

WELFARE AND INSTITUTIONS CODE

SECTION 14131-14138

14131. The Medi-Cal Benefits Program comprises a department-administered uniform schedule of health care benefits. Notwithstanding any other provision of this chapter, "health care services" shall be limited to the benefits set forth in this article and in Section 14021.

14131.15. (a) In geographic areas in which Medi-Cal managed care plans contracting under this chapter or Chapter 8 (commencing with Section 14200) are operating with capacity to enroll additional qualifying Medi-Cal beneficiaries, the director may, in the interest of bringing managed care principles to bear on the quality, costs, or utilization levels of the Medi-Cal program, designate any benefit or service included in the Medi-Cal program, at state option under federal medicaid rules, as a covered Medi-Cal benefit only when provided by a Medi-Cal managed care plan to a Medi-Cal enrollee of the plan.

(b) Where benefits and services have been designated by the director under subdivision (a), beneficiaries who are eligible to enroll in and reside in the service area of a managed care plan, and who desire coverage for such benefits and services, must enroll in a Medi-Cal managed care plan to receive them and shall, to the maximum extent permitted under federal law, remain enrolled in the plan.

(c) When managed care capacity is reached in an area in which Medi-Cal benefits have been designated under this section, the director may provide for the delivery of designated benefits or services to beneficiaries by contract to the extent permitted under this chapter, on a fee-for-service basis or a combination of both.

(d) Exercise of the director's discretion under this section shall not preclude Medi-Cal managed care contractors from applying their established medical necessity criteria, utilization control standards and policies and utilization review procedures in delivering designated services as permitted and controlled by Medi-Cal contract and other state and federal regulatory standards.

(e) Enactment of this section shall not impose any requirement on a Medi-Cal managed care plan to negotiate or enter into a contract or any other participation arrangement with any provider of a Medi-Cal benefit or service designated under subdivision (a).

(f) The department shall seek all federal waivers necessary to allow for federal financial participation in expenditures under this section.

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.

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

(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) Waiver Program.

(2) The department shall seek a waiver for a program to provide comprehensive clinical family planning services as described in paragraph (8). 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. The services shall be provided under the program only if the waiver is approved by the federal Centers for Medicare and Medicaid Services in accordance with Section 1396n of Title 42 of the United States Code and only to the extent that federal financial participation is available for the services.

(3) Solely for the purposes of the waiver 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) 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.

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

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

14132.01. (a) Notwithstanding any other provision of law, a community clinic or free clinic licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code or an intermittent clinic operating pursuant to subdivision (h) of Section 1206 of the Health and Safety Code, that has a valid license pursuant to Article 13 (commencing with Section 4180) of Chapter 9 of Division 2 of the Business and Professions Code shall bill and be reimbursed, as described in this section, for drugs and supplies covered under the Medi-Cal program and Family PACT Waiver Program.

(b) (1) A clinic described in subdivision (a) shall bill the Medi-Cal program and Family PACT Waiver Program for drugs and

supplies covered under those programs at the lesser of cost or the clinic's usual charge made to the general public.

(2) For purposes of this section, "cost" means an aggregate amount equivalent to the sum of the actual acquisition cost of a drug or supply plus a clinic dispensing fee not to exceed twelve dollars (\$12) per billing unit as identified in either the Family PACT Policies, Procedures, and Billing Instructions Manual, or the Medi-Cal Inpatient/Outpatient Provider Manual governing outpatient clinic billing for drugs and supplies, as applicable. For purposes of this section, "cost" for a take-home drug that is dispensed for use by the patient within a specific timeframe of five or less days from the date medically indicated means actual acquisition cost for that drug plus a clinic dispensing fee, not to exceed seventeen dollars (\$17) per prescription. Reimbursement shall be at the lesser of the amount billed or the Medi-Cal reimbursement rate, and shall not exceed the net cost of these drugs or supplies when provided by retail pharmacies under the Medi-Cal program.

(c) A clinic described in subdivision (a) that furnishes services free of charge, or at a nominal charge, as defined in subsection (a) of Section 413.13 of Title 42 of the Code of Federal Regulations, or that can demonstrate to the department, upon request, that it serves primarily low-income patients, and its customary practice is to charge patients on the basis of their ability to pay, shall not be subject to reimbursement reductions based on its usual charge to the general public.

(d) Federally qualified health centers and rural health clinics that are clinics as described in subdivision (a) may bill and be reimbursed as described in this section, upon electing to be reimbursed for pharmaceutical goods and services on a fee-for-service basis, as permitted by subdivision (k) of Section 14132.100.

(e) A clinic that otherwise meets the qualifications set forth in subdivision (a), that is eligible to, but that has elected not to, utilize drugs purchased under the 340B Discount Drug Program for its Medi-Cal patients, shall provide notification to the Health Resources and Services Administration's Office of Pharmacy Affairs that it is utilizing non-340B drugs for its Medi-Cal patients in the manner and to the extent required by federal law.

14132.05. The department shall provide the fiscal and appropriate policy committees of the Legislature with a copy of their submittal to the federal Health Care Financing Administration pertaining to any evaluation completed regarding the Family PACT federal waiver required by subdivision (aa) of Section 14132.

14132.06. (a) Services specified in this section that are provided by a local educational agency are covered Medi-Cal benefits, to the extent federal financial participation is available, and subject to utilization controls and standards adopted by the department, and consistent with Medi-Cal requirements for physician prescription, order, and supervision.

(b) Any provider enrolled on or after January 1, 1993, to provide services pursuant to this section may bill for those services provided on or after January 1, 1993.

(c) Nothing in this section shall be interpreted to expand the current category of professional health care practitioners permitted to directly bill the Medi-Cal program.

(d) Nothing in this section is intended to increase the scope of practice of any health professional providing services under this section or Medi-Cal requirements for physician prescription, order, and supervision.

(e) (1) For the purposes of this section, the local educational agency, as a condition of enrollment to provide services under this section, shall be considered the provider of services. A local educational agency provider, as a condition of enrollment to provide services under this section, shall enter into, and maintain, a contract with the department in accordance with guidelines contained in regulations adopted by the director and published in Title 22 of the California Code of Regulations.

(2) Notwithstanding paragraph (1), a local educational agency providing services pursuant to this section shall utilize current safety net and traditional health care providers, when those providers are accessible to specific schoolsites identified by the local educational agency to participate in this program, rather than adding duplicate capacity.

(f) For the purposes of this section, covered services may include all of the following local educational agency services:

(1) Health and mental health evaluations and health and mental health education.

(2) Medical transportation.

(3) Nursing services.

(4) Occupational therapy.

(5) Physical therapy.

(6) Physician services.

(7) Mental health and counseling services.

(8) School health aide services.

(9) Speech pathology services. These services may be provided by either of the following:

(A) A licensed speech pathologist.

(B) A credentialed speech-language pathologist, to the extent authorized by Chapter 5.3 (commencing with Section 2530) of Division 2 of the Business and Professions Code.

(10) Audiology services.

(11) Targeted case management services for children with an individualized education plan (IEP) or an individualized family service plan (IFSP).

(g) Local educational agencies may, but need not, provide any or all of the services specified in subdivision (f).

(h) For the purposes of this section, "local educational agency" means the governing body of any school district or community college district, the county office of education, a state special school, a California State University campus, or a University of California campus.

(i) Any local educational agency provider enrolled to provide service pursuant to this section on January 1, 1995, may bill for targeted case management services for children with an individualized education plan (IEP) or an individualized family service plan (IFSP), provided on or after January 1, 1995.

(j) Notwithstanding any other provision of law, a community college district, a California State University campus, or a University of California campus, consistent with the requirements of

this section, may bill for services provided to any student, regardless of age, who is a Medi-Cal recipient.

14132.1. As used in this chapter "surgical center" means a surgical clinic that is licensed under Section 1203 of the Health and Safety Code. Pursuant to Section 14105, the director shall establish the rates of payment for services provided by surgical centers.

14132.10. (a) Pediatric day health care provided by a health facility licensed under paragraph (11) of subdivision (a) of Section 1250.1 of the Health and Safety Code is a covered benefit under this chapter subject to terms, conditions, and utilization controls developed by the department. Pediatric day care does not include inpatient long-term care or family respite care.

(b) The department shall publish emergency regulations for pediatric day health care services by October 1, 1997. These regulations shall reimburse providers at a rate that shall be determined by the department, consistent with efficiency, economy, and quality of care until a new rate is determined on the basis of a cost study conducted by the department.

(c) Coverage for pediatric day health care services shall be available only to the extent that no additional net program costs are incurred.

(d) The department shall not approve a request for authorization of pediatric day health care when the beneficiary for whom the authorization is requested is an inpatient in a licensed health care facility.

(e) The department shall not approve a request for authorization of pediatric day care if the department determines that the total cost incurred by the Medi-Cal program for providing pediatric day health care services and all other medically necessary services to the individual beneficiary is greater than the total cost incurred by the Medi-Cal program in providing medically equivalent services at the beneficiary's otherwise appropriate level of institutional or home care.

(f) Coverage for pediatric day health care services shall be available only to the extent that federal financial participation in the cost of providing these services is available pursuant to a federally approved state plan amendment including those services as a Medi-Cal program benefit.

14132.100. (a) The federally qualified health center services described in Section 1396d(a)(2)(C) of Title 42 of the United States Code are covered benefits.

(b) The rural health clinic services described in Section 1396d(a)(2)(B) of Title 42 of the United States Code are covered benefits.

(c) Federally qualified health center services and rural health clinic services shall be reimbursed on a per-visit basis in accordance with the definition of "visit" set forth in subdivision (g).

(d) Effective October 1, 2004, and on each October 1, thereafter, until no longer required by federal law, federally qualified health center (FQHC) and rural health clinic (RHC) per-visit rates shall be increased by the Medicare Economic Index applicable to primary care services in the manner provided for in Section 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to January 1, 2004, FQHC and RHC per-visit rates shall be adjusted by the Medicare Economic Index in accordance with the methodology set forth in the state plan in effect on October 1, 2001.

(e) (1) An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC. Rate changes based on a change in the scope of services provided by an FQHC or RHC shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(2) Subject to the conditions set forth in subparagraphs (A) to (D), inclusive, of paragraph (3), a change in scope of service means any of the following:

(A) The addition of a new FQHC or RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate.

(B) A change in service due to amended regulatory requirements or rules.

(C) A change in service resulting from relocating or remodeling an FQHC or RHC.

(D) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.

(E) An increase in service intensity attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

(F) Any changes in any of the services described in subdivision (a) or (b), or in the provider mix of an FQHC or RHC or one of its sites.

(G) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in subdivision (a) or (b), including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(H) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.

(I) Any changes in the scope of a project approved by the federal Health Resources and Service Administration (HRSA).

(3) No change in costs shall, in and of itself, be considered a scope-of-service change unless all of the following apply:

(A) The increase or decrease in cost is attributable to an increase or decrease in the scope of services defined in subdivisions (a) and (b), as applicable.

(B) The cost is allowable under Medicare reasonable cost principles set forth in Part 413 (commencing with Section 413) of Subchapter B of Chapter 4 of Title 42 of the Code of Federal Regulations, or its successor.

(C) The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination

thereof.

(D) The net change in the FQHC's or RHC's rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75-percent threshold shall be applied to the average per-visit rate of all sites for the purposes of calculating the cost associated with a scope-of-service change. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

(4) An FQHC or RHC may submit requests for scope-of-service changes once per fiscal year, only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(5) An FQHC or RHC shall submit a scope-of-service rate change request within 90 days of the beginning of any FQHC or RHC fiscal year occurring after the effective date of this section, if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope of services provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If an FQHC or RHC discontinues providing onsite pharmacy or dental services, it shall submit a scope-of-service rate change request within 90 days of the beginning of the following fiscal year. The rate change shall be effective as provided for in paragraph (4). As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent.

(6) Notwithstanding paragraph (4), if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of-service change, the adjusted reimbursement rate for that scope-of-service change shall be made retroactive to the date the scope-of-service change was initially implemented. Scope-of-service changes under this paragraph shall be required to be submitted within the later of 150 days after the adoption and issuance of the written instructions by the department, or 150 days after the end of the FQHC's or RHC's fiscal year ending in 2003.

(7) All references in this subdivision to "fiscal year" shall be construed to be references to the fiscal year of the individual FQHC or RHC, as the case may be.

(f) (1) An FQHC or RHC may request a supplemental payment if extraordinary circumstances beyond the control of the FQHC or RHC occur after December 31, 2001, and PPS payments are insufficient due to these extraordinary circumstances. Supplemental payments arising from extraordinary circumstances under this subdivision shall be solely and exclusively within the discretion of the department and shall not be subject to subdivision (1). These supplemental payments shall be determined separately from the scope-of-service adjustments described in subdivision (e). Extraordinary circumstances include, but are not limited to, acts of nature, changes in applicable requirements in the Health and Safety Code, changes in applicable licensure requirements, and changes in applicable rules or regulations. Mere inflation of costs alone, absent extraordinary

circumstances, shall not be grounds for supplemental payment. If an FQHC's or RHC's PPS rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, then a supplemental payment is not warranted.

(2) The department shall accept requests for supplemental payment at any time throughout the prospective payment rate year.

(3) Requests for supplemental payments shall be submitted in writing to the department and shall set forth the reasons for the request. Each request shall be accompanied by sufficient documentation to enable the department to act upon the request. Documentation shall include the data necessary to demonstrate that the circumstances for which supplemental payment is requested meet the requirements set forth in this section. Documentation shall include all of the following:

(A) A presentation of data to demonstrate reasons for the FQHC's or RHC's request for a supplemental payment.

(B) Documentation showing the cost implications. The cost impact shall be material and significant, two hundred thousand dollars (\$200,000) or 1 percent of a facility's total costs, whichever is less.

(4) A request shall be submitted for each affected year.

(5) Amounts granted for supplemental payment requests shall be paid as lump-sum amounts for those years and not as revised PPS rates, and shall be repaid by the FQHC or RHC to the extent that it is not expended for the specified purposes.

(6) The department shall notify the provider of the department's discretionary decision in writing.

(g) (1) An FQHC or RHC "visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse. For purposes of this section, "physician" shall be interpreted in a manner consistent with the Centers for Medicare and Medicaid Services' Medicare Rural Health Clinic and Federally Qualified Health Center Manual (Publication 27), or its successor, only to the extent that it defines the professionals whose services are reimbursable on a per-visit basis and not as to the types of services that these professionals may render during these visits and shall include a medical doctor, osteopath, podiatrist, dentist, optometrist, and chiropractor. A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a comprehensive perinatal services practitioner, as defined in Section 51179.1 of Title 22 of the California Code of Regulations, providing comprehensive perinatal services, a four-hour day of attendance at an adult day health care center, and any other provider identified in the state plan's definition of an FQHC or RHC visit.

(2) (A) A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a dental hygienist or a dental hygienist in alternative practice.

(B) Notwithstanding subdivision (e), an FQHC or RHC that currently includes the cost of the services of a dental hygienist in alternative practice for the purposes of establishing its FQHC or RHC rate shall apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, shall bill these services as a separate visit. However, multiple encounters with dental professionals that take place on the same day shall constitute a single visit. The department shall develop the

appropriate forms to determine which FQHC's or RHC rates shall be adjusted and to facilitate the calculation of the adjusted rates. An FQHC's or RHC's application for, or the department's approval of, a rate adjustment pursuant to this subparagraph shall not constitute a change in scope of service within the meaning of subdivision (e). An FQHC or RHC that applies for an adjustment to its rate pursuant to this subparagraph may continue to bill for all other FQHC or RHC visits at its existing per-visit rate, subject to reconciliation, until the rate adjustment for visits between an FQHC or RHC patient and a dental hygienist or a dental hygienist in alternative practice has been approved. Any approved increase or decrease in the provider's rate shall be made within six months after the date of receipt of the department's rate adjustment forms pursuant to this subparagraph and shall be retroactive to the beginning of the fiscal year in which the FQHC or RHC submits the request, but in no case shall the effective date be earlier than January 1, 2008.

(C) An FQHC or RHC that does not provide dental hygienist or dental hygienist in alternative practice services, and later elects to add these services, shall process the addition of these services as a change in scope of service pursuant to subdivision (e).

(h) If FQHC or RHC services are partially reimbursed by a third-party payer, such as a managed care entity (as defined in Section 1396u-2(a)(1)(B) of Title 42 of the United States Code), the Medicare Program, or the Child Health and Disability Prevention (CHDP) program, the department shall reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate, and may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

(i) (1) An entity that first qualifies as an FQHC or RHC in the year 2001 or later, a newly licensed facility at a new location added to an existing FQHC or RHC, and any entity that is an existing FQHC or RHC that is relocated to a new site shall each have its reimbursement rate established in accordance with one of the following methods, as selected by the FQHC or RHC:

(A) The rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or adjacent area with a similar caseload.

(B) In the absence of three comparable FQHCs or RHCs with a similar caseload, the rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or an adjacent service area, or in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics.

(C) At a new entity's one-time election, the department shall establish a reimbursement rate, calculated on a per-visit basis, that is equal to 100 percent of the projected allowable costs to the FQHC or RHC of furnishing FQHC or RHC services during the first 12 months of operation as an FQHC or RHC. After the first 12-month period, the projected per-visit rate shall be increased by the Medicare Economic Index then in effect. The projected allowable costs for the first 12 months shall be cost settled and the prospective payment reimbursement rate shall be adjusted based on actual and allowable cost per visit.

(D) The department may adopt any further and additional methods of

setting reimbursement rates for newly qualified FQHCs or RHCs as are consistent with Section 1396a(bb)(4) of Title 42 of the United States Code.

(2) In order for an FQHC or RHC to establish the comparability of its caseload for purposes of subparagraph (A) or (B) of paragraph (1), the department shall require that the FQHC or RHC submit its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report. FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit to the department a completed report in the format applicable to the prior calendar year. FQHCs or RHCs that have not previously submitted an annual utilization report shall submit to the department a completed report in the format applicable to the prior calendar year. The FQHC or RHC shall not be required to submit the annual utilization report for the comparable FQHCs or RHCs to the department, but shall be required to identify the comparable FQHCs or RHCs.

(3) The rate for any newly qualified entity set forth under this subdivision shall be effective retroactively to the later of the date that the entity was first qualified by the applicable federal agency as an FQHC or RHC, the date a new facility at a new location was added to an existing FQHC or RHC, or the date on which an existing FQHC or RHC was relocated to a new site. The FQHC or RHC shall be permitted to continue billing for Medi-Cal covered benefits on a fee-for-service basis until it is informed of its enrollment as an FQHC or RHC, and the department shall reconcile the difference between the fee-for-service payments and the FQHC's or RHC's prospective payment rate at that time.

(j) Visits occurring at an intermittent clinic site, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, of an existing FQHC or RHC, or in a mobile unit as defined by paragraph (2) of subdivision (b) of Section 1765.105 of the Health and Safety Code, shall be billed by and reimbursed at the same rate as the FQHC or RHC establishing the intermittent clinic site or the mobile unit, subject to the right of the FQHC or RHC to request a scope-of-service adjustment to the rate.

(k) An FQHC or RHC may elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. These costs shall be adjusted out of the FQHC's or RHC's clinic base rate as scope-of-service changes. An FQHC or RHC that reverses its election under this subdivision shall revert to its prior rate, subject to an increase to account for all MEI increases occurring during the intervening time period, and subject to any increase or decrease associated with applicable scope-of-services adjustments as provided in subdivision (e).

(l) FQHCs and RHCs may appeal a grievance or complaint concerning ratesetting, scope-of-service changes, and settlement of cost report audits, in the manner prescribed by Section 14171. The rights and remedies provided under this subdivision are cumulative to the rights and remedies available under all other provisions of law of this state.

(m) The department shall, by no later than March 30, 2008, promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the

extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for Medicare and Medicaid Services for any waivers that would be necessary to implement this section.

(n) The department shall implement this section only to the extent that federal financial participation is obtained.

14132.101. (a) Notwithstanding paragraphs (4) and (5) of subdivision (e) of Section 14132.100, a scope-of-service change request, whether mandatory or permissive, shall be timely when filed within 150 days following the beginning of the federally qualified health center's or rural health clinic's fiscal year following the year in which the change occurred.

