WELFARE AND INSTITUTIONS CODE - WIC

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

PART 3.3. Health Care Coverage Assistance [15800 - 15895] *(Part 3.3 added by Stats. 2013, Ch. 23, Sec. 68.)*

CHAPTER 2. Medi-Cal Access Program [15810 - 15849] *(Heading of Chapter 2 amended by Stats. 2014, Ch. 31, Sec. 65.)*

15810. (a) This chapter, formerly known as the AIM-Linked Infants Program, shall be known, and may be cited, as the Medi-Cal Access Program.

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

(Repealed (in Sec. 66) and added by Stats. 2014, Ch. 31, Sec. 67. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, by its own provisions.)

15811. (a) The definitions contained in this section govern the construction of this chapter, unless the context requires otherwise.

(b) “Access-linked infant” means any infant born to a woman enrolled in either the program under this chapter or the Access for Infants and Mothers Program under Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code.

(c) “Applicant” means an individual who applies for coverage through the program.

(d) “Department” means the State Department of Health Care Services.

(e) “Fund” means the Perinatal Insurance Fund.

(f) “Health education services relating to tobacco use” means tobacco use prevention and education services, including, when appropriate, tobacco use cessation services, in accordance with protocols established by the department in coordination with the California Tobacco Control Program of the State Department of Public Health.

(g) “Participating health plan” means a health plan with which the department contracts to provide health care services to individuals eligible pursuant to Section 15832.

(h) “Program” means the Medi-Cal Access Program.

(i) “Subscriber” means an individual who is eligible for and enrolled in the program.

(j) “Subscriber contribution” means the cost to the subscriber to participate in the program.

(k) This section shall become operative on July 1, 2014.

(Repealed (in Sec. 68) and added by Stats. 2014, Ch. 31, Sec. 69. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, by its own provisions.)

15814. (a) The department, in coordination with the California Tobacco Control Program of the State Department of Public Health, shall develop protocols relating to health education for tobacco use to the extent necessary to comply with paragraph (1) of subdivision (b) of Section 30122 of the Revenue and Taxation Code. These protocols shall include, but not be limited to, all of the following:

(1) Referral to perinatal and related support services.

(2) Outreach services and assessment of smoking status.

(3) Individualized counseling and advocacy services.

(4) Motivational messages.

(5) Cessation services, if appropriate.

(6) Incentives to maintain a healthy lifestyle.

(7) Followup assessment.

(8) Maintenance and relapse prevention services.

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

(Added by Stats. 2014, Ch. 31, Sec. 70. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, by its own provisions.)

15818. (a) Each participating health plan contracting with the department pursuant to this chapter shall provide health education services related to tobacco use to all program participants to the extent necessary to comply with paragraph (1) of subdivision (b) of Section 30122 of the Revenue and Taxation Code.

(b) The education activities required by subdivision (a) shall include all of the following:

(1) Dissuading persons from beginning to smoke.

(2) Encouraging smoking cessation.

(3) Providing information on the health effects of tobacco use on the user, children, and nonsmokers.

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

(Added by Stats. 2014, Ch. 31, Sec. 71. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, by its own provisions.)

15822. Health care services under the program shall include, but are not limited to, all of the following:

(a) Preventive, screening, diagnostic, and treatment services furnished directly by a licensed clinic, either onsite or by formal written contract, on a case-managed basis, to patients who remain less than 24 hours at the clinic for an illness or injury, advice, counseling, outreach, and translation as needed.

(b) Physician services.

(c) Emergency first aid, perinatal, obstetric, radiology, laboratory, and nutrition services.

(d) Services of advanced practice nurses or mid-level practitioners who are authorized to perform any of the services listed in this section within the scope of their licensure.

(e) All services and benefits set forth in Chapter 7 (commencing with Section 14000) of Part 3.

(Added by Stats. 2013, Ch. 23, Sec. 68. (AB 82) Effective June 27, 2013.)

15824. To the extent permitted by federal law, services for individuals eligible under this chapter shall be provided, at the department's discretion and to the extent the department determines the selected delivery system is cost effective, through the Medi-Cal fee-for-service or managed care delivery system, or both.

(Added by Stats. 2013, Ch. 23, Sec. 68. (AB 82) Effective June 27, 2013.)

15826. (a) The department shall administer the program and may do all of the following:

(1) Determine eligibility criteria for the program. These criteria shall include the requirements set forth in Section 15832.

(2) Determine the eligibility of applicants.

(3) Determine when subscribers are covered and the extent and scope of coverage.

