AMENDED IN SENATE SEPTEMBER 1, 2015

AMENDED IN SENATE JUNE 19, 2015

AMENDED IN ASSEMBLY MAY 28, 2015

california legislature—2015–16 regular session

ASSEMBLY BILL No. 1231

Introduced by Assembly Member Wood

February 27, 2015

An act to amend Section 14132 of the Welfare and Institutions Code, relating to Medi-Cal.

legislative counsel's digest

AB 1231, as amended, Wood. Medi-Cal: nonmedical transportation.

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

This bill would add to the schedule of benefits nonmedical transportation, as defined, subject to utilization controls, for a beneficiary to obtain covered specialty care Medi-Cal services, if those services are more than 60 minutes or 30 miles from the beneficiary's place of residence. The bill would specify that these provisions shall not be interpreted to add a new benefit to the Medi-Cal program. The bill would require the department to adopt regulations by July 1, 2017. Commencing 6 months after the effective date of this act, the bill would

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

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

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

1 SECTION 1. Section 14132 of the Welfare and Institutions
2 Code is amended to read:
3 14132. The following is the schedule of benefits under this
4 chapter:
5 (a) Outpatient services are covered as follows:
6 Physician, hospital or clinic outpatient, surgical center,
7 respiratory care, optometric, chiropractic, psychology, podiatric,
8 occupational therapy, physical therapy, speech therapy, audiology,
9 acupuncture to the extent federal matching funds are provided for
10 acupuncture, and services of persons rendering treatment by prayer
11 or healing by spiritual means in the practice of any church or
12 religious denomination insofar as these can be encompassed by
13 federal participation under an approved plan, subject to utilization
14 controls.
15 (b) (1) Inpatient hospital services, including, but not limited
16 to, physician and podiatric services, physical therapy and
17 occupational therapy, are covered subject to utilization controls.
18 (2) For Medi-Cal fee-for-service beneficiaries, emergency
19 services and care that are necessary for the treatment of an
20 emergency medical condition and medical care directly related to
21 the emergency medical condition. This paragraph shall not be
22 construed to change the obligation of Medi-Cal managed care
23 plans to provide emergency services and care. For the purposes of
24 this paragraph, "emergency services and care" and "emergency
25 medical condition" shall have the same meanings as those terms
26 are defined in Section 1317.1 of the Health and Safety Code.
27 (c) Nursing facility services, subacute care services, and services
28 provided by any category of intermediate care facility for the
29 developmentally disabled, including podiatry, physician, nurse
30 practitioner services, and prescribed drugs, as described in
31 subdivision (d), are covered subject to utilization controls.
32 Respiratory care, physical therapy, occupational therapy, speech
33 therapy, and audiology services for patients in nursing facilities

1 and any category of intermediate care facility for the
2 developmentally disabled are covered subject to utilization controls.
3 (d) (1) Purchase of prescribed drugs is covered subject to the
4 Medi-Cal List of Contract Drugs and utilization controls.
5 (2) Purchase of drugs used to treat erectile dysfunction or any
6 off-label uses of those drugs are covered only to the extent that
7 federal financial participation is available.
8 (3) (A) To the extent required by federal law, the purchase of
9 outpatient prescribed drugs, for which the prescription is executed
10 by a prescriber in written, nonelectronic form on or after April 1,
11 2008, is covered only when executed on a tamper resistant
12 prescription form. The implementation of this paragraph shall
13 conform to the guidance issued by the federal Centers for Medicare
14 and Medicaid Services but shall not conflict with state statutes on
15 the characteristics of tamper resistant prescriptions for controlled
16 substances, including Section 11162.1 of the Health and Safety
17 Code. The department shall provide providers and beneficiaries
18 with as much flexibility in implementing these rules as allowed
19 by the federal government. The department shall notify and consult
20 with appropriate stakeholders in implementing, interpreting, or
21 making specific this paragraph.
22 (B) Notwithstanding Chapter 3.5 (commencing with Section
23 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
24 the department may take the actions specified in subparagraph (A)
25 by means of a provider bulletin or notice, policy letter, or other
26 similar instructions without taking regulatory action.
27 (4) (A) (i) For the purposes of this paragraph, nonlegend has
28 the same meaning as defined in subdivision (a) of Section
29 14105.45.
30 (ii) Nonlegend acetaminophen-containing products, with the
31 exception of children's acetaminophen-containing products,
32 selected by the department are not covered benefits.
33 (iii) Nonlegend cough and cold products selected by the
34 department are not covered benefits. This clause shall be
35 implemented on the first day of the first calendar month following
36 90 days after the effective date of the act that added this clause,
37 or on the first day of the first calendar month following 60 days
38 after the date the department secures all necessary federal approvals
39 to implement this section, whichever is later.