(b) Notwithstanding subdivision (a), and notwithstanding subdivision (e) of Section 14132.100, a federally qualified health center described in Section 14132.102 shall be deemed to have filed a scope-of-service change in a timely manner upon compliance with the requirements set forth in subdivision (c) of Section 14132.102.

14132.102. (a) With the exception of clinics and hospital outpatient departments that are subject to Section 14105.24, federally qualified health centers (FQHCs) that are receiving cost-based reimbursement under the terms of the Los Angeles County 1115 Waiver Demonstration Project on June 30, 2005, shall be required to transition to a prospective payment system (PPS) rate upon expiration of that waiver. These FQHCs shall be referred to in this section as "Los Angeles cost-based FQHCs."

(b) For visits occurring on or after July 1, 2005, Los Angeles cost-based FQHCs shall receive a PPS rate equivalent to the following:

(1) FQHC sites that were in existence during the FQHC's 2000 fiscal year shall be permitted to elect their 2000 per-visit rates or the average of the 1999 and 2000 per-visit rates as reported on the cost reports submitted for those fiscal years adjusted as described in subdivision (c).

(2) FQHC sites that were first qualified as an FQHC after the site's 2000 fiscal year shall receive a base rate equivalent to the first full fiscal year rate, as audited on the cost report submitted for that fiscal year and adjusted as described in subdivision (c).

(3) Sites that were first qualified as an FQHC after the site's 2000 fiscal year, and that have not yet filed a cost report for their first full fiscal year shall have a rate set in accordance with subdivision (i) of Section 14132.100 and adjusted as described in subdivision (c).

(c) The base rates described in this section shall be adjusted in the manner described in subdivision (d), paragraphs (1), (2), (3), and (7) of subdivision (e), and subdivision (f) of Section 14132.100.

(d) For Los Angeles cost-based FQHCs, as defined in subdivision (a), no new cost reports shall be required in order to claim scope-of-service changes occurring in fiscal years prior to July 1, 2005. Only the following information shall be required by the department:

(1) A description of the events triggering any applicable rate changes in the form of Worksheet 1 of the Change in Scope-of-Service Request form developed for fiscal years 2004 and thereafter, modified to identify the applicable fiscal year in which the scope change occurred.

(2) The two worksheets to the Change in Scope-of-Service Request form summarizing the health center's health care practitioners and services for the applicable fiscal year or years.

(e) Change in Scope-of-Service Request forms for changes occurring prior to July 1, 2005, shall be filed with the department no later than July 1, 2006, and shall be deemed to have been filed only when both the Medi-Cal cost report for the applicable period and the referenced Change in Scope-of-Service Request form worksheets have been filed with the department. The date of filing shall be the date on which either the Medi-Cal cost report or the referenced Change in Scope-of-Service Request forms are received by the department, whichever is later.

(f) Notwithstanding Section 14132.107, the department shall calculate a tentative scope-of-service rate adjustment based on 80 percent of the difference in the "as reported" scope-of-service per visit cost. This adjustment shall occur no later than 150 days after receipt of the Medi-Cal cost report and the referenced Change in Scope-of-Service Request forms. Within 12 months after receipt of request forms, the department shall complete its FQHC fiscal year audit of the Medi-Cal cost report and associated Change in Scope-of-Service Request and final rate adjustment pursuant to that audit. The final rate adjustment will be retroactive to July 1, 2005. Nothing in this subdivision shall be construed to extend the time period for review and finalization of cost reports as set forth in Section 14170.

(g) The department shall, by no later than March 30, 2006, promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for Medicare and Medicaid Services for any waivers that would be necessary to implement this section.

(h) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and only to the extent that all necessary federal approvals are obtained and there is an appropriation for the purposes of implementing this section, the department may implement this section without taking any regulatory action and by means of a provider bulletin or similar instructions.

14132.107. Claims for reimbursement under subdivision (e) of Section 14132.100 shall be finalized by the department within 150 days of receipt of the claims for reimbursement. These claims for reimbursement shall be paid within 30 days of being finalized by the department. However, the payment of those amounts that are disputed shall be subject to the requirements, timeframes, and procedures specified in Section 14171. Scope changes going forward shall be finalized within 90 days of receipt and paid within 30 days of being finalized by the department.

14132.108. Notwithstanding any other provision of law, requests for rate adjustments for scope-of-service rate changes under paragraph (4) of subdivision (e) of Section 14132.100 for an FQHC's or RHC's fiscal year ending in 2004 shall be deemed to have been filed in a timely manner so long as it is filed within 90 days following the end of the 150-day timeframe applicable to scope-of-service changes occurring from January 1, 2001, to the end of an FQHC's or RHC's 2003 fiscal year, as specified in paragraph (6) of subdivision (e) of Section 14132.100.

14132.15. For purposes of subdivision (p) of Section 14132, "rehabilitation services" means services intended to assist physically or cognitively impaired persons to achieve or regain their maximum functional potential for mobility, self-care, and independent living.

14132.16. Mammography for screening or diagnostic purposes upon the referral of a patient's physician shall be covered under this chapter on or after January 1, 1988, to the extent required or permitted by federal law.

14132.17. Annual cervical cancer tests for screening or diagnostic purposes, upon the referral of a patient's physician, is a covered benefit under this chapter, on or after January 1, 1991, to the extent required or permitted by federal law.

14132.18. (a) Community supported living arrangement services approved by the United States Department of Health and Human Services in accordance with Section 1396v of Title 42 of the United States Code is a covered benefit under this chapter to the extent that federal financial participation is available for those services and shall be subject to the terms, conditions, and duration of any waiver obtained from the Secretary of the United States Department of Health and Human Services.

(b) (1) The department, in consultation with the State Department of Developmental Services, shall submit an application to the secretary for approval to provide community supported living arrangement services and seek any federal waivers necessary to implement this subdivision.

(2) State matching funds for the federal medicaid funding shall come out of purchase of services funds of the regional centers, established pursuant to Article 1 (commencing with Section 4620) of Chapter 5 of Division 4.5 and it is the intent of the Legislature that no new funds from the General Fund shall be appropriated for this purpose.

(c) The department, in consultation with the State Department of Developmental Services, shall establish and maintain program standards for quality assurance and minimum protection to protect the

health, safety, and welfare of individuals receiving community supported living arrangement services and as otherwise necessary to implement this section.

(d) In order to facilitate the design and development of community supported living arrangement services; program regulations implementing, interpreting, or making specific the provisions of subdivision (a) shall not be subject to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. This subdivision shall become inoperative on January 1, 1997.

(e) If the provision of community supported living arrangements as a covered benefit under this chapter receive federal approval, the department shall collect patient-specific cost data and compare the costs of providing community supported living arrangements under this chapter with the costs experienced prior to the provision of community supported living arrangements as a covered benefit under this chapter.

(f) This section shall cease to be operative if the Director of Health Services determines (1) California's application for federal funds under the community supported living arrangements medicaid state plan option is not accepted; (2) California's application for renewal of funding for community supported living arrangements is not accepted during the course of the grant; (3) federal funding for community supported living arrangements ceases to be available; or (4) California determines that it no longer chooses to participate in the community supported living arrangements medicaid state plan option.

14132.21. The department, in consultation with the State Department of Alcohol and Drug Programs, shall assess the feasibility of applying to the federal Health Care Financing Administration for a Medicaid State Plan amendment to provide targeted case management to pregnant substance-abusing women and women who have given birth to a drug-exposed or alcohol-exposed infant. These women may be identified through self-referral, family planning or health clinics, public or private hospitals, drug treatment programs, the Medi-Cal program, or other public assistance or health treatment programs. Women eligible for services under the targeted case management program would be provided the following case management services:

(a) Intake and service needs assessment of women currently receiving Medi-Cal benefits.

(b) Development of a coordinated health and treatment plan for the eligible woman and her infant, listing needed services.

(c) Case management services to assist with gaining access to needed medical, social, educational, and other services.

(d) Referral to any of the following programs that are listed in the woman's health and treatment plan:

(1) Child Health and Disability Prevention Program.

(2) Supplementary Food Program for Women, Infants, and Children (WIC).

(3) Drug abuse treatment and detoxification programs.

(4) In-home support services to enhance the woman's utilization of drug treatment programs, and prenatal and perinatal care services.

(5) Transportation to health and drug treatment services.

(6) Crisis assistance to address health and drug treatment needs.

(7) Other case management services authorized by the federal Health Care Financing Administration.

14132.22. (a) For purposes of this section, dental restorative materials are limited to composite resin, glass ionomer cement, resin ionomer cement, and amalgam, as described on the Dental Board of California's dental materials factsheet.

(b) A provider of services that includes the provision of dental restorative materials to a beneficiary under this chapter may recommend, after consultation with the beneficiary, a dental restorative material other than the covered benefit of amalgam.

(c) A provider may claim and receive the reimbursement rate for an amalgam restoration when using a different dental restorative material.

14132.23. (a) (1) Except as set forth in paragraph (2), and notwithstanding any other provision of law or regulation, the active and retentive phases of orthodontic treatment covered under the Medi-Cal program shall be reimbursed on a quarterly basis, as determined by dividing the sum of the authorized treatment allowances by the estimated number of three-month periods that the patient's treatment will require, subject to the department's utilization controls.

(2) The retentive phase of orthodontic treatment shall be reimbursed pursuant to paragraph (1) only until the department implements the Code on Dental Procedures and Nomenclature, as published by the American Dental Association in its Current Dental Terminology manual, at which time paragraph (1) shall not apply to retentive phase orthodontic services that are covered under the Medi-Cal program.

(b) This section shall become operative on July 1, 2008.

14132.24. (a) The department shall develop and implement a program to provide a community-living support benefit to eligible Medi-Cal beneficiaries. The department shall submit any waiver application, modification of any existing waiver, or amendment to the Medicaid state plan, that is necessary to provide this benefit, and shall implement the benefit only to the extent that federal financial participation is available.

(b) The community-living support benefit shall include both of the following:

(1) (A) Reimbursement for an array of health-related and psychosocial services provided or coordinated at community-based housing sites that enable beneficiaries to remain in the least restrictive and most homelike environment while receiving the health-related services, including personal care and psychosocial services, necessary to protect their health and well-being. These community-based housing units may include, but are not limited to, the living area or unit within a facility that is specifically designed to provide ongoing assisted living services, licensed residential care facilities for the elderly, publicly funded senior

and disabled housing projects, or supportive housing sites that serve chronically homeless individuals with chronic or disabling health conditions.

(B) For purposes of this section, "assisted living services" includes, but is not limited to, assistance with personal activities of daily living, including dressing, feeding, toileting, bathing, grooming, mobility, and associated tasks, to help provide for and maintain physical and psychological comfort.

(2) Access to community-living support services provided or coordinated at the community-based housing site, including, but not limited to, the personal care and health services specified in paragraph (8) of subdivision (a) of Section 1788 of the Health and Safety Code, and the health related support services specified in Section 53290 of the Health and Safety Code.

(c) Services available through the community-living support benefit shall not duplicate services available through the Medi-Cal state plan, other Medi-Cal waivers, or other programs financed by the state.

(d) An individual shall be eligible for the community-living support benefit if he or she is eligible for the Medi-Cal program, is a resident of San Francisco who would otherwise be homeless, living in shelters, or institutionalized, and meets one or both of the following criteria:

(1) The State Department of Mental Health determines that he or she would benefit from supportive housing, as defined in subdivision (c) of Section 53260 of the Health and Safety Code.

(2) The department determines that he or she is eligible for placement in a skilled nursing facility, as defined in subdivision (c) of Section 1250 of the Health and Safety Code, or an intermediate care facility, as defined in subdivision (d) of that section.

(e) The department may modify the eligibility criteria specified in subdivision (d), if needed, to qualify the community-living support benefit for federal financial participation.

(f) The department shall seek to maximize resources for community-based housing by coordinating the community-living support benefit with existing efforts to coordinate care, improve health outcomes, and reduce long-term care costs for the targeted population.

(g) This section shall be implemented only upon adoption of a resolution by the Board of Supervisors of the City and County of San Francisco providing county funds for use by the state to match federal Medicaid funds to receive federal funds for services provided under the waiver specified in this section, and for any costs associated with implementing and monitoring the waiver, to limit additional state costs.

14132.25. On or before July 1, 1983, the State Department of Health Services shall establish a subacute care program in health facilities in order to more effectively use the limited Medi-Cal dollars available while, at the same time, ensuring needed services for these patients. The subacute care program shall be available to patients in facilities who meet subacute care criteria. Subacute care may be provided by any facility designated by the director as meeting the subacute care criteria, and which has an approved provider participation agreement with the State Department of Health

Services.

The State Department of Health Services shall develop a rate of reimbursement for this subacute care program. Reimbursement rates will be determined in accordance with methodology developed by the State Department of Health Services, specified in regulation, and may include the following:

- (1) All inclusive per diem rates.
- (2) Individual patient specific rates according to the needs of the individual subacute care patient.
- (3) Other rates subject to negotiation with the health facility.

However, reimbursement at subacute care rates shall only be implemented when funds are available for this purpose pursuant to the annual Budget Act.

The department may negotiate and execute an agreement with any health facility which meets the standards for providing subacute care. An agreement may be negotiated or established between the health facility and the department for subacute care based on individual patient assessment. The department shall establish level of care criteria and appropriate utilization controls for patients eligible for the subacute care program.

For the purposes of this section, subacute patient care shall be defined by the state department based on the results of its study pursuant to Chapter 1211 of the Statutes of 1980.

14132.26. (a) The department shall develop a program that requires a waiver of federal law to test the efficacy of providing an assisted living benefit to beneficiaries under the Medi-Cal program. Assisted living benefits shall include, but are not limited to, the care and supervision activities specified in Section 1569.2 of the Health and Safety Code and Section 87101 of Title 22 of the California Code of Regulations, and other health-related services. The program developed pursuant to this section shall be known as the waiver program for purposes of this section. The department shall submit any necessary waiver applications or modifications to the medicaid state plan to the Health Care Financing Administration to implement the waiver program, and shall implement the waiver program only to the extent federal financial participation is available.

(b) The department shall develop the waiver program in conjunction with other state departments, consumers, consumer advocates, housing and service providers, and experts in the fields of gerontology, geriatric health, nursing services, and independent living.

(c) The assisted living benefit shall be designed to provide eligible individuals with a range of services that enable them to remain in the least restrictive and most homelike environment while receiving the medical and personal care necessary to protect their health and well-being. Benefits provided pursuant to this waiver program shall include only those not otherwise available under the state plan, and may include, but are not limited to, medicine management, coordination with a primary health care provider, and case management.

(d) (1) Eligible individuals shall be those who are eligible for the Medi-Cal program and are determined by the department to be eligible for placement in a nursing facility, as defined under subdivisions (c) and (d) of Section 1250 of the Health and Safety Code. Eligibility shall be based on an assessment of an individual's

ability to perform functional and instrumental activities of daily living, as well as the individual's medical diagnosis and prognosis, and other criteria, including other Medi-Cal services that the beneficiary is receiving, as specified in the waiver.

(2) An eligible individual shall participate in the waiver program only if he or she is fully informed of the program and the nature of the assisted living benefit and indicates in writing his or her choice to participate.

(e) (1) The waiver program shall test the effectiveness of providing a Medi-Cal assisted living benefit through two service delivery approaches, as specified in paragraphs (2) and (3).

(2) Under the first model, an assisted living benefit shall be provided to residents of licensed residential care facilities. Facility participation in the program shall be determined by the department in conjunction with the State Department of Social Services and in accordance with the criteria for participation specified in the waiver. Under this model the facility operator shall be responsible for the provision of services allowed under the benefit, either directly or through contracts with other provider agencies, as permitted and specified in the waiver. During participation in the waiver program, residential care facilities shall comply with all terms and conditions of the waiver. The department and the State Department of Social Services, may, as determined necessary and appropriate, waive provisions contained in Division 2 (commencing with Section 1200) of the Health and Safety Code, subdivision (h) of Section 14132.95, and Title 22 of the California Code of Regulations for facilities providing services to waiver program participants.

(3) Under the second model, an assisted living benefit shall be provided to residents in publicly funded senior and disabled housing projects. Under this model an independent agency, pursuant to a contract with the department, shall be responsible for the provision of case management and other services to eligible individuals, as specified in the waiver.

(f) The department shall evaluate the effectiveness of the waiver program.

(1) The evaluation shall include, but not be limited to, participant satisfaction, health, and safety, the quality of life of the participant receiving the assisted living benefit, and demonstration of the cost neutrality of the waiver program as specified in federal guidelines.

(2) The evaluation shall estimate the projected savings, if any, in the budgets of state and local governments if the program was expanded statewide.

(3) The evaluation shall be submitted to the appropriate policy and fiscal committees of the Legislature on or before January 1, 2003.

(g) The department shall limit the number of participants in the waiver program during the initial three years of its operation to a number that will be statistically significant for purposes of the program evaluation and that meets any requirements of the federal Health Care Financing Administration, including a request to waive statewide implementation requirements for the waiver program during the initial years of evaluation.

(h) In implementing this section, the department may enter into contracts for the provision of essential administrative and other services. Contracts entered into under this section may be on a

noncompetitive bid basis, and shall be exempt from the requirements of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(i) The department shall not implement the waiver program specified in subdivision (a) if the benefits provided pursuant to the waiver program will result in additional costs to the Medi-Cal program.

(j) The waiver program shall be developed and implemented only to the extent that funds are appropriated or otherwise available for that purpose.

14132.27. (a) (1) The department shall apply for a waiver of federal law pursuant to Section 1396n of Title 42 of the United States Code to test the efficacy of providing a disease management benefit to beneficiaries under the Medi-Cal program. A disease management benefit shall include, but not be limited to, the use of evidence-based practice guidelines, supporting adherence to care plans, and providing patient education, monitoring, and healthy lifestyle changes.

(2) The waiver developed pursuant to this section shall be known as the Disease Management Waiver. The department shall submit any necessary waiver applications or modifications to the Medicaid State Plan to the federal Centers for Medicare and Medicaid Services to implement the Disease Management Waiver, and shall implement the waiver only to the extent federal financial participation is available.

(b) The Disease Management Waiver shall be designed to provide eligible individuals with a range of services that enable them to remain in the least restrictive and most homelike environment while receiving the medical care necessary to protect their health and well-being. Services provided pursuant to this waiver program shall include only those not otherwise available under the state plan, and may include, but are not limited to, medication management, coordination with a primary care provider, use of evidence-based practice guidelines, supporting adherence to a plan of care, patient education, communication and collaboration among providers, and process and outcome measures. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waiver.

(c) Eligibility for the Disease Management Waiver shall be limited to those persons who are eligible for the Medi-Cal program as aged, blind, and disabled persons or those persons over 21 years of age who are not enrolled in a Medi-Cal managed care plan, or eligible for the federal Medicare program, and who are determined by the department to be at risk of, or diagnosed with, select chronic diseases, including, but not limited to, advanced atherosclerotic disease syndromes, congestive heart failure, and diabetes. Eligibility shall be based on the individual's medical diagnosis and prognosis, and other criteria, as specified in the waiver.

(d) The Disease Management Waiver shall test the effectiveness of providing a Medi-Cal disease management benefit. The department shall evaluate the effectiveness of the Disease Management Waiver.

(1) The evaluation shall include, but not be limited to, participant satisfaction, health and safety, the quality of life of the participant receiving the disease management benefit, and

demonstration of the cost neutrality of the Disease Management Waiver as specified in federal guidelines.

(2) The evaluation shall estimate the projected savings, if any, in the budgets of state and local governments if the Disease Management Waiver was expanded statewide.

(3) The evaluation shall be submitted to the appropriate policy and fiscal committees of the Legislature on or before January 1, 2008.

(e) The department shall limit the number of participants in the Disease Management Waiver during the initial three years of its operation to a number that will be statistically significant for purposes of the waiver evaluation and that meets any requirements of the federal government, including a request to waive statewide implementation requirements for the waiver during the initial years of evaluation.

(f) In undertaking this Disease Management Waiver, the director may enter into contracts for the purpose of directly providing Disease Management Waiver services.

(g) The department shall seek all federal waivers necessary to allow for federal financial participation under this section.

(h) The Disease Management Waiver shall be developed and implemented only to the extent that funds are appropriated or otherwise available for that purpose.

(i) The department shall not implement this section if any of the following apply:

(1) The department's application for federal funds under the Disease Management Waiver is not accepted.

(2) Federal funding for the waiver ceases to be available.

