

W&I Sections Referenced in Title 22 Section 51179.5 (Personal Supervision)

10725. The director may adopt regulations, orders, or standards of general application to implement, interpret, or make specific the law enforced by the department, and such regulations, orders, and standards shall be adopted, amended, or repealed by the director only in accordance with the provisions of Chapter 4.5 (commencing with Section 11371), Part 1, Division 3, Title 2 of the Government **Code**, provided that regulations relating to services need not be printed in the California Administrative **Code** or California Administrative Register if they are included in the publications of the department. Such authority also may be exercised by the director's designee.

In adopting regulations the director shall strive for clarity of language which may be readily understood by those administering services or subject to such regulations.

The rules of the department need not specify or include the detail of forms, reports or records, but shall include the essential authority by which any person, agency, organization, association or institution subject to the supervision or investigation of the department is required to use, submit or maintain such forms, reports or records.

14053. (a) The term "health care services" means the benefits set forth in Article 4 (commencing with Section 14131) of this chapter and in Section 14021. The term includes inpatient hospital services for any individual under 21 years of age in an institution for mental diseases. Any individual under 21 years of age receiving inpatient psychiatric hospital services immediately preceding the date on which he or she attains age 21 may continue to receive these services until he or she attains age 22. The term also includes early and periodic screening, diagnosis, and treatment for any individual under 21 years of age.

(b) The term "health care services" does not include, except to the extent permitted by federal law, any of the following:

(1) Care or services for any individual who is an inmate of an institution (except as a patient in a medical institution).

(2) Care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis.

(3) Care or services for any individual who is 21 years of age or over, except as provided in the first paragraph of this section, and has not attained 65 years of age and who is a patient in an institution for mental disease.

(4) Inpatient services provided to individuals 21 to 64 years of age, inclusive, in an institution for mental diseases operating under a consolidated license with a general acute care hospital pursuant to Section 1250.8 of the Health and Safety **Code**, unless federal financial participation is available for such inpatient services.

14105. (a) The director shall prescribe the policies to be followed in the administration of this chapter, may limit the rates of payment for health care services, and shall adopt any rules and regulations as are necessary for carrying out, but are not inconsistent with, the provisions thereof.

The policies and regulations shall include rates for payment for services not rendered under a contract pursuant to Chapter 8 (commencing with Section 14200). In order to implement expeditiously the budgeting decisions of the Legislature, the director shall, to the extent permitted by federal law, adopt regulations setting rates that reflect these budgeting decisions within one month after the enactment of the Budget Act and of any other

appropriation that changes the level of funding for Medi-Cal services. The proposed regulations shall be submitted to the Department of Finance no later than five days prior to the date of adoption. With the written approval of the Department of Finance, the director shall adopt the regulations as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Part 1, Division 3, Title 2 of the Government **Code**). For purposes of that act, the adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety or general welfare.

(b) (1) Insofar as practical, consistent with the efficient and economical administration of this part, the department shall afford recipients of public assistance a choice of managed care arrangements under which they shall receive health care benefits and a choice of primary care providers under each managed care arrangement.

(2) Notwithstanding any other provision of law, Medi-Cal beneficiaries shall be entitled to affirmatively select, or to be assigned by default to, any primary care provider as defined in paragraph (1) of subdivision (b) of Section 14088.

(3) Notwithstanding any other provision of law, when a Medi-Cal beneficiary is assigned, from any source, to a primary care physician, as defined in Section 14254, and that primary care physician is an employee of a primary care provider, as defined in paragraph (1) of subdivision (b) of Section 14088, the assignment shall constitute an assignment to the primary care provider.

(c) If, in the judgment of the director, the actions taken by the director under subdivision (c) of Section 14120 will not be sufficient to operate the Medi-Cal program within the limits of appropriated funds, he or she may limit the scope and kinds of health care services, except for minimum coverage as defined in Section 14056, available to persons who are not eligible under Section 14005.1. When and if necessary, that action shall be taken by the director in ways consistent with the requirements of the federal Social Security Act.

(d) The director shall adopt regulations implementing regulatory changes required to initially implement, and annually update, the United States Health Care Financing Administration's common procedure coding system as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government **Code**. For the purposes of the Administrative Procedure Act, the adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. These regulations shall become effective immediately upon filing with the Secretary of State.

(e) Notwithstanding any other provision of law, prospective reimbursement for any services provided to a Medi-Cal beneficiary in a nursing facility that is a distinct part of an acute care hospital shall not exceed the audited costs of the facility providing the services.