1 (iv) Beneficiaries under the Early and Periodic Screening,
2 Diagnosis, and Treatment Program shall be exempt from clauses
3 (ii) and (iii).
4 (B) Notwithstanding Chapter 3.5 (commencing with Section
5 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
6 the department may take the actions specified in subparagraph (A)
7 by means of a provider bulletin or notice, policy letter, or other
8 similar instruction without taking regulatory action.
9 (e) Outpatient dialysis services and home hemodialysis services,
10 including physician services, medical supplies, drugs and
11 equipment required for dialysis, are covered, subject to utilization
12 controls.
13 (f) Anesthesiologist services when provided as part of an
14 outpatient medical procedure, nurse anesthetist services when
15 rendered in an inpatient or outpatient setting under conditions set
16 forth by the director, outpatient laboratory services, and X-ray
17 services are covered, subject to utilization controls. Nothing in
18 this subdivision shall be construed to require prior authorization
19 for anesthesiologist services provided as part of an outpatient
20 medical procedure or for portable X-ray services in a nursing
21 facility or any category of intermediate care facility for the
22 developmentally disabled.
23 (g) Blood and blood derivatives are covered.
24 (h) (1) Emergency and essential diagnostic and restorative
25 dental services, except for orthodontic, fixed bridgework, and
26 partial dentures that are not necessary for balance of a complete
27 artificial denture, are covered, subject to utilization controls. The
28 utilization controls shall allow emergency and essential diagnostic
29 and restorative dental services and prostheses that are necessary
30 to prevent a significant disability or to replace previously furnished
31 prostheses that are lost or destroyed due to circumstances beyond
32 the beneficiary's control. Notwithstanding the foregoing, the
33 director may by regulation provide for certain fixed artificial
34 dentures necessary for obtaining employment or for medical
35 conditions that preclude the use of removable dental prostheses,
36 and for orthodontic services in cleft palate deformities administered
37 by the department's California Children Services Program.
38 (2) For persons 21 years of age or older, the services specified
39 in paragraph (1) shall be provided subject to the following
40 conditions:

1 (A) Periodontal treatment is not a benefit.
2 (B) Endodontic therapy is not a benefit except for vital
3 pulpotomy.
4 (C) Laboratory processed crowns are not a benefit.
5 (D) Removable prosthetics shall be a benefit only for patients
6 as a requirement for employment.
7 (E) The director may, by regulation, provide for the provision
8 of fixed artificial dentures that are necessary for medical conditions
9 that preclude the use of removable dental prostheses.
10 (F) Notwithstanding the conditions specified in subparagraphs
11 (A) to (E), inclusive, the department may approve services for
12 persons with special medical disorders subject to utilization review.
13 (3) Paragraph (2) shall become inoperative July 1, 1995.
14 (i) Medical transportation is covered, subject to utilization
15 controls.
16 (j) Home health care services are covered, subject to utilization
17 controls.
18 (k) Prosthetic and orthotic devices and eyeglasses are covered,
19 subject to utilization controls. Utilization controls shall allow
20 replacement of prosthetic and orthotic devices and eyeglasses
21 necessary because of loss or destruction due to circumstances
22 beyond the beneficiary's control. Frame styles for eyeglasses
23 replaced pursuant to this subdivision shall not change more than
24 once every two years, unless the department so directs.
25 Orthopedic and conventional shoes are covered when provided
26 by a prosthetic and orthotic supplier on the prescription of a
27 physician and when at least one of the shoes will be attached to a
28 prosthesis or brace, subject to utilization controls. Modification
29 of stock conventional or orthopedic shoes when medically
30 indicated, is covered subject to utilization controls. When there is
31 a clearly established medical need that cannot be satisfied by the
32 modification of stock conventional or orthopedic shoes,
33 custom-made orthopedic shoes are covered, subject to utilization
34 controls.
35 Therapeutic shoes and inserts are covered when provided to
36 beneficiaries with a diagnosis of diabetes, subject to utilization
37 controls, to the extent that federal financial participation is
38 available.
39 (*l*) Hearing aids are covered, subject to utilization controls.
40 Utilization controls shall allow replacement of hearing aids

