 30 of the fiscal year in which these rates are established.

(e) Notwithstanding any other law, rates for reimbursing substance use disorder services allowable under the Medi-Cal program and rendered to Medi-Cal beneficiaries shall be effective from July 1 through June 30 of the fiscal year in which these rates are established.

(Amended by Stats. 2012, Ch. 34, Sec. 224. (SB 1009) Effective June 27, 2012. Operative July 1, 2012, by Sec. 254 of Ch. 34.)

14021.51. (a) For purposes of this section, "narcotic treatment program services" includes, but is not limited to, all of the following:

(1) Admission, physical evaluation, and diagnosis.

(2) Drug screening.

(3) Pregnancy tests.

(4) Narcotic replacement therapy dosing.

(5) Any medication approved under Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), and all biological products licensed under Section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders.

(6) (A) Intake assessment, treatment planning, and counseling services.

(B) The frequency of counseling, behavioral therapy, or medical psychotherapy, outcomes, and rates shall be addressed through guidance issued by the department pursuant to subdivision (k). For purposes of this paragraph, these services include substance use services to pregnant and postpartum Medi-Cal beneficiaries.

(b) (1) The department shall establish a narcotic replacement therapy dosing fee for methadone.

(2) In addition to the narcotic replacement therapy dosing fee specified in paragraph (1), a narcotic treatment program shall be reimbursed for the ingredient costs of methadone dispensed to a Medi-Cal beneficiary. These costs may be determined on an average daily dose of methadone, as set forth by the department.

(c) Reimbursement for narcotic treatment program services shall be based on a per capita uniform statewide daily reimbursement rate for each individual patient, as established by the department. The uniform statewide daily reimbursement rate for narcotic treatment program services shall be based upon, if available and appropriate, all of the following:

(1) The outpatient rates for the same or similar services under the fee-for-service Medi-Cal program.

(2) Cost report data.

(3) Other data deemed reliable and relevant by the department.

(4) The rate studies completed pursuant to Section 54 of Chapter 197 of the Statutes of 1996.

(d) The uniform statewide daily reimbursement rate for ancillary services shall not exceed, for individual services or in the aggregate, the outpatient rates for the same or similar services under the fee-for-service Medi-Cal program.

(e) The uniform statewide daily reimbursement rate shall be established after consultation with narcotic treatment program providers and county alcohol and drug program administrators.

(f) Reimbursement for narcotic treatment program services shall be limited to those services specified in state law and any authorized federally approved Medicaid state plan amendments or waivers related to the Drug Medi-Cal program, and shall be provided in accordance with federal and state law governing the licensing and administration of narcotic treatment programs.

(g) Reimbursement under this section shall be limited to claims for narcotic treatment program services at the uniform statewide daily reimbursement rate for these services. These rates shall be exempt from the requirements of Section 14021.6.

(h) (1) Reimbursement to a narcotic treatment program provider shall be limited to the lower of the uniform statewide daily reimbursement rate, pursuant to subdivision (c), or the provider's usual and customary charge to the general public for the same or similar service.

(2) (A) Reimbursement paid by a county to a narcotic treatment program provider for services provided to any person subject to Section 1210.1 or 3063.1 of the Penal Code, and for which the individual client is not liable to pay, is not a usual and customary charge to the general public for the purposes of this section.

(B) Subparagraph (A) is not a change in, but is declaratory of, existing law.

(i) A program shall not be reimbursed for services or medications not rendered to or received by a patient of a narcotic treatment program.

(j) Reimbursement for narcotic treatment program services shall be administered by the department and any county electing to participate in the program. Utilization and payment for these services shall be subject to federal Medicaid and state utilization and audit requirements.

(k) 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, may implement, interpret, or make specific this section, in whole or in part, by means of bulletins or similar instructions, until the time that any necessary regulations are adopted.

(l) The department shall adopt regulations necessary to implement this section by July 1, 2023.

(m) This section shall be implemented to the extent that any necessary federal approval of state plan amendments or other federal approvals, including waivers, are obtained, and federal financial participation is available and not otherwise jeopardized.

(Amended by Stats. 2020, Ch. 12, Sec. 50. (AB 80) Effective June 29, 2020.)

14021.52. (a) (1) The Legislature finds and declares all of the following:

(A) Medical treatment for indigent patients who are not eligible for Medi-Cal is essential to protecting the public health.

(B) The Legislature supports the adoption of standardized and simplified forms and procedures in order to promote the drug treatment of indigent patients who are not eligible for Medi-Cal.

(C) Providers should not be required by the state to subsidize the medical treatment provided to indigent patients who are not eligible for Medi-Cal.

(D) The Legislature supports the therapeutic value of indigent patients who are not eligible for Medi-Cal contributing some level of fees for drug treatment services in order to support the goals of those drug treatment services.

(2) It is the intent of the Legislature in enacting this section to encourage narcotic treatment program providers to serve indigent patients who are not eligible for Medi-Cal. It is also the intent of the Legislature that the department allow narcotic treatment program providers to charge therapeutic fees for providing drug treatment to indigent patients who are not eligible for Medi-Cal if the providers establish a fee scale that complies with the documentation requirements established pursuant to this section and federal law.

(b) (1) The Legislature recognizes that narcotic treatment program providers are reimbursed for controlled substances provided under the Drug Medi-Cal Treatment Program, also known as Drug Medi-Cal, and pursuant to federal law at a rate that is the lower of the per capita uniform statewide daily reimbursement or Drug Medi-Cal rate, or the provider's usual and customary charge to the general public for the same or similar services.

(2) It furthers the intent of the Legislature to ensure that narcotic treatment programs in the state are able to serve indigent clients and that there is an exception to the reimbursement requirements described in paragraph (1), as the federal law has been interpreted by representatives with the federal Centers for Medicare and Medicaid Services. Pursuant to this exception, if a narcotic treatment program provider that is serving low-income non-Drug Medi-Cal clients complies with a federal requirement for the application of a sliding indigency scale, the reduced charges under the sliding indigency scale shall not lower the provider's usual and customary charge determination for purposes of Medi-Cal reimbursement.

(c) A licensed narcotic treatment program provider that serves low-income non-Drug Medi-Cal clients shall be deemed in compliance with federal and state law, for purposes of the application of the exception described in paragraph (2) of subdivision (b), and avoid audit disallowances, if the provider implements a sliding indigency scale that meets all of the following requirements:

(1) The maximum fee contained in the scale shall be the provider's full nondiscounted, published charge and shall be at least the rate that Drug Medi-Cal would pay for the same or similar services provided to Drug Medi-Cal clients.

(2) The sliding indigency scale shall provide for an array of different charges, based upon a client's ability to pay, as measured by identifiable variables. These variables may include, but need not be limited to, financial information and the number of dependents of the client.

(3) Income ranges shall be in increments that result in a reasonable distribution of clients paying differing amounts for services based on differing abilities to pay.

(4) A provider shall obtain written documentation that supports an indigency allowance under the sliding indigency scale established pursuant to this section, including a financial determination. In cases where this written documentation cannot be

obtained, the provider shall document at least three attempts to obtain this written documentation from a client.

(5) The provider shall maintain all written documentation that supports an indigency allowance under this section, including, if used, the financial evaluation form set forth in Section 14021.53.

(6) Written policies shall be established and maintained that set forth the basis for determining whether an indigency allowance may be granted under this section and establish what documentation shall be requested from a client.

(d) In developing the sliding indigency scale, a narcotic treatment program provider shall consider, but need not include, any or all of the following components:

(1) Vertically, the rows would reflect increments of family or household income. There would be a sufficient number of increments to allow for differing charges, such as a six hundred dollar ($600) increase per interval.

(2) Horizontally, the columns would provide for some other variable, such as family size, in which case, the columns would reflect the number of people dependent on the income, including the client.

(3) Each row, except the first and last rows, would contain at least two different fee amounts and each of the columns, four or more in number, would contain at least six different fee amounts.

(4) The cells would contain an array of fees so that no fee would be represented in more than 25 percent of the cells.

