WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 24. STATE-ONLY FAMILY PLANNING PROGRAM [24000 - 24027] *(Division 24 added by Stats. 1996, Ch. 197, Sec. 52.)*

24000. There is established in the State Department of Health Care Services the State-Only Family Planning Program to provide comprehensive clinical family planning services to low-income men and women. This division shall be known and may be cited as the State-Only Family Planning Program.

(Amended by Stats. 2012, Ch. 23, Sec. 121. (AB 1467) Effective June 27, 2012.)

24001. (a) (1) For purposes of this division, “family planning” 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, natural family planning, abstinence methods and basic, limited fertility management. 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. Family planning shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, not including contraceptives, or pregnancy care that is not incident to the diagnosis of pregnancy.

(2) Family planning services for males shall be expanded to include laboratory tests for sexually transmitted infections and comprehensive physical examinations. Within 60 days of approval of the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program, provided for pursuant to subdivision (aa) of Section 14132, the department shall seek to amend the waiver to add this expansion. The implementation of this paragraph shall be dependent upon federal approval and receipt of federal financial participation.

(b) For purposes of this division, “department” means the State Department of Health Care Services.

(Amended by Stats. 2012, Ch. 23, Sec. 122. (AB 1467) Effective June 27, 2012.)

24003. (a) A person shall be eligible to receive services pursuant to this chapter provided that the following conditions are met:

(1) The person is a resident of California.

(2) The person has a family income at or below 200 percent of the federal poverty level.

(3) The person has no other source of health care coverage unless the use of that health care coverage would create a barrier to access because of confidentiality.

(4) The person is not otherwise eligible for existing Medi-Cal services without a share of cost.

(b) Notwithstanding any other provision of law, the provision of family planning services shall not require the consent of anyone other than the person who is to receive the services.

(c) Eligibility shall be determined at point of service by the provider. The provider shall obtain information on the individual’s family size, income, and health care coverage and then, based on that information, determine if the individual meets the eligibility criteria specified in subdivision (a). All individuals who meet the eligibility requirements shall be certified by the provider as eligible for services under the program. A Medi-Cal share of cost shall not be used to deny access to family planning services under the program. The department may require the collection on a voluntary basis or the use of the individual’s social security number, or both. No services shall be denied to a client if a social security number is not provided.

(d) Eligibility shall be based on the individual's self-declaration of gross annual or monthly income, family size, and other source of health care coverage, signed under penalty of perjury at each annual eligibility certification. No asset information shall be used to determine eligibility.

(e) The department may establish a copayment system for services provided pursuant to this chapter that is based upon the income level of the individual and the cost of the service provided. No individual whose documented family income is at or below 100 percent of the federal poverty level shall be subject to copayment. The copayment fee shall not be used to deny access to family planning services. State reimbursement to the provider shall be offset by that amount of the copayment collected from the eligible individual. The department shall notify providers on an annual basis of the copayment fee schedule.

(Added by Stats. 1996, Ch. 197, Sec. 52. Effective July 22, 1996.)

24003.2. The basic preventive health services covered under this program shall include measles, mumps, and rubella vaccines for women of reproductive age. Within 60 days of approval of the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program, provided for pursuant to subdivision (aa) of Section 14132, the department shall seek to amend the waiver to add this expansion. The implementation of this section shall be dependent upon federal approval and receipt of federal financial participation.

(Added by Stats. 1999, Ch. 146, Sec. 71. Effective July 22, 1999.)

24003.5. Any male or female of reproductive age who is not at risk for pregnancy and is eligible for the program shall have available the scope of benefits provided by the program. Within 60 days of approval of the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program, provided for pursuant to subdivision (aa) of Section 14132, the department shall seek to amend the waiver to add this expansion. The implementation of this section shall be dependent upon federal approval and receipt of federal financial participation.

(Added by Stats. 1999, Ch. 146, Sec. 72. Effective July 22, 1999.)

24005. (a) This section applies to the Family Planning, Access, Care, and Treatment Program identified in subdivision (aa) of Section 14132 and this program.

(b) Only licensed medical personnel with family planning skills, knowledge, and competency may provide the full range of family planning medical services covered in this program.

(c) Medi-Cal enrolled providers, as determined by the department, shall be eligible to provide family planning services under the program when these services are within their scope of practice and licensure. Those clinical providers electing to participate in the program and approved by the department shall provide the full scope of family planning education, counseling, and medical services specified for the program, either directly or by referral, consistent with standards of care issued by the department.