14132.28. (a) If the department decides to terminate or not renew a health facility's subacute care services provider contract, the department shall notify the health facility 30 days before the termination or nonrenewal becomes effective.

(b) (1) Once the department has notified the health facility pursuant to subdivision (a), the department shall provide guidance to the health facility regarding expectations for the transfer of patients. The guidance shall consider the need to minimize trauma of a patient due to transfer, and shall ensure, prior to any transfer or discharge, that the facility has complied with the transfer and discharge requirements of Section 1336.2 of the Health and Safety Code, subsection (a) of Section 483.12 of Title 42 of the Code of Federal Regulations, and any other state and federal laws applicable to the transfer and discharge of patients of a nursing facility, as defined in subdivision (k) of Section 1250 of the Health and Safety Code. The department's Medi-Cal division shall coordinate with the department's Licensing and Certification Division in developing the guidance for the protection of patients' transfer rights.

(2) Prior to any transfer, the health facility shall continue to provide the subacute level of services required by a patient and shall comply with state laws governing subacute staffing levels. The health facility shall continue to be paid commensurate with that subacute level of service. If the health facility fails to comply with applicable state laws regarding subacute staffing levels, the facility shall be paid at the facility's Medi-Cal nursing facility rate.

(3) Any health facility that has a subacute services provider contract that has been terminated or has not been renewed may not be reimbursed commensurate with the subacute level of service for patients admitted after the contract is terminated or not renewed, unless and until the facility obtains a new subacute services provider contract. The facility may be reimbursed commensurate with the subacute level of service where the patient returns to the facility during the bed-hold period. Where the patient returns to the facility following the bed-hold period, the facility shall be reimbursed at the facility's Medi-Cal nursing facility rate.

14132.29. (a) A health facility that has a subacute services provider contract with the department under this chapter shall comply with the patient transfer and discharge requirements of this section.

(b) Before patients are transferred due to any change in the status of the license or operation of the facility, including the termination of the subacute services provider contract by the department, the facility shall comply with the transfer and discharge requirements of Section 1336.2 of the Health and Safety Code, subsection (a) of Section 483.12 of Title 42 of the Code of Federal Regulations, and any other state and federal laws applicable to the transfer and discharge of patients of a nursing facility, as defined in subdivision (k) of Section 1250 of the Health and Safety Code.

(c) All of the rights and procedures that apply to the appeal of the transfer or discharge of a nursing facility patient pursuant to the sections cited in subdivision (b) shall apply to an appeal pursuant to this subdivision. The facility shall ensure that each patient and patient's representative is notified of this right to appeal. The notification shall be in writing and shall be communicated in a language and manner that is understood by the patient or patient's representative.

14132.3. In addition to any other criteria as provided in subdivision (p) of Section 14132, no reimbursement shall be made pursuant to this chapter for any service in a general acute care hospital for which a special permit or a supplemental service approval is required pursuant to Section 1256.1 of the Health and Safety Code unless that general acute care hospital has first obtained a special permit or a supplemental service approval from the State Department of Health Services.

14132.34. (a) Human milk and human milk derivatives supplied by a mothers' milk bank for human consumption are a covered service under this chapter.

(b) For purposes of this section, "mothers' milk bank" means any person, firm, or corporation which engages in the not-for-profit procurement, processing, storage, distribution, or use of human milk, contributed by volunteer donors, in compliance with standards prescribed by the Human Milk Banking Association of North America.

14132.35. (a) Outpatient rehabilitation services are covered under this chapter, subject to utilization controls.

(b) The department and the Medi-Cal field offices shall not discriminate against elderly recipients in authorizing services under this section, and shall recognize the importance of rehabilitation services in allowing elderly persons to remain independent and at home.

(c) Rehabilitation services may be provided in group settings, including what is referred to as stroke centers which offer programs and group training for adults in therapeutic exercise, activities of daily living, speech remediation, or counseling.

(d) In order to be eligible for reimbursement under this section, stroke centers shall be certified as participating providers and meet the rules and regulations of the department. Stroke centers shall meet the requirements for licensure of either adult day health care centers or outpatient rehabilitation clinics.

14132.36. (a) To the extent that federal financial participation becomes available, residential care for alcohol and drug exposed pregnant women and women in the postpartum perinatal period is a covered service under this chapter, subject to utilization controls.

(b) For purposes of this section, "residential care" shall consist of those services specified in the interagency agreement between the State Department of Alcohol and Drug Programs and the State Department of Health Services.

(c) The State Department of Alcohol and Drug Programs shall be the agency responsible for establishing the residential care programs. The department shall, for the purposes of this section, provide funds from the department's budget for the purpose of obtaining federal matching funds under Title XIX of the Social Security Act (42 U.S.C. Sec. 1396, and following) for the residential care programs.

14132.38. (a) Home infusion treatments with tocolytic agents for pregnant women shall be covered under this chapter. This coverage shall be subject to both of the following:

(1) Utilization controls.

(2) Clinical guidelines or protocols as outlined in peer-reviewed professional journals.

(b) By October 1, 2009, the department shall prepare, or contract for the preparation of, a report evaluating the medical effectiveness and cost-effectiveness of infusion treatments with tocolytic agents. The report shall determine, to the extent possible, changes in the health, birth weight, and length of term for newborns using tocolytic treatments, and shall provide a comparison to a representative control population that does not use tocolytic treatments. The report shall include a summary of peer-reviewed research findings on the effectiveness of tocolytic agents in the medical literature.

(c) This section shall remain in effect only until January 1, 2010,

and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2010, deletes or extends that date.

14132.39. Midwifery services provided by a licensed midwife shall be covered under this chapter, to the extent that federal financial participation is available, and, subject to utilization controls.

14132.4. Nurse-midwifery services provided by a certified nurse-midwife shall be covered under the provisions of this chapter, to the extent required by federal law, subject to utilization controls.

14132.41. (a) Services provided by a certified nurse practitioner shall be covered under this chapter to the extent authorized by federal law, and subject to utilization controls. The department shall permit a certified nurse practitioner to bill Medi-Cal independently for his or her services. If a certified nurse practitioner chooses to bill Medi-Cal independently for his or her services, the department shall make payment directly to the certified nurse practitioner.

(b) For purposes of this section, "certified" means nationally board certified in a recognized specialty.

14132.42. Benefits under this chapter shall not be restricted for inpatient hospital care to a time period less than 48 hours following a normal vaginal delivery and less than 96 hours following delivery by caesarean section. However, coverage for inpatient hospital care may be for a time period less than 48 or 96 hours following a delivery if both of the following conditions are met:

(a) The decision to discharge the mother and newborn before the 48- or 96-hour time period is made by the treating physicians in consultation with the mother.

(b) A postdischarge followup visit for the mother and newborn within 48 hours of discharge, when prescribed by the treating physician, is also a covered benefit under this chapter. The visit shall be by a licensed health care provider whose scope of practice includes postpartum care and newborn care. The visit shall include, at a minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The treating physician shall disclose to the mother the availability of a postdischarge visit, including an in-home visit, physician office visit, or plan facility visit. The treating physician, in consultation with the mother, shall determine whether the postdischarge visit shall occur at home, the plan's facility, or the treating physician's office after assessment of certain factors. These factors shall include, but not be limited to, the transportation needs of the family and environmental and social risks.

14132.44. (a) Targeted case management (TCM), pursuant to Section 1915(g) of the Social Security Act as amended by Public Law 99-272 (42 U.S.C. Sec. 1396n(g)), shall be covered as a benefit, effective January 1, 1995. Nothing in this section shall be construed to require any local governmental agency to implement TCM.

(b) A TCM provider furnishing TCM services shall be a local governmental agency under contract with the department to provide TCM services. Local educational agencies shall not be providers of case management services under this section.

(c) A TCM provider may contract with a nongovernmental entity or the University of California, or both, to provide TCM services on its behalf under the conditions specified by the department in regulations.

(d) Each TCM provider shall have all of the following:

(1) Established procedures for performance monitoring.

(2) A countywide system to prevent duplication of services and to ensure coordination and continuity of care among providers of case management services provided to beneficiaries who are eligible to receive case management services from two or more programs.

(3) A fee mechanism effective January 1, 1995, specific to TCM services provided, which may vary by program.

(e) A TCM service provider, a nongovernmental entity or the University of California, or both, under contract with a TCM provider may provide TCM services to one or all of the following groups of Medi-Cal beneficiaries, which shall be defined in regulation:

(1) High-risk persons.

(2) Persons who have language or other comprehension barriers.

(3) Persons on probation.

(4) Persons who have exhibited an inability to handle personal, medical, or other affairs.

(5) Persons abusing alcohol or drugs, or both.

(6) Adults at risk of institutionalization.

(7) Adults at risk of abuse or neglect.

(f) (1) A local governmental agency that elects to provide TCM services to the groups specified in subdivision (e) shall, for each fiscal year, for the purpose of obtaining federal medicaid matching funds, submit an annual cost report as prescribed by the department that certifies all of the following:

(A) The availability and expenditure of 100 percent of the nonfederal share for the provision of TCM services from the local governmental agency's general fund or from any other funds allowed under federal law and regulation.

(B) The amount of funds expended on allowable TCM services.

(C) Its expenditures represent costs that are eligible for federal financial participation.

(D) The costs reflected in the annual cost reports used to determine TCM rates are developed in compliance with the definitions contained in the Office of Management and Budget (OMB) Circular A-87.

(E) Case management services provided in accordance with Section 1396n(g) of Title 42 of the United States Code will not duplicate case management services provided under any home- and community-based services waiver.

(F) Claims for providing case management services pursuant to this section will not duplicate claims made to public agencies or private entities under other program authorities for the same purposes.

(G) The requirements of subdivision (d) have been met.

(2) The department shall deny any claim if it determines that any certification required by this subdivision is not adequately supported for purposes of federal financial participation.

(g) Only a local governmental agency may submit TCM service claims to the department for the performance of TCM services.

(h) During the period from January 1, 1995, through June 30, 1995, TCM services shall be reimbursed according to the interim mechanism developed by the state and the Health Care Financing Administration, which is reflected in the document entitled "Agreement Between the Health Care Financing Administration and the State of California, Department of Health Services." For the 1995-96 fiscal year, the department shall establish an initial rate of reimbursement. Effective July 1, 1996, and thereafter, TCM services shall be reimbursed in accordance with regulations that shall be adopted by the department.

(i) The department, in consultation with local governmental agencies, and consistent with federal regulations, and the State Medicaid Manual of the Department of Health and Human Services, Health Care Financing Administration, shall adopt regulations that define TCM services, establish the standards under which TCM services qualify as a Medi-Cal reimbursable service, prescribe the methodology for determining the rate of reimbursement, and establish a claims submission and processing system and method to certify local matching expenditures.

(j) (1) Notwithstanding any other provision of this section, the state shall be held harmless, in accordance with paragraphs (2) and (3) from any federal audit disallowance and interest resulting from payments made by the federal medicaid program as reimbursement for claims for providing TCM services pursuant to this section, less the amounts already remitted to the state pursuant to subdivision (m) for the disallowed claim.

(2) To the extent that a federal audit disallowance and interest results from a claim or claims for which any local governmental agency has received reimbursement for TCM services, the department shall recoup from the local governmental agency that submitted that disallowed claim, through offsets or by a direct billing, amounts equal to the amount of the disallowance and interest, in that fiscal year, less the amounts already remitted to the state pursuant to subdivision (m) for the disallowed claim. All subsequent claims submitted to the department applicable to any previously disallowed claim, may be held in abeyance, with no payment made, until the federal disallowance issue is resolved.

(3) Notwithstanding paragraphs (1) and (2), to the extent that a federal audit disallowance and interest results from a claim or claims for which the local governmental agency has received reimbursement for TCM services performed by a nongovernmental entity or the University of California, or both, under contract with, and on behalf of, the participating local governmental agency, the department shall be held harmless by that particular local governmental agency for 100 percent of the amount of any such federal audit disallowance and interest, less the amounts already remitted to the state pursuant to subdivision (m) for the disallowed claim.

(k) The use of local matching funds required by this section shall not create, lead to, or expand the health care funding obligations or service obligations for current or future years for each local governmental agency, except as required by this section or as may be

required by federal law.

(1) TCM services are services which assist beneficiaries to gain access to needed medical, social, educational, and other services. Services provided by TCM providers, and their subcontractors, shall be defined in regulation, and shall include at least one of the following:

- (1) Assessment.
- (2) Plan development.
- (3) Linkage and consultation.
- (4) Assistance in accessing services.
- (5) Periodic review.
- (6) Crisis assistance planning.

(m) (1) Each local government agency shall contribute to the department a portion of the agency's general fund that has been made available due to the coverage of services described in this section under the Medi-Cal program. The contributed funds shall be reinvested in health services through the Medi-Cal program. The total contribution amount shall be equal to 33 1/3 percent of the amounts that have been made available under this section, but in no case shall this contribution exceed twenty million dollars (\$20,000,000) in a fiscal year less the amount contributed pursuant to subdivision (m) of Section 14132.47. Beginning with the 1994-95 fiscal year, each local governmental agency's share of the total contribution shall be determined by claims submitted and approved for payment through January 1 of the following calendar year. Claims received and approved for payment after January 1 for dates of service in the previous fiscal year shall be included in the following year's calculation. Each local governmental agency's share of the contribution for the previous fiscal year shall be determined no later than February 15 and shall be remitted to the state no later than April 1 of each year. The contribution amount shall be paid from nonfederal, general fund revenues, and shall be deposited in the Targeted Case Management Claiming Fund, which is hereby created, for transfer to the Health Care Deposit Fund.

(2) Moneys received by the department pursuant to this subdivision are hereby continuously appropriated, notwithstanding Section 13340 of the Government Code, to the department for the support of the Medi-Cal program, and the funds shall be administered in accordance with procedures prescribed by the Department of Finance. If not paid as provided in this section, the department may offset payments due to each local governmental agency from the state, not related to payments required to be made pursuant to this section, in order to recoup these funds for the Targeted Case Management Claiming Fund.

(3) This subdivision shall only apply to claims approved for the 1994-95 to 1997-98 fiscal years, inclusive.

(n) As a condition of participation and in consideration of the joint effort of the local governmental agencies and the department in implementing this section and the ongoing need of local governmental agencies to receive technical support from the department, as well as assistance in claims processing and program monitoring, the local governmental agencies shall cover the costs of the administrative activities performed by the department. Each local governmental agency shall annually pay a portion of the total costs of administrative activities performed by the department through a mechanism agreed to by the department and the local governmental agencies, or if no agreement is reached by August 1 of each year, directly to the state. The department shall determine and report the

staffing requirements upon which projected costs will be based. Projected costs shall include the anticipated salaries, benefits, and operating expenses necessary to administer targeted case management.

(o) For the purposes of this section a "local governmental agency" means a county or chartered city.

14132.45. Regulations implementing, interpreting, or making specific the provisions of subdivision (z) of Section 14132 shall not be subject to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

14132.46. Pursuant to Sections 14024 and 14124.90, the Director of Health Services may recover for the cost of targeted case management services rendered under Section 14132.44 to eligible Medi-Cal beneficiaries, from any person, corporation, or partnership who, at the time services are rendered, has a contractual or legal obligation to pay for the services.

14132.47. (a) It is the intent of the Legislature to provide local governmental agencies the choice of participating in either or both of the Targeted Case Management (TCM) and Administrative Claiming process programs at their option, subject to the requirements of this section and Section 14132.44.

(b) The department may contract with each participating local governmental agency or each local educational consortium to assist with the performance of administrative activities necessary for the proper and efficient administration of the Medi-Cal program, pursuant to Section 1396b(a) of Title 42 of the United States Code, Section 1903a of the federal Social Security Act, and this activity shall be known as the Administrative Claiming process.

(c) (1) As a condition for participation in the Administrative Claiming process, each participating local governmental agency or each local educational consortium shall, for the purpose of claiming federal medicaid matching funds, enter into a contract with the department and shall certify to the department the amount of local governmental agency or each local educational consortium general funds or any other funds allowed under federal law and regulation expended on the allowable administrative activities.

(2) The department shall deny the claim if it determines that the certification is not adequately supported for purposes of federal financial participation.

(d) Each participating local governmental agency or local educational consortium may subcontract with nongovernmental entities to assist with the performance of administrative activities necessary for the proper and efficient administration of the Medi-Cal program under the conditions specified by the department in regulations.

(e) Each Administrative Claiming process contract shall include a requirement that each participating local governmental agency or each local educational consortium submit a claiming plan in a manner that

shall be prescribed by the department in regulations, developed in consultation with local governmental agencies.

(f) The department shall require that each participating local governmental agency or each local educational consortium certify to the department both of the following:

(1) The availability and expenditure of 100 percent of the nonfederal share of the cost of performing Administrative Claiming process activities. The funds expended for this purpose shall be from the local governmental agency's general fund or the general funds of local educational agencies or from any other funds allowed under federal law and regulation.

(2) In each fiscal year that its expenditures represent costs that are eligible for federal financial participation for that fiscal year. The department shall deny the claim if it determines that the certification is not adequately supported for purposes of federal financial participation.

(g) (1) Notwithstanding any other provision of this section, the state shall be held harmless, in accordance with paragraphs (2) and (3), from any federal audit disallowance and interest resulting from payments made to a participating local governmental agency or local educational consortium pursuant to this section, less the amounts already remitted to the state pursuant to subdivision (m) for the disallowed claim.

(2) To the extent that a federal audit disallowance and interest results from a claim or claims for which any participating local governmental agency or local educational consortium has received reimbursement for Administrative Claiming process activities, the department shall recoup from the local governmental agency or local educational consortium that submitted the disallowed claim, through offsets or by a direct billing, amounts equal to the amount of the disallowance and interest, in that fiscal year, less the amounts already remitted to the state pursuant to subdivision (m) for the disallowed claim. All subsequent claims submitted to the department applicable to any previously disallowed administrative activity or claim, may be held in abeyance, with no payment made, until the federal disallowance issue is resolved.

(3) Notwithstanding paragraph (2), to the extent that a federal audit disallowance and interest results from a claim or claims for which the participating local governmental agency or local educational consortium has received reimbursement for Administrative Claiming process activities performed by a nongovernmental entity under contract with, and on behalf of, the participating local governmental agency or local educational consortium, the department shall be held harmless by that particular participating local governmental agency or local educational consortium for 100 percent of the amount of the federal audit disallowance and interest, less the amounts already remitted to the state pursuant to subdivision (m) for the disallowed claim.

(h) The use of local matching funds required by this section shall not create, lead to, or expand the health care funding obligations or service obligations for current or future years for any participating local governmental agency or local educational consortium, except as required by this section or as may be required by federal law.

(i) The department shall deny any claim from a participating local governmental agency or local educational consortium if the department determines that the claim is not adequately supported in

accordance with criteria established pursuant to this subdivision and implementing regulations before it forwards the claim for reimbursement to the federal medicaid program. In consultation with local government agencies and local educational consortia, the department shall adopt regulations that prescribe the requirements for the submission and payment of claims for administrative activities performed by each participating local governmental agency and local educational consortium.

(j) Administrative activities shall be those determined by the department to be necessary for the proper and efficient administration of the state's medicaid plan and shall be defined in regulation.

(k) If the department denies any claim submitted under this section, the affected participating local governmental agency or local educational consortium may, within 30 days after receipt of written notice of the denial, request that the department reconsider its action. The participating local governmental agency or local educational consortium may request a meeting with the director or his or her designee within 30 days to present its concerns to the department after the request is filed. If the director or his or her designee cannot meet, the department shall respond in writing indicating the specific reasons for which the claim is out of compliance to the participating local governmental agency or local educational consortium in response to its appeal. Thereafter, the decision of the director shall be final.

(l) Participating local governmental agencies or local educational consortium may claim the actual costs of nonemergency, nonmedical transportation of Medi-Cal eligibles to Medi-Cal covered services, under guidelines established by the department, to the extent that these costs are actually borne by the participating local governmental agency or local educational consortium. A local educational consortium may only claim for nonemergency, nonmedical transportation of Medi-Cal eligibles for Medi-Cal covered services, through the Medi-Cal administrative activities program. Medi-Cal medical transportation services shall be claimed under the local educational agency Medi-Cal billing option, pursuant to Section 14132.06.