(4) Determine subscriber contribution amounts schedules, subject to the following:

(A) Subscriber contributions for Access-linked infants shall not be greater than those applicable on March 23, 2010, for infants enrolled pursuant to clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 of the Insurance Code.

(B) Subscriber contributions for mothers shall conform with the maintenance of effort requirements under the federal Patient Protection and Affordable Care Act (Public Law 111-148), or any amendment or extension of that act.

(C) (i) Effective July 1, 2022, to the extent allowable under federal law, and notwithstanding the provisions of this chapter to the contrary, the department may elect not to impose subscriber contributions for purposes of this program as described in Section

15849 for an applicable coverage period,

(ii) If the department elects to not impose subscriber contributions for an applicable coverage period pursuant to clause (i) or elects to reinstate such subscriber contributions 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.

(5) Provide coverage through Medi-Cal delivery systems and contract for the administration of the program and the enrollment of subscribers. Any contract entered into pursuant to this chapter shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of General Services. The department shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on projected and actual subscriber enrollments in a total amount not to exceed the amount appropriated for the program.

(6) Authorize expenditures to pay program expenses that exceed subscriber contributions, and to administer the program as necessary.

(7) Develop a promotional component of the program to make Californians aware of the program and the opportunity that it presents.

(8) (A) Issue rules and regulations as necessary to administer the program.

(B) During the 2011–12 to 2014–15 fiscal years, inclusive, the adoption and readoption of regulations pursuant to this chapter shall be deemed to be an emergency that calls for immediate action 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 the department describe facts showing the need for immediate action and from review by the Office of Administrative Law.

(9) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this chapter.

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

(Amended by Stats. 2022, Ch. 47, Sec. 135. (SB 184) Effective June 30, 2022.)

15827. (a) The department shall administer the program in a manner that ensures that program expenditures do not exceed amounts available in the fund.

(b) This section shall be implemented only if and to the extent that it does 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.

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

(Added by Stats. 2014, Ch. 31, Sec. 74. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, by its own provisions.)

15828. The department shall coordinate with other state agencies, as appropriate, to help ensure continuity of health care services.

(Added by Stats. 2013, Ch. 23, Sec. 68. (AB 82) Effective June 27, 2013.)

15830. (a) The department may contract with a variety of health plans and types of health care service delivery systems in order to offer subscribers a choice of plans, providers, and types of service delivery.

(b) Participating health plans contracting with the department pursuant to this chapter shall provide benefits or coverage to subscribers only as determined by the department pursuant to subdivision (b) of Section 15826.

(Added by Stats. 2013, Ch. 23, Sec. 68. (AB 82) Effective June 27, 2013.)

15832. (a) To be eligible to participate in the program, a person shall meet all of the requirements in either paragraph (1) or (2):

(1) (A) Be pregnant or in the postpartum period as specified in Section 15840 and a resident of the state. A person who is a member of a federally recognized California Indian tribe is a resident of the state for these purposes.

(B) Have a household income that is above 208 percent of the official federal poverty level but does not exceed 317 percent of the official federal poverty level.

(C) Agree to the payment of the complete subscriber contribution. A federally recognized California Indian tribal government may make the subscriber contributions on behalf of a member of the tribe only if a contribution on behalf of members of

federally recognized California Indian tribes does not limit or preclude federal financial participation under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.). If a federally recognized California Indian tribal government makes a contribution on behalf of a member of the tribe, the tribal government shall ensure that the subscriber is made aware of all the health care delivery options available in the county where the member resides.

(2) (A) Be a child under two years of age who is delivered by a mother enrolled in the program under this chapter. Except as stated in this section, these infants shall be automatically enrolled in the program.

(B) For the applicable month, not be enrolled in employer-sponsored health care coverage, or have been enrolled in that health care coverage in the prior three months or enrolled in full-scope Medi-Cal without a share of cost. Exceptions may be identified in regulations or other guidance and shall, at minimum, include all exceptions applicable to the Healthy Families Program on and after March 23, 2010.

(C) Be subject to subscriber contributions as determined by the department.

(3) For infants identified in paragraph (2), all of the following shall apply:

(A) Enrollment in the program shall cover the first 12 months of the infant's life unless the infant is determined eligible for Medi-Cal benefits under Section 14005.26. An infant shall be screened for eligibility under Section 14005.26 immediately after the infant is born. If the infant is eligible under Section 14005.26, the infant shall be automatically enrolled in the Medi-Cal program on that basis.

