AMENDED IN ASSEMBLY JULY 2, 2014

AMENDED IN ASSEMBLY JUNE 18, 2014

AMENDED IN SENATE MAY 28, 2014

AMENDED IN SENATE APRIL 22, 2014

AMENDED IN SENATE APRIL 9, 2014

SENATE BILL No. 1053

Introduced by Senator Mitchell
(Coauthors: Senators DeSaulnier, Evans, and Wolk)
(Coauthors: Assembly Members Ammiano, Garcia, Mullin, Skinner, Ting, and Wieckowski)

February 18, 2014

An act to amend Section 1367.25 of the Health and Safety Code, ~~and~~ to amend Section 10123.196 of the Insurance Code, *and to amend Section 14132 of the Welfare and Institutions Code,* relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1053, as amended, Mitchell. Health care coverage: contraceptives.

Existing law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various reforms to the health insurance market. Among other things, PPACA requires a nongrandfathered group health plan and a health insurance issuer offering group or individual insurance coverage to provide coverage, without imposing cost-sharing requirements, for certain preventive services, including those preventive care and screenings for women provided in specified guidelines. PPACA requires those plans and issuers to provide coverage without cost sharing for all federal Food and Drug Administration approved contraceptive

methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed by a provider, except as specified.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy that provides coverage for outpatient prescription drug benefits to provide coverage for a variety of federal Food and Drug Administration (FDA) approved prescription contraceptive methods designated by the plan or insurer, except as specified. Existing law authorizes a religious employer, as defined, to request a contract or policy without coverage of FDA approved contraceptive methods that are contrary to the employer's religious tenets and, if so requested, requires a contract or policy to be provided without that coverage. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2014, to cover essential health benefits, which are defined to include the health benefits covered by particular benchmark plans.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive specified health care services, including family planning services, subject to certain utilization controls. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans.

This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2016, to provide coverage for women for all prescribed and FDA approved female contraceptive drugs, devices, and products, as well as voluntary sterilization procedures, contraceptive education and counseling, and related followup services. The bill would prohibit a nongrandfathered plan contract or health insurance policy from imposing any cost-sharing requirements or other restrictions or delays with respect to this coverage, ~~except as specified. The~~ *but would authorize cost-sharing for equivalent nonpreferred drugs, devices, or products unless, among other exceptions, the enrollee is a Medi-Cal beneficiary,*

as specified. The bill would include Medi-Cal managed plans, as specified, in the definition of a health care service plan for purposes of these provisions.

The bill would retain the provision authorizing a religious employer to request a contract or policy without coverage of FDA approved contraceptive methods that are contrary to the employer's religious tenets. Because a willful violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The bill would require utilization controls for family planning services for Medi-Cal managed care plans to be subject the cost-sharing requirements described above.

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

This bill would provide that no reimbursement is required by this act for a specified reason.

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

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

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

(a) California has a long history of expanding timely access to birth control to prevent unintended pregnancy.

(b) The federal Patient Protection and Affordable Care Act includes a contraceptive coverage guarantee as part of a broader requirement for health insurance carriers and plans to cover key preventive care services without out-of-pocket costs for patients.

(c) The Legislature intends to build on existing state and federal law to promote gender equity and women's health and to ensure greater contraceptive coverage equity and timely access to all federal Food and Drug Administration approved methods of birth control for women covered by health care service plan contracts and health insurance policies in California.

(d) Medical management techniques such as denials, step therapy, or prior authorization in public and private health care coverage can impede access to the most effective contraceptive methods.