(m) (1) Each participating local governmental agency shall contribute to the department a portion of the agency's general fund that has been made available due to the coverage of administrative activities described in this section under the Medi-Cal program. The contributed funds shall be reinvested in health services through the Medi-Cal program. The total contribution amount shall be equal to 33 1/3 percent of amounts made available under this section, but in no case shall the contribution exceed twenty million dollars (\$20,000,000) a fiscal year less the amount contributed pursuant to subdivision (m) of Section 14132.44. Beginning with the 1994-95 fiscal year, each local governmental agency's share of the total contribution shall be determined by claims submitted and approved for payment through January 1 of the following calendar year. Claims received and approved for payment after January 1 for dates of service in the previous fiscal year shall be included in the following year's calculation. Each local governmental agency's share of the contribution for the previous fiscal year shall be determined no later than February 15 and shall be remitted to the state no later than April 1 of each year. The contribution amount shall be paid from nonfederal, general fund revenues and shall be deposited in

the Administrative Claiming Fund for transfer to the Health Care Deposit Fund.

(2) Moneys received by the department pursuant to this subdivision are hereby continuously appropriated to the department for support of the Medi-Cal program, and the funds shall be administered in accordance with procedures prescribed by the Department of Finance. If not paid as provided in this section, the department may offset payments due to each participating local governmental agency from the state, not related to payments required to be made pursuant to this section in order to recoup these funds for the Administrative Claiming Fund.

(3) This subdivision shall only apply to claims approved for the 1994-95 to 1997-98 fiscal years, inclusive.

(n) As a condition of participation in the Administrative Claiming process and in recognition of revenue generated to each participating local governmental agency and each local educational consortium in the Administrative Claiming process, each participating local governmental agency and each local educational consortium shall pay an annual participation fee through a mechanism agreed to by the state and local governmental agencies and local educational consortia, or, if no agreement is reached by August 1 of each year, directly to the state. The participation fee shall be used to cover the cost of administering the Administrative Claiming process, including, but not limited to, claims processing, technical assistance, and monitoring. The department shall determine and report staffing requirements upon which projected costs will be based. The amount of the participation fee shall be based upon the anticipated salaries, benefits, and operating expenses, to administer the Administrative Claiming process and other costs related to that process.

(o) For the purposes of this section "participating local governmental agency" means a county, chartered city, Native American Indian tribe, tribal organization, or subgroup of a Native American Indian tribe or tribal organization, under contract with the department pursuant to subdivision (b).

(p) For purposes of this section, "local educational agency" means a local educational agency, as defined in subdivision (h) of Section 14132.06, that participates under the Administrative Claiming process as a subcontractor to the local educational consortium in its service region.

(q) (1) For purposes of this section, "local educational consortium" means a local agency that is one of the service regions of the California County Superintendent Educational Services Association.

(2) Each local educational consortium shall contract with the department pursuant to paragraph (1) of subdivision (c).

(r) (1) Each participating local educational consortium shall be responsible for the local educational agencies in its service region that participate in the Administrative Claiming process. This responsibility includes, but is not limited to, the preparation and submission of all administrative claiming plans, training of local educational agency staff, overseeing the local educational agency time survey process, and the submission of detailed quarterly invoices on behalf of any participating local educational agency.

(2) Each participating local educational consortium shall ensure local educational agency compliance with all requirements of the Administrative Claiming process established for local governmental

agencies.

(3) Ninety days prior to the initial participation in the Administrative Claiming process, each local educational consortium shall notify the department of its intent to participate in the process, and shall identify each local educational agency that will be participating as its subcontractor.

(s) (1) Each local educational agency that elects to participate in the Administrative Claiming process shall submit claims through its local educational consortium or through the local governmental agency, but not both.

(2) Each local educational agency participating as a subcontractor to a local educational consortium shall comply with all requirements of the Administrative Claiming process established for local governmental agencies.

(t) For the purposes of this section, a "nongovernmental entity" does not include an entity or person administered by, affiliated with, or employed by a participating local governmental agency or a local educational consortium.

(u) The requirements of subdivision (m) shall not apply to claims for administrative activities, pursuant to the Administrative Claiming process, performed by public health programs administered by the state.

(v) A participating local governmental agency or a local educational consortium may charge an administrative fee to any entity claiming Administrative Claiming through that agency.

(w) The department shall continue to administer the Administrative Claiming process in conformity with federal requirements.

(x) The department shall provide technical assistance to all participating local governmental agencies and local educational consortia in order to maximize federal financial participation in the Administrative Claiming process.

(y) This section shall be applicable to Administrative Claiming process activities performed, and to moneys paid to participating local governmental agencies for those activities in the 1994-95 fiscal year and thereafter, and to local educational consortia in the 1998-99 fiscal year and thereafter.

14132.48. Targeted case management services to which Sections 14132.44 and 14132.47 does not apply, and as specified in Section 1915(g) of the federal Social Security Act, as amended by Public Law 99-272 (42 U.S.C. Section 1396n(g)), shall be covered as a benefit under this chapter, subject to utilization controls, for the following populations:

(a) Persons served by regional centers administered by the State Department of Developmental Services.

(b) Persons served in other programs administered by the State Department of Developmental Services.

(c) Persons receiving services pursuant to Section 14021.3.

(d) Persons in programs determined appropriate by the director.

14132.49. (a) Upon federal approval of the state plan amendments made pursuant to Section 14021.7 for federal financial assistance, targeted case management, pursuant to subdivision (g) of Section

1396n of Title 42 of the United States Code, is covered as a benefit, subject to the availability of funding through the budget process, and subject to utilization controls, for pregnant and parenting adolescents and their children.

(b) In administering subdivision (a), the department shall limit the targeted case management benefit to the amount of General Fund or other public moneys, and federal matching funds made available in the Budget Act or other legislation.

(c) The department may redirect General Fund moneys for local assistance for existing adolescent family life programs to the extent necessary to provide state matching funds for implementation of subdivision (a). The amount which may be redirected shall not exceed the amount appropriated for local assistance for the Adolescent Family Life Program.

(d) It is the intent of the Legislature that the additional federal matching funds made available by implementation of subdivision (a) be used to expand the Adolescent Family Life Program and not supplant General Fund or other public moneys or federal funds provided for pursuant to Titles V and XIX of the federal Social Security Act (Sec. 701 and following, and Sec. 1396 and following, respectively, of Title 42 of the United States Code).

(e) Determinations to continue, expand, or terminate the program shall be based on all of the following:

(1) The department's assessment of the effect of Medi-Cal funding for services on the effectiveness of the Adolescent Family Life Program.

(2) A determination of the amount of federal funds received for this service.

(3) An assessment of the cost-effectiveness of the services to the General Fund.

(4) An estimate of the amount of federal funds that could be received by expanding the project to all adolescent family programs statewide.

(f) The department shall submit, not later than June 30, 1993, amendments to the state plan required to implement the amendments made to this section during the 1992 portion of the 1991-92 Regular Session for approval by the Secretary of Health and Human Services.

14132.55. For the purposes of reimbursement under the Medi-Cal program, a speech pathologist or audiologist shall be licensed by the Speech-Language Pathology and Audiology Examining Committee of the Medical Board of California or similarly licensed by a comparable agency in the state in which he or she practices. Licensed speech-language pathologists or licensed audiologists are authorized to utilize and shall be reimbursed for the services of those personnel in the process of completing requirements under the provisions of subdivision (d) of Section 2532.2 of the Business and Professions Code.

14132.6. External prostheses constructed of silicon or other comparable materials, prosthetic implants, and reconstructive surgery incident to mastectomy shall be deemed medically necessary and shall be covered under this chapter. As used in this section, "mastectomy"

means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.

Coverage under this section shall include the provision of initial and subsequent prosthetic devices pursuant to an order of the patient's physician.

14132.62. (a) Reconstructive surgery shall be covered under this chapter, as defined in subdivision (c), when necessary to achieve the purposes specified in paragraphs (1) or (2) of subdivision (c). Nothing in this section shall be construed to require coverage for cosmetic surgery, as defined in subdivision (d).

(b) No individual, other than a licensed physician competent to evaluate the specific clinical issues involved in the care requested, may deny initial requests for authorization of coverage for treatment pursuant to this section. For a treatment authorization request submitted by a podiatrist or an oral and maxillofacial surgeon, the request may be reviewed by a similarly licensed individual competent to evaluate the specific clinical issues involved in the care requested.

(c) "Reconstructive surgery" means surgery performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

- (1) To improve function.
- (2) To create a normal appearance, to the extent possible.

(d) "Cosmetic surgery" means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

(e) In connection with the interpretation of the definition of reconstructive surgery, a proposed surgical procedure may be subject to prior authorization and utilization review that may include, but need not be limited to, denial under any of the following circumstances:

(1) There is another more appropriate surgical procedure that will be approved for the enrollee.

(2) The procedure or procedures offer only a minimal improvement in the appearance of the enrollee, as defined in regulations adopted by the department.

(3) Denial of payment for procedures performed without prior authorization.

(f) This section shall become operative July 1, 1999.

14132.63. (a) An orthotist or prosthetist providing services under this chapter shall be required to be certified in orthotics or prosthetics by either the Board for Orthotist Certification or the American Board of Certification in Orthotics and Prosthetics.

(b) This section shall remain in effect only until the date that the director executes a declaration, that shall be retained by the director, stating that the department has adopted regulations requiring an orthotist or prosthetist to be certified in orthotics or prosthetics by either the Board for Orthotist Certification or the American Board of Certification in Orthotics and Prosthetics, as a

condition of providing orthotist or prosthetic services under this chapter, and as of that date is repealed.

14132.69. (a) Notwithstanding any other provision of law, donor and recipient organ transplant surgeries are covered under the Medi-Cal program when an organ transplant is provided to a beneficiary who is eligible for full-scope benefits under this chapter in a medical facility that meets the requirements of, and is approved by, the department.

(b) Any donor or recipient organ transplant surgeries authorized by the department pursuant to this chapter are subject to utilization controls.

(c) 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, interpret, or make specific this section by means of all-county letters, provider bulletins, or other instructions, without taking any further regulatory action.

(d) This section shall not apply to Section 14133.8.

14132.71. (a) For purposes of donor and recipient organ transplant surgeries, the department shall establish standards as to both the circumstances and the criteria that the department will use for approving facilities eligible for receiving reimbursement under the Medi-Cal program.

(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 implement, interpret, or make specific this section by means of all-county letters, provider bulletins, or other instructions, without taking any further regulatory action.

14132.72. (a) It is the intent of the Legislature to recognize the practice of telemedicine as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with the provider.

(b) For the purposes of this section, "telemedicine" and "interactive" are defined as those terms are defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.

(c) (1) Commencing July 1, 1997, face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for services appropriately provided through telemedicine, subject to reimbursement policies developed by the Medi-Cal program to compensate licensed health care providers who provide health care services, that are otherwise covered by the Medi-Cal program, through telemedicine. The audio and visual telemedicine system used shall, at a minimum, have the capability of meeting the procedural definition of the Current Procedural Terminology Fourth Edition (CPT-4) codes which represent the service provided through telemedicine. The telecommunications equipment shall be of a level of quality to adequately complete all necessary components to document the level of service for the CPT-4 code billed. If a peripheral diagnostic scope is required to assess the

patient, it shall provide adequate resolution or audio quality for decisionmaking.

(2) The department shall report to the appropriate committees of the Legislature, by January 1, 2000, on the application of telemedicine to provide home health care; emergency care; critical and intensive care, including neonatal care; psychiatric evaluation; psychotherapy; and medical management as potential Medi-Cal benefits.

(d) The Medi-Cal program shall not be required to pay for consultation provided by the health care provider by telephone or facsimile machines.

(e) The Medi-Cal program shall pursue private or federal funding to conduct an evaluation of the cost-effectiveness and quality of health care provided through telemedicine by those providers who are reimbursed for telemedicine services by the program.

14132.725. (a) Commencing July 1, 2006, to the extent that federal financial participation is available, face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for teleophthalmology and teledermatology by store and forward. Services appropriately provided through this store and forward process are subject to billing and reimbursement policies developed by the department.

(b) For purposes of this section, "teleophthalmology and teledermatology by store and forward" means an asynchronous transmission of medical information to be reviewed at a later time by a physician at a distant site who is trained in ophthalmology or dermatology, where the physician at the distant site reviews the medical information without the patient being present in real time. A patient receiving teleophthalmology or teledermatology by store and forward shall be notified of the right to receive interactive communication with the distant specialist physician, and shall receive an interactive communication with the distant specialist physician, upon request. If requested, communication with the distant specialist physician may occur either at the time of the consultation, or within 30 days of the patient's notification of the results of the consultation.

(c) 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, interpret, and make specific this section by means of all county letters, provider bulletins, and similar instructions.

(d) On or before January 1, 2008, the department shall report to the Legislature the number and type of services provided, and the payments made related to the application of store and forward telemedicine as provided, under this section as a Medi-Cal benefit.

(e) The health care provider shall comply with the informed consent provisions of subdivisions (c) to (g), inclusive, of, and subdivisions (i) and (j) of, Section 2290.5 of the Business and Professions Code when a patient receives teleophthalmology or teledermatology by store and forward.

(f) This section shall remain in effect only until January 1, 2009, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2009, deletes or extends that date.

14132.73. The State Department of Health Services shall allow psychiatrists to receive fee-for-service Medi-Cal reimbursement for services provided through telemedicine until June 30, 2004, or until the State Department of Mental Health and mental health plans, in collaboration with stakeholders, develop a method for reimbursing psychiatric services provided through telemedicine that is administratively feasible for the mental health plans, primary care providers, and psychiatrists providing the services, whichever occurs later.

14132.74. (a) The department, in consultation with interested stakeholders, shall develop, as a pilot project, a pediatric palliative care benefit to evaluate whether, and to what extent, such a benefit should be offered under the Medi-Cal program. The pilot project shall be implemented only to the extent that federal financial participation is available.

(b) Beneficiaries eligible to receive the pediatric palliative care benefit shall be under 21 years of age. The department may further limit the population served by the pilot project to a size deemed sufficient to make the evaluation required pursuant to subdivision (a).

(c) Services covered under the pediatric palliative care benefit shall be designed to meet the unique needs of children, and shall include those types of services that are available through the Medi-Cal hospice benefit. The benefit shall also include the following services, regardless of whether those services are covered under the Medi-Cal hospice benefit:

(1) Hospice services that are provided at the same time that curative treatment is available, to the extent that the services are not duplicative.

(2) Hospice services provided to individuals whose conditions may result in death, regardless of the estimated length of the individual's remaining period of life.

(3) Any other services that the department determines to be appropriate.

(d) The department, in consultation with interested stakeholders, shall determine the medical conditions and prognoses that render a beneficiary eligible for the benefit.

(e) Providers authorized to provide services under the pilot program shall include licensed hospice agencies and home health agencies licensed to provide hospice care, subject to criteria developed by the department for provider participation.

(f) (1) The department shall submit any necessary application to the federal Centers for Medicare and Medicaid Services for a waiver to implement the pilot project described in this section. The department shall determine the form of waiver most appropriate to achieve the purposes of this section. The waiver request shall be included in any waiver application submitted within 12 months after the effective date of this section, or shall be submitted as an independent application within that time period. After federal approval is secured, the department shall implement the waiver within 12 months of the date of approval.

(2) The waiver shall be designed to cover a period of time necessary to evaluate the medical necessity for, and

cost-effectiveness of, a pediatric palliative care benefit. The results of the pilot project shall be made available to the Legislature and appropriate policy and fiscal committees to determine the effectiveness of the benefit.

(g) 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 provisions of this section by means of provider bulletins or similar instructions, without the adoption of regulations. The department shall notify the fiscal and appropriate policy committees of the Legislature of its intent to issue a provider bulletin or other similar instruction at least five days prior to issuance.

(h) (1) Nothing in this section shall result in the elimination or reduction of any covered benefits or services under the Medi-Cal program or the California Children's Services Program.

(2) This section shall not affect an individual's eligibility to receive, concurrently with the benefit provided for in this section, any services, including home health services, for which the individual would have been eligible in the absence of this section.

14132.765. (a) No treatment authorization request shall be required for the provision of prosthetic devices or for the replacement or repair of prosthetic devices, if the cost does not exceed five hundred dollars (\$500).

(b) No treatment authorization request shall be required for the provision of orthotic devices or for the replacement or repair of orthotic devices, if the cost does not exceed two hundred fifty dollars (\$250).

(c) The department shall implement subdivisions (a) and (b) commencing March 1, 1994.

(d) Notwithstanding subdivision (c), the department shall implement subdivisions (a) and (b) only if one of the following occurs:

(1) The report required by Section 14132.76 contains a conclusion that the pilot demonstration program required by that section was cost-effective.

(2) The report required by Section 14132.76 is not submitted to the appropriate committees of the Legislature by December 31, 1993.

(d) Notwithstanding subdivisions (a) and (b), the director may reinstate the requirement for prior authorization if the director determines that the elimination of the requirement results in unnecessary utilization, after notice to the Joint Legislative Budget Committee 30 days prior to the reinstatement of the requirement for prior authorization.

14132.77. (a) (1) Any rural hospital may request to participate in a two-year pilot project to perform delegated acute inpatient hospital treatment authorization review under the Medi-Cal program.

(2) Any hospital that elects to participate in the pilot project under this section shall enter into an agreement with the department to ensure the appropriateness of the treatments and services that it provides to a Medi-Cal beneficiary.

(3) Any rural hospital that elects to participate in a pilot

project pursuant to this section shall remain in the project for not less than one year, unless it is removed by the department pursuant to subdivision (c).

(b) The department shall review, on a random basis, every six months, up to 25 percent of the Medi-Cal beneficiaries treated by each participating hospital. As long as a hospital participates in a pilot project authorized by this section, reviews required by this section shall not interfere with, or delay, the processing of the hospital's claims for payment. Consistent with subdivision (c), if the department finds that a hospital participating in a pilot project under this section is accumulating a significant overpayment, the department shall notify the provider.

(c) (1) (A) If the department determines, as a result of a review required by subdivision (b), that the hospital has provided treatment that cannot be approved by the department, the department shall take an immediate disallowance that shall require offsets against pending Medi-Cal payments and any direct payment that may be required by the department. The disallowance shall be based on full extrapolation of the sample to the universe of Medi-Cal days covered by the sample period.

(B) In addition to the requirements of subparagraph (A), if the department determines that the hospital has provided treatment that cannot be approved by the department for 3 percent or more of the Medi-Cal beneficiary days, the department shall take corrective action relative to the hospital's participation in the pilot project.

The corrective action shall include at least one of the following actions:

(i) The revocation of the hospital's participation pursuant to subdivision (a).

(ii) An increased random review process.

(iii) Mandatory educational programs.

(2) After the random review required by subdivision (b), the hospital shall, through the reduction of the regularly scheduled periodic interim payment over a one-year period, pay the state an amount equal to the reimbursement received by the hospital for services for which approval has been denied and extrapolated pursuant to paragraph (1). This paragraph does not preclude any hospital from appealing a determination of the department under Article 5.3 (commencing with Section 14170). However, any issue under appeal shall not delay any disallowance or corrective action taken by the department under paragraph (1) until the appeal is resolved.

(d) The department may reinstate any hospital's participation revoked pursuant to subdivision (c) if, after a period of three months, the hospital's requests for a treatment authorization are not denied in 3 percent or more of the Medi-Cal days.

(e) Six months after the conclusion of the first year of the pilot project, the department shall prepare a report with an evaluation of the project and shall submit it to the appropriate committees of the Legislature. The department shall include its determination as to whether the project should be extended, modified, or terminated in the report and the basis for any determinations made by the department.

(f) (1) As part of the pilot project implemented under this section, the department may, subject to federal approval, authorize the reimbursement of a participating rural hospital at a predetermined amount every two weeks or on some other basis determined to be appropriate by the department. Following every

six-month period, the department shall immediately begin adjustment of any overpayment or underpayment, based on the amount paid to the provider as compared to the actual amount of claims approved by the department. Any hospital that is selected to participate in the pilot project under this section that elects to be paid for acute inpatient services under this subdivision shall be subject to the payment provisions of this section for the duration of the hospital's participation in the pilot project.

(2) The amount of reimbursement under paragraph (1) shall be based on the actual claims payment experience for each hospital for the immediately preceding period of six months and rate adjustments made in accordance with existing Medi-Cal reimbursement requirements.

