WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000 - 18999.98] *(Division 9 added by Stats. 1965, Ch. 1784.)*

PART 3. AID AND MEDICAL ASSISTANCE [11000 - 15771] *(Part 3 added by Stats. 1965, Ch. 1784.)*

CHAPTER 7. Basic Health Care [14000 - 14199.87] *(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)*

ARTICLE 4. The Medi-Cal Benefits Program [14131 - 14138] *(Heading of Article 4 renumbered from Article 4.2 by Stats. 1977, Ch. 1252.)*

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.

(Amended by Stats. 1975, Ch. 1005.)

14131.05. (a) Notwithstanding any other provision of this chapter or Chapter 8 (commencing with Section 14200), optional hearing aid benefits are subject to per beneficiary benefit cap amounts under the Medi-Cal program.

(b) For the purposes of this section, “benefit cap amount” means the maximum amount of Medi-Cal coverage for optional hearing aid benefits as specified in subdivision (c), for each beneficiary, for each fiscal year.

(c) (1) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to this part at the November 5, 2024, statewide general election, hearing aid benefits are subject to a benefit cap amount of one thousand five hundred ten dollars ($1,510).

(2) Notwithstanding paragraph (1), if the voters do not approve the addition of Chapter 7.5 (commencing with Section 14199.100) to this part at the November 5, 2024, statewide general election, hearing aid benefits are subject to a benefit cap amount of no less than one thousand five hundred ten dollars ($1,510). Under that circumstance, the benefit cap amount shall be set by the department and may be adjusted annually, any revisions to the benefit cap shall be subject to the provisions of Sections 14124.162 and 14124.163.

(d) Pregnancy-related benefits and benefits for the treatment of other conditions that might complicate the pregnancy are not subject to the benefit cap amount in subdivision (c).

(e) The benefit cap amount in subdivision (c) does not apply to the following:

(1) Beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment Program.

(2) Beneficiaries receiving long-term care in a nursing facility that is both of the following:

(A) A skilled nursing facility or intermediate care facility as defined in subdivisions (c), (d), (e), (g), and (h), respectively, of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the program established by Section 14132.20.

(B) A licensed nursing facility pursuant to subdivision (k) of Section 1250 of the Health and Safety Code.

(f) For managed care health plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), except for contracts with the Senior Care Action Network and AIDS Healthcare Foundation, payments for optional hearing aid benefits shall be reduced by the actuarial equivalent amount of the benefit reductions resulting from the implementation of the benefit cap amount specified in this section pursuant to contract amendments or change orders effective on July 1, 2011, or any date thereafter.

(g) This section shall be implemented only to the extent permitted by federal law.

(h) Notwithstanding 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), the department may implement the provisions of this section by means of all-county letters, provider bulletins, or similar instructions, without taking further regulatory action.

(i) This section shall be implemented on the first day of the first calendar month following 210 days after the effective date of this section, or on the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later. If the implementation date occurs after July 1, 2011, then the benefit cap described in subdivision (c) for the first year of implementation shall be applied from the implementation date through June 30 of the state fiscal year in which implementation commences. Thereafter, the benefit cap shall apply on a state fiscal year basis.

(Amended by Stats. 2024, Ch. 40, Sec. 64. (SB 159) Effective June 29, 2024.)

14131.10. (a) Notwithstanding this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591), in order to implement changes in the level of funding for health care services, specific optional benefits are excluded from coverage under the Medi-Cal program.

(b) (1) The following optional benefits are excluded from coverage under the Medi-Cal program:

(A) Adult dental services, except as specified in paragraph (2).

(i) This exclusion shall be in effect only through December 31, 2017, and adult dental services shall be covered under the Medi-Cal program as of January 1, 2018, or the effective date of any necessary federal approvals, whichever is later.

(ii) The restoration of adult dental services pursuant to clause (i) shall be effective only to the extent any necessary federal approvals are obtained as required by subdivision (f).

(B) Audiology services and speech therapy services.

(C) Chiropractic services.

(D) Optometric and optician services, including services provided by a fabricating optical laboratory, except as provided in subdivision (g).

(E) Podiatric services.

(F) Incontinence creams and washes.

(2) (A) Medical and surgical services provided by a doctor of dental medicine or dental surgery, which, if provided by a physician, would be considered physician services, and which services may be provided by either a physician or a dentist in this state, are covered.

(B) Emergency procedures are also covered in the categories of service specified in subparagraph (A). The director may adopt regulations for any of the services specified in subparagraph (A).

