

AMENDED IN ASSEMBLY MARCH 26, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 1424

Introduced by Assembly Member Achadjian

February 27, 2015

An act to amend Section ~~14132~~ 5604 of the Welfare and Institutions Code, relating to ~~Medi-Cal~~ *mental health*.

LEGISLATIVE COUNSEL'S DIGEST

AB 1424, as amended, Achadjian. ~~Medi-Cal: benefits~~. *Mental health: community mental health board.*

Existing law requires each community mental health service to have a mental health board consisting of 10 to 15 members who are appointed by the governing body, and encourages counties to appoint individuals who have experience with and knowledge of the mental health system. Existing law requires 50% of the board membership to be consumers, or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services. Existing law prohibits a member of the board, or his or her spouse, from being a full-time or part-time county employee of a county mental health services, an employee of the State Department of Health Care Services, or an employee of, or a paid member of the governing body of, a mental health contract agency.

This bill would exempt from this prohibition a consumer of mental health services who obtained employment with an employer described above as a part of his or her recovery and holds a position in which he or she has no interest, influence, or authority over any financial or contractual matter concerning the employer, and would require that

member to abstain from voting on any financial or contractual issue concerning his or her employer that may come before the board.

~~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 provided under the Medi-Cal program, which includes specified outpatient services and inpatient hospital services, subject to utilization controls.~~

~~This bill would make technical, nonsubstantive changes to these provisions.~~

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

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

1 *SECTION 1. Section 5604 of the Welfare and Institutions Code*
2 *is amended to read:*

3 5604. (a) (1) Each community mental health service shall
4 have a mental health board consisting of 10 to 15 members,
5 depending on the preference of the county, appointed by the
6 governing body, except that boards in counties with a population
7 of less than 80,000 may have a minimum of five members. One
8 member of the board shall be a member of the local governing
9 body. Any county with more than five supervisors shall have at
10 least the same number of members as the size of its board of
11 supervisors. Nothing in this section shall be construed to limit the
12 ability of the governing body to increase the number of members
13 above 15. Local mental health boards may recommend appointees
14 to the county supervisors. Counties are encouraged to appoint
15 individuals who have experience *with* and knowledge of the mental
16 health system. The board membership should reflect the ethnic
17 diversity of the client population in the county.

18 (2) Fifty percent of the board membership shall be consumers,
19 or the parents, spouses, siblings, or adult children of consumers,
20 who are receiving or have received mental health services. At least
21 20 percent of the total membership shall be consumers, and at least
22 20 percent shall be families of consumers.

1 (3) (A) In counties under 80,000 population, at least one
2 member shall be a consumer, and at least one member shall be a
3 parent, spouse, sibling, or adult child of a consumer, who is
4 receiving, or has received, mental health services.

5 (B) Notwithstanding subparagraph (A), a board in a county with
6 a population under 80,000 that elects to have the board exceed the
7 five-member minimum permitted under paragraph (1) shall be
8 required to comply with paragraph (2).

9 (b) The term of each member of the board shall be for three
10 years. The governing body shall equitably stagger the appointments
11 so that approximately one-third of the appointments expire in each
12 year.

13 (c) If two or more local agencies jointly establish a community
14 mental health service under Article 1 (commencing with Section
15 6500) of Chapter 5 of Division 7 of Title 1 of the Government
16 Code, the mental health board for the community mental health
17 service shall consist of an additional two members for each
18 additional agency, one of whom shall be a consumer or a parent,
19 spouse, sibling, or adult child of a consumer who has received
20 mental health services.

21 (d) ~~No~~ (1) *Except as provided in paragraph (2), no* member
22 of the board or his or her spouse shall be a full-time or part-time
23 county employee of a county mental health service, an employee
24 of the State Department of Health Care Services, or an employee
25 of, or a paid member of the governing body of, a mental health
26 contract agency.

27 (2) *A consumer of mental health services who has obtained*
28 *employment with an employer described in paragraph (1) as part*
29 *of his or her recovery and holds a position in which he or she does*
30 *not have any interest, influence, or authority over any financial*
31 *or contractual matter concerning the employer may be appointed*
32 *to the board. The member shall abstain from voting on any*
33 *financial or contractual issue concerning his or her employer that*
34 *may come before the board.*

35 (e) Members of the board shall abstain from voting on any issue
36 in which the member has a financial interest as defined in Section
37 87103 of the Government Code.

38 (f) If it is not possible to secure membership as specified *in this*
39 *section* from among persons who reside in the county, the
40 governing body may substitute representatives of the public interest

1 in mental health who are not full-time or part-time employees of
2 the county mental health service, the State Department of Health
3 Care Services, or on the staff of, or a paid member of the governing
4 body of, a mental health contract agency.

5 (g) The mental health board may be established as an advisory
6 board or a commission, depending on the preference of the county.