(e) A narcotic treatment program provider that uses the financial evaluation form instructions and financial form set forth in Section 14021.53 in obtaining written documentation that supports an indigency allowance as required under paragraph (4) of subdivision (c) shall be deemed in compliance with that paragraph.

(Added by Stats. 2012, Ch. 36, Sec. 77. (SB 1014) Effective June 27, 2012. Operative July 1, 2012, by Sec. 83 of Ch. 36.)

14021.53. A narcotic treatment program provider may use the following instructions and financial evaluation form to comply with the requirements of paragraph (4) of subdivision (c) of Section 14021.52:

FINANCIAL EVALUATION FORM INSTRUCTIONS

MONTHLY INCOME DATA—This data should specify the source and the amount and be supported by sufficient documentation. Income data may include, but are not limited to, income received as a paid employee, unemployment benefits, disability benefits, pension payments, family income, savings income, or other sources.

MONTHLY EXPENSES DATA—This data is not required unless there is no evidence or documentation of income data. Expense data may include, but are not limited to, any known expenses related to the following:

(1) Court-ordered payments, such as child support, fines, debts, restitution, or other payments.

(2) Housing-related expenses, such as rent, mortgage, insurance, utilities, or other obligations.

(3) Transportation costs, such as any related expenses, including automobile payments or automobile insurance payments.

(4) Insurance coverage should also be noted if it produces either an expense or benefit to the client.

CLIENT MONTHLY TREATMENT FEE—The following applies to this data:

(1) The amount box indicates the client's fee according to his or her location on the sliding scale.

(2) The adjusted client monthly fee box is to be filled only if the fee to be charged differs from the fee indicated by the client's location on the sliding scale.

(3) If the fee is adjusted from what the sliding scale would indicate, a reason for the adjustment must be provided. (Valid reasons might include extraordinary medical expenses for a client suffering from HIV/AIDS, etc.)

PLEASE NOTE—The documentation for this form requires that the provider make at least three documented attempts to collect documentation from a client. Any questions on this form may be directed to the department at (____).

(Added by Stats. 2012, Ch. 36, Sec. 78. (SB 1014) Effective June 27, 2012. Operative July 1, 2012, by Sec. 83 of Ch. 36.)

14021.6. (a) For the fiscal years prior to the 2004–05 fiscal year, and subject to the requirements of federal law, the maximum allowable rates for the Drug Medi-Cal Treatment Program shall be determined by computing the median rate from available cost data by modality from the fiscal year that is two years prior to the year for which the rate is being established.

(b) (1) For the 2007–08 fiscal year, and subsequent fiscal years, and subject to the requirements of federal law, the maximum allowable rates for the Drug Medi-Cal Treatment Program shall be determined by computing the median rate from the most recently completed cost reports, by specific service codes that are consistent with the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg).

(2) For the 2005–06 and 2006–07 fiscal years, if the State Department of Health Care Services determines that reasonably reliable and complete cost report data are available, the methodology specified in this subdivision shall be applied to either or both of those years. If reasonably reliable and complete cost report data are not available, the State Department of Health Care Services shall establish rates for either or both of those years based upon the usual, customary, and reasonable charge for the services to be provided, as the department may determine in its discretion. This subdivision does not modify subdivision (h) of Section 14124.24, which requires certain providers to submit performance reports.

(c) Notwithstanding subdivision (a), for the 1996–97 fiscal year, the rates for nonperinatal outpatient methadone maintenance services shall be set at the rate established for the 1995–96 fiscal year.

(d) Notwithstanding subdivision (a), the maximum allowable rate for group outpatient drug free services shall be set on a per person basis. A group shall consist of a minimum of 2 and a maximum of 12 individuals, at least one of which shall be a Medi-Cal eligible beneficiary. For groups consisting of two individuals, if one of the individuals is ineligible for Medi-Cal, the individual who is ineligible for Medi-Cal shall be receiving outpatient drug free services for a substance use disorder diagnosed by a physician.

(e) The department shall develop individual and group rates for extensive counseling for outpatient drug free treatment, based on a 50-minute individual or a 90-minute group hour, not to exceed the total rate established for subdivision (d).

(f) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of bulletins or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 1, 2020, 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 that added this paragraph, and notwithstanding Section 10231.5 of the Government Code, the department shall, on a semiannual basis and in compliance with Section 9795 of the Government Code, provide a status report to the Legislature until the regulations have been adopted.

(2) Notwithstanding paragraph (1) and Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may annually establish and update the statewide maximum allowable reimbursement rates specified in this section by means of bulletins or similar instructions.

(g) Bills for services under the Drug Medi-Cal Treatment Program shall be submitted no later than 12 months from the date of service.

(Amended by Stats. 2023, Ch. 42, Sec. 119. (AB 118) Effective July 10, 2023.)

14021.7. (a) The department shall amend the state plan for medical assistance under the Medicaid program pursuant to subdivision (g) of Section 1396n of Title 42 of the United States Code, to add targeted case management services for those pregnant and parenting adolescents and their children, targeted by the department, in those localities served on January 1, 1991, by the Adolescent Family Life Program (Article 1 (commencing with Section 124175) of Chapter 4 of Part 2 of Division 106 of the Health and Safety Code), as a covered benefit under the Medi-Cal program. The department shall submit the amended plan for federal approval by April 1, 1991.

(b) For purposes of this section, the term “targeted case management services” shall be defined as those services provided to pregnant and parenting adolescents pursuant to Article 1 (commencing with Section 124175) of Chapter 4 of Part 2 of Division 106 of the Health and Safety Code.

(c) Upon federal approval for federal financial assistance, the department shall establish the standards under which targeted case management services qualify as a Medi-Cal reimbursable service, subject to the availability of funding through the budget process, and shall develop an appropriate rate of reimbursement, subject to utilization controls.

(Amended by Stats. 1996, Ch. 1023, Sec. 469. Effective September 29, 1996.)

14021.8. The department may not utilize any information regarding whether a beneficiary’s psychiatric inpatient admission was made on a voluntary or involuntary basis for the purpose of determining eligibility for Medi-Cal claim reimbursement.

(Added by Stats. 2001, Ch. 506, Sec. 10. Effective January 1, 2002.)

14021.9. (a) Notwithstanding any other law, for the 2009–10 fiscal year, a 10-percent reduction shall be applied to rates for Drug Medi-Cal services developed by the State Department of Alcohol and Drug Programs pursuant to Section 11758.42 of the Health and Safety Code and Sections 14021.35, 14021.5, and 14021.6.

(b) For the 2010–11 and 2011–12 fiscal years, rates for Drug Medi-Cal services shall be the lower of the following:

(1) The rates developed by the State Department of Alcohol and Drug Programs pursuant to Section 11758.42 of the Health and Safety Code and Sections 14021.35, 14021.5, and 14021.6.

(2) The rates applicable in the 2009–10 fiscal year pursuant to subdivision (a), adjusted for the cumulative growth in the Implicit Price Deflator for the Costs of Goods and Services to Governmental Agencies, as reported by the Department of Finance.

(c) For the 2012–13 fiscal year and each fiscal year thereafter, rates for Drug Medi-Cal reimbursable services shall be the lower of the following:

(1) The rates developed pursuant to Sections 14021.35, 14021.51, and 14021.6.

(2) The rates applicable in the 2009–10 fiscal year pursuant to subdivision (a), adjusted for the cumulative growth in the Implicit Price Deflator for the Costs of Goods and Services to Governmental Agencies, as reported by the Department of Finance.

(d) The rate reductions applicable for the 2009–10 fiscal year pursuant to subdivision (a) shall be applied retroactively to July 1, 2009.

(Amended by Stats. 2012, Ch. 36, Sec. 79. (SB 1014) Effective June 27, 2012. Operative July 1, 2012, by Sec. 83 of Ch. 36.)

14022. (a) This section shall be known as the “Medi-Cal Conflict of Interest Law.”

It is the intent of the Legislature that provisions be made for disclosure of the interests of providers of service in the services, facilities and organizations to which they refer Medi-Cal recipients so that it is possible to determine the extent to which conflicts of interests may exist because of such referrals.