(d) The department shall require providers to enter into clinical agreements with the department to ensure compliance with standards and requirements to maintain the fiscal integrity of the program. Provider applicants, providers, and persons with an ownership or control interest, as defined in federal Medicaid regulations, shall be required to submit to the department their social security numbers to the full extent allowed under federal law. All state and federal statutes and regulations pertaining to the audit or examination of Medi-Cal providers apply to this program.

(e) Clinical provider agreements shall be signed by the provider under penalty of perjury. The department may screen applicants at the initial application and at any reapplication pursuant to requirements developed by the department to determine provider suitability for the program.

(f) The department may complete a background check on clinical provider applicants for the purpose of verifying the accuracy of information provided to the department for purposes of enrolling in the program and in order to prevent fraud and abuse. The background check may include, but not be limited to, unannounced onsite inspection prior to enrollment, review of business records, and data searches. If discrepancies are found to exist during the preenrollment period, the department may conduct additional inspections prior to enrollment. Failure to remediate significant discrepancies as prescribed by the director may result in denial of the application for enrollment. Providers that do not provide services consistent with the standards of care or that do not comply with the department's rules related to the fiscal integrity of the program may be disenrolled as a provider from the program at the sole discretion of the department.

(g) The department shall not enroll any applicant who, within the previous 10 years:

(1) Has been convicted of any felony or misdemeanor that involves fraud or abuse in any government program, that relates to neglect or abuse of a patient in connection with the delivery of a health care item or service, or that is in connection with the interference with, or obstruction of, any investigation into health care related fraud or abuse.

(2) Has been found liable for fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse in any government program.

(h) In addition, the department may deny enrollment to any applicant that, at the time of application, is under investigation by the department or any local, state, or federal government law enforcement agency for fraud or abuse. The department shall not deny enrollment to an otherwise qualified applicant whose felony or misdemeanor charges did not result in a conviction solely on the basis of the prior charges. If it is discovered that a provider is under investigation by the department or any local, state, or federal government law enforcement agency for fraud or abuse, that provider shall be subject to immediate disenrollment from the program.

(i) (1) (A) Except as provided in subparagraph (B), the program shall disenroll as a program provider any individual who, or any entity that, has a license, certificate, or other approval to provide health care that is revoked or suspended by a federal, California, or other state's licensing, certification, or other approval authority, has otherwise lost that license, certificate, or approval, or has surrendered that license, certificate, or approval while a disciplinary hearing on the license, certificate, or approval was pending. The disenrollment shall be effective on the date the license, certificate, or approval is revoked, lost, or surrendered.

(B) (i) The department may elect to not disenroll an individual or entity as a provider in the program pursuant to subparagraph (A) if the revocation, suspension, or loss of the individual's or entity's license, certification, or other approval in another state, or if the pending disciplinary hearing during which the individual or entity surrendered the license, certification, or other approval in another state, is based solely on conduct that is not deemed to be unprofessional conduct under California law.

(ii) The department shall seek any federal approvals that it deems necessary to implement this subparagraph. This subparagraph shall be implemented only to the extent that the department obtains any necessary federal approvals and that federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.

(2) (A) Except as provided in subparagraph (B), a provider shall be subject to disenrollment if the provider submits claims for payment for the services, goods, supplies, or merchandise provided, directly or indirectly, to a program beneficiary, by an individual or entity that has been previously suspended, excluded, or otherwise made ineligible to receive, directly or indirectly, reimbursement from the program or from the Medi-Cal program and the individual has previously been listed on either the Suspended and Ineligible Provider List, which is published by the department, to identify suspended and otherwise ineligible providers or any list published by the federal Office of the Inspector General regarding the suspension or exclusion of individuals or entities from the federal Medicare and Medicaid programs, to identify suspended, excluded, or otherwise ineligible providers.

(B) (i) Subparagraph (A) does not apply if the sole basis for an individual's listing on either the Suspended and Ineligible Provider List or any list published by the federal Office of the Inspector General regarding the suspension or exclusion of individuals or entities from the federal Medicare and Medicaid programs, to identify suspended, excluded, or otherwise ineligible providers, is conduct that is not deemed to be unprofessional conduct under California law.

(ii) The department shall request a waiver or any other federal approvals that it deems necessary to implement this subparagraph. This subparagraph shall be implemented only to the extent that the department obtains any necessary federal approvals and that federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.