(g) For purposes of this section, "rural hospital" means a small and rural hospital as defined in Section 124840 of the Health and Safety Code.

(h) The scope of the pilot project shall be subject to federal approval and the necessary resources made available from sources other than the General Fund or savings from program efficiencies that may be identified for this purpose.

(i) The department shall implement this section only upon receipt of all appropriate federal waivers.

14132.8. Services covered under this chapter shall include rehabilitative services for the physically or cognitively impaired stroke patient, or a patient who has brain injury for whom the medical prognosis and signs indicate potential for faster or more complete recovery, or maintenance or prevention of degeneration, in a variety of situations, including acute inpatient intensive rehabilitation immediately after the occurrence of stroke or injury, inpatient maintenance for the chronically impaired in a hospital or long-term care facility, outpatient services in a rehabilitation clinic or an adult day health care center, and in-home care or home health agency services for the patient at home.

Rehabilitative services for the physically or cognitively impaired patient only for those whom the medical prognosis and signs indicate potential for faster or more complete recovery, or maintenance or prevention of degeneration, shall be considered to fall within the definition of medical necessity, as that term is used in Section 14133.3.

For purposes of this section, "brain injury" means clinically evident brain damage resulting directly or indirectly from tumor, trauma, infection, anoxia, or vascular lesions not primarily due to degenerative or aging processes which result in temporary or permanent physical or cognitive deficits.

This section shall not negate the department's utilization review authority under subdivision (a) of Section 14133.

14132.81. (a) The purchase of identification bracelets for eligible recipients under the Medi-Cal program who have Alzheimer's Disease or some other cognitive defect, or medication allergies that could be life threatening, shall be a covered benefit under this chapter.

(b) The bracelets shall be purchased from an organization which maintains a 24-hour toll-free telephone number for emergency or

medical personnel to make inquiries.

(c) The director shall develop regulations to implement this section.

(d) For purposes of this section "eligible recipients" means those persons who, in addition to qualifying for benefits under this chapter, have been determined by a licensed physician and surgeon to need the benefit authorized by this section.

(e) Benefits shall be provided under this section only to the extent that full federal financial participation is made available.

(f) Benefits shall be provided under this section only when the director determines that two or more organizationally independent providers are available to supply the benefit authorized by this section.

14132.88. (a) Notwithstanding subdivision (h) of Section 14132 and to the extent funds are made available in the annual Budget Act for this purpose, the following are covered benefits for beneficiaries 21 years of age or older under this chapter:

(1) One dental prophylaxis cleaning per year.

(2) One initial dental examination by a dentist.

(b) The following are covered benefits for beneficiaries under 21 years of age under this chapter:

(1) Two dental prophylaxis cleanings per year.

(2) Two periodic dental examinations per year.

(c) For persons 21 years of age or older, laboratory-processed crowns on posterior teeth are not a covered benefit except when a posterior tooth is necessary as an abutment for any fixed or removable prosthesis.

(d) Any prefabricated crown made from ADA-approved materials may be used on posterior teeth and may be reimbursed as a stainless steel crown.

(e) The department shall reduce the rate of subgingival curettage and root planing by 41 percent for all beneficiaries except those residing in a skilled nursing facility or an intermediate care facility for the developmentally disabled. Notwithstanding Section 14105 and Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this subdivision by means of a provider bulletin or similar instruction, without taking regulatory action.

(f) (1) Except as provided in paragraph (2), the department shall require pretreatment radiograph documentation on posttreatment claims to establish the medical necessity for dental restorations. The pretreatment documentation required under this subdivision is intended to reduce fraudulent claims for unnecessary dental fillings.

In order to avoid any undue barriers to accessing dental care, the department shall stipulate that the pretreatment radiograph documentation for posttreatment claims will be required only when there are four or more dental fillings being completed in any 12-month period.

(2) For any beneficiary who is under four years of age, or who, regardless of age, has a developmental disability, as defined in subdivision (a) of Section 4512, radiographs or photographs that indicate decay on any tooth surface shall be considered sufficient documentation to establish the medical necessity for treatment provided.

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

Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this subdivision by means of a provider bulletin or similar instruction, without taking regulatory action.

14132.9. Notwithstanding subdivision (h) of Section 14132, any utilization controls imposed under such subdivision shall not include mandatory examination by any person not licensed as a dentist under the Dental Practice Act.

14132.90. (a) As of September 15, 1995, day care habilitative services, pursuant to subdivision (c) of Section 14021 shall be provided only to alcohol and drug exposed pregnant women and women in the postpartum period, or as required by federal law.

(b) (1) Notwithstanding any other provision of law, except to the extent required by federal law, if, as of May 15, 2000, the projected costs for the 1999-2000 fiscal year for outpatient drug abuse services, as described in Section 14021, exceed forty-five million dollars (\$45,000,000) in state General Fund moneys, then the outpatient drug free services, as defined in Section 51341.1 of Title 22 of the California Code of Regulations, shall not be a benefit under this chapter as of July 1, 2000.

(2) Notwithstanding paragraph (1), narcotic replacement therapy and Naltrexone shall remain benefits under this chapter.

(3) Notwithstanding paragraph (1), residential care, outpatient drug free services, and day care habilitative services, for alcohol and drug exposed pregnant women and women in the postpartum period shall remain benefits under this chapter.

(c) Expenditures for services purchased at the direction of county welfare departments on behalf of CalWORKs recipients shall not be included in the computation of costs for subdivision (b).

(d) For the 1999-2000 fiscal year and each fiscal year thereafter, there shall be separate annual fiscal year General Fund appropriations for drug Medi-Cal perinatal services (Item 4200-104-0001 of the Budget Act), drug Medi-Cal nonperinatal services (Item 4200-103-0001 of the Budget Act), nondrug Medi-Cal perinatal services (Item 4200-102-0001 of the Budget Act), and nondrug Medi-Cal nonperinatal services (Item 4200-101-0001 of the Budget Act).

(e) Notwithstanding any other provision of law, the State Department of Alcohol and Drug Programs shall maintain a contingency reserve of the reappropriated General Fund moneys for the purpose of drug Medi-Cal program expenditures.

(f) Unexpended General Fund moneys appropriated for the drug Medi-Cal program may be transferred for use as nondrug Medi-Cal county expenditures in the current or budget years. Unexpended General Fund moneys shall not be transferred from nondrug Medi-Cal to the drug Medi-Cal program for purposes of providing matching funds for federal financial participation.

14132.91. (a) Subject to the availability of funding, the department shall conduct a dental outreach and education program for Medi-Cal beneficiaries. The program shall inform Medi-Cal

beneficiaries of the availability of dental care and provide information regarding recommended frequencies for regular and preventive dental care, how to obtain Medi-Cal dental care, how to avoid inappropriate care or fraudulent providers, and how to obtain assistance in getting care or resolving problems with dental care.

(b) The program shall particularly target underserved populations and parents of young and adolescent children, and it shall include the following components:

(1) Incorporation of dental themes and information in ongoing outreach and advertising efforts, including those for Medi-Cal and the Healthy Families program.

(2) Education and outreach materials for inclusion in mailings to beneficiaries.

(3) Education and consumer protection materials for display and distribution at sites providing Medi-Cal dental care, clinics, and other health care facilities and sites.

(c) The department shall consult with dental professional groups and experts, community organizations, advertising and media experts, and other parties, as the department deems appropriate, in order to develop and structure the program in an effective and efficient manner.

14132.92. (a) Notwithstanding subdivision (a) of Section 4512, or any other provision of this chapter or Chapter 8 (commencing with Section 14200), services provided on or after July 1, 2000, by facilities defined in subdivisions (e) and (h) of Section 1250 of the Health and Safety Code that are otherwise covered services under this chapter shall be reimbursed by the Medi-Cal program when provided to a Medi-Cal beneficiary that has a developmental disability as defined in Section 6001(8) of Title 42 of the United States Code or is a person with a related condition as defined in Section 435.1009 of Title 42 of the Code of Federal Regulations, provided that the Medi-Cal beneficiary was residing in a licensed intermediate care facility/developmentally disabled-habilitative or a licensed intermediate care facility/developmentally disabled-nursing on July 1, 2000, but only for as long as the beneficiary continues, from that date, to reside in a licensed intermediate care facility/developmentally disabled-habilitative or a licensed intermediate care facility/developmentally disabled-nursing.

(b) Nothing in subdivision (a) shall eliminate, for purposes of reimbursement under this section, the requirements and time limits set forth in Section 14115, or any regulations adopted thereunder.

(c) The department shall seek further financial participation, and shall seek federal approval of a state plan amendment if necessary under Section 440.150 of Title 42 of the Code of Federal Regulations, for services provided pursuant to subdivision (a). If federal financial participation is not made available for the services, the services nonetheless shall be reimbursed from the General Fund.

14132.93. It is the intent of the Legislature that if services meeting the conditions of subdivision (a) of Section 14132.92 have been provided to a Medi-Cal beneficiary during the time period of June 15, 1998, to July 2, 2000, and notwithstanding Section 14115, a

bill for these services is submitted on behalf of each beneficiary receiving these services postmarked to the department on or before April 30, 2001, the services shall be reimbursed by the General Fund.

However, the department shall seek federal financial participation and shall seek federal approval of a state plan amendment if necessary under Section 440.150 of Title 42 of the Code of Federal Regulations, for these services provided during that period. If federal financial participation is not made available for that period, the services nonetheless shall be reimbursed from the General Fund.

14132.94. (a) Subject to approval by the Centers for Medicare and Medicaid Services of a medicaid state plan amendment electing the Programs of All-Inclusive Care for the Elderly (PACE) as a state medicaid option, as provided for by Subtitle I (commencing with Section 4801) of Title IV of the Balanced Budget Act of 1997 (Public Law 105-33) and Part 460 (commencing with Section 460.2) of Subchapter E of Title 42 of the Code of Federal Regulations, PACE program services shall become a covered benefit of the Medi-Cal program, subject to utilization controls and eligibility criteria that require that the beneficiary be certifiable for nursing facility services based on Medi-Cal criteria.

(b) Covered services under the PACE benefit of the Medi-Cal program include those set forth in 42 C.F.R. 460.92.

14132.95. (a) Personal care services, when provided to a categorically needy person as defined in Section 14050.1 is a covered benefit to the extent federal financial participation is available if these services are:

(1) Provided in the beneficiary's home and other locations as may be authorized by the director subject to federal approval.

(2) Authorized by county social services staff in accordance with a plan of treatment.

(3) Provided by a qualified person.

(4) Provided to a beneficiary who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services described in this section.

(b) The department shall seek federal approval of a state plan amendment necessary to include personal care as a Medicaid service pursuant to subdivision (f) of Section 440.170 of Title 42 of the Code of Federal Regulations. For any persons who meet the criteria specified in subdivision (a) or (p), but for whom federal financial participation is not available for a service or services under this section, eligibility for the service or services shall be determined according to the waiver authorized pursuant to Section 14132.951. If federal financial participation for the service or services is not available under this section or Section 14132.951, eligibility for the service or services shall be determined pursuant to Article 7 (commencing with Section 12300) of Chapter 3.

(c) Subdivision (a) shall not be implemented unless the department has obtained federal approval of the state plan amendment described

in subdivision (b), and the Department of Finance has determined, and has informed the department in writing, that the implementation of this section will not result in additional costs to the state relative to state appropriation for in-home supportive services under Article 7 (commencing with Section 12300) of Chapter 3, in the 1992-93 fiscal year.

(d) (1) For purposes of this section, personal care services shall mean all of the following:

- (A) Assistance with ambulation.
- (B) Bathing, oral hygiene and grooming.
- (C) Dressing.
- (D) Care and assistance with prosthetic devices.
- (E) Bowel, bladder, and menstrual care.
- (F) Skin care.
- (G) Repositioning, range of motion exercises, and transfers.
- (H) Feeding and assurance of adequate fluid intake.
- (I) Respiration.
- (J) Paramedical services.
- (K) Assistance with self-administration of medications.

(2) Ancillary services including meal preparation and cleanup, routine laundry, shopping for food and other necessities, and domestic services may also be provided as long as these ancillary services are subordinate to personal care services. Ancillary services may not be provided separately from the basic personal care services.

(e) (1) (A) After consulting with the State Department of Social Services, the department shall adopt emergency regulations to establish the amount, scope, and duration of personal care services available to persons described in subdivision (a) in the fiscal year whenever the department determines that General Fund expenditures for personal care services provided under this section and expenditures of both General Fund moneys and federal funds received under Title XX of the federal Social Security Act for services pursuant to Article 7 (commencing with Section 12300) of Chapter 3, are expected to exceed the General Fund appropriation and the federal appropriation under Title XX of the federal Social Security Act provided for the 1992-93 fiscal year pursuant to Article 7 (commencing with Section 12300) of Chapter 3, as it read on June 30, 1992, as adjusted for caseload growth or as increased in the Budget Act or appropriated by statute. At least 30 days prior to filing these regulations with the Secretary of State, the department shall give notice of the expected content of these regulations to the fiscal committees of both houses of the Legislature.

(B) In establishing the amount, scope, and duration of personal care services, the department shall ensure that General Fund expenditures for personal care services provided for under this section and expenditures of both General Fund moneys and federal funds received under Title XX of the federal Social Security Act for services pursuant to Article 7 (commencing with Section 12300) of Chapter 3, do not exceed the General Fund appropriation and the federal appropriation under Title XX of the federal Social Security Act provided for the 1992-93 fiscal year pursuant to Article 7 (commencing with Section 12300) of Chapter 3, as it read on June 30, 1992, as adjusted for caseload growth or as increased in the Budget Act or appropriated by statute.

(C) For purposes of this subdivision, "caseload growth" means an adjustment factor determined by the department based on (1) growth in

the number of persons eligible for benefits under Chapter 3 (commencing with Section 12000) on the basis of their disability, (2) the average increase in the number of hours in the program established pursuant to Article 7 (commencing with Section 12300) of Chapter 3 in the 1988-89 to 1992-93 fiscal years, inclusive, due to the level of impairment, and (3) any increase in program costs that is required by an increase in the mandatory minimum wage.

(2) In establishing the amount, scope, and duration of personal care services pursuant to this subdivision, the department may define and take into account, among other things:

(A) The extent to which the particular personal care services are essential or nonessential.

(B) Standards establishing the medical necessity of the services to be provided.

(C) Utilization controls.

(D) A minimum number of hours of personal care services that must first be assessed as needed as a condition of receiving personal care services pursuant to this section.

The level of personal care services shall be established so as to avoid, to the extent feasible within budgetary constraints, medical out-of-home placements.

(3) To the extent that General Fund expenditures for services provided under this section and expenditures of both General Fund moneys and federal funds received under Title XX of the federal Social Security Act for services pursuant to Article 7 (commencing with Section 12300) of Chapter 3 in the 1992-93 fiscal year, adjusted for caseload growth, exceed General Fund expenditures for services provided under this section and expenditures of both General Fund moneys and federal funds received under Title XX of the federal Social Security Act for services pursuant to Article 7 (commencing with Section 12300) of Chapter 3 in any fiscal year, the excess of these funds shall be expended for any purpose as directed in the Budget Act or as otherwise statutorily disbursed by the Legislature.

(f) Services pursuant to this section shall be rendered, under the administrative direction of the State Department of Social Services, in the manner authorized in Article 7 (commencing with Section 12300) of Chapter 3, for the In-Home Supportive Services program. A provider of personal care services shall be qualified to provide the service and shall be a person other than a member of the family. For purposes of this section, a family member means a parent of a minor child or a spouse.

(g) The maximum number of hours available under the In-Home Supportive Services program pursuant to Article 7 (commencing with Section 12300) of Chapter 3, Section 14132.951, and this section, combined, shall be 283 hours per month.

(h) Personal care services shall not be provided to residents of facilities licensed by the department, and shall not be provided to residents of a community care facility or a residential care facility for the elderly licensed by the Community Care Licensing Division of the State Department of Social Services.

(i) Subject to any limitations that may be imposed pursuant to subdivision (e), determination of need and authorization for services shall be performed in accordance with Article 7 (commencing with Section 12300) of Chapter 3.

(j) (1) To the extent permitted by federal law, reimbursement rates for personal care services shall be equal to the rates in each

county for the same mode of services in the In-Home Supportive Services program pursuant to Article 7 (commencing with Section 12300) of Chapter 3, plus any increase provided in the annual Budget Act for personal care services rates or included in a county budget pursuant to paragraph (2).

(2) (A) The department shall establish a provider reimbursement rate methodology to determine payment rates for the individual provider mode of service that does all of the following:

(i) Is consistent with the functions and duties of entities created pursuant to Section 12301.6.

(ii) Makes any additional expenditure of state general funds subject to appropriation in the annual Budget Act.

(iii) Permits county-only funds to draw down federal financial participation consistent with federal law.

(B) This ratesetting method shall be in effect in time for any rate increases to be included in the annual Budget Act.

(C) The department may, in establishing the ratesetting method required by subparagraph (A), do both of the following:

(i) Deem the market rate for like work in each county, as determined by the Employment Development Department, to be the cap for increases in payment rates for individual practitioner services.

(ii) Provide for consideration of county input concerning the rate necessary to ensure access to services in that county.

(D) If an increase in individual practitioner rates is included in the annual Budget Act, the state-county sharing ratio shall be as established in Section 12306. If the annual Budget Act does not include an increase in individual practitioner rates, a county may use county-only funds to meet federal financial participation requirements consistent with federal law.

(3) (A) By November 1, 1993, the department shall submit a state plan amendment to the federal Health Care Financing Administration to implement this subdivision. To the extent that any element or requirement of this subdivision is not approved, the department shall submit a request to the federal Health Care Financing Administration for any waivers as would be necessary to implement this subdivision.

(B) The provider reimbursement ratesetting methodology authorized by the amendments to this subdivision in the 1993-94 Regular Session of the Legislature shall not be operative until all necessary federal approvals have been obtained.

(k) (1) The State Department of Social Services shall, by September 1, 1993, notify the following persons that they are eligible to participate in the personal care services program:

(A) Persons eligible for services pursuant to the Pickle Amendment, as adopted October 28, 1976.

(B) Persons eligible for services pursuant to subsection (c) of Section 1383c of Title 42 of the United States Code.

(2) The State Department of Social Services shall, by September 1, 1993, notify persons to whom paragraph (1) applies and who receive advance payment for in-home supportive services that they will qualify for services under this section without a share of cost if they elect to accept payment for services on an arrears rather than an advance payment basis.

(1) An individual who is eligible for services subject to the maximum amount specified in subdivision (b) of Section 12303.4 shall be given the option of hiring his or her own provider.

(m) The county welfare department shall inform in writing any individual who is potentially eligible for services under this section of his or her right to the services.

(n) It is the intent of the Legislature that this entire section be an inseparable whole and that no part of it be severable. If any portion of this section is found to be invalid, as determined by a final judgment of a court of competent jurisdiction, this section shall become inoperative.

(o) Paragraphs (2) and (3) of subdivision (a) shall be implemented so as to conform to federal law authorizing their implementation.

(p) (1) Personal care services shall be provided as a covered benefit to a medically needy aged, blind, or disabled person, as defined in subdivision (a) of Section 14051, to the same extent and under the same requirements as they are provided under subdivision (a) of this section to a categorically needy, aged, blind, or disabled person, as defined in subdivision (a) of Section 14050.1, and to the extent that federal financial participation is available.

(2) The department shall seek federal approval of a state plan amendment necessary to include personal care services described in paragraph (1) as a Medicaid service pursuant to subdivision (f) of Section 440.170 of Title 42 of the Code of Federal Regulations.

(3) In the event that the Department of Finance determines that expenditures of both General Fund moneys for personal care services provided under this subdivision to medically needy aged, blind, or disabled persons together with expenditures of both General Fund moneys and federal funds received under Title XX of the federal Social Security Act for all aged, blind, and disabled persons receiving in-home supportive services pursuant to Article 7 (commencing with Section 12300) of Chapter 3, in the 2000-01 fiscal year or in any subsequent fiscal year, are expected to exceed the General Fund appropriation and the federal appropriation received under Title XX of the federal Social Security Act for expenditures for all aged, blind, and disabled persons receiving in-home supportive services provided in the 1999-2000 fiscal year pursuant to Article 7 (commencing with Section 12300) of Chapter 3, as it read on June 30, 1998, as adjusted for caseload growth or as changed in the Budget Act or by statute or regulation, then this subdivision shall cease to be operative on the first day of the month that begins after the expiration of a period of 30 days subsequent to a notification in writing by the Director of the Department of Finance to the chairperson of the committee in each house that considers appropriations, the chairpersons of the committees and the appropriate subcommittees in each house that consider the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(4) Solely for purposes of paragraph (3), caseload growth means an adjustment factor determined by the department based on:

(A) Growth in the number of persons eligible for benefits under Chapter 3 (commencing with Section 12000) on the basis of their disability.