1 necessary because of loss or destruction due to circumstances
2 beyond the beneficiary's control.
3 (m) Durable medical equipment and medical supplies are
4 covered, subject to utilization controls. The utilization controls
5 shall allow the replacement of durable medical equipment and
6 medical supplies when necessary because of loss or destruction
7 due to circumstances beyond the beneficiary's control. The
8 utilization controls shall allow authorization of durable medical
9 equipment needed to assist a disabled beneficiary in caring for a
10 child for whom the disabled beneficiary is a parent, stepparent,
11 foster parent, or legal guardian, subject to the availability of federal
12 financial participation. The department shall adopt emergency
13 regulations to define and establish criteria for assistive durable
14 medical equipment in accordance with the rulemaking provisions
15 of the Administrative Procedure Act (Chapter 3.5 (commencing
16 with Section 11340) of Part 1 of Division 3 of Title 2 of the
17 Government Code).
18 (n) Family planning services are covered, subject to utilization
19 controls. However, for Medi-Cal managed care plans, any
20 utilization controls shall be subject to Section 1367.25 of the Health
21 and Safety Code.
22 (o) Inpatient intensive rehabilitation hospital services, including
23 respiratory rehabilitation services, in a general acute care hospital
24 are covered, subject to utilization controls, when either of the
25 following criteria are met:
26 (1) A patient with a permanent disability or severe impairment
27 requires an inpatient intensive rehabilitation hospital program as
28 described in Section 14064 to develop function beyond the limited
29 amount that would occur in the normal course of recovery.
30 (2) A patient with a chronic or progressive disease requires an
31 inpatient intensive rehabilitation hospital program as described in
32 Section 14064 to maintain the patient's present functional level as
33 long as possible.
34 (p) (1) Adult day health care is covered in accordance with
35 Chapter 8.7 (commencing with Section 14520).
36 (2) Commencing 30 days after the effective date of the act that
37 added this paragraph, and notwithstanding the number of days
38 previously approved through a treatment authorization request,
39 adult day health care is covered for a maximum of three days per
40 week.

1 (3) As provided in accordance with paragraph (4), adult day
2 health care is covered for a maximum of five days per week.
3 (4) As of the date that the director makes the declaration
4 described in subdivision (g) of Section 14525.1, paragraph (2)
5 shall become inoperative and paragraph (3) shall become operative.
6 (q) (1) Application of fluoride, or other appropriate fluoride
7 treatment as defined by the department, and other prophylaxis
8 treatment for children 17 years of age and under are covered.
9 (2) All dental hygiene services provided by a registered dental
10 hygienist, registered dental hygienist in extended functions, and
11 registered dental hygienist in alternative practice licensed pursuant
12 to Sections 1753, 1917, 1918, and 1922 of the Business and
13 Professions Code may be covered as long as they are within the
14 scope of Denti-Cal benefits and they are necessary services
15 provided by a registered dental hygienist, registered dental
16 hygienist in extended functions, or registered dental hygienist in
17 alternative practice.
18 (r) (1) Paramedic services performed by a city, county, or
19 special district, or pursuant to a contract with a city, county, or
20 special district, and pursuant to a program established under former
21 Article 3 (commencing with Section 1480) of Chapter 2.5 of
22 Division 2 of the Health and Safety Code by a paramedic certified
23 pursuant to that article, and consisting of defibrillation and those
24 services specified in subdivision (3) of former Section 1482 of the
25 article.
26 (2) All providers enrolled under this subdivision shall satisfy
27 all applicable statutory and regulatory requirements for becoming
28 a Medi-Cal provider.
29 (3) This subdivision shall be implemented only to the extent
30 funding is available under Section 14106.6.
31 (s) In-home medical care services are covered when medically
32 appropriate and subject to utilization controls, for beneficiaries
33 who would otherwise require care for an extended period of time
34 in an acute care hospital at a cost higher than in-home medical
35 care services. The director shall have the authority under this
36 section to contract with organizations qualified to provide in-home
37 medical care services to those persons. These services may be
38 provided to patients placed in shared or congregate living
39 arrangements, if a home setting is not medically appropriate or
40 available to the beneficiary. As used in this section, “in-home