(3) The department shall deactivate, immediately and without prior notice, the provider numbers used by a provider to obtain reimbursement from the program when warrants or documents mailed to a provider's mailing address, its pay to address, or its service address, if any, are returned by the United States Postal Service as not deliverable or when a provider has not submitted a claim for reimbursement from the program for one year. Prior to taking this action, the department shall use due diligence in attempting to contact the provider at its last known telephone number and to ascertain if the return by the United States Postal Service is by mistake and shall use due diligence in attempting to contact the provider by telephone or in writing to ascertain whether the provider wishes to continue to participate in the Medi-Cal program. If deactivation pursuant to this section occurs, the provider shall meet the requirements for reapplication as specified in regulation.

(4) For purposes of this subdivision:

(A) "Mailing address" means the address that the provider has identified to the department in its application for enrollment as the address at which it wishes to receive general program correspondence.

(B) "Pay to address" means the address that the provider has identified to the department in its application for enrollment as the address at which it wishes to receive warrants.

(C) "Service address" means the address that the provider has identified to the department in its application for enrollment as the address at which the provider will provide services to program beneficiaries.

(j) Subject to Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, the department may enter into contracts to secure consultant services or information technology including, but not limited to, software,

data, or analytical techniques or methodologies for the purpose of fraud or abuse detection and prevention. Contracts under this section shall be exempt from the Public Contract Code.

(k) Enrolled providers shall attend specific orientation approved by the department in comprehensive family planning services. Enrolled providers who insert IUDs or contraceptive implants shall have received prior clinical training specific to these procedures.

(l) Upon receipt of reliable evidence that would be admissible under the administrative adjudication provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, of fraud or willful misrepresentation by a provider under the program or commencement of a suspension under Section 14123, the department may do any of the following:

(1) Collect any State-Only Family Planning Program or Family Planning, Access, Care, and Treatment Program overpayment identified through an audit or examination, or any portion thereof from any provider. Notwithstanding Section 100171 of the Health and Safety Code, a provider may appeal the collection of overpayments under this section pursuant to procedures established in Article 5.3 (commencing with Section 14170) of Chapter 7 of Part 3 of Division 9. Overpayments collected under this section shall not be returned to the provider during the pendency of any appeal and may be offset to satisfy audit or appeal findings, if the findings are against the provider. Overpayments shall be returned to a provider with interest if findings are in favor of the provider.

(2) Withhold payment for any goods or services, or any portion thereof, from any State-Only Family Planning Program or Family Planning, Access, Care, and Treatment Program provider. The department shall notify the provider within five days of any withholding of payment under this section. The notice shall do all of the following:

(A) State that payments are being withheld in accordance with this paragraph and that the withholding is for a temporary period and will not continue after it is determined that the evidence of fraud or willful misrepresentation is insufficient or when legal proceedings relating to the alleged fraud or willful misrepresentation are completed.

(B) Cite the circumstances under which the withholding of the payments will be terminated.

(C) Specify, when appropriate, the type or types of claimed payments being withheld.

(D) Inform the provider of the right to submit written evidence that is evidence that would be admissible under the administrative adjudication provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, for consideration by the department.

(3) Notwithstanding Section 100171 of the Health and Safety Code, a provider may appeal a withholding of payment under this section pursuant to Section 14043.65. Payments withheld under this section shall not be returned to the provider during the pendency of any appeal and may be offset to satisfy audit or appeal findings.

(m) As used in this section:

(1) “Abuse” means either of the following:

(A) Practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the Medicaid program, the Medicare Program, the Medi-Cal program, including the Family Planning, Access, Care, and Treatment Program, identified in subdivision (aa) of Section 14132, another state’s Medicaid program, or the State-Only Family Planning Program, or other health care programs operated, or financed in whole or in part, by the federal government or any state or local agency in this state or any other state.

(B) Practices that are inconsistent with sound medical practices and result in reimbursement, by any of the programs referred to in subparagraph (A) or other health care programs operated, or financed in whole or in part, by the federal government or any state or local agency in this state or any other state, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care.

(2) “Fraud” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(3) “Provider” means any individual, partnership, group, association, corporation, institution, or other entity, and the officers, directors, owners, managing employees, or agents of any partnership, group, association, corporation, institution, or other entity, that provides services, goods, supplies, or merchandise, directly or indirectly, to a beneficiary and has been enrolled in the program.

(4) “Convicted” means any of the following:

(A) A judgment of conviction has been entered against an individual or entity by a federal, state, or local court, regardless of whether there is a post-trial motion or an appeal pending or the judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed.