(C) Effective May 1, 2014, or the effective date of any necessary federal approvals as required by subdivision (f), whichever is later, for persons 21 years of age or older, adult dental benefits, subject to utilization controls, are limited to all the following medically necessary services:

(i) Examinations, radiographs/photographic images, prophylaxis, and fluoride treatments.

(ii) Amalgam and composite restorations.

(iii) Stainless steel, resin, and resin window crowns.

(iv) Anterior root canal therapy.

(v) Complete dentures, including immediate dentures.

(vi) Complete denture adjustments, repairs, and relines.

(D) Services specified in this paragraph shall be included as a covered medical benefit under the Medi-Cal program pursuant to Section 14132.89.

(3) Pregnancy-related services and services for the treatment of other conditions that might complicate the pregnancy are not excluded from coverage under this section.

(c) The optional benefit exclusions do not apply to either of the following:

(1) Beneficiaries under the Early and Periodic Screening, Diagnostic, and Treatment Program.

(2) Beneficiaries receiving long-term care in a nursing facility that is both:

(A) A skilled nursing facility or intermediate care facility as defined in subdivisions (c) and (d) of Section 1250 of the Health and Safety Code.

(B) Licensed pursuant to subdivision (k) of Section 1250 of the Health and Safety Code.

(d) This section shall only be implemented to the extent permitted by federal law.

(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 the provisions of this section by means of all-county letters, provider bulletins, or similar instructions, without taking further regulatory action.

(f) This section shall be implemented only to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

(g) (1) Effective no sooner than January 1, 2020, or January 1 of the subsequent calendar year following the legislative action pursuant to paragraph (2), whichever is later, and subject to paragraph (2) and subdivision (f), optometric and optician services, including services provided by a fabricating optical laboratory, shall be covered benefits under the Medi-Cal program.

(2) The restoration of optometric and optician services pursuant to this subdivision is contingent upon the Legislature including funding for these services in the state budget process.

(h) Effective no sooner than January 1, 2020, all of the following optional benefits shall be covered benefits under the Medi-Cal program:

(1) Audiology services and speech therapy services.

(2) Podiatric services.

(3) Incontinence creams and washes.

(Amended by Stats. 2021, Ch. 143, Sec. 386. (AB 133) Effective July 27, 2021. Operative July 1, 2016, by Stats. 2016, Ch. 30, Sec. 36.)

14131.11. (a) Notwithstanding any other provision of this chapter or Chapter 8 (commencing with Section 14200), any increase in the amount charged to the Medi-Cal program for patient care or treatment that is directly related to an identifiable provider-preventable condition is excluded from reimbursement under Medi-Cal, in accordance with criteria set forth in federal and state law and the state's Medi-Cal State Plan, except when the provider-preventable condition existed prior to the initiation of treatment for that patient by that provider.

(b) The exclusion from reimbursement specified in subdivision (a) applies to the amounts charged for the care and treatment of individuals eligible under the Medi-Cal program, both in fee-for-service and managed care delivery systems, including individuals dually eligible for both the Medicare and Medi-Cal programs, individuals eligible under the California Children's Services Program, and individuals eligible under the Genetically Handicapped Persons Program.

(c) Exclusion from reimbursement under Medi-Cal pursuant to this section for increased amounts charged to Medi-Cal related to a provider-preventable condition shall be limited to the extent the identified provider-preventable condition would otherwise result in an increase in payment and the state can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable condition.

(d) For health care-acquired conditions, the department may limit application of the exclusion from reimbursement as appropriate for specific populations, including, but not limited to, the pediatric population, after consultation with the federal government and stakeholders.

(e) For health care-acquired conditions, the exclusion of reimbursement is initially limited to only those services provided by inpatient hospitals. For other provider-preventable conditions, the exclusion from reimbursement applies to health care services provided by any provider. This subdivision shall not limit the department from excluding from reimbursement those services provided in additional care settings as determined by the department. The department shall notify and consult with appropriate stakeholders prior to implementing, interpreting, or making specific this subdivision.

(f) Medi-Cal providers, in both fee-for-service and managed care delivery systems, shall report the occurrence of any provider-preventable condition in any individual identified in subdivision (b) that did not exist prior to initiation of treatment by that provider.

The report shall be made to the department as specified by the department, regardless of whether or not the provider seeks Medi-Cal reimbursement for services to treat the provider-preventable condition.

(g) If a provider in either a fee-for-service or managed care delivery system receives a Medi-Cal payment or reimbursement for any increase in costs for patient care or treatment directly related to an identifiable provider-preventable condition that was not present when the individual initiated treatment with that provider, the provider shall reimburse those costs to the department or plan.