(B) The average increase in the number of hours in the program established pursuant to Article 7 (commencing with Section 12300) of Chapter 3 in the 1994-95 to 1998-99 fiscal years, inclusive, due to the level of impairment.

(C) Any increase in program cost that is required by an increase in hourly costs pursuant to the Budget Act or statute.

(5) In the event of a final judicial determination by any court of appellate jurisdiction or a final determination by the Administrator of the federal Centers for Medicare and Medicaid Services that personal care services must be provided to any medically needy person who is not aged, blind, or disabled, then this subdivision shall cease to be operative on the first day of the first month that begins after the expiration of a period of 30 days subsequent to a notification in writing by the Director of Finance to the chairperson of the committee in each house that considers appropriations, the chairpersons of the committees and the appropriate subcommittees in each house that consider the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(6) If this subdivision ceases to be operative, all aged, blind, and disabled persons who would have been eligible to receive services under this section shall be immediately eligible for services under the IHSS Plus waiver authorized pursuant to Section 14132.951, if otherwise eligible, upon this section becoming inoperative. If this section becomes inoperative and a person is ineligible for the IHSS Plus waiver, then eligibility shall be determined under the In-Home Supportive Services program pursuant to Article 7 (commencing with Section 12300) of Chapter 3.

14132.951. (a) It is the intent of the Legislature that the State Department of Health Services seek approval of a Medicaid waiver under the federal Social Security Act in order that the services available under Article 7 (commencing with Section 12300) of Chapter 3, known as the In-Home Supportive Services program, may be provided as a Medi-Cal benefit under this chapter, to the extent federal financial participation is available. The waiver shall be known as the "IHSS Plus waiver."

(b) To the extent feasible, the IHSS Plus waiver described in subdivision (a) shall incorporate the eligibility requirements, benefits, and operational requirements of the In-Home Supportive Services program as it exists on the effective date of this section. The director shall have discretion to modify eligibility requirements, benefits, and operational requirements as needed to secure approval of the Medicaid waiver.

(c) Upon implementation of the IHSS Plus waiver, and to the extent federal financial participation is available, the services available through the In-Home Supportive Services program shall be furnished as benefits of the Medi-Cal program through the IHSS Plus waiver to persons who meet the eligibility requirements of the IHSS Plus waiver. The benefits shall be limited by the terms and conditions of the IHSS Plus waiver and by the availability of federal financial participation.

(d) Upon implementation of the IHSS Plus waiver:

(1) A person who is eligible for the IHSS Plus waiver shall no longer be eligible to receive services under the In-Home Supportive Services program to the extent those services are available through the IHSS Plus waiver.

(2) A person shall not be eligible to receive services pursuant to the IHSS Plus waiver to the extent those services are available pursuant to Section 14132.95.

(e) Services provided pursuant to this section shall be rendered, under the administrative direction of the State Department of Social

Services, in the manner authorized in Article 7 (commencing with Section 12300) of Chapter 3, for the In-Home Supportive Services program.

(f) Services shall not be provided to residents of facilities licensed by the department, and shall not be provided to residents of a community care facility or a residential care facility for the elderly licensed by the State Department of Social Services.

(g) To the extent permitted by federal law, reimbursement rates for services shall be equal to the rates in each county for the same mode of services in the In-Home Supportive Services program pursuant to Article 7 (commencing with Section 12300) of Chapter 3.

(h) (1) Notwithstanding the Administrative Procedure Act, 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 provisions of this section through all-county welfare director letters or similar publications. Actions taken to implement, interpret, or make specific this section shall not be subject to the Administrative Procedure Act or to the review and approval of the Office of Administrative Law. Upon request of the department, the Office of Administrative Law shall publish the regulations in the California Code of Regulations. All county welfare director letters or similar publications authorized pursuant to this section shall remain in effect for no more than 18 months.

(2) The department may also adopt emergency regulations implementing the provisions of this section. The adoption of regulations implementing this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. Any emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and shall remain in effect for no more than 18 months by which time final regulations shall be adopted.

The department shall seek input from the entities listed in Section 12305.72 when developing the regulations, all county welfare director letters, or similar publications.

(i) In the event of a conflict between the terms of the IHSS Plus waiver and any provision of this part or any regulation, all-county welfare directors letters or similar publications adopted for the purpose of implementing this part, the terms of the waiver shall control to the extent that the services are covered by the waiver. If the department determines that a conflict exists, the department shall issue updated instructions to counties for the purposes of implementing necessary program changes. The department shall post a copy of, or a link to, the instructions on its Web site.

(j) (1) Notwithstanding subdivision (b) or any other provision of this section, the department shall not waive or modify the provisions of Section 12301.2, 12301.6, 12302.25, 12306.1, or 12309.

(2) Upon receipt of the IHSS Plus waiver, the director shall report to the Legislature on any modifications in benefits or eligibility and operational requirements of the In-Home Supportive Services program required for receipt of the waiver.

14132.955. Personal care services that are provided pursuant to Section 14132.95 shall include services in the recipient's place of

employment if both of the following conditions are met:

(a) The personal care services are limited to those that are currently authorized for the recipient in the recipient's home and those services are to be utilized by the recipient at the recipient's place of employment to enable the recipient to obtain, retain, or return to, work. Authorized services utilized by the recipient at the recipient's place of employment shall be services that are relevant and necessary in supporting and maintaining employment. However, work place services shall not be used to supplant any reasonable accommodations required of an employer by the Americans with Disabilities Act (42 U.S.C. Sec. 12101 et seq.) or other legal entitlements or third-party obligations.

(b) The provision of personal care services at the recipient's place of employment shall be authorized only to the extent that the total hours utilized at the work place are within the total personal care services hours authorized for the recipient in the home. Additional personal care services hours may not be authorized in connection with a recipient's employment.

14132.96. Medi-Cal personal care services provider rates established as provided in the state plan under Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code, by an in-home supportive services public authority established pursuant to paragraph (2) of subdivision (a) and paragraph (4) of subdivision (b) of Section 12301.6 shall be reviewed by the county in which the in-home supportive services public authority operates, to determine that the rates are consistent with the county budget and that the county will be able to fund any increase in its share of costs, prior to the submission of the rates to the department. Certification of the county's ability to fund any increase in rates shall accompany the submission of rates to the department.

14132.966. (a) Services provided by a physician assistant are a covered benefit under this chapter to the extent authorized by federal law and subject to utilization controls.

(b) Subject to subdivision (a), all services performed by a physician assistant within his or her scope of practice that would be a covered benefit if performed by a physician and surgeon shall be a covered benefit under this chapter.

(c) The department shall not impose chart review, countersignature, or other conditions of coverage or payment on a physician and surgeon supervising physician assistants that are more stringent than requirements imposed by Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code or regulations of the Medical Board of California promulgated under that chapter.

14132.97. (a) For purposes of this section, "waiver personal care services" means personal care services authorized by the department for persons who are eligible for either nursing or model nursing facility waiver services. Waiver personal care services shall be

defined in these respective waivers, shall differ in scope from personal care services that may be authorized in Section 14132.95, and shall not replace any hours of services authorized or that may be authorized under Section 14132.95.

(b) An individual may receive waiver personal care services if all of the following conditions are met:

(1) The individual has been approved by the department to receive services in accordance with a waiver approved under Section 1915(c) of the federal Social Security Act (42 U.S.C. Sec. 1396n(c)) for persons who would otherwise require care in a nursing facility.

(2) The individual has doctor's orders that specify that he or she requires waiver personal care services in order to remain in his or her own home.

(3) The individual chooses, either personally or through a substitute decisionmaker who is recognized under state law for purposes of giving consent for medical treatment, to receive waiver personal care services, as well as medically necessary skilled nursing services, in order to remain in his or her own home.

(4) The waiver personal care services and all other waiver services for the individual do not result in costs that exceed the fiscal limit established under the waiver.

(c) The department shall notify the administrator of the in-home supportive services program in the county of residence of any individual who meets all requirements of subdivision (b) and has been authorized by the department to receive waiver personal care services. The county of residence shall then do the following:

(1) Inform the department of the personal care services that the individual is authorized to receive under Section 14132.95 at the time he or she becomes eligible for waiver personal care services.

(2) Determine the individual's eligibility for personal care services under Section 14132.95 if he or she is not currently authorized to receive those services and if he or she has not been previously determined eligible for those services.

(3) Implement the department's authorization for waiver personal care services for the individual at the quantity and scope authorized by the department.

(d) (1) Waiver personal care services approved by the department for individuals who meet the requirements of subdivision (b) may be provided in either of the following ways, or a combination of both:

(A) By a licensed and certified home health agency participating in the Medi-Cal program.

(B) By one or more providers of personal care services under Article 7 (commencing with Section 12300) of Chapter 3 and subdivision (d) of Section 14132.95, when the individual elects, in writing, to utilize these service providers.

(2) The department shall approve waiver personal care services for individuals who meet the requirements of subdivision (b) only when the department finds that the individual's receipt of waiver personal care services is necessary in order to enable the individual to be maintained safely in his or her own home and community.

(3) When waiver personal care services are provided by a licensed and certified home health agency, the home health agency shall receive payment in the manner by which it would receive payment for any other service approved by the department.

(4) When waiver personal care services are provided by one or more providers of personal care services under Article 7 (commencing with Section 12300) of Chapter 3 and subdivision (d) of Section 14132.95,

the providers shall receive payment on a schedule and in a manner by which providers of personal care services receive payment. The State Department of Social Services shall commence making payments for waiver personal care services when its payment system has been modified to accommodate those payments. No county shall be obligated to administer waiver personal care services until the State Department of Social Services payment system has been modified to accommodate those payments. However, any county or public authority or nonprofit consortium that administers the in-home supportive services program and personal care services program may pay providers for the delivery of waiver personal care services if it chooses to do so. In such a case, the county, public authority, or nonprofit consortium shall be reimbursed by the department for the waiver personal care services authorized by the department and provided to an individual upon submittal of documentation as required by the waiver, and in accordance with the requirements of the department.

(e) Waiver personal care services shall not count as alternative resources in a county's determination of the amount of services an individual may receive under Section 14132.95.

(f) Any administrative costs to the State Department of Social Services, a county, or a public authority or nonprofit consortium associated with implementing this section shall be considered administrative costs under the waiver and shall be reimbursed by the department.

(g) Two hundred fifty thousand dollars (\$250,000) is appropriated from the General Fund to the State Department of Social Services for the 1998-99 fiscal year for the purpose of making changes to the case management, information, and payrolling system that are necessary for the implementation of this section.

(h) This section shall not be implemented until the department has obtained federal approval of any necessary amendments to the existing nursing facility and model nursing facility waivers and the state plan under Title 19 of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.). Any amendments to the existing nursing facility and model nursing facility waivers and the state plan which are deemed to be necessary by the director shall be submitted to the federal Health Care Financing Administration by April 1, 1999.

(i) The department shall implement this section only to the extent that its implementation results in fiscal neutrality, as required under the terms of the waivers.

14132.98. (a) For a beneficiary diagnosed with cancer and accepted into a phase I, phase II, phase III, or phase IV clinical trial for cancer, the Medi-Cal program shall provide coverage for all routine patient care costs related to the clinical trial if the beneficiary's treating physician, who is providing covered health care services to the beneficiary under the Medi-Cal program, recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the beneficiary.

For purposes of this section, a clinical trial's endpoints shall not be defined exclusively to test toxicity, but shall have a therapeutic intent.

(b) (1) "Routine patient care costs" means the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the

Medi-Cal program if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program, including:

(A) Health care services typically provided absent a clinical trial.

(B) Health care services required solely for the provision of the investigational drug, item, device, or service.

(C) Health care services required for the clinically appropriate monitoring of the investigational item or service.

(D) Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.

(E) Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

(2) For purposes of this section, "routine patient care costs" does not include the costs associated with the provision of any of the following:

(A) Drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial.

(B) Services other than health care services, such as travel, housing, companion expenses, and other nonclinical expenses, that a beneficiary may require as a result of the treatment being provided for purposes of the clinical trial, except as required under the Medicaid Program (42 U.S.C. Sec. 1396a et seq.).

(C) Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.

(D) Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage by the Medi-Cal program.

(E) Health care services customarily provided by the research sponsors free of charge for any beneficiary in the trial.

(c) The treatment shall be provided in a clinical trial that either:

(1) Involves a drug that is exempt under federal regulations from a new drug application.

(2) Is approved by one of the following:

(A) One of the National Institutes of Health.

(B) The federal Food and Drug Administration, in the form of an investigational new drug application.

(C) The United States Department of Defense.

(D) The United States Veterans' Administration.

(d) Nothing in this section shall be construed to prohibit the Medi-Cal program from restricting coverage for clinical trials to participating hospitals and physicians in California unless the protocol for the clinical trial is not provided for at a California hospital or by a California physician.

(e) The provision of services when required by this section shall not, in itself, give rise to liability on the part of the Medi-Cal program.

14132.99. For services provided pursuant to Chapter 7 (commencing with Section 14000) of Part 3 of Division 9, Section 14499.5, or

Chapter 1 (commencing with Section 101525) to Chapter 4 (commencing with Section 101825), inclusive, of Part 4 of Division 101 of the Health and Safety Code, the cost for services defined in Section 1370.6 of the Health and Safety Code, and Sections 14087.11 and 14132.98 shall be provided by state only funds if federal financial participation is not available.

14132.99. (a) For the purposes of this section, "facility residents" means individuals who are currently residing in a nursing facility and whose care is paid for by Medi-Cal either with or without a share of cost. The term "facility residents" also includes individuals who are hospitalized and who are or will be waiting for transfer to a nursing facility.

(b) An additional 500 slots beyond those currently authorized for the home- and community-based Level A/B nursing facility waiver shall be added and 250 of these slots shall be reserved for residents residing in facilities and transitioning out of facilities.

(c) For those patients who are in acute care hospitals and who are pending placement in a nursing facility, the department shall expedite the processing of waiver applications in order to divert hospital discharges from nursing facilities into the community.

(d) The nursing facility Level A/B waivers shall be amended to add the following services:

(1) One-time community transition services as defined and allowed by the federal Centers for Medicare and Medicaid Services, including, but not limited to, security deposits that are required to obtain a lease on an apartment or home, essential furnishings, and moving expenses required to occupy and use a community domicile, set-up fees, or deposits for utility or service access, including, but not limited to, telephone, electricity, and heating, and health and safety assurances, including, but not limited to, pest eradication, allergen control, or one-time cleaning prior to occupancy. These costs shall not exceed five thousand dollars (\$5,000).

(2) Habilitation services, as defined in Section 1915(c)(5) of the federal Social Security Act (42 U.S.C. Sec. 1396n(c)(5)), and in attachment 3-d to the July 25, 2003, State Medicaid Directors Letter re Olmstead Update No. 3, to mean services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home- and community-based settings.

(e) When requesting the renewal of the waiver, the department shall consider expanding the number of waiver slots. Prior to submission of the waiver renewal request, the department shall notify the appropriate fiscal and policy committees of the Legislature of the number of waiver slots included in the waiver renewal request along with supportive data for those slots.

(f) The department shall implement this section only to the extent it can demonstrate fiscal neutrality within the overall department budget, and federal fiscal neutrality as required under the terms of the federal waiver, and only if the department has obtained the necessary approvals and receives federal financial participation from the federal Centers for Medicare and Medicaid Services. Contingent upon federal approval of the waiver expansion, implementation shall commence within six months of the department receiving authorization for the necessary resources to provide the services to additional

waiver participants.

14132.992. (a) (1) By March 15, 2009, the department shall submit to the federal Centers for Medicare and Medicaid Services a home- and community-based services waiver application pursuant to Section 1396n(c) of Title 42 of the United States Code, or an amendment of the state plan for home- and community-based services pursuant to Section 1396n(i) of Title 42 of the United States Code, to serve at least 100 adults with acquired traumatic brain injuries who otherwise would require care in a Medi-Cal funded nursing facility or an intermediate care facility for persons with developmental disabilities or, for the amendment of the state plan, who would meet the eligibility criteria in Section 1396n(i).

(2) As authorized by Section 1396n(c)(3) and 1396n(i)(3) of Title 42 of the United States Code, the waiver or amendment of the state plan shall waive the statewide application of this section as well as comparability of services so that waiver services may be provided by one or more of the sites designated to provide services to persons with acquired traumatic brain injury pursuant to Section 4356.

(3) The waiver services to be provided to eligible Medi-Cal recipients shall include case management services, community reintegration and supported living services, vocational supportive services including prevocational services, neuropsychological assessments, and rehabilitative services provided by project sites currently serving persons with acquired traumatic brain injuries pursuant to Chapter 5 (commencing with Section 4353).

(4) The waiver services to be provided shall include as a habilitation service pursuant to Section 1396n(c)(5) of Title 42 of the United States Code "extended supported employment services" to support and maintain an individual with an acquired traumatic brain injury in supported employment following that individual's transition from support provided as a vocational rehabilitation service, including job coaching, by the State Department of Rehabilitation pursuant to paragraphs (1) and (5) of subdivision (a) of Section 19150.

(5) The waiver services to be provided shall include rehabilitative therapies, including, but not limited to, occupational therapy, physical therapy, speech therapy, and cognitive therapy, that are different in kind and scope from state plan services.

(6) The waiver shall require an aggregate cost-effectiveness formula be used.

(b) The development process of the home- and community-based services waiver application or state plan amendment shall include the solicitation of the opinions and help of the affected communities, including the working group members pursuant to Section 4357.1 and representatives of project sites currently serving persons with acquired traumatic brain injuries pursuant to Chapter 5 (commencing with Section 4353) of Part 3 of Division 4.

(c) The waiver or state plan amendment shall be implemented only if the following conditions are met:

(1) Federal financial participation is available for the services under the waiver or state plan amendment.

(2) Cost neutrality is achieved in accordance with the terms and conditions of the waiver or state plan amendment and the requirements of the federal Centers for Medicare and Medicaid Services.

(3) State funds are appropriated, otherwise made available, or

both, for this waiver or state plan amendment, including funds for staff to develop, implement, administer, monitor, and oversee the waiver or state plan amendment.

(d) It is the intent of the Legislature that the home- and community-based services waiver or state plan amendment augment funds available to meet the needs of persons with acquired traumatic brain injuries served by the participating project sites in accordance with subdivision (b) of Section 4358.5.

14132aa. (a) Services provided by facilities licensed as congregate living health facilities to individuals diagnosed as having acquired immune deficiency syndrome (AIDS), are a covered benefit under this chapter, subject to utilization controls.

(b) Congregate living health facilities shall be reimbursed for services covered by this section at a rate set by the department and the provision of those services shall be subject to audit.

(c) This section shall be operative only to the extent that federal medicaid financial participation is made available pursuant to Subchapter XIX (commencing with Section 1396) of Title 42 of the United States Code.

14133. Utilization controls that may be applied to the services set forth in Section 14132 which are subject to utilization controls shall be limited to:

(a) Prior authorization, which is approval by a department consultant, of a specified service in advance of the rendering of that service based upon a determination of medical necessity. Prior authorization includes authorization for multiple services which are requested and granted on the basis of an extended treatment plan where there is a need for continuity in the treatment of a chronic or extended condition.

(b) Postservice prepayment audit, which is review for medical necessity and program coverage after service was rendered but before payment is made. Payment may be withheld or reduced if the service rendered was not a covered benefit, deemed medically unnecessary or inappropriate. Nothing in this subdivision shall supersede the claims processing deadlines provided by Section 14104.3.

(c) Postservice postpayment audit, which is review for medical necessity and program coverage after service was rendered and the claim paid. The department may take appropriate steps to recover payments made if subsequent investigation uncovers evidence that the claim should not have been paid.

(d) Limitation on number of services, which means certain services may be restricted as to number within a specified time frame.

(e) Review of services pursuant to Professional Standards Review Organization agreements entered into in accordance with Section 14104.