(b) As used in this section, the term “referral” means (1) the referral of a recipient by a provider of service to any other provider of service; (2) the placement of a recipient by a provider of service in any facility; or (3) the obtaining, requesting, ordering or prescribing of services or supplies by a provider of service on behalf of a recipient from any other provider of service.

As used in this section, the term “immediate family” includes the spouse and children of the provider of service, the parents of the provider of service and his spouse, and the spouses of the children of the provider of service.

(c) A payment under this chapter shall not be made to a provider of service or to any facility or organization in which he or his immediate family has a significant beneficial interest, for services rendered in connection with any referral of a recipient, unless there is on file with the director and the Advisory Health Council a statement of the nature and extent of such interest.

(d) This section shall become operative only upon the date of which Section 1902(a)(4)(C) of the federal Social Security Act, as added by Public Law 95-559 is repealed, held invalid by a court of appeal, or otherwise made inoperative.

(Amended by Stats. 2015, Ch. 303, Sec. 606. (AB 731) Effective January 1, 2016. Section conditionally operative by its own provisions. Note: Until this section is operative, see related provisions in Article 1.6, commencing with Section 14047.)

14022.1. Any nursing facility or any category of intermediate care facility for the developmentally disabled participating in the Medi-Cal program shall supply to the department full and complete information as to the identity (a) of each person having, directly or indirectly, an ownership interest of 10 percent or more in the facility, or, who is owner, in whole or part, of any mortgage, deed of trust, note, or other obligation secured, in whole or part, by the facility, or any of the property or assets of the facility, (b) in case a facility is organized as a corporation, of each officer and director of the corporation, and (c) in case a facility is organized as a partnership, of each partner; and shall promptly report any changes which would affect the current accuracy of the information so required to be supplied.

(Amended by Stats. 1990, Ch. 1329, Sec. 13. Effective September 26, 1990.)

14022.3. Long-term health care facilities shall reveal to applicants for admission, or their designated representatives, orally and in writing and prior to admission, whether the facility participates in the Medi-Cal program, and the circumstances under which the law permits a Medi-Cal recipient to be transferred involuntarily.

(Added by Stats. 1985, Ch. 11, Sec. 19. Effective March 6, 1985.)

14022.4. (a) Any nursing facility or any category of intermediate care facility for the developmentally disabled currently certified to participate in the Medi-Cal program may not voluntarily withdraw from the program unless all of the following conditions are met:

(1) The facility shall file with the department a notice of intent to withdraw from the Medi-Cal program.

(2) Except for patients to be transferred or discharged only for medical reasons, or for patients' welfare or that of other patients, or for nonpayment for his or her stay, the facility shall not subsequently evict any Medi-Cal recipient or private pay patient residing in the facility at the time the notice of intent to withdraw from the Medi-Cal program is filed.

(3) Patients admitted to the facility on or after the date of the notice of intent to withdraw from the Medi-Cal program shall be advised orally and in writing of both the following:

(A) That the facility intends to withdraw from the Medi-Cal program.

(B) That notwithstanding Section 14124.7, the facility is not required to keep a new resident who converts from private pay to Medi-Cal.

(b) Subdivision (a) shall not apply to facilities that have filed, prior to May 1, 1987, a notice of intent to withdraw from the Medi-Cal program.

(c) The department shall notify the appropriate substate ombudsmen monthly as to which facilities have filed a notice of intent to withdraw from the Medi-Cal program. This information shall also be made available to the public and noted in facility files available in each district office.

(d) The facility may formally withdraw from the Medi-Cal program when all patients residing in the facility at the time the facility filed the notice of intent to withdraw from the Medi-Cal program no longer reside in the facility.

(e) If a facility that has withdrawn as a Medi-Cal provider pursuant to this section subsequently reapplies to the department to become a Medi-Cal provider, the department shall require as a condition of becoming a Medi-Cal provider that the facility enter into a five-year Medi-Cal provider contract with the department.

(f) This section shall be inoperative in the event federal law or federal or state appellate judicial decisions prohibit implementation or invalidate any part of this section.

(g) (1) This section does not apply to any facility which ceases operations entirely.

(2) For purposes of this subdivision, "ceases operations entirely" means not being in operation for a period of not less than 12 months.

(Amended by Stats. 2012, Ch. 728, Sec. 198. (SB 71) Effective January 1, 2013. Conditionally inoperative as provided in subd. (f).)

14022.5. (a) It is the intent of the Legislature to recognize the challenges and unique dental treatment needs of the developmentally disabled population that cannot be addressed within the current structure of benefits, frequency of allowable procedures, and treatment authorization procedures for assistance programs relating to dental benefits.

(b) The department shall work in cooperation with the State Department of Developmental Services, and in consultation with the California Dental Association, to provide existing data directly to the fiscal and policy committees of the Legislature specified in subdivision (c), by April 1, 2003, describing the characteristics of dental services received by Medi-Cal beneficiaries who are eligible to receive dental services under the Lanterman Developmental Disability Services Act (Division 4.5 (commencing with Section 4500)), who can be easily identified, including, but not limited to, the frequency of utilization of dental procedures and services, and types of dental procedures and services.

(c) The committees to whom the data shall be provided include all of the following:

(1) The Senate Committee on Health and Human Services.

(2) The Senate Budget Subcommittee Number 3 on Health, Human Services, Labor, and Veterans Affairs.

(3) The Assembly Committee on Health.

(4) The Assembly Committee on Human Services.

(5) The Assembly Budget Subcommittee Number 1 on Health and Human Services.

(d) It is the intent of the Legislature that the information described in subdivision (b) will be used to identify possible program modifications that are more appropriate to serve the population described in subdivision (b), and that are more efficient and more effective in serving this population, while remaining cost-neutral.

(Added by Stats. 2002, Ch. 522, Sec. 1. Effective January 1, 2003.)

14023. (a) Any applicant for coverage under this chapter who at the time of application has any other contractual or legal entitlement to any health care service defined in Section 14053, and who willfully fails at that time to disclose the fact of such other entitlement,

or falsely represents that he or she does not have such other entitlement, is guilty of a misdemeanor.

(b) Any person eligible under this chapter who, subsequent to the date of application for such assistance or coverage under this chapter, acquires any other contractual or legal entitlement to any health care service defined in Section 14053, and willfully fails or refuses to give notice thereof to his county welfare department within 10 days of such acquisition, is guilty of a misdemeanor.

(c) Any person eligible under this chapter who has any other contractual or legal entitlement to any health care service defined in Section 14053, and who knowing that he or she must use such entitlement first, obtains any such service under Medi-Cal without first having utilized and exhausted his or her other contractual or legal entitlement thereto or therefor, is guilty of a misdemeanor.

(d) Any applicant shall by virtue of becoming eligible under this chapter have irrevocably assigned the benefits of any contractual or legal entitlement for health care to the State Director of Health Services to the extent that the services were paid for under this chapter.

(Amended by Stats. 1985, Ch. 1354, Sec. 14.)

14023.7. Any provider of service seeking payment for health care services for a person eligible for these services under this chapter shall first seek to obtain payment from any private or public health insurance coverage to which the person is entitled, where the provider is aware of this coverage and to the extent the coverage extends to these services, prior to submitting a claim to the department for the payment of any unpaid balance for these services. In the event that a claim submitted to a private or public health insurer has not been paid within 90 days of billing by the provider, a claim may be submitted to the department.

(Added by Stats. 1983, Ch. 323, Sec. 125.4. Effective July 1, 1983.)

14024. When health care services are provided to a person under this chapter who at the time the service is provided has any other contractual or legal entitlement to such services, the director shall have the right to recover from the person, corporation, or partnership who owes such entitlement, the amount which would have been paid to the person entitled thereto, or to a third party in his behalf, or the value of the service actually provided, if the person entitled thereto was entitled to services. The Attorney General may, to recover under this section, institute and prosecute legal proceedings against the person, corporation, or partnership owing such entitlement in the appropriate court in the name of the director.