(f) Notwithstanding any other provision of law, reimbursement for anesthesiology, surgical services, and the professional component of radiology procedures **except for comprehensive perinatal and obstetrical services** shall be reduced by 9.5 percent of the amount of reimbursement provided for any of those services prior to the operative date of this subdivision. The director may exclude emergency surgical services performed in the emergency department of a general acute care hospital. To be excluded, emergency surgical services must be performed by an emergency room physician or a physician on the emergency department's on-call list.

(g) (1) It is the intent of the Legislature in enacting this subdivision to enable the department to obtain Medicare cost reports for the purpose of

evaluating its Medi-Cal reimbursement rate methodology for nursing facilities.

(2) Skilled nursing facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety **Code** shall submit copies of all Medicare cost reports to the department by October 1, 1995, for reporting periods that ended between July 1, 1993, and June 30, 1995.

On or after July 1, 1995, those facilities shall submit the copies to the department on the date that the Medicare cost reports are submitted to the Medicare fiscal intermediary.

(3) Hospitals providing skilled nursing care licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety **Code** shall submit a copy of all Medicare cost reports for reporting periods ended:

(A) January 1, 1993, through June 30, 1995, to the department by October 1, 1995.

(B) On or after July 1, 1995, to the department when the Medicare cost reports are submitted to the Medicare fiscal intermediary.

14124.5. (a) The director may, in accordance with the provisions of Section 10725, adopt, amend or repeal, in accordance with Chapter 4.5 (commencing with Section 11371) of Part 1, Division 3, Title 2 of the Government **Code**, such reasonable rules and regulations as may be necessary or proper to carry out the purposes and intent of this chapter and to enable it to exercise the powers and perform the duties conferred upon it by this chapter, not inconsistent with any of the provisions of any statute of this state.

(b) All regulations heretofore adopted by the State Department of Health or any predecessor department pursuant to this chapter and in effect immediately preceding the operative date of this section, shall remain in effect and shall be fully enforceable unless and until readopted, amended, or repealed by the director in accordance with the provisions of Section 10725.

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

(a) Outpatient services are covered as follows:

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

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

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

and any category of intermediate care facility for the developmentally disabled are covered subject to utilization controls.

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

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

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

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

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

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

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

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

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

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

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

facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

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

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

(A) Periodontal treatment is not a benefit.

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

(C) Laboratory processed crowns are not a benefit.

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

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

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

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

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

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

(k) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

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

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

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

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

(n) Family planning services are covered, subject to utilization controls.

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

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

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

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

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

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

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

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

(2) All dental hygiene services provided by a registered dental hygienist in alternative practice pursuant to Sections 1768 and 1770 of the Business and Professions **Code** may be covered as long as they are within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental hygienist in alternative practice.

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

article, and consisting of defibrillation and those services specified in subdivision (3) of Section 1482 of the article.

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

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

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

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

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

Beneficiaries receiving in-home medical care services are entitled

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

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

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

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

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

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

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

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

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

The director may under this section contract with organizations

qualified to provide, directly or by subcontract, services provided for in this subdivision to eligible beneficiaries. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract **Code**.

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

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

(2) The department shall seek a waiver in accordance with Section 1315 of Title 42 of the United States **Code**, or a state plan amendment adopted in accordance with Section 1396a(a)(10)(A)(ii)(XXI)(ii)(2) of Title 42 of the United States **Code**, which was added to Section 1396a of Title 42 of the United States **Code** by Section 2303(a)(2) of the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), for a program to provide comprehensive clinical family planning services as described in paragraph (8). Under the waiver, the program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. Under the state plan amendment, which shall replace the waiver and shall be known as the Family PACT successor state plan amendment, the program shall be operated only in accordance with this subdivision and the statutes and regulations in paragraph (4). The state shall use the standards and processes imposed by the state on January 1, 2007, including the application of an eligibility discount factor to the extent required by the federal Centers for Medicare and Medicaid Services, for purposes of determining eligibility as permitted under Section 1396a(a)(10)(A)(ii)(XXI)(ii)(2) of Title 42 of the United States **Code**. To the extent that federal financial participation is available, the program shall continue to conduct education, outreach, enrollment, service delivery, and evaluation services as specified under the waiver. The services shall be provided under the program only if the waiver and, when applicable, the successor state plan amendment are approved by the federal Centers for Medicare and Medicaid Services and only to the extent that federal financial participation is available for the services. Nothing in this section shall prohibit the department from seeking the Family PACT successor state plan amendment during the operation of the waiver.