(h) For purposes of this section, “provider-preventable condition,” “health care-acquired condition,” and “other provider-preventable condition” are defined as set forth in Section 447.26(b) of Title 42 of the Code of Federal Regulations.

(i) A provider is prohibited from pursuing payment or reimbursement from a beneficiary for any increased amounts directly related to treatment for, and related to, the provider-preventable condition.

(j) (1) 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 plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action, until the time regulations are adopted. Prior to issuing any letter, bulletin, or similar instruction authorized pursuant to this section, the department shall notify and consult with stakeholders, including advocates, providers, and beneficiaries. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance. It is the intent of the Legislature that the department be provided temporary authority as necessary to implement program changes until completion of the regulatory process, which shall further address and take into account the input of stakeholders.

(2) 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 no later than January 1, 2017. The department may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted under this section. The initial adoption of emergency regulations and one readoption of emergency regulations implementing this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare.

(3) Initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the one readoption of emergency regulations shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(k) The department shall seek any necessary federal approvals for the implementation of this section.

(l) This section shall be implemented only to the extent that federal financial participation is not jeopardized.

(m) This section shall be implemented in accordance with the methodology set forth in the state plan in effect on July 1, 2012, and subsequently in accordance with any future methodologies approved by the federal Centers for Medicare and Medicaid Services.

(Added by Stats. 2014, Ch. 31, Sec. 50. (SB 857) Effective June 20, 2014.)

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.

(Added by Stats. 1992, Ch. 722, Sec. 120. Effective September 15, 1992.)

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

(2) For a Medi-Cal fee-for-service beneficiary, emergency services and care that are necessary for the treatment of an emergency medical condition and medical care directly related to the emergency medical condition. This paragraph does not change the obligation of Medi-Cal managed care plans to provide emergency services and care. For the purposes of this paragraph, “emergency services and care” and “emergency medical condition” have the same meanings as those terms are defined in Section 1317.1 of the Health and Safety Code.

(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 persons with developmental disabilities are covered subject to utilization controls.

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

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

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

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

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

(ii) Nonlegend acetaminophen-containing products, including children’s acetaminophen-containing products, selected by the department are covered benefits.

(iii) Nonlegend cough and cold products selected by the department are covered benefits.

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

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

(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetist services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and x-ray services are covered, subject to utilization controls. This subdivision does not require prior authorization for anesthesiologist services provided as part of an outpatient medical procedure or for portable x-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses that are lost or destroyed due to circumstances beyond the beneficiary's control. Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions that preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children's 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 on July 1, 1995.

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

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

(k) (1) 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.

(2) 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. If 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.

(3) Therapeutic shoes and inserts are covered when provided to a beneficiary 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. However, for Medi-Cal managed care plans, utilization controls shall be subject to Section 1367.25 of the Health and Safety Code.

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

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

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

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

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

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

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

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

(2) All dental hygiene services provided by a registered dental hygienist, registered dental hygienist in extended functions, and registered dental hygienist in alternative practice licensed pursuant to Sections 1753, 1917, 1918, and 1922 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, registered dental hygienist in extended functions, or 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 former 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 former Section 1482 of the article.

(2) A provider 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) (1) In-home medical care services are covered when medically appropriate and subject to utilization controls, for a beneficiary 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 a patient placed in a shared or congregate living arrangement, if a home setting is not medically appropriate or available to the beneficiary.

(2) As used in this subdivision, “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.

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

(A) Level-of-care and cost-of-care evaluations.

(B) Expenses, directly attributable to home care activities, for materials.

(C) Physician fees for home visits.

(D) Expenses directly attributable to home care activities for shelter and modification to shelter.

(E) Expenses directly attributable to additional costs of special diets, including tube feeding.

(F) Medically related personal services.

(G) Home nursing education.

(H) Emergency maintenance repair.

(I) Home health agency personnel benefits that permit coverage of care during periods when regular personnel are on vacation or using sick leave.

(J) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.

(K) Emergency and nonemergency medical transportation.

(L) Medical supplies.

(M) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.

(N) Utility use directly attributable to the requirements of home care activities that are in addition to normal utility use.

(O) Special drugs and medications.

(P) Home health agency supervision of visiting staff that is medically necessary, but not included in the home health agency rate.

(Q) Therapy services.

(R) Household appliances and household utensil costs directly attributable to home care activities.

(S) Modification of medical equipment for home use.

(T) Training and orientation for use of life-support systems, including, but not limited to, support of respiratory functions.