(B) (i) At the end of the 12 months, as a condition of continued eligibility, the subscriber shall provide income information. The infant shall be disenrolled from the program if the annual household income exceeds 317 percent of the federal poverty level, or if the infant is eligible for full-scope Medi-Cal with no share of cost.

(ii) Effective January 1, 2014, when determining eligibility for benefits under the program, income shall be determined, counted, and valued in accordance with the requirements of Section 1397bb(b)(1)(B) 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) At the end of their first and second year in the program, infants shall be screened for eligibility for the Medi-Cal program.

(4) If at any time the director determines that the eligibility criteria established under this chapter for the program may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), any amendment or extension of that act, or any similar federal legislation affecting federal financial participation, the director may alter the eligibility criteria to the extent necessary for the state to receive that federal financial participation.

(5) (A) Effective July 1, 2024, or the effective date for implementation of the Children's Presumptive Eligibility Program portal pursuant to Section 14011.7, whichever is later, all qualified Medi-Cal providers participating in presumptive eligibility programs shall use the electronic Newborn Hospital Gateway process, as described in Section 14148.04, to report the birth of an infant eligible under this chapter who is born in their facilities, including hospitals, birthing centers, or other birthing settings, within 72 hours after the birth, or one business day after discharge, whichever is sooner.

(B) The inclusion of infants eligible under this chapter in the Newborn Hospital Gateway process shall commence on July 1, 2024, or on the effective date for implementation of the Children's Presumptive Eligibility Program portal pursuant to Section 14011.7, whichever is later.

(b) (1) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election and the conditions described in paragraph (1) of subdivision (b) of Section 15832, as added by Section 137 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 (2) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

(2) If the voters do not approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election and the conditions described in paragraph (1) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2026, or the date certified by the department pursuant to paragraph (2) of subdivision (b) of Section 15832, as added by Section 137 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. 2023, Ch. 42, Sec. 162) by Stats. 2024, Ch. 40, Sec. 74. (SB 159) Effective June 29, 2024. Conditionally inoperative on or after January 1, 2025 as prescribed by its own provisions. Repealed on January 1 following the inoperative date. See later operative version amended by Sec. 75 of Stats. 2024, Ch. 40.)

15832. (a) To be eligible to participate in the program, a person shall meet all of the requirements in either paragraph (1) or (2):

(1) (A) Be pregnant or in the postpartum period as specified in Section 15840 and a resident of the state. A person who is a member of a federally recognized California Indian tribe is a resident of the state for these purposes.

(B) Have a household income that is above 208 percent of the official federal poverty level but does not exceed 317 percent of the official federal poverty level.

(C) Agree to the payment of the complete subscriber contribution. A federally recognized California Indian tribal government may make the subscriber contributions on behalf of a member of the tribe only if a contribution on behalf of members of federally recognized California Indian tribes does not limit or preclude federal financial participation under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.). If a federally recognized California Indian tribal government makes a contribution on behalf of a member of the tribe, the tribal government shall ensure that the subscriber is made aware of all the health care delivery options available in the county where the member resides.

(2) (A) Be a child under two years of age who is delivered by a mother enrolled in the program under this chapter. Except as stated in this section, these infants shall be automatically enrolled in the program.

(B) For the applicable month, not be enrolled in employer-sponsored health care coverage, or have been enrolled in that health care coverage in the prior three months or enrolled in full-scope Medi-Cal without a share of cost. Exceptions may be identified in regulations or other guidance and shall, at minimum, include all exceptions applicable to the Healthy Families Program on and after March 23, 2010.

(C) Be subject to subscriber contributions as determined by the department.

(3) For infants identified in paragraph (2), all of the following shall apply:

(A) Enrollment in the program shall cover the first 12 months of the infant's life unless the infant is determined eligible for Medi-Cal benefits under Section 14005.26. An infant shall be screened for eligibility under Section 14005.26 immediately after the infant is born. If the infant is eligible under Section 14005.26, the infant shall be automatically enrolled in the Medi-Cal program on that basis.

(B) (i) At the end of the 12 months, the infant shall remain continuously eligible for the Medi-Cal program until they are five years of age. A redetermination of Medi-Cal eligibility shall not be conducted before the child reaches five years of age, except as specified in Section 14005.255. This clause shall be implemented to the extent that any necessary federal approvals are obtained and federal financial participation is available. The department shall seek any necessary federal approvals to implement this clause.