(B) A federal, state, or local court has made a finding of guilt against an individual or entity.

(C) A federal, state, or local court has accepted a plea of guilty or nolo contendere by an individual or entity.

(D) An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement in which judgment of conviction has been withheld.

(5) “Professionally recognized standards of health care” means statewide or national standards of care, whether in writing or not, that professional peers of the individual or entity whose provision of care is an issue, recognize as applying to those peers practicing or providing care within a state. When the United States Department of Health and Human Services has declared a treatment modality not to be safe and effective, practitioners that employ that treatment modality shall be deemed not to meet professionally recognized standards of health care. This definition shall not be construed to mean that all other treatments meet professionally recognized standards of care.

(6) “Unnecessary or substandard items or services” means those that are either of the following:

(A) Substantially in excess of the provider’s usual charges or costs for the items or services.

(B) Furnished, or caused to be furnished, to patients, whether or not covered by Medicare, Medicaid, or any of the state health care programs to which the definitions of applicant and provider apply, and which are substantially in excess of the patient’s needs, or of a quality that fails to meet professionally recognized standards of health care. The department’s determination that the items or services furnished were excessive or of unacceptable quality shall be made on the basis of information, including sanction reports, from the following sources:

(i) The professional review organization for the area served by the individual or entity.

(ii) State or local licensing or certification authorities.

(iii) Fiscal agents or contractors, or private insurance companies.

(iv) State or local professional societies.

(v) Any other sources deemed appropriate by the department.

(7) “Enrolled or enrollment in the program” means authorized under any and all processes by the department or its agents or contractors to receive, directly or indirectly, reimbursement for the provision of services, goods, supplies, or merchandise to a program beneficiary.

(n) In lieu of, or in addition to, the imposition of any other sanctions available, including the imposition of a civil penalty under Section 14123.2 or 14171.6, the program may impose on providers any or all of the penalties pursuant to Section 14123.25, in accordance with the provisions of that section. In addition, program providers shall be subject to the penalties contained in Section 14107.

(o) (1) Notwithstanding any other law, every primary supplier of pharmaceuticals, medical equipment, or supplies shall maintain accounting records to demonstrate the manufacture, assembly, purchase, or acquisition and subsequent sale, of any pharmaceuticals, medical equipment, or supplies, to providers. Accounting records shall include, but not be limited to, inventory records, general ledgers, financial statements, purchase and sales journals, and invoices, prescription records, bills of lading, and delivery records.

(2) For purposes of this subdivision, the term “primary supplier” means any manufacturer, principal labeler, assembler, wholesaler, or retailer.

(3) Accounting records maintained pursuant to paragraph (1) are subject to audit or examination by the department or its agents. The audit or examination may include, but is not limited to, verification of what was claimed by the provider. These accounting records shall be maintained for three years from the date of sale or the date of service.

(p) Each provider of health care services rendered to any program beneficiary shall keep and maintain records of each service rendered, the beneficiary to whom rendered, the date, and any additional information that the department may by regulation require. Records required to be kept and maintained pursuant to this subdivision shall be retained by the provider for a period of three years from the date the service was rendered.

(q) A program provider applicant or a program provider shall furnish information or copies of records and documentation requested by the department. Failure to comply with the department’s request shall be grounds for denial of the application or automatic disenrollment of the provider.

(r) A program provider may assign signature authority for transmission of claims to a billing agent subject to Sections 14040, 14040.1, and 14040.5.

(s) Moneys payable or rights existing under this division shall be subject to any claim, lien, or offset of the State of California, and any claim of the United States of America made pursuant to federal statute, but shall not otherwise be subject to enforcement of a money judgment or other legal process, and no transfer or assignment, at law or in equity, of any right of a provider of health care to any payment shall be enforceable against the state, a fiscal intermediary, or carrier.

(t) (1) Notwithstanding any other law, within 30 calendar days of receiving a complete application for enrollment into the Family PACT Program from an affiliate primary care clinic licensed under Section 1218.1 of the Health and Safety Code, the department shall do one of the following:

(A) Approve the provider's Family PACT Program application, provided the applicant meets the Family PACT Program provider enrollment requirements set forth in this section.

(B) If the provider is an enrolled Medi-Cal provider in good standing, notify the applicant in writing of any discrepancies in the Family PACT Program enrollment application. The applicant shall have 30 days from the date of written notice to correct any identified discrepancies. Upon receipt of all requested corrections, the department shall approve the application within 30 calendar days.