SEC. 2. Section 1367.25 of the Health and Safety Code is amended to read:

1367.25. (a) A group health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 2000, through December 31, 2015, inclusive, and an individual health care service plan contract that is amended, renewed, or delivered on or after January 1, 2000, through December 31, 2015, inclusive, except for a specialized health care service plan contract, shall provide coverage for the following, under general terms and conditions applicable to all benefits:

(1) A health care service plan contract that provides coverage for outpatient prescription drug benefits shall include coverage for a variety of federal Food and Drug Administration (FDA) approved prescription contraceptive methods designated by the plan. In the event the patient's participating provider, acting within his or her scope of practice, determines that none of the methods designated by the plan is medically appropriate for the patient's medical or personal history, the plan shall also provide coverage for another FDA approved, medically appropriate prescription contraceptive method prescribed by the patient's provider.

(2) Benefits for an enrollee under this subdivision shall be the same for an enrollee's covered spouse and covered nonspouse dependents.

(b) (1) A group or individual health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 2016, shall provide coverage for all of the following for women:

(A) All FDA approved contraceptive drugs, devices, and products for women, including drugs, devices, and products available over the counter, as prescribed by the enrollee's provider.

(B) Voluntary sterilization procedures.

(C) Patient education and counseling on contraception.

(D) Followup services related to the drugs, devices, products, and procedures covered under this subdivision, including, but not limited to, management of side effects, counseling for continued adherence, and device removal.

(2) (A) Except for a grandfathered health plan, and subject to subparagraph (B), a health care service plan subject to this subdivision shall not impose a deductible, coinsurance, copayment,

or any other cost-sharing requirement on the coverage provided pursuant to this subdivision.

(B) A health care service plan may cover a generic or preferred drug, device, or product without cost sharing and impose cost sharing for equivalent nonpreferred drugs, devices, or ~~products~~ *products, except that cost sharing shall not be imposed on any Medi-Cal beneficiary*. However, if a generic or preferred version of a drug, device, or product is not available, or is deemed medically inadvisable by the enrollee's provider, a health care service plan shall provide coverage for the nonpreferred drug, device, or product without cost sharing.

(3) Except as otherwise authorized under this section, a health care service plan shall not impose any restrictions or delays on the coverage required under this subdivision.

(4) Benefits for an enrollee under this subdivision shall be the same for an enrollee's covered spouse and covered nonspouse dependents.

(5) For purposes of paragraphs (2) and (3) of this subdivision, "health care service plan" shall include Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

(c) Notwithstanding any other provision of this section, a religious employer may request a health care service plan contract without coverage for FDA approved contraceptive methods that are contrary to the religious employer's religious tenets. If so requested, a health care service plan contract shall be provided without coverage for contraceptive methods.

(1) For purposes of this section, a "religious employer" is an entity for which each of the following is true:

(A) The inculcation of religious values is the purpose of the entity.

(B) The entity primarily employs persons who share the religious tenets of the entity.

(C) The entity serves primarily persons who share the religious tenets of the entity.

(D) The entity is a nonprofit organization as described in Section 6033(a)(2)(A)i or iii, of the Internal Revenue Code of 1986, as amended.

(2) Every religious employer that invokes the exemption provided under this section shall provide written notice to prospective enrollees prior to enrollment with the plan, listing the contraceptive health care services the employer refuses to cover for religious reasons.

(d) Nothing in this section shall be construed to exclude coverage for contraceptive supplies as prescribed by a provider, acting within his or her scope of practice, for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause, or for contraception that is necessary to preserve the life or health of an enrollee.

(e) Nothing in this section shall be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a plan provides coverage for contraceptive drugs, devices, and products.

(f) Nothing in this section shall be construed to require an individual or group health care service plan contract to cover experimental or investigational treatments.

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

(1) "Grandfathered health plan" has the meaning set forth in Section 1251 of PPACA.

(2) "PPACA" 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), and any rules, regulations, or guidance issued thereunder.

(3) With respect to health care service plan contracts issued, amended, or renewed on or after January 1, 2016, "provider" means an individual who is certified or licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or an initiative act referred to in that division, or Division 2.5 (commencing with Section 1797).