(ii) Effective January 1, 2014, when determining eligibility for benefits under the program, income shall be determined, counted, and valued in accordance with the requirements of Section 1397bb(b)(1)(B) 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) At the end of their first and second year in the program, and subsequent years, up to five years of age, the child shall be screened for eligibility for the Medi-Cal program.

(4) If at any time the director determines that the eligibility criteria established under this chapter for the program may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), any amendment or extension of that act, or any similar federal legislation affecting federal financial participation, the director may alter the eligibility criteria to the extent necessary for the state to receive that federal financial participation.

(5) (A) Effective July 1, 2024, or the effective date for implementation of the Children's Presumptive Eligibility Program portal pursuant to Section 14011.7, whichever is later, all qualified Medi-Cal providers participating in presumptive eligibility programs shall use the electronic Newborn Hospital Gateway process, as described in Section 14148.04, to report the birth of an infant eligible under this chapter who is born in their facilities, including hospitals, birthing centers, or other birthing settings, within 72 hours after the birth, or one business day after discharge, whichever is sooner.

(B) The inclusion of infants eligible under this chapter in the Newborn Hospital Gateway process shall commence on July 1, 2024, or on the effective date for implementation of the Children's Presumptive Eligibility Program portal pursuant to Section 14011.7, whichever is later.

(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 (d).

(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) 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.

(d) 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.

(e) (1) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, 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.

(2) If the voters do not approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, this section shall be repealed as of January 1, 2025.

(Amended (as amended by Stats. 2023, Ch. 42, Sec. 163) by Stats. 2024, Ch. 40, Sec. 75. (SB 159) Effective June 29, 2024. Section conditionally operative on January 1, 2025, or later, as prescribed by its own provisions.)

15833. (a) A person eligible pursuant to paragraph (1) of subdivision (a) of Section 15832 shall not be eligible to participate in the program if, at the time of application, she is eligible for Medi-Cal without a share of cost or for Medicare.

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

(Added by Stats. 2014, Ch. 31, Sec. 77. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, by its own provisions.)

15834. A person shall not be eligible for covered services under the program if those services are covered through private health care coverage arrangements at the time of eligibility.

(Added by Stats. 2013, Ch. 23, Sec. 68. (AB 82) Effective June 27, 2013.)

15835. (a) Subscribers enrolled pursuant to paragraph (1) of subdivision (a) of Section 15832 shall not be disenrolled for failure to pay subscriber contributions. The department may impose or contract for collection actions to collect unpaid subscriber contributions.

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

(Added by Stats. 2014, Ch. 31, Sec. 78. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, by its own provisions.)

15836. (a) If a subscriber is dissatisfied with any action, or failure to act, that has occurred in connection with eligibility or covered services under this chapter, the subscriber may appeal to the department and shall be accorded an opportunity for a fair hearing. Hearings may be conducted pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(b) The department may place a lien on compensation or benefits that are recovered or recoverable by a subscriber for whom benefits have been provided under a policy or plan issued under this chapter from any party or parties responsible for the compensation or benefits.

(Added by Stats. 2013, Ch. 23, Sec. 68. (AB 82) Effective June 27, 2013.)

15838. (a) A provider who is furnished documentation of a subscriber's enrollment in the program shall not seek reimbursement or attempt to obtain payment for any covered services provided to that subscriber other than from the participating health plan or insurer covering the subscriber or from the department.

(b) Subdivision (a) shall not apply to any copayment required by the department under this chapter for the covered services provided to the subscriber.

(c) For purposes of this chapter, “provider” means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services and includes as that term is defined in subdivision (o) of Section 14043.1.

(Added by Stats. 2013, Ch. 23, Sec. 68. (AB 82) Effective June 27, 2013.)

15839. (a) Services that would be covered under the program that are provided to pregnant women who, after receiving those services, are subsequently determined to be eligible for coverage under this chapter may be reimbursed as determined by the department. In no case shall services received prior to 40 days before a woman’s date of application be eligible for reimbursement.

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

(Added by Stats. 2014, Ch. 31, Sec. 79. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, by its own provisions.)

15840. (a) (1) At a minimum, coverage provided pursuant to this chapter shall be provided to subscribers during one pregnancy, and until the end of the month in which the 60th day after pregnancy occurs, and to eligible children less than two years of age who were born of a pregnancy covered under this program or the Access for Infants and Mothers program under former Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code to a woman enrolled in the Access for Infants and Mothers program.