To the extent permitted by federal law and subject to the director's prior right to recover upon any contractual or legal entitlement or other third-party liability for the cost incurred in rendering care, the provider of services shall remain entitled to recover remaining unpaid charges to the extent that any third party is obligated to pay the charges by reason of the beneficiary's other contractual entitlement. Any claim shall not be permitted to the extent that the claim would reduce the director's right to recover pursuant to Section 14124.78.

The provider of services shall be required to notify the department of any potential contractual or legal entitlement or other third-party liability within 60 days of discovery. A provider who has obtained proof of Medi-Cal eligibility and who makes a claim for payment by any third party shall disclose in the claim that the patient is a Medi-Cal beneficiary.

(Amended by Stats. 1985, Ch. 776, Sec. 3.)

14025. (a) Any person who buys or sells a Medi-Cal card, Medi-Cal label, or Medi-Cal beneficiary identification number is guilty of a public offense punishable by imprisonment in the county jail for not more than one year, or in the state prison, or by a fine not exceeding five thousand dollars ($5,000), or by both the fine and imprisonment.

(b) Any person who barters for the purpose of resale or commercial exchange a Medi-Cal card, Medi-Cal label, or Medi-Cal beneficiary identification number is guilty of a public offense punishable by imprisonment in the county jail for not more than one year, or in the state prison, or by a fine not exceeding five thousand dollars ($5,000), or by both the fine and imprisonment.

(c) This section shall not apply to any peace officer or any other person working under the peace officer's immediate direction, supervision, or instruction while investigating Medi-Cal fraud or other related crimes in the performance of his or her official duties.

(Added by Stats. 1989, Ch. 1267, Sec. 1.)

14026. (a) It is a misdemeanor for a Medi-Cal beneficiary to furnish, give, or lend his Medi-Cal card or labels to any person other than a provider of service as required under Medi-Cal regulations.

(b) It is a misdemeanor for any person to use a Medi-Cal card other than the one which was issued to him or her to obtain health care services. This subdivision shall not apply to the use of a Medi-Cal card of a family member by another family member if the person using the card is, in fact, eligible under this chapter.

(c) This section shall not apply to any peace officer while investigating Medi-Cal fraud or other crimes in performance of his official duties or to any person working under the peace officer's immediate direction, supervision, or instruction when such peace officer has been issued a Medi-Cal card pursuant to Section 14026.5.

(Amended by Stats. 1984, Ch. 752, Sec. 1.)

14026.5. (a) The State Director of Health Services may issue Medi-Cal cards to Medi-Cal fraud investigators for the purpose of conducting investigations of Medi-Cal fraud, or a violation of the Medical Practice Act as set forth in Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code upon written request to the State Director of Health Services, or his or her designee, from the head of the requesting agency stating the purpose of the investigation. The request shall be based upon a specific complaint or information alleging Medi-Cal fraud. The request shall be based upon a specific complaint or information from an outside agency pursuant to its standard procedure for referring cases to another agency where there is suspicion of Medi-Cal fraud.

(b) (1) Upon a complaint by any individual alleging information creating a reasonable suspicion that any person is engaging in Medi-Cal fraud, the State Director of Health Services shall issue Medi-Cal cards for the purpose of conducting investigations of Medi-Cal fraud, or a violation of the Medical Practice Act as set forth in Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, upon an order of a magistrate issued upon a showing of reasonable suspicion that the person being investigated has committed or is committing Medi-Cal fraud or a violation of the Medical Practice Act as set forth in Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

(2) For purposes of this section, “reasonable suspicion” means that a peace officer subjectively entertains such a suspicion and that it is objectively reasonable for him or her to do so. The facts shall be those that would cause any reasonable peace officer in a like position drawing when appropriate on his or her training and experience, to suspect the same criminal activity and the same involvement by the person in question. A showing of reasonable suspicion may be made either by written statement under penalty of perjury or by oral statement taken under oath, recorded and transcribed.

(c) Nothing in this section shall be construed to mean that it is the exclusive method for conducting investigations for Medi-Cal fraud or for violations of the Medical Practice Act as set forth in Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

(d) The State Department of Health Services shall report to the Legislature every six months commencing June 1, 1981, on the utilization of Medi-Cal cards issued pursuant to this section. The report shall include, among other matters, a description of the types of criminal investigations conducted pursuant thereto.

(Amended by Stats. 2004, Ch. 193, Sec. 238. Effective January 1, 2005.)

14027. (a) The department may designate participating county health service agencies as health care service providers of home nursing services, subject to appropriate statutory licensing and certification requirements.

(b) Any county designated as a health care provider of home nursing services pursuant to subdivision (a) shall act as a fiscal intermediary for the provision of home nursing services and pass through to the licensed individuals rendering those nursing services, in total, all Medi-Cal reimbursements received for those nursing services.

(c) The Medi-Cal reimbursement rate applicable to nursing services reimbursed through a designated county health service agency shall be the current Medi-Cal rate applicable to those services.

(d) For purposes of this section, “designated provider of home nursing services” means any participating county health services agency designated as a provider of home nursing services pursuant to subdivision (a).

(Added by Stats. 1988, Ch. 1161, Sec. 1.)

14028. (a) (1) In order to ensure appropriate oversight of psychotropic medications prescribed for children, pursuant to Section 2245 of the Business and Professions Code, the department and the State Department of Social Services, pursuant to a data-sharing agreement that shall meet the requirements of all applicable state and federal laws and regulations, shall provide the Medical Board of California with information regarding Medi-Cal physicians and their prescribing patterns of psychotropic medications and related services for individuals described in subparagraphs (B) and (C) of paragraph (1) of subdivision (c). The data concerning psychotropic medications and related services shall be drawn from existing data sources maintained by the departments. Every five years, the Medical Board of California, the department, and the State Department of Social Services shall consult and revise the methodology, if determined to be necessary.

(2) At minimum, the department, on an annual basis, shall share with the Medical Board of California data, including, but not limited to, pharmacy claims data for all foster children who are or have been on three or more psychotropic medications for 90 days or more. Prior to the release of this data, personal identifiers such as name, date of birth, address, and social security number shall be removed and a unique identifier shall be submitted. For each foster child who falls into these categories, the department shall submit the following information to the board:

(A) A list of the psychotropic medications prescribed.

(B) The start and stop dates, if any, for each psychotropic medication prescribed.

(C) The prescriber's name and contact information.

(D) The child's or adolescent's year of birth.

(E) Any other information that is deidentified and necessary to the Medical Board of California to allow the board to exercise its statutory authority as an oversight entity.

(F) The unit and quantity of the medication and the number of days' supply of the medication.

(b) The Medical Board of California shall contract for consulting services from, if available, a psychiatrist who has expertise and specializes in pediatric care for the purpose of reviewing the data provided to the board pursuant to subdivision (a). The consultant shall consider the treatment guidelines published by the department and the State Department of Social Services when assessing prescribing patterns.

(c) The Medical Board of California, pursuant to subdivision (a), shall analyze prescribing patterns by population for both of the following:

(1) Children adjudged as dependent children under Section 300 and placed in foster care.

(2) A minor adjudged a ward of the court under Section 601 or 602 who has been removed from the physical custody of the parent and placed into foster care.

(d) This section shall remain in effect only until January 1, 2027, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2027, deletes or extends that date.

(Added by Stats. 2016, Ch. 840, Sec. 3. (SB 1174) Effective January 1, 2017. Repealed as of January 1, 2027, by its own provisions.)

14029. Whenever a request for services authorized pursuant to subdivision (s), (t), or (v) of Section 14132 is made to the department for a child who is being case-managed by the California Children's Services program, any decision to transfer the child to the home setting shall be made only in consultation with the California Children's Services program case manager for the child.

(Added by Stats. 1997, Ch. 294, Sec. 59. Effective August 18, 1997.)