(C) If the provider is not an enrolled Medi-Cal provider in good standing, the department shall not proceed with the actions described in this subdivision until the department receives confirmation of good standing and enrollment as a Medi-Cal provider.

(2) The effective date of enrollment into the Family PACT Program shall be the later of the date the department receives confirmation of enrollment as a Medi-Cal provider, or the date the applicant meets all Family PACT Program provider enrollment requirements set forth in this section.

(u) Providers, or the enrolling entity, shall make available to all applicants and beneficiaries prior to, or concurrent with, enrollment, information on the manner in which to apply for insurance affordability programs, in a manner determined by the State Department of Health Care Services. The information provided shall include the manner in which applications can be submitted for insurance affordability programs, information about the open enrollment periods for the California Health Benefit Exchange, and the continuous enrollment aspect of the Medi-Cal program.

(Amended by Stats. 2024, Ch. 880, Sec. 1. (SB 1131) Effective January 1, 2025.)

24006. (a) This section applies to the Family Planning, Access, Care, and Treatment (Family PACT) Program identified in subdivision (aa) of Section 14132.

(b) A site certifier shall be a clinician employed by, or contracted with, the primary care clinic or the affiliate primary care clinic and who oversees the provision of Family PACT services at the clinic.

(c) A clinic corporation that operates a primary care clinic and that serves as a parent clinic, as described in Section 1218.1 of the Health and Safety Code, and one or more of its affiliate primary care clinics may enroll multiple, but no more than 10, service addresses under one site certifier.

(d) Any orientation or training that the department requires of a site certifier shall comply with each of the following:

(1) Is offered at least once every other month.

(2) Is offered through a virtual platform.

(3) Is updated at least annually to be consistent with current laws, policies, and medical standards.

(e) As used in this section, the following terms have the following meanings:

(1) "Affiliate primary care clinic" has the same meaning as set forth in Section 1218.1 of the Health and Safety Code.

(2) "Primary care clinic" has the same meaning as set forth in subdivision (a) of Section 1204 of the Health and Safety Code.

(3) "Service address" has the same meaning as set forth in Section 24005.

(4) "Site certifier" means an individual identified by the enrolled or enrolling provider to be responsible for ensuring that all practitioners and personnel providing services on behalf of the Family PACT Program complete and track required trainings approved by the Office of Family Planning within the department on an annual basis.

(Added by Stats. 2024, Ch. 880, Sec. 2. (SB 1131) Effective January 1, 2025.)

24007. (a) The department shall determine the scope of benefits for the program, which shall include, but is not limited to, the following:

(1) Family planning related services and male and female sterilization. Family planning services for men and women include emergency and complication services directly related to the contraceptive method and followup, consultation, and referral services, as indicated, that may require treatment authorization requests.

(2) All United States Department of Health and Human Services, Federal Drug Administration-approved birth control methods, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.

(3) Culturally and linguistically appropriate health education and counseling services, including informed consent; psychosocial and medical aspects of contraception, sexuality, fertility, pregnancy, and parenthood; infertility; reproductive health care; preconceptual and nutrition counseling; prevention and treatment of sexually transmitted infection; use of contraceptive methods, devices, and supplies; possible contraceptive consequences and followup; interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(4) 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.

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

(6) (A) Home test kits for sexually transmitted diseases, including any laboratory costs of processing the kit, that are deemed medically necessary or appropriate and ordered directly by an enrolled Family PACT clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.

(B) For purposes of this paragraph, “home test kit” means a product used for a test recommended by the federal Centers for Disease Control and Prevention guidelines or the United States Preventive Services Task Force that has been CLIA-waived, FDA-cleared or -approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting.

(C) Reimbursement under this subparagraph shall be contingent upon the addition of codes specific to home test kits in the Current Procedural Terminology or Healthcare Common Procedure Coding System to comply with Health Insurance Portability and Accountability Act requirements. The home test kit shall be sent by the enrolled Family PACT provider to a Medi-Cal-enrolled laboratory with fee based on Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule.

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

(b) Benefits under this program shall be effective in 30 days after notice to providers, but not sooner than January 1, 1997.

(Amended by Stats. 2021, Ch. 486, Sec. 9. (SB 306) Effective January 1, 2022.)

24007.5. The program formulary shall include all federal Food and Drug Administration approved contraceptive drugs, devices, and supplies that are authorized by the Medi-Cal program.

(Added by Stats. 1999, Ch. 146, Sec. 74. Effective July 22, 1999.)