SEC. 3. Section 10123.196 of the Insurance Code is amended to read:

10123.196. (a) An individual or group policy of disability insurance issued, amended, renewed, or delivered on or after January 1, 2000, through December 31, 2015, inclusive, that provides coverage for hospital, medical, or surgical expenses, shall provide coverage for the following, under the same terms and conditions as applicable to all benefits:

(1) A disability insurance policy that provides coverage for outpatient prescription drug benefits shall include coverage for a variety of federal Food and Drug Administration (FDA) approved prescription contraceptive methods, as designated by the insurer. If an insured's health care provider determines that none of the methods designated by the disability insurer is medically appropriate for the insured's medical or personal history, the insurer shall, in the alternative, provide coverage for some other FDA approved prescription contraceptive method prescribed by the patient's health care provider.

(2) Coverage with respect to an insured under this subdivision shall be identical for an insured's covered spouse and covered nonspouse dependents.

(b) (1) A group or individual policy of disability insurance, except for a specialized health insurance policy, that is issued, amended, renewed, or delivered on or after January 1, 2016, shall provide coverage for all of the following for women:

(A) All FDA approved contraceptive drugs, devices, and products for women, including drugs, devices, and products available over the counter, as prescribed by the insured's provider.

(B) Voluntary sterilization procedures.

(C) Patient education and counseling on contraception.

(D) Followup services related to the drugs, devices, products, and procedures covered under this subdivision, including, but not limited to, management of side effects, counseling for continued adherence, and device removal.

(2) (A) Except for a grandfathered health plan, and subject to subparagraph (B), a disability insurer subject to this subdivision shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to this subdivision.

(B) A disability insurer may cover a generic or preferred drug, device, or product without cost sharing and impose cost sharing for an equivalent nonpreferred drug, device, or product. However, if a generic or preferred version of a drug, device, or product is not available, or is deemed medically inadvisable by the insured's provider, a disability insurer shall provide coverage for the nonpreferred drug, device, or product without cost sharing.

(3) Except as otherwise authorized under this section, an insurer shall not impose any restrictions or delays on the coverage required under this subdivision.

(4) Coverage with respect to an insured under this subdivision shall be identical for an insured's covered spouse and covered nonspouse dependents.

(c) Nothing in this section shall be construed to deny or restrict in any way any existing right or benefit provided under law or by contract.

(d) Nothing in this section shall be construed to require an individual or group disability insurance policy to cover experimental or investigational treatments.

(e) Notwithstanding any other provision of this section, a religious employer may request a disability insurance policy without coverage for contraceptive methods that are contrary to the religious employer's religious tenets. If so requested, a disability insurance policy shall be provided without coverage for contraceptive methods.

(1) For purposes of this section, a "religious employer" is an entity for which each of the following is true:

(A) The inculcation of religious values is the purpose of the entity.

(B) The entity primarily employs persons who share the religious tenets of the entity.

(C) The entity serves primarily persons who share the religious tenets of the entity.

(D) The entity is a nonprofit organization pursuant to Section 6033(a)(2)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

(2) Every religious employer that invokes the exemption provided under this section shall provide written notice to any prospective employee once an offer of employment has been made, and prior to that person commencing that employment, listing the contraceptive health care services the employer refuses to cover for religious reasons.

(f) Nothing in this section shall be construed to exclude coverage for contraceptive supplies as prescribed by a provider, acting within his or her scope of practice, for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or

eliminating symptoms of menopause, or for contraception that is necessary to preserve the life or health of an insured.

(g) This section shall only apply to disability insurance policies or contracts that are defined as health benefit plans pursuant to subdivision (a) of Section 10198.6, except that for accident only, specified disease, or hospital indemnity coverage, coverage for benefits under this section shall apply to the extent that the benefits are covered under the general terms and conditions that apply to all other benefits under the policy or contract. Nothing in this section shall be construed as imposing a new benefit mandate on accident only, specified disease, or hospital indemnity insurance.

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

(1) "Grandfathered health plan" has the meaning set forth in Section 1251 of PPACA.