14029.5. (a) (1) Commencing January 1, 2008, immediately following the issuance of an order of the juvenile court, pertaining to the disposition of a ward of the county, committing that ward to a juvenile hall, camp, or ranch for 30 days or longer, the county juvenile detention facility shall provide the appropriate county welfare department with the ward's name, his or her scheduled or actual release date, any known information regarding the ward's Medi-Cal status prior to disposition, and sufficient information, when available, for the county welfare department to begin the process of determining the ward's eligibility for benefits under this chapter, including, if the ward is a minor, contact information for the ward's parent or guardian, if available.

(2) If the ward is a minor, prior to providing information to the county welfare department pursuant to paragraph (1), the county juvenile detention facility shall notify the parent or guardian, in writing, of its intention to submit the information required by that paragraph to the county welfare department. The parent or guardian shall be given a reasonable time to opt out of the Medi-Cal eligibility determination provided for under this section, in which case the county juvenile detention facility shall not comply with paragraph (1).

(3) For purposes of this section, "ward" means a person in the custody of a county juvenile detention facility.

(b) (1) Upon receipt of the information described in paragraph (1) of subdivision (a), and pursuant to the protocols and procedures developed pursuant to subdivision (c), the county welfare department shall initiate an application for any ward not already enrolled in the Medi-Cal program, and determine the individual's eligibility for benefits under the Medi-Cal program. If the ward is a minor, the county welfare department shall promptly contact the parent or guardian to arrange for completion of the application. If the cooperation of the minor's parent or guardian is necessary to complete the application, but the parent or guardian fails to cooperate in completing the application, the county welfare department shall deny the application in accordance with due process requirements. The county shall expedite the application of a ward who, according to the information provided pursuant to paragraph (1) of subdivision (a), is scheduled to be released in fewer than 45 days.

(2) If the county welfare department determines that the ward does not meet the eligibility requirements for the Medi-Cal program, the county welfare department, with the consent of the ward's parent or guardian, if the ward is a minor, shall forward the ward's information to the appropriate entity to determine eligibility for the Healthy Families Program, or other appropriate health coverage program, as determined by the department.

(3) If the county welfare department determines that a ward meets eligibility requirements for the Medi-Cal program, the county shall provide sufficient documentation to enable the ward to obtain necessary medical care upon his or her release from custody.

(c) 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 any further regulatory action. Thereafter, the department shall adopt regulations, as necessary, to implement this section 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.

(d) The department shall seek any federal waivers necessary for the implementation of this section.

(Amended by Stats. 2008, Ch. 546, Sec. 2. Effective January 1, 2009.)

14029.8. Section 124260 of the Health and Safety Code shall not apply to the receipt of benefits under the Medi-Cal program.

(Added by Stats. 2010, Ch. 503, Sec. 2. (SB 543) Effective January 1, 2011.)

14029.91. (a) The department shall require all managed care plans contracting with the department to provide Medi-Cal services to provide language assistance services to limited-English-proficient (LEP) Medi-Cal beneficiaries who are mandatorily enrolled in managed care in the following manner:

(1) (A) Oral interpretation services shall be provided in any language on a 24-hour basis at key points of contact.

(B) Oral interpretation services shall be provided by an interpreter that, at a minimum, meets all of the following qualifications:

(i) Demonstrated proficiency in speaking and understanding both spoken English and the language spoken by the LEP beneficiary.

(ii) The ability to interpret effectively, accurately, and impartially, both receptively and expressly, to and from the language spoken by the LEP beneficiary and English, using any necessary specialized vocabulary, terminology, and phraseology.

(iii) Adherence to generally accepted interpreter ethics principles, including client confidentiality.

(C) A managed care plan shall not require an LEP beneficiary to provide the beneficiary's own interpreter or rely on a staff member who does not meet the qualifications described in subparagraph (B) to communicate directly with the LEP beneficiary.

(D) A managed care plan shall not rely on an adult or minor child accompanying the LEP beneficiary to interpret or facilitate communication except under either of the following circumstances:

(i) In an emergency, as defined by the department, and an interpreter who meets the qualifications described in subparagraph (A) is not immediately available for the LEP beneficiary.

(ii) If the LEP beneficiary specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide that assistance, and reliance on that accompanying adult for that assistance is appropriate under the circumstances.

(2) Translation services shall be provided to the language groups identified by the department.

(3) Written notice of the availability of free language assistance services shall be provided in English and in the top 15 languages spoken by LEP individuals in California, as determined by the department, and consistent with the requirements identified in Part 92 of Title 45 of the Code of Federal Regulations and Section 1557 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18116).

(b) The department shall determine when an LEP population meets the requirement for translation services using one of the following numeric thresholds:

(1) A population group of at least 3,000 or 5 percent of the beneficiary population, whichever is fewer, mandatory managed care Medi-Cal beneficiaries, residing in the service area, who indicate their primary language as other than English.

(2) A population group of mandatory managed care Medi-Cal beneficiaries, residing in the service area, who indicate their primary language as other than English, and that meet a concentration standard of 1,000 beneficiaries in a single ZIP Code or 1,500 beneficiaries in two contiguous ZIP Codes.

(c) The department shall make this determination if any of the following occurs:

(1) A nonmanaged care county becomes a new managed care county.

(2) A new population group becomes a mandatory Medi-Cal managed care beneficiary population.

(3) A period of three years has passed since the last determination.

(d) The department shall instruct managed care plans, by means of incorporating the requirement into plan contracts, all-plan letters, or similar instructions, of the language groups that meet the numeric thresholds.

(e) A managed care plan shall notify beneficiaries, prospective beneficiaries, and members of the public of all of the following information:

(1) The availability of language assistance services, including oral interpretation and translated written materials, free of charge and in a timely manner, when those services are necessary to provide meaningful access to health care programs or activities to LEP beneficiaries.

(2) The availability of appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities.

(3) A managed care plan does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

(4) The availability of a grievance procedure and how to file a grievance, including identification of, and contact information for, the designated managed care plan representative.

(5) How to file a discrimination complaint with the United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex.

(f) (1) The information described in paragraph (3) of subdivision (a) and subdivision (e) shall be provided in the following manner:

(A) In the evidence of coverage.

(B) Posted in conspicuous physical locations where the managed care plan interacts with the public.

(C) On the internet website published and maintained by the managed care plan in a manner that allows a beneficiary, prospective beneficiary, and members of the public to easily locate the information.

(2) To the extent the information described in paragraph (3) of subdivision (a) and subdivision (e) is not included in existing informational notices, a managed care plan shall add this information at the time of the next regularly scheduled update of the applicable publication.

(g) The amendments made to this section by the act that added this subdivision shall be implemented by the department only to the extent that federal financial participation is available and is not otherwise jeopardized.

(h) This section does not apply to mental health plans contracting with the department pursuant to Section 14712.

(i) For purposes of this section, a person is “limited-English-proficient” if the person speaks English less than very well.

(Amended by Stats. 2019, Ch. 497, Sec. 314. (AB 991) Effective January 1, 2020.)

14029.92. (a) The department shall notify Medi-Cal beneficiaries, prospective beneficiaries, and members of the public of all of the following information:

(1) The availability of language assistance services, including oral interpretation and translated written materials, free of charge and in a timely manner, when those services are necessary to provide meaningful access to individuals with limited English proficiency.

(2) The availability of appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities.

(3) The department does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

(4) The availability of the grievance procedure and how to file a grievance, including identification of, and contact information for, the designated department representative.

(5) How to file a discrimination complaint with the United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex.

(b) Written notice of the availability of free language assistance services shall be provided in English and in the top 15 languages spoken by limited-English-proficient individuals in California, as determined by the department, and consistent with the requirements identified in Part 92 of Title 45 of the Code of Federal Regulations and Section 1557 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18116).

(c) (1) The information described in subdivisions (a) and (b) shall be provided in the following manner:

(A) In the department's Medi-Cal informational publications.

(B) Posted in conspicuous physical locations where the department interacts with the public.

(C) On the department's Internet Web site, in a manner that allows beneficiaries, prospective beneficiaries, and members of the public to easily locate the information.