1 medical care service" includes utility bills directly attributable to
2 continuous, 24-hour operation of life-sustaining medical equipment,
3 to the extent that federal financial participation is available.
4 As used in this subdivision, in-home medical care services
5 include, but are not limited to:
6 (1) Level-of-care and cost-of-care evaluations.
7 (2) Expenses, directly attributable to home care activities, for
8 materials.
9 (3) Physician fees for home visits.
10 (4) Expenses directly attributable to home care activities for
11 shelter and modification to shelter.
12 (5) Expenses directly attributable to additional costs of special
13 diets, including tube feeding.
14 (6) Medically related personal services.
15 (7) Home nursing education.
16 (8) Emergency maintenance repair.
17 (9) Home health agency personnel benefits that permit coverage
18 of care during periods when regular personnel are on vacation or
19 using sick leave.
20 (10) All services needed to maintain antiseptic conditions at
21 stoma or shunt sites on the body.
22 (11) Emergency and nonemergency medical transportation.
23 (12) Medical supplies.
24 (13) Medical equipment, including, but not limited to, scales,
25 gurneys, and equipment racks suitable for paralyzed patients.
26 (14) Utility use directly attributable to the requirements of home
27 care activities that are in addition to normal utility use.
28 (15) Special drugs and medications.
29 (16) Home health agency supervision of visiting staff that is
30 medically necessary, but not included in the home health agency
31 rate.
32 (17) Therapy services.
33 (18) Household appliances and household utensil costs directly
34 attributable to home care activities.
35 (19) Modification of medical equipment for home use.
36 (20) Training and orientation for use of life-support systems,
37 including, but not limited to, support of respiratory functions.
38 (21) Respiratory care practitioner services as defined in Sections
39 3702 and 3703 of the Business and Professions Code, subject to
40 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 that 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 that are authorized and reimbursable under this chapter, and services that 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

1 Code by Section 2303(a)(2) of the federal Patient Protection and
2 Affordable Care Act (PPACA) (Public Law 111-148), for a
3 program to provide comprehensive clinical family planning
4 services as described in paragraph (8). Under the waiver, the
5 program shall be operated only in accordance with the waiver and
6 the statutes and regulations in paragraph (4) and subject to the
7 terms, conditions, and duration of the waiver. Under the state plan
8 amendment, which shall replace the waiver and shall be known as
9 the Family PACT successor state plan amendment, the program
10 shall be operated only in accordance with this subdivision and the
11 statutes and regulations in paragraph (4). The state shall use the
12 standards and processes imposed by the state on January 1, 2007,
13 including the application of an eligibility discount factor to the
14 extent required by the federal Centers for Medicare and Medicaid
15 Services, for purposes of determining eligibility as permitted under
16 Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States
17 Code. To the extent that federal financial participation is available,
18 the program shall continue to conduct education, outreach,
19 enrollment, service delivery, and evaluation services as specified
20 under the waiver. The services shall be provided under the program
21 only if the waiver and, when applicable, the successor state plan
22 amendment are approved by the federal Centers for Medicare and
23 Medicaid Services and only to the extent that federal financial
24 participation is available for the services. Nothing in this section
25 shall prohibit the department from seeking the Family PACT
26 successor state plan amendment during the operation of the waiver.
27 (3) Solely for the purposes of the waiver or Family PACT
28 successor state plan amendment and notwithstanding any other
29 law, the collection and use of an individual's social security number
30 shall be necessary only to the extent required by federal law.
31 (4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005,
32 and 24013, and any regulations adopted under these statutes shall
33 apply to the program provided for under this subdivision. No other
34 provision of law under the Medi-Cal program or the State-Only
35 Family Planning Program shall apply to the program provided for
36 under this subdivision.
37 (5) Notwithstanding Chapter 3.5 (commencing with Section
38 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
39 the department may implement, without taking regulatory action,
40 the provisions of the waiver after its approval by the federal Centers