(2) (A) Upon the effective date reflected in any necessary federal approvals obtained by the department pursuant to subdivision (c) of Section 14005.185, a subscriber described in paragraph (1) shall be eligible for an additional 10-month period following the 60-day postpartum period, for a total of 12 months of continuous eligibility after the end of pregnancy.

(B) This paragraph shall be implemented only if, and to the extent that, any necessary federal approvals are obtained pursuant to Section 14005.185 and federal financial participation is available, and subject to an annual appropriation by the Legislature for this purpose.

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

(c) Medically necessary prescription drugs shall be a required benefit in the coverage provided pursuant to this chapter.

(d) To the extent required pursuant to Section 15818 to comply with paragraph (1) of subdivision (b) of Section 30122 of the Revenue and Taxation Code, health education services related to tobacco use shall be a benefit in the coverage provided under this chapter.

(e) (1) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, and the conditions described in paragraph (1) of subdivision (b) of Section 15832, as added by Section 137 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 (2) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

(2) If the voters do not approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, and the conditions described in paragraph (1) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2026, or the date certified by the department pursuant to paragraph (2) of subdivision (b) of Section 15832, as added by Section 137 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. 138) by Stats. 2024, Ch. 40, Sec. 77. (SB 159) Effective June 29, 2024. Conditionally inoperative on or after January 1, 2025, by its own provisions. Repealed January 1 following the inoperative date. See later operative version as amended by Sec. 78 of Stats. 2024, Ch. 40.)

15840. (a) (1) At a minimum, coverage provided pursuant to this chapter shall be provided to subscribers during one pregnancy, and until the end of the month in which the 60th day after pregnancy occurs, and to eligible children less than two years of age, or less than five years of age pursuant to Section 15832, who were born of a pregnancy covered under this program or the Access for Infants and Mothers program under former Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code to a person enrolled in the Access for Infants and Mothers program.

(2) (A) Upon the effective date reflected in any necessary federal approvals obtained by the department pursuant to subdivision (c) of Section 14005.185, a subscriber described in paragraph (1) shall be eligible for an additional 10-month period following the 60-day postpartum period, for a total of 12 months of continuous eligibility after the end of pregnancy.

(B) This paragraph shall be implemented only if, and to the extent that, any necessary federal approvals are obtained pursuant to Section 14005.185 and federal financial participation is available, and subject to an annual appropriation by the Legislature

for this purpose.

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

(c) Medically necessary prescription drugs shall be a required benefit in the coverage provided pursuant to this chapter.

(d) To the extent required pursuant to Section 15818 to comply with paragraph (1) of subdivision (b) of Section 30122 of the Revenue and Taxation Code, health education services related to tobacco use shall be a benefit in the coverage provided under this chapter.

(e) (1) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, this section shall become operative on January 1, 2025, or the date certified by the department pursuant to paragraph (2) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

(2) If the voters do not approve the addition of Chapter 7.5 (commencing with Section 14199.100) to Part 3 of this division at the November 5, 2024, statewide general election, this section shall become operative on January 1, 2026, or the date certified by the department pursuant to paragraph (2) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

(Amended (as added by Stats. 2022, Ch. 47, Sec. 137) by Stats. 2024, Ch. 40, Sec. 78. (SB 159) Effective June 29, 2024. Section conditionally operative on January 1, 2025, or later, as prescribed by its own provisions. Conditionally repealed on January 1 directly following that date, as prescribed by its own provisions.)

15841. (a) Through its courts, 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 Care Services may accept or use moneys under Title XXI of the Social Security Act (known as the Children's Health Insurance Program or 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 and this chapter only when, during the period of coverage, the woman is the beneficiary. The scope of services covered under Medi-Cal and this chapter, 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 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.

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

(Added by Stats. 2014, Ch. 31, Sec. 82. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, by its own provisions.)

15842. Notwithstanding any other law, for a subscriber who is determined by the California Children's Services Program to be eligible for benefits under the program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, a provider shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. Providers shall refer a child whom they reasonably suspect of having a medical condition that is eligible for services under the California Children's Services Program to the California Children's Services Program. The California Children's Services Program shall provide case management and authorization of services if the child is found to be medically eligible for the California Children's Services Program. Diagnosis and treatment services that are authorized by the California Children's Services Program shall be performed by paneled providers for that program and approved special care centers of that program in accordance with treatment plans approved by the California Children's Services Program. All other services provided under this chapter shall be available to the subscriber.

(Added by Stats. 2013, Ch. 23, Sec. 68. (AB 82) Effective June 27, 2013.)