24009. Family planning services are confidential. All information about personal facts and circumstances obtained by the provider shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the individual’s written consent, except as required by law or as may be necessary to provide emergency services to the individual or as required by the department to administer this program. Information may be disclosed in summary, statistical, or other form that does not identify particular individuals.

(Added by Stats. 1996, Ch. 197, Sec. 52. Effective July 22, 1996.)

24011. (a) Providers shall submit claims for reimbursement for services provided on or after January 1, 1997, or receipt of notice from the department, whichever is later, and covered by this program, to the fiscal intermediary of the department for payment. Charges and individual information shall be submitted on the form or in the format specified by the department for the state-only family planning program, and providers shall be reimbursed at the rates established for those services by the department.

(b) The department shall use existing contractual claims processing services in order to promote efficiency and to maximize use of funds.

(c) Claims for state-only family planning services provided through prescription, including laboratory and pharmaceutical, shall be reimbursed in a manner determined by the department. Eligible individuals shall not be charged for any state-only family planning laboratory or pharmaceutical services.

(d) Claims for method-related complications requiring approved treatment authorization requests shall be reimbursed regardless of category of medical service.

(Added by Stats. 1996, Ch. 197, Sec. 52. Effective July 22, 1996.)

24013. (a) Notwithstanding any other provision of law, the department may adopt any procedures as are necessary for the review of a grievance or complaint concerning the processing of claims or payment of moneys alleged by a provider of services to be payable by reason of any of the provisions of this division.

(b) Any applicant for, or recipient of, services under the state-only family planning program shall have a right to a hearing conducted by the department regarding the person's eligibility or receipt of services. A proposed decision from the administrative law judge shall be submitted to the State Director of Health Services for adoption, modification, or rehearing. The decision of the director shall be final. A person shall not have a right to contest changes made to the eligibility standards or benefits of the state-only family planning program.

(Added by Stats. 1996, Ch. 197, Sec. 52. Effective July 22, 1996.)

24015. The department may adopt emergency regulations as necessary to implement and administer this chapter in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The initial adoption of any emergency regulations following January 1, 1997, shall be deemed to be an emergency and necessary for immediate preservation of the public peace, health and safety, or general welfare. Emergency regulations adopted pursuant to this act shall remain in effect no more than 180 days.

(Added by Stats. 1996, Ch. 197, Sec. 52. Effective July 22, 1996.)

24017. The program shall be exempt from the requirements of Chapter 7 (commencing with Section 11700) of Part 1 of Division 3 of Title 2 of the Government Code and Chapter 3 (commencing with Section 12100) of Division 2 of Part 2 of the Public Contract Code as those requirements apply to the use of contractual claims processing services by the department.

(Added by Stats. 1996, Ch. 197, Sec. 52. Effective July 22, 1996.)

24021. The department shall conduct an evaluation of the effectiveness and efficiency of the program, including expanded access and reduction of unintended pregnancies, and shall report to the Legislature by no later than January 1, 2000. The department may use local assistance funds allocated to the State-Only Family Planning Program for the evaluation of the program.

(Added by Stats. 1996, Ch. 197, Sec. 52. Effective July 22, 1996.)

24023. It is the intent of the Legislature that the State Department of Health Services shall, effective March 1, 1997, conduct no other general statewide program for the provision of comprehensive clinical family planning services as referenced in Chapter 8.5 (commencing with Section 14500) of Part 3 of Division 9, while the State-Only Family Planning Program authorized by this division is in effect. For the purpose of avoiding a disruption of services, to the extent the implementation of the State-Only Family Planning Program does not occur on or before March 1, 1997, the Director of Health Services may extend the general statewide program for the provision of comprehensive clinical family planning services as referenced in Chapter 8.5 (commencing with Section 14500) of Part 3 of Division 9. This extension shall be made only upon notification to the Chairperson of the Joint Legislative Budget Committee and the chairperson of the committee in each house that considers appropriations and under no condition shall extend beyond 120 days.

(Added by Stats. 1996, Ch. 197, Sec. 52. Effective July 22, 1996.)

24027. The State-Only Family Planning Program established under this division is hereby reenacted and continued in existence in order to continue to provide comprehensive, clinical family planning services to those persons who are not eligible to receive these services under the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program established pursuant to subdivision (aa) of Section 14132, and to those persons who are not eligible to receive family planning services pursuant to subdivision (n) of Section 14132 without a share of cost.

(Repealed and added by Stats. 1999, Ch. 146, Sec. 76. Effective July 22, 1999.)