AMENDED IN SENATE SEPTEMBER 4, 2015

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,~~ *controls and federally permissible time and distance standards,* 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.~~ *services.* 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.

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

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

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

1 (2) Commencing 30 days after the effective date of the act that
2 added this paragraph, and notwithstanding the number of days
3 previously approved through a treatment authorization request,
4 adult day health care is covered for a maximum of three days per
5 week.
6 (3) As provided in accordance with paragraph (4), adult day
7 health care is covered for a maximum of five days per week.
8 (4) As of the date that the director makes the declaration
9 described in subdivision (g) of Section 14525.1, paragraph (2)
10 shall become inoperative and paragraph (3) shall become operative.
11 (q) (1) Application of fluoride, or other appropriate fluoride
12 treatment as defined by the department, and other prophylaxis
13 treatment for children 17 years of age and under are covered.
14 (2) All dental hygiene services provided by a registered dental
15 hygienist, registered dental hygienist in extended functions, and
16 registered dental hygienist in alternative practice licensed pursuant
17 to Sections 1753, 1917, 1918, and 1922 of the Business and
18 Professions Code may be covered as long as they are within the
19 scope of Denti-Cal benefits and they are necessary services
20 provided by a registered dental hygienist, registered dental
21 hygienist in extended functions, or registered dental hygienist in
22 alternative practice.
23 (r) (1) Paramedic services performed by a city, county, or
24 special district, or pursuant to a contract with a city, county, or
25 special district, and pursuant to a program established under former
26 Article 3 (commencing with Section 1480) of Chapter 2.5 of
27 Division 2 of the Health and Safety Code by a paramedic certified
28 pursuant to that article, and consisting of defibrillation and those
29 services specified in subdivision (3) of former Section 1482 of the
30 article.
31 (2) All providers enrolled under this subdivision shall satisfy
32 all applicable statutory and regulatory requirements for becoming
33 a Medi-Cal provider.
34 (3) This subdivision shall be implemented only to the extent
35 funding is available under Section 14106.6.
36 (s) In-home medical care services are covered when medically
37 appropriate and subject to utilization controls, for beneficiaries
38 who would otherwise require care for an extended period of time
39 in an acute care hospital at a cost higher than in-home medical
40 care services. The director shall have the authority under this

1 section to contract with organizations qualified to provide in-home
2 medical care services to those persons. These services may be
3 provided to patients placed in shared or congregate living
4 arrangements, if a home setting is not medically appropriate or
5 available to the beneficiary. As used in this section, "in-home
6 medical care service" includes utility bills directly attributable to
7 continuous, 24-hour operation of life-sustaining medical equipment,
8 to the extent that federal financial participation is available.
9 As used in this subdivision, in-home medical care services
10 include, but are not limited to:
11 (1) Level-of-care and cost-of-care evaluations.
12 (2) Expenses, directly attributable to home care activities, for
13 materials.
14 (3) Physician fees for home visits.
15 (4) Expenses directly attributable to home care activities for
16 shelter and modification to shelter.
17 (5) Expenses directly attributable to additional costs of special
18 diets, including tube feeding.
19 (6) Medically related personal services.
20 (7) Home nursing education.
21 (8) Emergency maintenance repair.
22 (9) Home health agency personnel benefits that permit coverage
23 of care during periods when regular personnel are on vacation or
24 using sick leave.
25 (10) All services needed to maintain antiseptic conditions at
26 stoma or shunt sites on the body.
27 (11) Emergency and nonemergency medical transportation.
28 (12) Medical supplies.
29 (13) Medical equipment, including, but not limited to, scales,
30 gurneys, and equipment racks suitable for paralyzed patients.
31 (14) Utility use directly attributable to the requirements of home
32 care activities that are in addition to normal utility use.
33 (15) Special drugs and medications.
34 (16) Home health agency supervision of visiting staff that is
35 medically necessary, but not included in the home health agency
36 rate.
37 (17) Therapy services.
38 (18) Household appliances and household utensil costs directly
39 attributable to home care activities.
40 (19) Modification of medical equipment for home use.