15844. A child enrolled in the program under this chapter who has a medical condition that is eligible for services pursuant to the California Children's Services Program, and whose family is not financially eligible for the California Children's Services Program, shall have the medically necessary treatment services for his or her California Children's Services Program eligible medical condition authorized and paid for by the California Children's Services Program. County expenditures for the payment of services for the child shall be waived and these expenditures shall be paid for by the state from Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.) funds and state general funds.

(Added by Stats. 2013, Ch. 23, Sec. 68. (AB 82) Effective June 27, 2013.)

15846. The department shall encourage all providers who provide services under the program to have viable protocols for screening and referring children needing supplemental services outside of the scope of the screening, preventive, and medically necessary and therapeutic services covered by the contract to public programs providing such supplemental services for which they may be eligible, as well as for coordination of care between the provider and the public programs. The public programs for which providers may be required to develop screening, referral, and care coordination protocols may include the California Children's Services Program, the regional centers, county mental health programs, programs administered by the Department of Alcohol and Drug Programs or its successor agency or agencies, and programs administered by local education agencies.

(Added by Stats. 2013, Ch. 23, Sec. 68. (AB 82) Effective June 27, 2013.)

15847. (a) It shall constitute unfair competition for purposes of Chapter 5 (commencing with Section 17200) of Part 2 of Division 7 of the Business and Professions Code for an insurer, an insurance agent or broker, or an administrator, as defined in Section 1759 of the Insurance Code, to refer an individual employee or employee's dependent to the program, or arrange for an individual employee or employee's dependent to apply to the program, for the purpose of separating that employee or employee's dependent from group health coverage provided in connection with the employee's employment.

(b) Any employee described in subdivision (a) shall have a personal right of action to enforce subdivision (a).

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

(Added by Stats. 2014, Ch. 31, Sec. 83. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, by its own provisions.)

15847.3. (a) It shall constitute an unfair labor practice contrary to public policy, and enforceable under Section 95 of the Labor Code, for any employer to refer an individual employee or employee's dependent to the program, or to arrange for an individual employee or employee's dependent to apply to the program, for the purpose of separating that employee or employee's dependent from group health coverage provided in connection with the employee's employment.

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

(Added by Stats. 2014, Ch. 31, Sec. 84. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, by its own provisions.)

15847.5. (a) It shall constitute an unfair labor practice contrary to public policy and enforceable under Section 95 of the Labor Code for any employer to change the employee-employer share-of-cost ratio or to make any other modification of maternity care coverage for employees or employees' dependents that results in the enrollment of the employees or employees' dependents in the program established pursuant to this chapter.

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

(Added by Stats. 2014, Ch. 31, Sec. 85. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, by its own provisions.)

15847.7. (a) For purposes of Sections 15847, 15847.3, and 15847.5, "group health coverage" includes any health care service plan, self-insured employee welfare benefit plan, or disability insurance providing medical or hospital benefits.

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

(Amended by Stats. 2015, Ch. 455, Sec. 62. (SB 804) Effective January 1, 2016.)

15848. (a) The Perinatal Insurance Fund is continued in existence in the State Treasury under the administration of the department.

(b) Amounts deposited in the fund shall only be used for the purposes specified by this chapter.

(c) Notwithstanding Section 13340 of the Government Code, the fund is hereby continuously appropriated, without regard to fiscal years, to the department, for the purposes specified in this chapter.

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

(Added by Stats. 2014, Ch. 31, Sec. 87. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, by its own provisions.)

15848.5. (a) The department shall authorize the expenditure of money in the fund to cover program expenses, including program expenses that exceed subscriber contributions.

(b) From money appropriated by the Legislature to the fund, the department may expend sufficient funds for operating expenses incurred in carrying out this chapter.

(c) The department shall develop and utilize all appropriate cost containment measures to maximize the coverage offered under the program.

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

(Added by Stats. 2014, Ch. 31, Sec. 88. (SB 857) Effective June 20, 2014. Section operative July 1, 2014, by its own provisions.)

15849. (a) Effective July 1, 2022, to the extent allowable under federal law, notwithstanding the provisions of this chapter to the contrary, the department may elect not to impose subscriber contributions for purposes of coverage as described in this chapter, including, but not limited to, subscriber contributions for Access-linked infants, for an applicable coverage period.

(b) If the department elects to not impose subscriber contributions for an applicable coverage period pursuant to subdivision (a) or elects to reinstate such subscriber contributions 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.

(Added by Stats. 2022, Ch. 47, Sec. 140. (SB 184) Effective June 30, 2022.)