7 SECTION 1. ~~Section 14132 of the Welfare and Institutions~~
8 ~~Code is amended to read:~~

9 ~~14132. The following is the schedule of benefits under this~~
10 ~~chapter:~~

11 (a) ~~Outpatient services are covered as follows:~~

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

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

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

33 (c) ~~Nursing facility services, subacute care services, and services~~
34 ~~provided by any category of intermediate care facility for the~~
35 ~~developmentally disabled, including podiatry, physician, nurse~~
36 ~~practitioner services, and prescribed drugs, as described in~~
37 ~~subdivision (d), are covered subject to utilization controls.~~
38 ~~Respiratory care, physical therapy, occupational therapy, speech~~
39 ~~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. This~~
18 ~~subdivision shall not 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 which 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 Article~~
21 ~~3 (commencing with Section 1480) of Chapter 2.5 of Division 2~~
22 ~~of the Health and Safety Code by a paramedic certified pursuant~~
23 ~~to that article, and consisting of defibrillation and those services~~
24 ~~specified in subdivision (3) of Section 1482 of the article.~~
25 ~~(2) All providers enrolled under this subdivision shall satisfy~~
26 ~~all applicable statutory and regulatory requirements for becoming~~
27 ~~a Medi-Cal provider.~~
28 ~~(3) This subdivision shall be implemented only to the extent~~
29 ~~funding is available under Section 14106.6.~~
30 ~~(s) In-home medical care services are covered when medically~~
31 ~~appropriate and subject to utilization controls, for beneficiaries~~
32 ~~who would otherwise require care for an extended period of time~~
33 ~~in an acute care hospital at a cost higher than in-home medical~~
34 ~~care services. The director shall have the authority under this~~
35 ~~section to contract with organizations qualified to provide in-home~~
36 ~~medical care services to those persons. These services may be~~
37 ~~provided to patients placed in shared or congregate living~~
38 ~~arrangements, if a home setting is not medically appropriate or~~
39 ~~available to the beneficiary. As used in this section, "in-home~~
40 ~~medical care service" includes utility bills directly attributable to~~

1 continuous, 24-hour operation of life-sustaining medical equipment,
2 to the extent that federal financial participation is available.
3 ~~As used in this subdivision, in-home medical care services~~
4 ~~include, but are not limited to:~~

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

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

9 (t) Home- and community-based services approved by the
10 United States Department of Health and Human Services are
11 covered to the extent that federal financial participation is available
12 for those services under the state plan or waivers granted in
13 accordance with Section 1315 or 1396n of Title 42 of the United
14 States Code. The director may seek waivers for any or all home-
15 and community-based services approvable under Section 1315 or
16 1396n of Title 42 of the United States Code. Coverage for those
17 services shall be limited by the terms, conditions, and duration of
18 the federal waivers.

19 (u) Comprehensive perinatal services, as provided through an
20 agreement with a health care provider designated in Section
21 14134.5 and meeting the standards developed by the department
22 pursuant to Section 14134.5, subject to utilization controls.

23 The department shall seek any federal waivers necessary to
24 implement this subdivision. The provisions for which appropriate
25 federal waivers cannot be obtained shall not be implemented.
26 Provisions for which waivers are obtained or for which waivers
27 are not required shall be implemented notwithstanding any inability
28 to obtain federal waivers for the other provisions. This subdivision
29 shall not be implemented unless matching funds from Subchapter
30 XIX (commencing with Section 1396) of Chapter 7 of Title 42 of
31 the United States Code are available.

32 (v) Early and periodic screening, diagnosis, and treatment for
33 any individual under 21 years of age is covered, consistent with
34 the requirements of Subchapter XIX (commencing with Section
35 1396) of Chapter 7 of Title 42 of the United States Code.

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

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

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

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

20 ~~The director may, under this section, contract with organizations~~
21 ~~qualified to provide, directly or by subcontract, services provided~~
22 ~~for in this subdivision to eligible beneficiaries. Contracts or~~
23 ~~agreements entered into pursuant to this division shall not be~~
24 ~~subject to the Public Contract Code.~~

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

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

36 ~~(2) The department shall seek a waiver in accordance with~~
37 ~~Section 1315 of Title 42 of the United States Code, or a state plan~~
38 ~~amendment adopted in accordance with Section~~
39 ~~1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code,~~
40 ~~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. This section shall not
25 prohibit the department from seeking the Family PACT successor
26 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 law under the Medi-Cal program or the State-Only Family Planning
35 Program shall apply to the program provided for under this
36 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 Health

1 Care Financing Administration and the provisions of this section
2 by means of an all-county letter or similar instruction to providers.
3 Thereafter, the department shall adopt regulations to implement
4 this section and the approved waiver in accordance with the
5 requirements of Chapter 3.5 (commencing with Section 11340) of
6 Part 1 of Division 3 of Title 2 of the Government Code. Beginning
7 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.~~

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

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

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