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

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

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government **Code**, the

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

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

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

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

(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug

Administration approved contraceptive drugs, devices, and supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

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

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

(i) Psychosocial and medical aspects of contraception.

(ii) Sexuality.

(iii) Fertility.

(iv) Pregnancy.

(v) Parenthood.

(vi) Infertility.

(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

(x) Use of contraceptive methods, federal Food and Drug

Administration approved contraceptive drugs, devices, and supplies.

(xi) Possible contraceptive consequences and followup.

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

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

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

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

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

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

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

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

(4) Notwithstanding Chapter 3.5 (commencing with Section 11340) of

Part 1 of Division 3 of Title 2 of the Government **Code**, the department may implement the amendments to this subdivision made by the act that added this paragraph by means of all-county letters, provider bulletins, or similar instructions, without taking regulatory action.

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

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

14134.5. All of the following provisions apply to the provision of services pursuant to subdivision (u) of Section **14132**:

(a) "Comprehensive perinatal provider" means any general practice physician, family practice physician, obstetrician-gynecologist, pediatrician, certified nurse midwife, a group, any of whose members is one of the above-named physicians, or any preferred provider organization or clinic enrolled in the Medi-Cal program and certified pursuant to the standards of this section.

(b) "Perinatal" means the period from the establishment of pregnancy to one month following delivery.

(c) "Comprehensive perinatal services" shall include, but not be limited to, the provision of the combination of services developed through the Department of Health Services Obstetrical Access Pilot Program.

(d) The comprehensive perinatal provider shall schedule visits with appropriate providers and shall track the patient to verify whether services have been received. As part of the reimbursement for coordinating these services, the comprehensive perinatal provider shall ensure the provision of the following services either through the provider's own service or through subcontracts or referrals to other providers:

(1) A psychosocial assessment and when appropriate referrals to counseling.

(2) Nutrition assessments and when appropriate referral to counseling on food supplement programs, vitamins and breast-feeding.

(3) Health, childbirth, and parenting education.

(e) Except where existing law prohibits the employment of physicians, a health care provider may employ or contract with all of the following medical and other practitioners for the purpose of providing the comprehensive services delineated in this section:

(1) Physicians, including a general practitioner, a family practice physician, a pediatrician, or an obstetrician-gynecologist.

(2) Certified nurse midwives.

(3) Nurses.

(4) Nurse practitioners.

(5) Physician assistants.

(6) Social workers.

(7) Health and childbirth educators.

(8) Registered dietitians.

The department shall adopt regulations which define the qualifications of any of these practitioners who are not currently included under the regulations adopted pursuant to this chapter.

Providers shall, as feasible, utilize staffing patterns which reflect the linguistic and cultural features of the populations they serve.

(f) The California Medical Assistance Program and the Maternal and Child Health Branch of the State Department of Health Services in consultation with the California Conference of Local Health Officers shall establish standards for health care providers and for services rendered pursuant to this subdivision.

(g) The department shall assist local health departments to establish a community perinatal program whose responsibilities may include certifying and monitoring providers of comprehensive perinatal services. The department shall provide the local health departments with technical assistance for the purpose of implementing the community perinatal program. The department shall, to the extent feasible, and to the extent funding for administrative costs is available, utilize local health departments in the administration of the perinatal program. If these funds are not available, the department shall use alternative means to implement the community perinatal program.

(h) It is the intent of the Legislature that the department shall establish a method for reimbursement of comprehensive perinatal providers which shall include a fee for coordinating services and which shall be sufficient to cover reasonable costs for the provision of comprehensive perinatal services. The department may utilize fees for service, capitated fees, or global fees to reimburse providers. However, if capitated or global fees are established, the department shall set minimum standards for the provision of services including, but not limited to, the number of prenatal visits and the amount and type of psychosocial, nutritional, and educational services patients shall receive.

Notwithstanding the type of reimbursement system, the comprehensive perinatal provider shall not be financially at risk for the provision of inpatient services. The provision of inpatient services which are not related to perinatal care shall not be subject to the provisions of this section. Inpatient services related to services pursuant to this subdivision shall be reimbursed, in accordance with Section 14081, 14086, 14087, or 14087.2, whichever is applicable.

(i) The department shall develop systems for monitoring and oversight of the comprehensive perinatal services provided in this section. The monitoring shall include, but shall not be limited to, collection of information using the perinatal data form.

(j) Participation for services provided pursuant to this section shall be voluntary. The department shall adopt patient rights safeguards for recipients of the comprehensive perinatal services.