1 (20) Training and orientation for use of life-support systems,
2 including, but not limited to, support of respiratory functions.
3 (21) Respiratory care practitioner services as defined in Sections
4 3702 and 3703 of the Business and Professions Code, subject to
5 prescription by a physician and surgeon.
6 Beneficiaries receiving in-home medical care services are entitled
7 to the full range of services within the Medi-Cal scope of benefits
8 as defined by this section, subject to medical necessity and
9 applicable utilization control. Services provided pursuant to this
10 subdivision, which are not otherwise included in the Medi-Cal
11 schedule of benefits, shall be available only to the extent that
12 federal financial participation for these services is available in
13 accordance with a home- and community-based services waiver.
14 (t) Home- and community-based services approved by the
15 United States Department of Health and Human Services are
16 covered to the extent that federal financial participation is available
17 for those services under the state plan or waivers granted in
18 accordance with Section 1315 or 1396n of Title 42 of the United
19 States Code. The director may seek waivers for any or all home-
20 and community-based services approvable under Section 1315 or
21 1396n of Title 42 of the United States Code. Coverage for those
22 services shall be limited by the terms, conditions, and duration of
23 the federal waivers.
24 (u) Comprehensive perinatal services, as provided through an
25 agreement with a health care provider designated in Section
26 14134.5 and meeting the standards developed by the department
27 pursuant to Section 14134.5, subject to utilization controls.
28 The department shall seek any federal waivers necessary to
29 implement the provisions of this subdivision. The provisions for
30 which appropriate federal waivers cannot be obtained shall not be
31 implemented. Provisions for which waivers are obtained or for
32 which waivers are not required shall be implemented
33 notwithstanding any inability to obtain federal waivers for the
34 other provisions. No provision of this subdivision shall be
35 implemented unless matching funds from Subchapter XIX
36 (commencing with Section 1396) of Chapter 7 of Title 42 of the
37 United States Code are available.
38 (v) Early and periodic screening, diagnosis, and treatment for
39 any individual under 21 years of age is covered, consistent with

1 the requirements of Subchapter XIX (commencing with Section
2 1396) of Chapter 7 of Title 42 of the United States Code.
3 (w) Hospice service that is Medicare-certified hospice service
4 is covered, subject to utilization controls. Coverage shall be
5 available only to the extent that no additional net program costs
6 are incurred.
7 (x) When a claim for treatment provided to a beneficiary
8 includes both services that are authorized and reimbursable under
9 this chapter, and services that are not reimbursable under this
10 chapter, that portion of the claim for the treatment and services
11 authorized and reimbursable under this chapter shall be payable.
12 (y) Home- and community-based services approved by the
13 United States Department of Health and Human Services for
14 beneficiaries with a diagnosis of AIDS or ARC, who require
15 intermediate care or a higher level of care.
16 Services provided pursuant to a waiver obtained from the
17 Secretary of the United States Department of Health and Human
18 Services pursuant to this subdivision, and which are not otherwise
19 included in the Medi-Cal schedule of benefits, shall be available
20 only to the extent that federal financial participation for these
21 services is available in accordance with the waiver, and subject to
22 the terms, conditions, and duration of the waiver. These services
23 shall be provided to individual beneficiaries in accordance with
24 the client's needs as identified in the plan of care, and subject to
25 medical necessity and applicable utilization control.
26 The director may under this section contract with organizations
27 qualified to provide, directly or by subcontract, services provided
28 for in this subdivision to eligible beneficiaries. Contracts or
29 agreements entered into pursuant to this division shall not be
30 subject to the Public Contract Code.
31 (z) Respiratory care when provided in organized health care
32 systems as defined in Section 3701 of the Business and Professions
33 Code, and as an in-home medical service as outlined in subdivision
34 (s).
35 (aa) (1) There is hereby established in the department, a
36 program to provide comprehensive clinical family planning
37 services to any person who has a family income at or below 200
38 percent of the federal poverty level, as revised annually, and who
39 is eligible to receive these services pursuant to the waiver identified