1 for Medicare and Medicaid Services and the provisions of this
2 section by means of an all-county letter or similar instruction to
3 providers. Thereafter, the department shall adopt regulations to
4 implement this section and the approved waiver in accordance
5 with the requirements of Chapter 3.5 (commencing with Section
6 11340) of Part 1 of Division 3 of Title 2 of the Government Code.
7 Beginning six months after the effective date of the act adding this
8 subdivision, the department shall provide a status report to the
9 Legislature on a semiannual basis until regulations have been
10 adopted.
11 (6) In the event that the Department of Finance determines that
12 the program operated under the authority of the waiver described
13 in paragraph (2) or the Family PACT successor state plan
14 amendment is no longer cost effective, this subdivision shall
15 become inoperative on the first day of the first month following
16 the issuance of a 30-day notification of that determination in
17 writing by the Department of Finance to the chairperson in each
18 house that considers appropriations, the chairpersons of the
19 committees, and the appropriate subcommittees in each house that
20 considers the State Budget, and the Chairperson of the Joint
21 Legislative Budget Committee.
22 (7) If this subdivision ceases to be operative, all persons who
23 have received or are eligible to receive comprehensive clinical
24 family planning services pursuant to the waiver described in
25 paragraph (2) shall receive family planning services under the
26 Medi-Cal program pursuant to subdivision (n) if they are otherwise
27 eligible for Medi-Cal with no share of cost, or shall receive
28 comprehensive clinical family planning services under the program
29 established in Division 24 (commencing with Section 24000) either
30 if they are eligible for Medi-Cal with a share of cost or if they are
31 otherwise eligible under Section 24003.
32 (8) For purposes of this subdivision, “comprehensive clinical
33 family planning services” means the process of establishing
34 objectives for the number and spacing of children, and selecting
35 the means by which those objectives may be achieved. These
36 means include a broad range of acceptable and effective methods
37 and services to limit or enhance fertility, including contraceptive
38 methods, federal Food and Drug Administration approved
39 contraceptive drugs, devices, and supplies, natural family planning,
40 abstinence methods, and basic, limited fertility management.

1 Comprehensive clinical family planning services include, but are
2 not limited to, preconception counseling, maternal and fetal health
3 counseling, general reproductive health care, including diagnosis
4 and treatment of infections and conditions, including cancer, that
5 threaten reproductive capability, medical family planning treatment
6 and procedures, including supplies and followup, and
7 informational, counseling, and educational services.
8 Comprehensive clinical family planning services shall not include
9 abortion, pregnancy testing solely for the purposes of referral for
10 abortion or services ancillary to abortions, or pregnancy care that
11 is not incident to the diagnosis of pregnancy. Comprehensive
12 clinical family planning services shall be subject to utilization
13 control and include all of the following:
14 (A) Family planning related services and male and female
15 sterilization. Family planning services for men and women shall
16 include emergency services and services for complications directly
17 related to the contraceptive method, federal Food and Drug
18 Administration approved contraceptive drugs, devices, and
19 supplies, and followup, consultation, and referral services, as
20 indicated, which may require treatment authorization requests.
21 (B) All United States Department of Agriculture, federal Food
22 and Drug Administration approved contraceptive drugs, devices,
23 and supplies that are in keeping with current standards of practice
24 and from which the individual may choose.
25 (C) Culturally and linguistically appropriate health education
26 and counseling services, including informed consent, that include
27 all of the following:
28 (i) Psychosocial and medical aspects of contraception.
29 (ii) Sexuality.
30 (iii) Fertility.
31 (iv) Pregnancy.
32 (v) Parenthood.
33 (vi) Infertility.
34 (vii) Reproductive health care.
35 (viii) Preconception and nutrition counseling.
36 (ix) Prevention and treatment of sexually transmitted infection.
37 (x) Use of contraceptive methods, federal Food and Drug
38 Administration approved contraceptive drugs, devices, and
39 supplies.
40 (xi) Possible contraceptive consequences and followup.