14133.01. (a) Notwithstanding any other provision of law, the director or his or her designee may apply prior authorization by designing a sampling methodology that will result in a generally acceptable audit standard for approval of a treatment authorization

request (TAR), or a class of TARs. The director or his or her designee shall determine the applicable sampling methodology based upon health care industry standards and discussions with applicable Medi-Cal providers or their representatives. This sampling methodology shall be implemented by no later than July 1, 2005, and an outline of it shall be provided to the fiscal and policy committees of both houses of the Legislature. It is the intent of the Legislature for the department to review the sampling methodology on an ongoing basis and update it as applicable on a periodic basis in order to keep abreast of health care industry trends and the need to manage an efficient and effective Medi-Cal program.

(b) The department shall pursue additional means to improve and streamline the treatment authorization request process including, where applicable, those identified by independent analyses such as the July 2003 report by the California Healthcare Foundation entitled Medi-Cal Treatment Authorizations and Claims Processing: Improving Efficiency and Access to Care, and those identified by Medi-Cal providers. It is the Legislature's intent that any identified improvements be cost-beneficial to the state and to the Medi-Cal program as a whole.

(c) 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, interpret, or make specific, this section by means of all-county letters, provider bulletins, or similar instructions. Thereafter, the department may 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.

14133.05. (a) Notwithstanding any other provision of law, a request for a treatment authorization received by the department shall be reviewed for medical necessity only.

(b) Any claim for a service that is authorized pursuant to a treatment authorization request that qualifies for approval under the requirements established by the department in regulations shall be reduced in accordance with Section 14115.

(c) If a provider does not agree with the decision on a treatment authorization request, the provider may appeal the decision pursuant to procedures set forth in regulations adopted by the department.

(d) Providers shall comply with the administrative remedies available to them prior to seeking a judicial remedy with respect to a decision of the department on a treatment authorization request.

14133.07. (a) Prior authorization for podiatric services provided on an outpatient or inpatient basis shall not be required when all of the following conditions are met:

(1) The services are provided by a doctor of podiatric medicine acting within the scope of his or her practice.

(2) The services are related to trauma, infection management, pain control, wound management, diabetic foot care, or limb salvage.

(3) The services are medically necessary.

(4) An urgent or emergency need for services exists at the time the service is provided.

(5) The patient was referred to the doctor of podiatric medicine by a physician.

(6) Prior authorization is not required for a physician providing the same service.

(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 implement, interpret, or make specific this section by means of all county letters, provider bulletins, or similar instructions.

(c) This section shall become operative October 1, 2006.

14133.1. (a) The director shall determine which of the utilization controls in Section 14133 shall be applied to any specific service or group of services which are subject to utilization controls. Each utilization control shall be reasonably related to the purpose for which it is imposed.

(b) Except as provided in Sections 14103.6 and 14133.15, neither prior authorization nor the limitation specified in subdivision (d) of Section 14133 shall be required for the first two services per month which are included among the services listed in subdivision (a) of Section 14132, or for the first two drug prescriptions purchased during any one month, provided that the prescription drugs are included in the Medi-Cal Drug Formulary and the prescription otherwise conforms to applicable formulary requirements.

(c) The director shall, after a determination of cost benefit, modify or eliminate the requirement of prior authorization as a control for treatment, supplies, or equipment which costs less than one hundred dollars (\$100), except for prescribed drugs, provided that the requirement of prior authorization for treatment, supplies, or equipment may be reinstated upon a finding by the department that the elimination of the requirement has resulted in unnecessary utilization, and upon notice to the Joint Legislative Budget Committee 30 days prior to the reinstatement of the requirement of prior authorization. Modification of the utilization controls may include establishing prior authorization review thresholds at levels other than one hundred dollars (\$100) if indicated by the cost-benefit analysis.

14133.10. (a) Where it is expected to be cost-effective, the director may, in conducting Medi-Cal acute care inpatient hospital utilization control, establish a program of aggressive case management of elective, nonemergency acute care hospital admissions for the purpose of reducing both the numbers and duration of acute care hospital stays by Medi-Cal beneficiaries.

(b) In conducting the case management program, the department may, conduct daily reviews to determine the need for additional days of inpatient care.

(c) In undertaking this case management program, the director may enter into contracts, on a bid or nonbid basis, for the purposes of obtaining the necessary expertise to train and educate utilization control staff in case management concepts, principles and techniques, identify and recommend cost-effective therapies, services and technology as alternatives to elective acute care hospitalization or

to directly provide the case management and diversion services.

(d) In order to achieve maximum cost savings the Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Therefore, contracts under this article may be on a nonbid basis, and shall be exempt from the provisions of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code. Contracts shall have no force and effect unless approved by the Department of Finance.

(e) The department shall seek all federal waivers necessary to allow for federal financial participation under this section.

14133.12. (a) The director shall apply utilization controls to continuous skilled nursing care services provided pursuant to the pilot program established under Section 14495.10, including, but not limited to, prior authorization and monitoring by the department. Prior authorization shall ensure that continuous skilled nursing care services are medically necessary, and that the provision of continuous skilled nursing care will avoid a transfer to, or placement at, a higher level of service. Monitoring shall be conducted by the department including, but not limited to, evaluation of quality of life, health, safety, and well-being of the beneficiary, and quality, efficiency, and cost effectiveness of the continuous skilled nursing care services. The department shall consult with the State Department of Developmental Services and regional centers to design monitoring efforts.

(b) Payment of the reimbursement rates established pursuant to Section 14110.55 shall be subject to all billing criteria of the Medi-Cal program and the utilization controls set forth in this section.

(c) This section shall become operative only if the federal waiver identified under Section 14495.10 is approved by the federal Health Care Financing Administration. The director shall maintain a record of the satisfaction of this condition.

14133.14. The criteria that the department shall use to identify providers to be placed on prior authorization for noninvasive testing procedures shall include, but not be limited to, Medi-Cal trend analysis, provider profiling data, provider and beneficiary history data, or appropriateness of the services as related to diagnosis, volume of services, utilization patterns, and specialty of provider. The existing prior authorization appeals process shall be available to these providers for denial of services.

14133.15. (a) The provision of services to beneficiaries eligible for medical assistance benefits may be subject to utilization controls, as provided for in Section 50793 of Title 22 of the California Administrative Code as the section existed on January 1, 1984, when the director finds that the utilization controls are necessary to carry out the provisions of this chapter.

(b) Where the director determines that a recipient has been abusing drugs or services, the recipient may, in order to prevent his

or her abuse, be placed on utilization controls for a maximum period of two years, which may be extended for an additional period upon a determination by the director that the potential for abuse still exists after notice and hearing, as set forth in subdivisions (f) and (g).

(c) If the director determines that a recipient has violated utilization controls placed upon that recipient pursuant to subdivision (b), the director may provide that the recipient shall receive medical assistance benefits referred, ordered, or prescribed through only one primary care provider of services for a maximum period of two years, which may be extended for an additional period upon a determination by the director that the potential for abuse still exists after notice and hearing, as set forth in subdivisions (f) and (g). The director shall afford the beneficiary an opportunity to nominate a primary care provider for department consideration. Circumvention of beneficiary utilization controls includes, but is not limited to, the following acts:

- (1) Altering restricted Medi-Cal identification cards.
- (2) Obtaining temporary nonrestricted cards.
- (3) Establishing an additional nonrestricted eligibility status.

(d) If a recipient is convicted of any misdemeanor or felony involving fraud or abuse either of medical assistance benefits or services, or in connection with any public assistance program, the director may restrict the recipient's eligibility for medical assistance benefits for a maximum period of two years, which may be extended for an additional period upon a determination by the director that the potential for fraud or abuse still exists and upon giving notice to the recipient setting forth the facts upon which the determination is made. The record of conviction or a certified copy thereof, certified by the clerk of the court in which the conviction is had, shall be conclusive evidence of the fact that the conviction occurred. A plea or verdict of guilty, or a conviction following a plea of nolo contendere, is deemed to be a conviction within the meaning of this section. The restriction shall not take effect earlier than the date of the director's order. Restriction following a conviction is not subject to the proceedings required in subdivision (g).

(e) Where the director determines that a recipient deliberately abuses or misuses program benefits, the director may provide that the recipient shall receive medical assistance benefits referred, ordered, or prescribed through only one primary care provider of services for a maximum period of two years, which may be extended for an additional period upon a determination by the director that a potential for abuse still exists after notice and hearing as set forth in subdivisions (f) and (g). Deliberate abuse or misuse of program benefits includes, but is not limited to, the following:

- (1) Forging prescriptions.
- (2) Sale or lending of Medi-Cal identification cards.
- (3) Collusion with providers for services or supplies.

(f) A recipient who commits a violation of subdivision (b), (c), or (e) shall be notified of the impending restriction, the reasons for the restriction and be provided an opportunity for a fair hearing.

(g) A recipient who commits a violation of subdivision (b), (c), or (e) is subject to restriction of fee for service Medi-Cal assistance benefits. The proceedings for restriction shall be conducted in accordance with Chapter 7 (commencing with Section

10950) of Part 2, or any rule or regulation promulgated by the director pursuant to this section.

(h) The imposition of restrictions, pursuant to this section, with respect to the eligibility of any individual shall not affect the eligibility of any other person for medical assistance benefits under this program, regardless of the relationship between that individual and the other person.

(i) This section shall not apply in any instance where a bona fide emergency exists which requires immediate treatment.

14133.16. (a) Notwithstanding subdivision (1) of Section 14132, hearing aids are covered when supplied by a hearing aid dispenser on prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available in the community, plus an audiological evaluation, which shall be performed by or under the supervision of the attending physician or by a licensed audiologist.

(b) Prior to prescribing a hearing aid, a physician or otolaryngologist shall perform a complete ear, nose, and throat examination.

(c) Prior to coverage, a hearing aid assessment shall be performed by the dispensing practitioner, either a physician, a licensed audiologist, or a licensed hearing aid dispenser acting within the scope of practice as described in Section 3306 of the Business and Professions Code.

(d) Coverage shall be based on the results of the examination, evaluation, and assessment required by this section.

(e) One hearing aid assessment within a 12-month period is a covered benefit. In the event the beneficiary receives more than one hearing aid assessment within a 12-month period, Medi-Cal shall reimburse the first valid claim received by the program for only one hearing aid assessment unless additional assessments are deemed to be medically necessary.

14133.2. (a) The director shall include in the Medi-Cal list of contract drugs any drug approved for the treatment of cancer by the federal Food and Drug Administration, so long as the manufacturer has executed a contract with the Health Care Financing Administration which provides for rebates in accordance with Section 1396r-8 of Title 42 of the United States Code. These drugs shall be exempt from the contract requirements of Section 14105.33.

(b) In addition to any drug added to the list of contract drugs pursuant to subdivision (a), any drug that meets either of the following criteria and for which the manufacturer has executed a contract with the Health Care Financing Administration that provides for rebates in accordance with Section 1396r-8 of Title 42 of the United States Code, shall be a Medi-Cal benefit, subject to utilization controls, unless the contract requirements of Section 14105.33 have been complied with:

(1) Any drug approved by the federal Food and Drug Administration for treatment of opportunistic infections associated with cancer.

(2) Any drug or biologic used in an anticancer chemotherapeutic

regimen for a medically accepted indication, which has either been approved by the federal Food and Drug Administration, or recognized for that use in one of the following:

(A) The American Medical Association Drug Evaluations.

(B) The United States Pharmacopoeia Dispensing Information.

(C) Two articles from peer reviewed medical journals that present data supporting the proposed use or uses as generally safe and effective.

14133.22. (a) Prescribed drugs shall be limited to no more than six per month, unless prior authorization is obtained.

(b) The limit in subdivision (a) shall not apply to patients receiving care in a nursing facility.

(c) The limit in subdivision (a) shall not apply to drugs for family planning.

(d) The department may issue Medi-Cal cards that contain labels for prescribed drugs to implement this section.

(e) In carrying out this section, the department may contract either directly, or through the fiscal intermediary, for pharmacy consultant staff necessary to accomplish the treatment authorization request reviews.

14133.225. Notwithstanding any other law, the department shall not provide or pay for any prescription drug or other therapy to treat erectile dysfunction for any person who is required to register pursuant to Section 290 of the Penal Code, except to the extent required under federal law. The department may require from the Department of Justice the information necessary to implement this section.

14133.23. (a) To the extent that federal financial participation is not available, the provision of drug benefits under this chapter to full-benefit dual eligible beneficiaries who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-101 et seq.) or under a Medicare Advantage-Prescription Drug plan (MA-PD plan) under Part C of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-21 et seq.), is eliminated, except as otherwise provided under this section.

(b) (1) Notwithstanding any other provision of law, only drug benefits for which federal financial participation is available shall be provided under this chapter to a full-benefit dual eligible beneficiary, except as otherwise provided under subdivision (c).

(2) As a benefit under this chapter, the department, subject to the approval of the Department of Finance and only to the extent that federal financial participation is available, may elect to provide a drug or drugs in a class of drugs not covered under Part D of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-101 et seq.) or under a MA-PD plan under Part C of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-21 et seq.) to full-benefit dual eligible beneficiaries.

(3) As a benefit under this chapter, and only to the extent that federal financial participation is available, the department shall

provide a drug or drugs to full-benefit dual eligible beneficiaries who are otherwise eligible to receive the drug or drugs due to their entitlement under Title 42 United States Code, Chapter 7, Title XVIII, Part A or their enrollment under Title 42 United States Code, Chapter 7, Title XVIII, Part B.

(4) Except as provided under paragraph (3) and subdivision (c), nothing in this section shall be interpreted to require the department to provide any drug or drugs not covered under Part D of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-101 et seq.) or under a MA-PD plan under Part C of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-21 et seq.) if federal financial participation is not available.

(c) (1) The department shall review the drug formularies of prescription drug plans under Part D of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-101 et seq.) or MA-PD plans under Part C of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-21 et seq.) available to full-benefit dual eligible beneficiaries.

(2) The department shall develop a process that would allow the department to provide to a full-benefit dual eligible beneficiary, on an emergency basis only, coverage for a drug or drugs not included on the full-benefit dual eligible beneficiary's prescription drug plan's formulary or by prior authorization under Part D of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-101 et seq.) or MA-PD plans under Part C of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-21 et seq.) for which federal financial participation is not available.

(3) Only to the extent that the Legislature made a specific appropriation to fund the provision of emergency drug benefits for which federal financial participation is not available to full-benefit dual eligible beneficiaries, the department shall provide, through the process described in paragraph (2), these emergency drug benefits to a full-benefit dual eligible beneficiary only when all of the following conditions are met:

(A) The drug is not available to the full-benefit dual eligible beneficiary under his or her plan's drug formulary or by prior authorization.

(B) The pharmacist provides or dispenses the drug as an emergency service.

(C) The quantity of the drug provided or dispensed is no greater than a 60-day supply.

(D) The pharmacist has not previously provided or dispensed nor has knowledge that another pharmacist has provided or dispensed the same drug for that full-benefit dual eligible beneficiary on or after January 1, 2006.

(E) The date of service is from January 1, 2006, through December 31, 2006, inclusive.

(4) The department may impose a pre- or post-service prepayment or postpayment review or audit, to review the medical necessity of emergency services provided to full-benefit dual eligible beneficiaries.

(d) The department shall seek approval of any amendments to the state plan necessary to implement this section as required by Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(e) 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, interpret or make specific this section by

means of all county letters, provider bulletins, or similar instructions. Thereafter, the department may 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.

(f) (1) Notwithstanding any other provision of this section, and only to the extent that funds are appropriated for this purpose, the department shall provide on a time-limited basis, as described in paragraphs (7) and (8), drug benefits to a full-benefit dual eligible beneficiary who is not able to obtain drug benefits from his or her Medicare Drug Plan only when one or more of the following conditions are met:

(A) The pharmacy has submitted a claim for the provision of drug benefits to the full-benefit dual eligible beneficiary's Medicare Drug Plan and the claim has been denied payment for reasons other than processing errors or omissions made by the pharmacy, lack of medical necessity, or health or safety reasons.

(B) The pharmacy is unable to submit a claim for the provision of drug benefits solely due to the unavailability of complete or accurate Medicare Drug Plan enrollment information from the full-benefit dual eligible beneficiary's Medicare Drug Plan, the federal Centers for Medicare and Medicaid Services, or entities under contract with the Centers for Medicare and Medicaid Services to provide enrollment information.

(C) The Medicare Drug Plan provides information that the full-benefit dual eligible beneficiary's deductible or copayment amount is higher than the copayment amounts that are established by Medicare for full-benefit dual eligible beneficiaries.

(2) The director may impose a pre- or post-service prepayment or postpayment review or audit to determine whether a pharmacy has accurately and in good faith established the existence of any condition certified by the pharmacy pursuant to subparagraph (A), (B), or (C) of paragraph (1) in support of a submitted claim to the department.

(3) If the claim submitted by the pharmacy to the Medicare Drug Plan meets the circumstances described in subparagraph (C) of paragraph (1), the department shall pay the Medi-Cal rate less the Medicare Drug Plan reimbursement amount and the Medicare copayment amount.

(4) To obtain reimbursement from the department, a pharmacy must be an enrolled provider in the Medi-Cal program and certify on its claims under penalty of perjury that one of the conditions specified in paragraph (1) exists.

(5) The department shall seek reimbursement from the federal government of all funds spent to comply with the provisions of this subdivision.

(6) To the extent that the department reimburses a pharmacy for claims authorized under this subdivision, the director shall have the right to recover or recoup the full cost expended by the state for that reimbursement from the full-benefit dual eligible beneficiary's Medicare Drug Plan.

(7) Reimbursement for claims authorized under this subdivision shall be limited to those drug benefits provided to a full-benefit dual eligible beneficiary from January 12, 2006, to February 15, 2006, inclusive.

(8) After February 15, 2006, the Governor may, upon notice to the Joint Legislative Budget Committee, extend coverage for drug benefits

to a full-benefit dual eligible beneficiary for coverage periods of up to 30 days each. In no event shall the reimbursement authorized by this paragraph extend beyond May 16, 2006.

(9) Any drug benefits made available to full-benefit dual eligible beneficiaries under the authority of this subdivision shall be limited to the funds appropriated by the Legislature to the department for this purpose. These drug benefits shall not be deemed to be an entitlement.

(g) (1) Notwithstanding any other provision of this section, and only to the extent that funds are appropriated for this purpose, beginning May 17, 2006, and ending January 31, 2007, the department shall provide emergency drug benefits to a full-benefit dual eligible beneficiary who is unable to obtain drug benefits from his or her Medicare Drug Plan only when one or more of the following conditions are met:

(A) The pharmacy has submitted a claim for the provision of drug benefits to the full-benefit dual eligible beneficiary's Medicare Drug Plan and the claim has been denied payment due to error by the Medicare Program and the pharmacy has made a good faith effort to resolve the error with the Medicare Drug Plan and the Medicare Program.

(B) The pharmacy is unable to submit a claim for the provision of drug benefits solely due to incomplete or inaccurate Medicare Drug Plan enrollment information from the full-benefit dual eligible beneficiary's Medicare Drug Plan, the federal Centers for Medicare and Medicaid Services, or entities under contract with the Centers for Medicare and Medicaid Services to provide enrollment information, and the pharmacy has attempted to resolve these problems with the Medicare facilitated enrollment contractor and the Medicare Drug Plan, where appropriate.

(C) The Medicare Drug Plan provides information that the full-benefit dual eligible beneficiary's deductible or copayment amount is higher than the copayment amounts that are established by Medicare for full-benefit dual eligible beneficiaries.

(D) Request for prior authorization or exception to the full-benefit dual eligible beneficiary's Medicare Drug Plan is required and was sought by the pharmacist, but the pharmacy does not receive a response within 24 hours for an emergency drug or within 72 hours for a nonemergency drug. When submitting a request for prior authorization to the department, a pharmacy shall show proof of the submission of the request that was made to either the Medicare Drug Plan or the beneficiary's prescribing physician.

(2) In providing these benefits, the department shall implement prepayment utilization controls, including prior authorization, and may implement postpayment reviews or audits to determine whether a pharmacy has accurately and in good faith established the existence of any condition certified by the pharmacy pursuant to subparagraph (A), (B), (C), or (D) of paragraph (1) in support of a submitted claim to the department.

(3) If the claim submitted by the pharmacy to the Medicare Drug Plan meets the circumstances described in subparagraph (C) of paragraph (1), the department shall pay only the difference between the copayment amount established by Medicare for full-benefit dual eligible beneficiaries and the actual copayment amount charged.