1 in paragraph (2). This program shall be known as the Family
2 Planning, Access, Care, and Treatment (Family PACT) Program.
3 (2) The department shall seek a waiver in accordance with
4 Section 1315 of Title 42 of the United States Code, or a state plan
5 amendment adopted in accordance with Section
6 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code,
7 which was added to Section 1396a of Title 42 of the United States
8 Code by Section 2303(a)(2) of the federal Patient Protection and
9 Affordable Care Act (PPACA) (Public Law 111-148), for a
10 program to provide comprehensive clinical family planning
11 services as described in paragraph (8). Under the waiver, the
12 program shall be operated only in accordance with the waiver and
13 the statutes and regulations in paragraph (4) and subject to the
14 terms, conditions, and duration of the waiver. Under the state plan
15 amendment, which shall replace the waiver and shall be known as
16 the Family PACT successor state plan amendment, the program
17 shall be operated only in accordance with this subdivision and the
18 statutes and regulations in paragraph (4). The state shall use the
19 standards and processes imposed by the state on January 1, 2007,
20 including the application of an eligibility discount factor to the
21 extent required by the federal Centers for Medicare and Medicaid
22 Services, for purposes of determining eligibility as permitted under
23 Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States
24 Code. To the extent that federal financial participation is available,
25 the program shall continue to conduct education, outreach,
26 enrollment, service delivery, and evaluation services as specified
27 under the waiver. The services shall be provided under the program
28 only if the waiver and, when applicable, the successor state plan
29 amendment are approved by the federal Centers for Medicare and
30 Medicaid Services and only to the extent that federal financial
31 participation is available for the services. Nothing in this section
32 shall prohibit the department from seeking the Family PACT
33 successor state plan amendment during the operation of the waiver.
34 (3) Solely for the purposes of the waiver or Family PACT
35 successor state plan amendment and notwithstanding any other
36 law, the collection and use of an individual's social security number
37 shall be necessary only to the extent required by federal law.
38 (4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005,
39 and 24013, and any regulations adopted under these statutes shall
40 apply to the program provided for under this subdivision. No other

1 provision of law under the Medi-Cal program or the State-Only
2 Family Planning Program shall apply to the program provided for
3 under this subdivision.
4 (5) 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 implement, without taking regulatory action,
7 the provisions of the waiver after its approval by the federal Centers
8 for Medicare and Medicaid Services and the provisions of this
9 section by means of an all-county letter or similar instruction to
10 providers. Thereafter, the department shall adopt regulations to
11 implement this section and the approved waiver in accordance
12 with the requirements of Chapter 3.5 (commencing with Section
13 11340) of Part 1 of Division 3 of Title 2 of the Government Code.
14 Beginning six months after the effective date of the act adding this
15 subdivision, the department shall provide a status report to the
16 Legislature on a semiannual basis until regulations have been
17 adopted.
18 (6) In the event that the Department of Finance determines that
19 the program operated under the authority of the waiver described
20 in paragraph (2) or the Family PACT successor state plan
21 amendment is no longer cost effective, this subdivision shall
22 become inoperative on the first day of the first month following
23 the issuance of a 30-day notification of that determination in
24 writing by the Department of Finance to the chairperson in each
25 house that considers appropriations, the chairpersons of the
26 committees, and the appropriate subcommittees in each house that
27 considers the State Budget, and the Chairperson of the Joint
28 Legislative Budget Committee.
29 (7) If this subdivision ceases to be operative, all persons who
30 have received or are eligible to receive comprehensive clinical
31 family planning services pursuant to the waiver described in
32 paragraph (2) shall receive family planning services under the
33 Medi-Cal program pursuant to subdivision (n) if they are otherwise
34 eligible for Medi-Cal with no share of cost, or shall receive
35 comprehensive clinical family planning services under the program
36 established in Division 24 (commencing with Section 24000) either
37 if they are eligible for Medi-Cal with a share of cost or if they are
38 otherwise eligible under Section 24003.
39 (8) For purposes of this subdivision, "comprehensive clinical
40 family planning services" means the process of establishing