(2) "PPACA" 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), and any rules, regulations, or guidance issued thereunder.

(3) With respect to policies of disability insurance issued, amended, or renewed on or after January 1, 2016, "health care provider" means an individual who is certified or licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or an initiative act referred to in that division, or Division 2.5 (commencing with Section 1797) of the Health and Safety Code.

SEC. 4. Section 14132 of the Welfare and Institutions Code is amended to read:

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

(a) Outpatient services are covered as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) Blood and blood derivatives are covered.

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

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

(A) Periodontal treatment is not a benefit.

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

(C) Laboratory processed crowns are not a benefit.

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

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

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

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

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

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

(k) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses

replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

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

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

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

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

(n) Family planning services are covered, subject to utilization controls. *However, for Medi-Cal managed care plans, utilization controls shall be subject to paragraphs (2) and (3) of subdivision (b) of Section 1367.25 of the Health and Safety Code.*

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

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

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

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

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

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

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

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

(2) All dental hygiene services provided by a registered dental hygienist, registered dental hygienist in extended functions, and registered dental hygienist in alternative practice licensed pursuant to Sections 1753, 1917, 1918, and 1922 of the Business and Professions Code may be covered as long as they are within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental hygienist, registered dental hygienist in extended functions, or registered dental hygienist in alternative practice.

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2

of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of Section 1482 of the article.

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

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

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

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

(1) Level of care and cost of care evaluations.

(2) Expenses, directly attributable to home care activities, for materials.

(3) Physician fees for home visits.

(4) Expenses directly attributable to home care activities for shelter and modification to shelter.

(5) Expenses directly attributable to additional costs of special diets, including tube feeding.

(6) Medically related personal services.

(7) Home nursing education.

(8) Emergency maintenance repair.

(9) Home health agency personnel benefits which permit coverage of care during periods when regular personnel are on vacation or using sick leave.

(10) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.

(11) Emergency and nonemergency medical transportation.

(12) Medical supplies.

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

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

(15) Special drugs and medications.

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

(17) Therapy services.

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

(19) Modification of medical equipment for home use.

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

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

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

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

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

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

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

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

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

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

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

The director may under this section contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to eligible beneficiaries. Contracts or

agreements entered into pursuant to this division shall not be subject to the Public Contract Code.

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

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

(2) The department shall seek a waiver in accordance with Section 1315 of Title 42 of the United States Code, or a state plan amendment adopted in accordance with Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code, which was added to Section 1396a of Title 42 of the United States Code by Section 2303(a)(2) of the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), for a program to provide comprehensive clinical family planning services as described in paragraph (8). Under the waiver, the program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. Under the state plan amendment, which shall replace the waiver and shall be known as the Family PACT successor state plan amendment, the program shall be operated only in accordance with this subdivision and the statutes and regulations in paragraph (4). The state shall use the standards and processes imposed by the state on January 1, 2007, including the application of an eligibility discount factor to the extent required by the federal Centers for Medicare and Medicaid Services, for purposes of determining eligibility as permitted under Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code. To the extent that federal financial participation is available, the program shall continue to conduct education, outreach, enrollment, service delivery, and evaluation services as specified under the waiver. The services shall be provided under the program only if the waiver and, when applicable, the successor state plan amendment are approved by the federal Centers for Medicare and

Medicaid Services and only to the extent that federal financial participation is available for the services. Nothing in this section shall prohibit the department from seeking the Family PACT successor state plan amendment during the operation of the waiver.

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

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

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

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

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

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

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

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

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

(i) Psychosocial and medical aspects of contraception.

(ii) Sexuality.

(iii) Fertility.

(iv) Pregnancy.

(v) Parenthood.

(vi) Infertility.

(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

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

(xi) Possible contraceptive consequences and followup.

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

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

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

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

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

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

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

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

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

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

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

~~SEC. 4.~~

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within

the meaning of Section 6 of Article XIII B of the California Constitution.

O