(2) To the extent the information described in subdivisions (a) and (b) is not included in existing informational notices, the department shall add this information at the time of the next regularly scheduled update of the applicable publication.

(d) This section shall be implemented only to the extent that federal financial participation is available and is not otherwise jeopardized.

(Amended by Stats. 2018, Ch. 92, Sec. 235. (SB 1289) Effective January 1, 2019.)

14040. (a) Each contract for fiscal intermediary services shall allow, to the extent practicable, providers to utilize electronic means for transmitting claims to the fiscal intermediary contractor. Means of transmission, and the manner and format used, shall be approved by the director. In determining which electronic means are acceptable, the director shall consider magnetic tape, computer-to-computer via telephone, diskettes, and any other methods which may become available through technological advancements.

(b) A provider, as defined in Section 14043.1, may assign signature authority for transmission of claims to the provider's authorized representative or the registered billing agent of the provider identified to the department pursuant to subdivision (c) of Section 14040.5.

(c) The department shall develop reasonable standards for participation and continued participation by providers and billing agents in the use of claims transmission methods utilized pursuant to this section. These standards shall be designed to ensure that providers and billing agents submit technically complete claims and to reduce the potential for fraud and abuse. The department shall notify providers and billing agents of any planned changes to the claims transmission standards prior to the implementation of the changes. A "technically complete claim" means any billing request for payment from a provider or the billing agent of the provider, including an original claim, claim inquiry, or appeal, that is submitted on the correct Medi-Cal claim form or electronic billing format, is fully and accurately completed, and includes all information and documentation required to be submitted on or with the claim pursuant to Medi-Cal billing and documentation requirements.

(d) To the extent required by federal and state law, the fiscal intermediary shall retain claim data submitted by providers or the billing agent of the provider pursuant to this section. The department shall, however, return to a provider or the billing agent of the provider original tapes, diskettes, and any other similar devices that are used by the provider or the billing agent of the provider pursuant to this section.

(e) In order to reduce the amount of paperwork or attachments which are required to be completed by a provider or the billing agent of the provider submitting a claim for reimbursement under this chapter to the fiscal intermediary, the department shall direct the fiscal intermediary to investigate and develop the means to incorporate as much information as possible on the electronic format.

(f) Each provider and billing agent submitting claims shall be responsible for ensuring that each claim submitted for reimbursement for services, goods, supplies, or merchandise rendered or supplied by the provider to a Medi-Cal beneficiary or under the Medi-Cal program meets the standards established by the department pursuant to this section.

(Amended by Stats. 2000, Ch. 322, Sec. 13. Effective January 1, 2001.)

14040.1. (a) "Billing agent" or "billing agent of the provider" means any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents of any partnership, group, association, corporation, institution, or entity, that submits claims on behalf of the provider, as defined in Section 14043.1, for reimbursement for services, goods, supplies, or merchandise rendered or provided directly or indirectly to a Medi-Cal beneficiary or under the Medi-Cal program. As used in this section a billing agent shall not include an authorized representative of a provider billing solely for that provider, a provider wholly owned entity billing solely for the provider, or a clinic licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code or exempt from licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code when preparing and submitting claims for services provided on behalf of the clinic. For purposes of this subdivision, an authorized representative shall be either an individual who is an employee of the provider or an individual with a familial relationship to the provider. For purposes of this section and Section 14040.5, an authorized representative, a provider wholly owned entity billing

solely for the provider, or a clinic that is licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code or exempt from licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code, when preparing and submitting claims for services provided on behalf of the clinic, shall be considered a provider.

(b) The department shall establish standards for the registration or continued registration of each billing agent. The standards shall establish time periods, no longer than a year from the date the standards become effective, after which, no billing agent shall submit a claim on behalf of a provider, as defined in Section 14043.1, for reimbursement for services, goods, supplies, or merchandise rendered or provided directly or indirectly by the provider to a Medi-Cal beneficiary or under the Medi-Cal program, unless that billing agent has been registered with the department. The department shall establish the standards for the registration or continued registration of billing agents pursuant to this subdivision, in consultation with interested parties, by the adoption of emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of these emergency regulations or readoption of the regulations shall be deemed to be an emergency necessary for the immediate preservation of the public peace, health and safety, or general welfare. Notwithstanding Chapter 3.5 (commencing with Section 11340 of Part 1 of Division 3 of Title 2 of the Government Code, emergency regulations adopted or readopted pursuant to this subdivision shall be exempt from review by the Office of Administrative Law. The emergency regulations authorized by this subdivision shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations.

(c) The department may complete a background check on applicants for registration or continued registration as a billing agent, for the purpose of verifying the accuracy of information provided by an applicant for registration or continued registration as a billing agent or in order to prevent fraud and abuse. The background check may include, but not be limited to, onsite inspection, review of business records, and data searches.

(d) As a condition of registration, or continued registration, as a billing agent, an applicant for registration as a billing agent shall provide to the department a surety bond of not less than fifty thousand dollars ($50,000). This subdivision shall become operative only if the director executes a declaration, that shall be retained by the director, stating that the surety bonds described in this paragraph are commercially offered throughout the state and by more than one vendor.

(Added by Stats. 2000, Ch. 322, Sec. 14. Effective January 1, 2001.)

14040.5. (a) A provider may, by written contract, do either of the following:

(1) Authorize a billing agent to submit claims, including electronic claims, on behalf of the provider for reimbursement for services, goods, supplies, or merchandise provided by the provider to the Medi-Cal program or a Medi-Cal beneficiary.

(2) Assign signature authority for transmission of the claims by the authorized billing agent.

(b) If a contract as described in subdivision (a) is entered into, the contract shall meet the requirements of Section 447.10 of Title 42 of the Code of Federal Regulations or shall have been approved by the federal Health Care Financing Administration for purposes of the Medicare program.

(c) Any provider intending to use a billing agent to submit claims for reimbursements to the Medi-Cal program shall provide, at least 30 days prior to the submission of any claims for reimbursement by the billing agent, written notification to the director of the name, including known legal and any known fictitious or “doing business as” names used by the billing agent, the address, and the telephone number of the billing agent.

(d) Billing agents shall register with the director and shall obtain a unique identifier prior to submitting any claims for reimbursement. This unique identifier shall be part of each claim for reimbursement submitted by the billing agent.

(e) (1) Any Medi-Cal claim submitted by a billing agent or provider failing to comply with the requirements of this section or Section 14040 or 14040.1, or the regulations adopted pursuant to these sections, shall be subject to denial by the director.

(2) The director may deny, suspend, or revoke the registration or continued registration of a billing agent based upon any of the following grounds:

(A) Failure of the billing agent to comply with this section or Section 14040.1 or the regulations adopted under these sections.

(B) Involvement of a billing agent in illegal submission of claims.

(C) The billing agent is under investigation for fraud or abuse, as defined in Section 14043.1, by the department or any federal, state, or local law enforcement agency.

(3) The director may immediately revoke or suspend the registration or continued registration of a billing agent upon the involvement of that billing agent in the filing of false or misleading information on claims submitted for services allegedly rendered, or when a billing agent has demonstrated a pattern of filing claims that are not technically complete claims as defined in

subdivision (c) of Section 14040. The director shall not take action to revoke or suspend a billing agent's registration or continued registration when the falsity or misleading nature of the information was the result of the provider's actions and not the billing agent's.

(4) Proceedings for suspension or revocation of the registration or continued registration of a billing agent pursuant to this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, except that hearings may be conducted by departmental hearing officers appointed by the director. The director may periodically contract with the Office of Administrative Hearings to conduct these hearings.

(5) The director shall provide written notification outlining the reasons for the proposed action to the billing agent 30 days in advance of a proposed suspension or revocation and shall allow the billing agent to demonstrate within those 30 days by comment why the suspension or revocation notice should not be issued.