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

1 (vii) Reproductive health care.
2 (viii) Preconception and nutrition counseling.
3 (ix) Prevention and treatment of sexually transmitted infection.
4 (x) Use of contraceptive methods, federal Food and Drug
5 Administration approved contraceptive drugs, devices, and
6 supplies.
7 (xi) Possible contraceptive consequences and followup.
8 (xii) Interpersonal communication and negotiation of
9 relationships to assist individuals and couples in effective
10 contraceptive method use and planning families.
11 (D) A comprehensive health history, updated at the next periodic
12 visit (between 11 and 24 months after initial examination) that
13 includes a complete obstetrical history, gynecological history,
14 contraceptive history, personal medical history, health risk factors,
15 and family health history, including genetic or hereditary
16 conditions.
17 (E) A complete physical examination on initial and subsequent
18 periodic visits.
19 (F) Services, drugs, devices, and supplies deemed by the federal
20 Centers for Medicare and Medicaid Services to be appropriate for
21 inclusion in the program.
22 (9) In order to maximize the availability of federal financial
23 participation under this subdivision, the director shall have the
24 discretion to implement the Family PACT successor state plan
25 amendment retroactively to July 1, 2010.
26 (ab) (1) Purchase of prescribed enteral nutrition products is
27 covered, subject to the Medi-Cal list of enteral nutrition products
28 and utilization controls.
29 (2) Purchase of enteral nutrition products is limited to those
30 products to be administered through a feeding tube, including, but
31 not limited to, a gastric, nasogastric, or jejunostomy tube.
32 Beneficiaries under the Early and Periodic Screening, Diagnosis,
33 and Treatment Program shall be exempt from this paragraph.
34 (3) Notwithstanding paragraph (2), the department may deem
35 an enteral nutrition product, not administered through a feeding
36 tube, including, but not limited to, a gastric, nasogastric, or
37 jejunostomy tube, a benefit for patients with diagnoses, including,
38 but not limited to, malabsorption and inborn errors of metabolism,
39 if the product has been shown to be neither investigational nor

1 experimental when used as part of a therapeutic regimen to prevent
2 serious disability or death.
3 (4) Notwithstanding Chapter 3.5 (commencing with Section
4 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
5 the department may implement the amendments to this subdivision
6 made by the act that added this paragraph by means of all-county
7 letters, provider bulletins, or similar instructions, without taking
8 regulatory action.
9 (5) The amendments made to this subdivision by the act that
10 added this paragraph shall be implemented June 1, 2011, or on the
11 first day of the first calendar month following 60 days after the
12 date the department secures all necessary federal approvals to
13 implement this section, whichever is later.
14 (ac) Diabetic testing supplies are covered when provided by a
15 pharmacy, subject to utilization controls.
16 (ad) (1) Nonmedical transportation is covered, subject to
17 utilization ~~controls,~~ *controls and federally permissible time and*
18 *distance standards,* for a beneficiary to obtain covered ~~specialty~~
19 ~~care~~ Medi-Cal ~~services, if those services are more than 60 minutes~~
20 ~~or 30 miles from the beneficiary's place of residence.~~ *services.*
21 (2) (A) "Nonmedical transportation" includes, but is not limited
22 to, roundtrip transportation for a beneficiary to obtain covered
23 ~~specialty care~~ Medi-Cal services by passenger car, taxicab, or any
24 other form of public or private conveyance. Nonmedical
25 transportation does not include the transportation of sick, injured,
26 invalid, convalescent, infirm, or otherwise incapacitated
27 beneficiaries by ambulances, litter vans, or wheelchair vans
28 licensed, operated, and equipped in accordance with state and local
29 statutes, ordinances, or regulations. Nonmedical transportation
30 includes, but is not limited to, mileage reimbursement for
31 conveyance by private vehicle, bus passes, taxi vouchers, or train
32 tickets.
33 (B) The cost of nonmedical transportation shall be paid for a
34 beneficiary who can attest in a manner to be specified by the
35 department that other available resources have been reasonably
36 exhausted.
37 (3) Nonmedical transportation shall be provided in a form and
38 manner that is accessible, in terms of physical and geographic
39 accessibility, for the beneficiary, and consistent with policies and
40 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) (A) Upon enactment of this subdivision, the department 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.

(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.

(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.

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