1 (xii) Interpersonal communication and negotiation of
2 relationships to assist individuals and couples in effective
3 contraceptive method use and planning families.
4 (D) A comprehensive health history, updated at the next periodic
5 visit (between 11 and 24 months after initial examination) that
6 includes a complete obstetrical history, gynecological history,
7 contraceptive history, personal medical history, health risk factors,
8 and family health history, including genetic or hereditary
9 conditions.
10 (E) A complete physical examination on initial and subsequent
11 periodic visits.
12 (F) Services, drugs, devices, and supplies deemed by the federal
13 Centers for Medicare and Medicaid Services to be appropriate for
14 inclusion in the program.
15 (9) In order to maximize the availability of federal financial
16 participation under this subdivision, the director shall have the
17 discretion to implement the Family PACT successor state plan
18 amendment retroactively to July 1, 2010.
19 (ab) (1) Purchase of prescribed enteral nutrition products is
20 covered, subject to the Medi-Cal list of enteral nutrition products
21 and utilization controls.
22 (2) Purchase of enteral nutrition products is limited to those
23 products to be administered through a feeding tube, including, but
24 not limited to, a gastric, nasogastric, or jejunostomy tube.
25 Beneficiaries under the Early and Periodic Screening, Diagnosis,
26 and Treatment Program shall be exempt from this paragraph.
27 (3) Notwithstanding paragraph (2), the department may deem
28 an enteral nutrition product, not administered through a feeding
29 tube, including, but not limited to, a gastric, nasogastric, or
30 jejunostomy tube, a benefit for patients with diagnoses, including,
31 but not limited to, malabsorption and inborn errors of metabolism,
32 if the product has been shown to be neither investigational nor
33 experimental when used as part of a therapeutic regimen to prevent
34 serious disability or death.
35 (4) Notwithstanding Chapter 3.5 (commencing with Section
36 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
37 the department may implement the amendments to this subdivision
38 made by the act that added this paragraph by means of all-county
39 letters, provider bulletins, or similar instructions, without taking
40 regulatory action.

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

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

(ad) (1) Nonmedical transportation is covered, subject to utilization controls, for a beneficiary to obtain covered specialty care Medi-Cal services, if those services are more than 60 minutes or 30 miles from the beneficiary's place of residence.

(2) *(A)* "Nonmedical transportation" includes, but is not limited to, roundtrip transportation for a beneficiary to obtain covered specialty care Medi-Cal services by passenger car, taxicab, or any other form of public or private conveyance. Nonmedical transportation does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated beneficiaries by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations. Nonmedical transportation includes, but is not limited to, mileage reimbursement for conveyance by private vehicle, bus passes, taxi vouchers, or train tickets.

(B) The cost of nonmedical transportation shall be paid for a beneficiary who can attest in a manner to be specified by the department that other available resources have been reasonably exhausted.

(3) Nonmedical transportation shall be provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the beneficiary, and consistent with policies and procedures established for a beneficiary with a disability.

(4) It is the intent of the Legislature in enacting this subdivision to affirm the requirement under Section 431.53 of Title 42 of the Code of Federal Regulations, in which the department is required to ensure necessary transportation for recipients to and from providers. This subdivision shall not be interpreted to add a new benefit to the Medi-Cal program.

(5) ~~The~~ *(A) Upon enactment of this subdivision, the* department ~~may seek approval of any necessary state plan amendments to implement this subdivision.~~ *shall seek any federal approvals*

necessary to implement this subdivision that the department determines are necessary to implement this subdivision. This subdivision shall not be implemented until all necessary federal approvals are obtained.

~~(6)~~

(B) This subdivision shall be implemented only to the extent that federal financial participation is available *and not otherwise jeopardized,* and any necessary federal approvals have been obtained.

~~(7)~~

(6) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. By July 1, 2017, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Commencing six months after the effective date of the act that added this subdivision, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

O