(6) If after consideration of the billing agent's comment, the director determines that the suspension or revocation is nonetheless warranted, the director shall notify the billing agent of the suspension or revocation and the effective date thereof and at the same time shall serve the billing agent with an accusation. In addition, the director shall send each provider utilizing the services of the billing agent written notice of the suspension or revocation of the billing agent. The suspension or revocation of the billing agent shall take effect 15 days from the date of the notification of the billing agent and service of the accusation. To the extent allowed by federal law, the director may waive any claims submission requirement to assist a provider in submitting or resubmitting claims to the Medi-Cal program when they are delayed because of a billing agent's suspension or revocation. Upon receipt of a notice of defense by the billing agent, the director shall set the matter for hearing within 30 days of the receipt of the notice. The suspension or revocation shall remain in effect until the hearing is completed and the director has made a final determination on the merits. The suspension or revocation shall, however, be deemed vacated if the director fails to make a final determination on the merits within 60 days of the completion of the original hearing.

(7) Paragraph (4) of this subdivision shall not apply where the suspension or revocation of a billing agent is based upon the conviction for any crime involving fraud, abuse of the Medi-Cal program, or suspension from the federal Medicare or medicaid programs, or where the billing agent has entered into a settlement in lieu of conviction for fraud or abuse in any government program, within the previous 10 years. In those instances, suspension or revocation shall be automatic and not subject to administrative appeal or hearing. In those instances, the director shall send each provider utilizing the services of the billing agent written notice of the automatic suspension or revocation of the billing agent. To the extent allowed by federal law, the director may waive any claims submission requirement to assist a provider in submitting or resubmitting claims to the Medi-Cal program when they are delayed because of a billing agent's automatic suspension or revocation.

(8) Notwithstanding Section 100171 of the Health and Safety Code, proceedings for the denial of the registration of a billing agent pursuant to this section shall be conducted in accordance with Section 14043.65. This subdivision shall not apply where the denial is based upon conviction of any crime involving fraud or abuse of the Medi-Cal program or the federal medicaid or Medicare programs, or exclusion by the federal government from the medicaid or Medicare programs. In this case, the denial shall be automatic and not subject to administrative appeal or hearing.

(f) For purposes of this section, "billing agent" has the same meaning as defined in Section 14040.1.

(g) As used in this section "provider" has the same meaning as defined in Section 14043.1.

(Amended by Stats. 2000, Ch. 322, Sec. 15. Effective January 1, 2001.)

14041. (a) The director shall develop and implement standards for the timely processing and payment of each claim type. The standards shall be sufficient to meet minimal federal requirements for the timely processing of claims.

(b) It is the intent of the Legislature that claim forms for use by physicians and hospitals be the same as claim forms in general use by other payors, including Medicare, to the extent compatible with the following:

(1) Requirements for maximum federal matching funds.

(2) The reasonable needs of the mechanized claims processing system.

(3) Maximum billing efficiency.

(4) The convenience of providers.

(Amended by Stats. 1987, Ch. 996, Sec. 1.)

14041.1. (a) Notwithstanding any other provision of law, and to the extent not otherwise conflicting with federal law, the department may hold for a period of one month, or direct the medical fiscal intermediary for the Medi-Cal program to hold for a period of one

month, payments to providers or their designated agents for health care services that are provided pursuant to this chapter, and payments to entities that contract with the department pursuant to this chapter, Chapter 8 (commencing with Section 14200) and Chapter 8.75 (commencing with Section 14591) for the delivery of health care services.

(b) The authority described in subdivision (a) shall be limited to payments for one month only, and only for a month ending prior to June 30, 2009.

(Amended by Stats. 2011, Ch. 367, Sec. 9. (AB 574) Effective January 1, 2012.)

14041.5. (a) The department shall develop, disseminate, and update, on a periodic basis, claims preparation and processing software programs that may be used on computers at individual provider or billing service sites. The software shall be made available, to the extent feasible, for the most common computers used in the provider community for use, on an optional basis, by clerical or billing personnel to facilitate the preparation and submission of Medi-Cal claims for services rendered.

(b) The software programs specified in subdivision (a) shall, to the extent possible:

(1) Contain all necessary validity edits utilized by the fiscal intermediary.

(2) Be designed to reasonably reduce common submission and billing errors.

(3) Contain features that provide options for the provider to use provider-developed files to reduce data entry requirements and improve reporting accuracy.

(4) Provide, at the provider's discretion, for the electronic or paper transmission of claims to the Medi-Cal fiscal intermediary.

(c) The department shall consult with affected provider groups prior to developing, disseminating, and updating claims preparation and processing software pursuant to this section.

(d) The department shall report to the Chairpersons of the Senate Health and Human Services Committee and Assembly Health Committee by April 1, 1990, on a plan and timetable for implementing this section. The plan and timetable shall identify provider groups for which the department plans to develop, disseminate, and update claims preparation and processing software.

(e) Notwithstanding the plan and timetable required by subdivision (d), the department shall develop and begin disseminating claims processing software programs to physician providers no later than January 1, 1991.

(f) The department shall, as part of implementing this section, provide technical assistance to providers, including, but not limited to, a user hotline and appropriate training materials. These materials shall cover the installation of the programs, use of the software to enter Medi-Cal claims data, and submission procedures.

(g) The software programs for the submission of Medi-Cal claims shall be made available to all interested parties for a reasonable initial fee, plus an annual subscription fee for updates, maintenance, and support provided to users. Fees shall be set so as to recover, as nearly as possible, the development, distribution, and ongoing support costs of software programs, instructional materials, or subsequent updates.

(h) Third-party vendors may obtain and enhance these programs for resale and provisions of value-added services to Medi-Cal providers. However, the state or any of its officials, employees, or agents shall bear no liability for software provided through any third party that has been altered or misused by any third party.

(i) Neither the state nor any of its officials, employees, or agents shall be responsible for any of the following:

(1) A provider's failure to meet Medi-Cal documentation and billing requirements, including timely billing pursuant to Section 14115.

(2) Alteration or misuse of the software in the submission of claims to the Medi-Cal program.

(3) Use of the software for any purpose other than the submission of claims to the Medi-Cal program.

(4) This subdivision shall not apply to any failure to meet Medi-Cal documentation and billing requirements that is substantiated as resulting from the use of software that is directly provided by the department and that contains proven flaws or defects that significantly contribute to the failure to meet those requirements.

(j) A provider or third party's eligibility to bill claims electronically by using software programs made available pursuant to this section shall be governed by Section 14040 and Section 14040.5, and any rules and regulations adopted by the director pursuant to these sections.

(Amended by Stats. 2004, Ch. 193, Sec. 239. Effective January 1, 2005.)

14042. Each contract for fiscal intermediary services shall provide for an automated system for verifying the eligibility of Medi-Cal recipients. The automated eligibility verification system shall provide the health care provider with a unique method of identifying the eligibility of the beneficiary. The provider shall include the eligibility identifier on the claim for payment. Where a recipient's eligibility has been verified by the automated system and the provider provides a unique identifier on the claim form, the director may not require any label, card impression, or any other evidence to establish the recipient's eligibility. The automated system for eligibility verification shall provide for the continuous updating of recipient eligibility determination.

The department shall periodically test the automated system for verifying recipient eligibility for completeness and accuracy, and report the findings of such testing to the Legislature. Unless and until the automated system for verifying recipient eligibility is accurate in at least 97 percent of the cases tested, the director shall provide for the issuance of proof-of-eligibility labels, or identity cards from which an identifying impression may be taken, or other evidence of eligibility to be used as a secondary recipient eligibility verification system. Notwithstanding the inability to provide verification of a recipient's eligibility through use of the automated system for eligibility verification, presentation of a claim for service with evidence of recipient eligibility as is provided for by the secondary system shall conclusively establish the recipient's eligibility.

On-line access shall be available to providers, at their discretion, upon the payment of a reasonable fee. The department shall establish the amount of the fees charged to providers for on-line access, which shall be based upon the costs of providing on-line access to providers.

(Added by Stats. 1982, Ch. 1508, Sec. 1.)

14042.1. (a) No earlier than January 1, 2018, the State Department of Health Care Services shall establish a Medically Tailored Meals Pilot Program to operate for a period of four years from the date the program is established, or until funding is no longer available for the program, whichever date is earlier.