(4) To obtain reimbursement from the department, a pharmacy must be an enrolled provider in the Medi-Cal program and certify on its claims under penalty of perjury that one of the conditions specified

in paragraph (1) exists.

(5) To the extent that the department reimburses a pharmacy for claims authorized under this subdivision, the director shall have the right to recover or recoup the full cost expended by the state for that reimbursement from the full-benefit dual eligible beneficiary's Medicare Drug Plan.

(6) Any drug benefits made available to full-benefit dual eligible beneficiaries under the authority of this subdivision shall not be deemed to be an entitlement. Beginning September 1, 2006, the department shall not cover drug benefits when prior authorization or exception to the full-benefit dual eligible beneficiary's Medicare Drug Plan is required, unless that authorization was sought by the physician and the Medicare Drug Plan does not provide a response within 24 hours for an emergency drug or within 72 hours for a nonemergency drug.

(h) (1) For the purposes of this section, a "full-benefit dual eligible beneficiary" means an individual who meets both of the following criteria:

(A) The beneficiary is eligible or would be eligible for coverage for the month for covered Part D drugs under a prescription drug plan under Part D of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-101 et seq.) or under a MA-PD plan under Part C of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-21 et seq.).

(B) Notwithstanding any other provision of this section, the beneficiary is determined eligible for full-scope services, including drug benefits, for which federal financial participation is available.

(2) For the purposes of this section, "Medicare Drug Plan" means a prescription drug plan under Part D of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-101 et seq.) or under a MA-PD plan under Part C of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-21 et seq.).

(i) Subdivisions (a) and (b) and paragraph (3) of subdivision (c) shall become operative on January 1, 2006.

14133.25. (a) The director shall identify those surgical and medical procedures capable of outpatient performance and establish conditions for assuring performance in an outpatient rather than inpatient setting when medically appropriate.

(b) The director shall identify and apply appropriate utilization controls to review outpatient and office medical and surgical procedures for medical necessity and program coverage. The director may under this section identify and require prior authorization for any specified outpatient or office medical or surgical procedure performed during a month without regard to the provisions of Section 14133.1, provided that, with respect to outpatient or office medical procedures, those medical procedures which remain not subject to prior authorization are sufficient in number and scope as to achieve the general purpose of Section 14133. 1.

(c) The director may establish a schedule of differential reimbursement rates to the operating surgeon for surgery procedures. Those surgery procedures which can safely be performed on an outpatient basis may be reimbursed at a higher level when performed in an outpatient setting than the same procedures performed on an inpatient basis.

(d) Provisions of this section shall not be applied to mental health services as defined under Division 5 (commencing with Section 5000) or Section 14021, or any other mental health services funded by the Medi-Cal program.

14133.3. (a) The director shall require fully documented medical justification from providers that the requested services are medically necessary to prevent significant illness, to alleviate severe pain, to protect life, or to prevent significant disability, on all requests for prior authorization.

(b) For services not subject to prior authorization controls, offered by noncontract hospitals in closed health facility planning areas to beneficiaries who were experiencing life-threatening or emergency situations, but could not be stabilized sufficiently in order to facilitate being transported to contracting hospitals, the director shall additionally determine utilization controls that shall be applied to ensure that the health care services provided and the conditions treated, are medically necessary to prevent significant illness, alleviate severe pain, to protect life, or prevent significant disability. These utilization controls shall take into account those diseases, illnesses, or injuries that require preventive health services or treatment to prevent serious deterioration of health.

(c) Nothing in this section shall preclude payment for family planning services or early and periodic screening, diagnosis, and treatment services mandated by federal law.

(d) For the purposes of this section, a "noncontract hospital" means a hospital that has not contracted with the department for the provision of inpatient services pursuant to Article 2.6 (commencing with Section 14081).

(e) This section shall not be applied to mental health services as defined under Division 5 (commencing with Section 5000) or Section 14021, or any other mental health services funded by the Medi-Cal program.

14133.37. For drugs covered under this chapter requiring prior authorization, the department shall ensure the timely and efficient processing of authorization requests by doing all of the following:

(a) Providing a response by telephone or other means of telecommunication within 24 hours of the receipt of an authorization request.

(b) To the extent permitted by federal law, providing for the dispensing of at least a 72-hour supply of a covered drug in an emergency situation, as defined by federal regulation.

14133.4. Notwithstanding any other provision of law, utilization controls adopted by the State Department of Health Services shall not include prior authorization for portable X-ray services provided in nursing facilities and all categories of intermediate care facilities for the developmentally disabled, as defined in Section 1250 of the Health and Safety Code.

14133.45. (a) Utilization controls adopted by the department shall not include prior authorization for renal dialysis treatment provided to eligible recipients for the treatment of end stage renal disease.

(b) For purposes of this section, "end stage renal disease" is the same as defined in subdivision (d) of Section 1794.02 of the Health and Safety Code.

(c) Notwithstanding the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of the Government Code, the department may implement this section by provider manual or similar notice without further regulatory action.

14133.5. There shall be established a two-year pilot program, whereby in Alameda County, utilization controls shall not be required when, pursuant to Title XVIII of the federal Social Security Act, a county hospital based utilization review committee has been established to determine the level of authorization for payment and a utilization plan has been filed with the department and approved by it. The department shall adopt rules and regulations to implement this section, within 60 days of the effective date of this act, including requirements that a hospital's utilization review committee shall demonstrate that it is more cost-effective than the Medi-Cal utilization control function.

No later than 18 months following the commencement of the pilot program, the department shall submit a report to the Legislature on the program.

14133.51. Notwithstanding Section 14133.5, the Alameda County pilot program, as established in Section 14133.5, shall be a permanent program.

14133.6. In acting upon prior authorization requests for nonemergency medical transportation services, the department shall consider all relevant information in its possession regarding the beneficiary for whom services are requested. The department shall act upon such requests in a timely and expeditious manner. The department shall not form separate units within its field offices to receive and act upon prior authorization requests for nonemergency medical transportation. The provisions of this section shall be applicable only in counties having a population in excess of 6,000,000.

14133.65. Prior authorization for the use of nonemergency medical transportation services by patients to and from dialysis treatment shall be approved for a period of up to one year when the patient has received the transportation services for the immediately preceding 12 months, the request for renewed prior authorization is supported by a physician's certification that the patient's condition is unlikely to improve during the period covered by the request, and the

department has determined that there is medical necessity for the service. Whenever there is a change or improvement in the patient's condition, the physician shall submit a new certification to the department.

14133.7. The department shall not require emergency certification statements for hospital inpatient claims which have been reviewed and approved by the department for appropriateness of emergency admission or length of stay.

14133.8. (a) A bone marrow transplant for the treatment of cancer for beneficiaries who are eligible for full-scope benefits under this chapter, shall be reimbursable under this chapter, when all of the following conditions are met:

(1) The bone marrow transplant is recommended by the recipient's physician.

(2) The bone marrow transplant is performed in a hospital that is approved for participation in the Medi-Cal program.

(3) The bone marrow transplant is a reasonable course of treatment and is approved by the hospital medical policy committee when there is an existing committee or a committee can be established.

(4) The bone marrow transplant has been deemed appropriate for the recipient by the program's medical consultant. The medical consultant shall not disapprove the bone marrow transplant solely on the basis that it is classified as experimental or investigational.

(b) The program shall provide reimbursement for both donor and recipient surgery.

(c) The department may establish inpatient rates of reimbursement not in accordance with the state plan for those hospitals not under contract with the state pursuant to Article 2.6 (commencing with Section 14081), provided that the state plan is subsequently amended to reflect the method of reimbursement.

(d) This section shall not be construed as prohibiting reimbursement for any bone marrow transplants otherwise provided for under this chapter.

(e) Any bone marrow transplant authorized by the department pursuant to this section shall be subject to utilization controls.

(f) 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, interpret, or make specific this section by means of all-county letters, provider bulletins, or other instructions, without taking any further regulatory action.

14133.85. (a) (1) Except as otherwise provided in this subdivision, prior authorization shall not be required for hospice services.

(2) Paragraph (1) shall not apply to any admission which violates federal law.

(b) Prior authorization shall be required for inpatient hospice services.

14133.9. The implementation of prior authorization permitted by subdivision (a) of Section 14133 shall be subject to all of the

following provisions:

(a) The department shall secure a toll free phone number for the use of providers of Medi-Cal services listed in Section 14132. For providers, the department shall provide access to an individual knowledgeable in the program to provide Medi-Cal providers with information regarding available services. Access shall include a toll-free phone number that provides reasonable access to that person. The number shall be operated 24 hours a day, seven days a week.

(b) For major categories of treatment subject to prior authorization, the department shall publicize and continue to develop its list of objective medical criteria that indicate when authorization should be granted. Any request meeting these criteria, as determined by the department, shall be approved, or deferred as authorized in subdivision (e) by specific medical information.

(c) The objective medical criteria required by subdivision (d) shall be adopted and published in accordance with the Administrative Procedure Act, and shall be made available at appropriate cost.

(d) When a proposed treatment meets objective medical criteria, and is not contraindicated, authorization for the treatment shall be provided within an average of five working days. When a treatment authorization request is not subject to objective medical criteria, a decision on medical necessity shall be made by a professional medical employee or contractor of the department within an average of five working days.

(e) Notwithstanding the provisions of subdivisions (c) and (d), the department shall adopt, by emergency regulations as provided by this subdivision, a list of elective services that the director determines may be nonurgent. In determining these services, the department shall be guided by commonly accepted medical practice parameters. Authorization for these services may be deferred for a period of up to 90 days. In making determinations regarding these referrals, the department may use criteria separate from, or in addition to, those specified in subdivision (c). These deferrals shall be determined through the treatment authorization request process. When a proposed service is on the list of elective services that the director determines may be considered nonurgent, authorization for the service shall be granted or deferred within an average of 10 working days. The State Department of Health Services may adopt emergency regulations to implement this subdivision in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The initial adoption of emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety or general welfare. Initial emergency regulations and the first readoption of those regulations shall be exempt from review by the Office of Administrative Law. The emergency regulations authorized by this subdivision shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations and shall remain in effect for no more than 120 days.

(f) The department shall submit to the Legislature, every three months, its treatment authorization request status report.

(g) Final decisions of the department on denial of requests for prior authorization for inpatient acute hospital care shall be reviewable upon request of a provider by a Professional Standards

Review Organization established pursuant to Public Law 92-603, or a successor organization if either of the following applies:

(1) The original decision on the request was not performed by a Professional Standards Review Organization, or its successor organization.

(2) The original decision on the request was performed by a Professional Standards Review Organization, or its successor organization, and the original decision was reversed by the department. The department shall contract with one or more of these organizations to, among other things, perform the review function required by this subdivision. The review performed by the contracting organization shall result in a finding that the department's decision is either appropriate or unjustified, in accordance with existing law, regulation, and medical criteria. The cost of each review shall be borne by the party that does not prevail.

The decision of this body shall be reviewable by civil action.

(h) This section, and any amendments made to Section 14103.6 by Assembly Bill 2254 of the 1985-86 Regular Legislative Session, shall not apply to treatment or services provided under contracts awarded by the department under which the contractor agrees to assume the risk of utilization or costs of services.

14134. Except for any prescription, refill, visit, service, device, or item for which the program's payment is ten dollars (\$10) or less, in which case no copayment shall be required, a recipient of services under this chapter shall be required to make copayments not to exceed the maximum permitted under federal regulations or federal waivers as follows:

(a) Copayment of five dollars (\$5) shall be made for nonemergency services received in an emergency room. For the purposes of this section, "nonemergency services" means any services not required for the alleviation of severe pain or the immediate diagnosis and treatment of severe medical conditions which, if not immediately diagnosed and treated, would lead to disability or death.

(b) Copayment of one dollar (\$1) shall be made for each drug prescription or refill.

(c) Copayment of one dollar (\$1) shall be made for each visit for services under subdivisions (a) and (h) of Section 14132.

(d) The copayment amounts set forth in subdivisions (a), (b), and (c) may be collected and retained or waived by the provider.

(e) The department shall not reduce the reimbursement otherwise due to providers as a result of the copayment. The copayment amounts shall be in addition to any reimbursement otherwise due the provider for services rendered under this program.

(f) This section does not apply to emergency services, family planning services, or to any services received by:

(1) Any child in AFDC-Foster Care, as defined in Section 11400.

(2) Any person who is an inpatient in a health facility, as defined in Section 1250 of the Health and Safety Code.

(3) Any person 18 years of age or under.

(4) Any woman receiving perinatal care.

(g) Subdivision (b) does not apply to any person 65 years of age or over.

(h) A provider of service shall not deny care or services to an individual solely because of that person's inability to copay under

this section. An individual shall, however, remain liable to the provider for any copayment amount owed.

(i) The department shall seek any federal waivers necessary to implement this section. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented, but provisions for which waivers are either obtained or found to be unnecessary shall be unaffected by the inability to obtain federal waivers for the other provisions.

(j) The director shall adopt any regulations necessary to implement this section 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. 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. The director shall transmit these emergency regulations directly to the Secretary of State for filing and the regulations shall become effective immediately upon filing. Upon completion of the formal regulation adoption process and prior to the expiration of the 120 day duration period of emergency regulations, the director shall transmit directly to the Secretary of State for filing the adopted regulations, the rulemaking file, and the certification of compliance as required by subdivision (e) of Section 11346.1 of the Government Code.

14134.1. Except as provided in subdivision (b) of Section 14134, no provider under this chapter may deny care or services to an individual eligible for such care or services under this chapter on account of the individual's inability to pay a copayment, as defined in Section 14134. The requirements of this section shall not extinguish the liability of the individual to whom the care or services were furnished for payment of the copayment.

14134.2. The reimbursement rate for any three or more laboratory services for the same patient on the same day, which are commonly performed in an automated manner, as defined by the department, shall be reimbursed at the rate established for automated services. The director shall exempt from this provision laboratory services performed for urgent medical reasons or in rural areas, as defined by the department, if performed as individual tests.

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.

14134.55. The department shall streamline and simplify existing Medi-Cal program procedures in order to improve access to lactation supports and breast pumps among Medi-Cal recipients.

14134.6. Long-term health care facilities may charge a resident only the actual price paid by the facility for goods and services actually supplied to the resident and may not charge for hospital gowns. Facilities in the original contract shall inform residents of charges for personal laundry and drycleaning, haircuts, beautician services, manicures, pedicures, phone calls, television rental, and any other services payable by the resident. The facility shall also inform residents of any changes in those charges, and shall indicate on a resident's bill every good, product, service, and medication for which the resident is being charged, including, if the patient is a senior citizen, whether or not a senior discount was obtained on the medication.

14135. To assure maximum federal financial participation under this chapter, the director shall establish an enrollment fee, premium or similar charge to the extent required by federal law.

14136. (a) No city or county shall establish equipment and personnel standards for the furnishing of nonemergency medical transportation services for eligible Medi-Cal beneficiaries which are in conflict with equipment and personnel standards for reimbursement established by the department pursuant to this chapter. No standard adopted by cities or counties shall require the use of ambulances to

supply nonemergency medical transportation, where that standard would conflict with Section 14136.1.

(b) No city or county shall establish any permit, license, or inspection fees in excess of the actual cost of providing services directly associated with the provision of a permit, license, or inspection of nonemergency medical transportation vehicles.

(c) Prior to collection of any permit, license, or inspection fees, the city or county shall provide the nonemergency medical transportation provider from whom the fees will be collected with an itemized cost analysis specifying how the fees will be used.

(d) Nothing in this section shall be construed to otherwise limit the authority of a city or county to license, inspect, or regulate nonemergency medical transportation services so long as the regulation is not in conflict with standards established by the department.

(e) Nothing in this section shall be construed to prevent a city or county from allowing both emergency and nonemergency medical transportation services to operate within its jurisdiction under a sole franchise when such a franchise has been determined necessary to assure the economic viability of those services.

(f) Nothing in this section shall be construed to restrict the authority of local government to issue or deny licenses or permits to operate medical transportation services within its jurisdiction on the basis of need and necessity findings.

14136.1. It is the intent of the Legislature that, in order for payment to be made to a medical transportation service provider, a patient who requires continuous intravenous medication, medical monitoring, or observation during transport and patients being transferred from an acute care facility to another acute care facility shall be transported by ambulance.

In other situations where nonemergency medical transportation is given, ambulances need not be used.

14136.3. No prior authorization shall be necessary for the provision of nonemergency medical transportation services to Medi-Cal beneficiaries when the beneficiary is being transported from an acute care hospital following a stay as an inpatient to a nursing facility or any category of intermediate care facility for the developmentally disabled licensed pursuant to Section 1250 of the Health and Safety Code.

14136.4. A written treatment authorization request for nonemergency medical transportation services for which a department employed medical consultant had provided conditional prior authorization to the provider of services via telephone, shall not be denied by the Medi-Cal field office when the written treatment authorization request subsequently submitted by the provider substantiates the medical information given with the earlier verbal request, so long as the beneficiary was eligible to receive such services.

14136.5. No entity which has received funds under paragraph (2) of subsection (b) of Section 1601 of the federal Urban Mass Transportation Act shall receive reimbursement for medical transportation services rendered to beneficiaries of the Medi-Cal program in any amount greater or higher than the fee charged by the provider to persons for whom services are not reimbursed by Medi-Cal.

14136.8. No reimbursement shall be made for medical transportation services provided pursuant to subdivision (i) of Section 14132 when the services are prescribed or ordered by a person who has a significant beneficial interest in the medical transportation services rendered unless the nature and extent of that interest have been disclosed in accordance with, and subject to, Section 51466 of Title 22 of the California Administrative Code.

14137. The State Department of Health Services, following review and approval from the State Health and Welfare Agency, shall seek all necessary waivers from the United States Department of Health and Human Services in order to provide in-home and community-based care, as provided for under Section 2176 of the federal Omnibus Budget Reconciliation Act of 1981. The waiver proposal shall specifically include plans for the provision of services to any person who would be eligible for community-based and in-home services, as defined by the Department of Health Services, and who would be eligible for the Medi-Cal program, provided for pursuant to this chapter, except for the person's income and who can, therefore, become eligible by meeting spend-down requirements.

14137.6. (a) Notwithstanding any other provision of law, and subject to federal financial participation, covered services under this chapter shall include, subject to utilization controls, medically necessary inpatient and outpatient services associated with the administration of any drug that has been classified by the department or the Food and Drug Administration as having treatment Investigational New Drug (IND) status, when the drug is being administered for the treatment of acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), or human immunodeficiency virus (HIV), to otherwise eligible persons.

(b) The department shall adopt emergency regulations pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code to implement this section. The adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, or safety. Notwithstanding the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, emergency regulations adopted by the department in order to implement this section shall not be subject to the review and approval of the Office of Administrative Law. These regulations shall become effective immediately upon filing with the Secretary of State.

(c) No part of this section shall be construed to require the department to pay for the cost of treatment IND drugs provided for research purposes by pharmaceutical companies or any other sponsors at no cost.

(d) Payment for care to any Medi-Cal eligible HIV infected person in need of treatment shall not be denied solely on the basis of the use of a drug having treatment IND status.

(e) When medically feasible, every effort shall be made to administer drugs having treatment IND status on an outpatient basis.

14137.8. Approval of a request for acute inpatient care shall be solely dependent upon the medical necessity for this care, as documented in the proposed treatment plan. Treatment with Investigational New Drugs, clinical trials, or other ancillary or investigational services, if medical necessity is otherwise documented, shall not in itself be construed to be part of a research study protocol, and shall not constitute grounds for denial on that basis.

14138. (a) To the extent permitted by federal law, the department shall purchase vaccines and biological products in bulk from the Centers for Disease Control or any other sources at the lowest cost possible, for use by providers of services under this chapter and the Child Health and Disability Prevention program under Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, in the immunization of eligible children.

(b) It is the intent of the Legislature that, to the maximum extent possible, any savings of General Fund moneys realized from the program established pursuant to this section shall be reinvested in programs that are most likely to increase access to, and the quality of, immunization services for children.

(c) In order to achieve maximum cost savings, the Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Therefore, contracts under this section may be on a nonbid basis and shall be exempt from the provisions of the Public Contract Code.

(d) No part of this section shall be construed to require the department to undertake distribution of vaccines and biological products.