(1) The department shall determine the number of eligible participants and providers in the program and shall use data from the Medi-Cal program to identify eligible beneficiaries for participation in the program.

(2) The program shall provide medically tailored meal intervention services to Medi-Cal participants with one or more of the following health conditions: congestive heart failure, cancer, diabetes, chronic obstructive pulmonary disease, or renal disease.

(3) The department may establish additional eligibility requirements based on acuity and other selection criteria. Each participant in the program shall receive a standard intervention, as determined by the department, of up to 21 meals per week for 12 to 24 weeks. The provided meals shall be medically tailored and designed to meet the specific nutritional needs of the participant's specific illness.

(4) The program shall be conducted in the Counties of Alameda, Los Angeles, Marin, San Diego, San Francisco, San Mateo, Santa Clara, and Sonoma.

(5) (A) At the conclusion of the program, the department shall use the data from the Medi-Cal program on the program participants to evaluate what impact, to the extent it can be determined, the program had on hospital readmissions, decreased admissions to long-term care facilities, and emergency room utilization.

(B) The department shall send a report containing its evaluation to the Legislature within 12 months after the end of the four-year program.

(C) The legislative report submitted pursuant to subparagraph (B) shall be submitted in compliance with Section 9795 of the Government Code.

(b) For the purposes of this section, "medically tailored meals" means a specifically tailored diet to address the participant's specific medical condition and associated symptoms.

(c) The department shall develop a methodology for reimbursing contractors, or other entities, as applicable, for services or activities provided pursuant to this section based on, and not to exceed, the aggregate amount of funds allocated per year for purposes of the program. The department may use up to 20 percent of the funds allocated per year for the program to support its administration and evaluation.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of policy letters, all-county letters, plan letters, or other similar instructions, without taking regulatory action.

(e) For purposes of implementing this section, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this section shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government

Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(f) The department shall seek any federal approvals necessary to implement this section, including any waivers it deems necessary to obtain federal financial participation for the program, and shall claim federal financial participation to the full extent permitted by law. If federal financial participation is unavailable, the department shall implement the program using available state-only funds, subject to annual appropriation by the Legislature.

(g) (1) For the 2021–2022 fiscal year, in addition to the Medically Tailored Meals Pilot Program specified under subdivisions (a) to (f), inclusive, the department shall implement the Short-Term Medically Tailored Meals Intervention Services Program to award funds to qualified entities providing medically tailored meals intervention services to eligible Medi-Cal beneficiaries who reside in a county identified in paragraph (4) with one or more of the following health conditions described in subparagraphs (A) to (H), inclusive, when meal services are unavailable under the Medically Tailored Meals Pilot Program:

(A) Diabetes.

(B) Chronic obstructive pulmonary disease.

(C) Renal disease.

(D) Chronic kidney disease.

(E) Cancer.

(F) Malnutrition.

(G) Human immunodeficiency virus or acquired immune deficiency syndrome.

(H) Congestive heart failure.

(2) The Short-Term Medically Tailored Meals Intervention Services Program shall cease to be operative when the funding allocated under the Budget Act of 2021 has been exhausted, or on June 30, 2022, whichever is sooner.

(3) (A) To the extent funding is available, an eligible Medi-Cal beneficiary shall receive medically tailored meals intervention services as specified in subparagraph (B).

(B) (i) For the 2021–2022 fiscal year, medically tailored meals intervention services shall be available to an eligible Medi-Cal beneficiary, and they shall receive up to 21 meals per week for 12 to 52 weeks, for a maximum of 52 weeks, depending on the medical diagnosis and need. The meals shall be medically tailored and designed to meet the specific nutritional needs of the Medi-Cal beneficiary's specific health condition.

(ii) To the extent funding is available, the medically tailored meals intervention services shall include medical nutrition therapy or counseling for the program's participants.

(C) The department may implement, as specified in subdivision (d), and in consultation with medically tailored meals providers, additional eligibility requirements for individuals to receive services under the Short-Term Medically Tailored Meals Intervention Services Program, based on acuity and other selection criteria.

(4) Funds appropriated for the Short-Term Medically Tailored Meals Intervention Services Program shall be awarded based on a methodology developed by the department to nonprofit and community-based organizations that have expertise as medically tailored meals providers in the Counties of Alameda, Contra Costa, Fresno, Kings, Los Angeles, Madera, Marin, San Diego, San Francisco, San Mateo, Santa Clara, Santa Cruz, Sonoma, and Tulare.

(5) Providers that are awarded funding to provide short-term medically tailored meals intervention services shall monitor and document the impacts of the Short-Term Medically Tailored Meals Intervention Services Program, including, but not limited to, the effect of this program on hospital readmissions, emergency room utilization, and health outcomes, to the extent data is available, and shall provide that information to the department upon request, and in a form and manner specified by the department. This information shall not be included in the data considered in evaluating the Medically Tailored Meals Pilot Program, as described in paragraph (5) of subdivision (a).

(6) The department shall develop a methodology for reimbursing contractors or other entities, as applicable, for services or activities provided pursuant to this subdivision based on, and not to exceed, the aggregate amount of funds allocated for purposes of this subdivision. The department shall allocate 5 percent of the funds to a nonprofit organization fiscal sponsor that shall coordinate the program to support its administration. The fiscal sponsor shall work with nonprofit members in relevant regions.

(7) To the extent permitted under applicable federal and state law, the department may use data from the Medi-Cal program to identify Medi-Cal beneficiaries eligible to receive services under the Short-Term Medically Tailored Meals Intervention Services Program.

(8) This subdivision shall be implemented only to the extent the department determines that federal financial participation under the Medi-Cal program is not jeopardized.

(h) This section shall remain in effect until the department submits its report containing its evaluation of the Medically Tailored Meals Pilot Program to the Legislature pursuant to subparagraph (B) of paragraph (5) of subdivision (a), or 12 months after the end of the Medically Tailored Meals Pilot Program or the Short-Term Medically Tailored Meals Intervention Services Program, whichever occurs last, and as of that date is repealed.

(Amended by Stats. 2021, Ch. 143, Sec. 368. (AB 133) Effective July 27, 2021. Section repealed on date prescribed by its own provisions.)

14042.2. (a) The Legislature finds and declares the following:

(1) The Medi-Cal Managed Care Ombudsman helps resolve issues between Medi-Cal managed care members and health plans, assists members with managed care related questions and problems, and answers questions from members.

(2) A pattern of inquiries, complaints, and grievances may be indicators of systemic problems regarding coverage and problems with access to care and warrant consideration.

(b) On a quarterly basis, the State Department of Health Care Services shall report on calls received by the Medi-Cal Managed Care Ombudsman. At a minimum, the report shall include the following:

(1) The number of contacts received, separated by inquiries and complaints.

(2) The average wait time for callers to answer.

(3) The number of calls abandoned.

(4) The result of contacts, including destination of referred calls, when possible.

(5) The average call time.

(6) Complaints, by issue type.

(7) The number of calls referred to another area of the department or to the Department of Managed Health Care for resolution.

(c) All data collected and reported shall include demographic information of beneficiaries, including race, ethnicity, age, gender, preferred language, language members were assisted in, and county of residence, and health plans of beneficiaries, to the extent known to the department at the time of the call. The department shall request, but not require, this information from members during the calls.

(d) The quarterly report shall include contacts from county mental health plan beneficiaries, as defined in Section 14700, including the requirements of subdivisions (a) and (b).

(e) The quarterly report shall be posted on the department’s internet website.

(f) The fourth quarterly report issued each year also shall include information pertaining to the following:

(1) Training protocols for staff, including cultural and linguistic competency.

(2) Assessment of contacts trends and actions taken by the State Department of Health Care Services as a result of contacts received.

(3) Consumer assistance protocols, procedures, and referral tools.

(Added by renumbering Section 14043.1 (as added by Stats. 2017, Ch. 52, Sec. 23) by Stats. 2019, Ch. 497, Sec. 320. (AB 991) Effective January 1, 2020.)