(U) 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.

(4) A beneficiary receiving in-home medical care services is 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 are covered to the extent that federal financial participation is available for those services under the state plan or waivers granted in accordance with Section 1315 or 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 1315 or 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) (1) Hospice services are covered, in accordance with Medicare requirements, and are subject to utilization controls. Coverage shall be available only to the extent that no additional net program costs are incurred.

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

(3) Notwithstanding any other law, the department, without taking any further regulatory action, may implement, interpret, or make specific this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions.

(x) When a claim for treatment provided to a beneficiary includes both services that are authorized and reimbursable under this chapter and services that 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 a beneficiary with a diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex, who requires 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 that 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 a beneficiary 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 an eligible beneficiary. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract Code.

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

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

(2) The department shall seek a waiver in accordance with Section 1315 of Title 42 of the United States Code, or a state plan amendment adopted in accordance with Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code, which was added to Section 1396a of Title 42 of the United States Code by Section 2303(a)(2) of the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), for a program to provide comprehensive clinical family planning services as described in paragraph (8). Under the waiver, the program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. Under the state plan amendment, which shall replace the waiver and shall be known as the Family PACT successor state plan amendment, the program shall be operated only in accordance with this subdivision and the statutes and regulations in paragraph (4). The state shall use the standards and processes imposed by the state on January 1, 2007, including the application of an eligibility discount factor to the extent required by the federal Centers for Medicare and Medicaid Services, for purposes of determining eligibility as permitted under Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code. To the extent that federal financial participation is available, the program shall continue to conduct education, outreach, enrollment, service delivery, and evaluation services as specified under the waiver. The services shall be provided under the program only if the waiver and, when applicable, the successor state plan amendment are approved by the federal Centers for Medicare and Medicaid Services and only to the extent that federal financial participation is available for the services. This section does not prohibit the department from seeking the Family PACT successor state plan amendment during the operation of the waiver.

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

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no spend down of excess income, 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 spend down of excess income or if they are otherwise eligible under Section 24003.

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

(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

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

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

(i) Psychosocial and medical aspects of contraception.

(ii) Sexuality.

(iii) Fertility.

(iv) Pregnancy.

(v) Parenthood.

(vi) Infertility.

(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

(x) Use of contraceptive methods, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies.

(xi) Possible contraceptive consequences and followup.

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

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

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

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

(G) (i) 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 Medi-Cal or Family PACT clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.

(ii) For purposes of this subparagraph, “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.

(iii) 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.

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

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

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

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

(4) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement the amendments to this subdivision made by the act that added this paragraph by means of all-county letters, provider bulletins, or similar instructions, without taking regulatory action.

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

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

(ad) (1) Nonmedical transportation is covered, subject to utilization controls and permissible time and distance standards, for a beneficiary to obtain covered Medi-Cal services.

(2) (A) (i) Nonmedical transportation includes, at a minimum, round trip transportation for a beneficiary to obtain covered Medi-Cal services by passenger car, taxicab, or any other form of public or private conveyance, and mileage reimbursement when conveyance is in a private vehicle arranged by the beneficiary and not through a transportation broker, bus passes, taxi vouchers, or train tickets.

(ii) Nonmedical transportation does not include the transportation of a sick, injured, invalid, convalescent, infirm, or otherwise incapacitated beneficiary by ambulance, litter van, or wheelchair van licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations.

(B) Nonmedical transportation shall be provided for a beneficiary who can attest in a manner to be specified by the department that other currently available resources have been reasonably exhausted. For a beneficiary enrolled in a managed care plan, nonmedical transportation shall be provided by the beneficiary's managed care plan. For a Medi-Cal fee-for-service beneficiary, the department shall provide nonmedical transportation when those services are not available to the beneficiary under Sections 14132.44 and 14132.47.

(3) Nonmedical transportation shall be provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the beneficiary and consistent with applicable state and federal disability rights laws.

(4) It is the intent of the Legislature in enacting this subdivision to affirm the requirement under Section 431.53 of Title 42 of the Code of Federal Regulations, in which the department is required to provide necessary transportation, including nonmedical transportation, for recipients to and from covered services. This subdivision shall not be interpreted to add a new benefit to the Medi-Cal program.

(5) The department shall seek any federal approvals that may be required to implement this subdivision, including, but not limited to, approval of revisions to the existing state plan that the department determines are necessary to implement this subdivision.

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

(7) Prior to the effective date of any necessary federal approvals, nonmedical transportation was not a Medi-Cal managed care benefit with the exception of when provided as an Early and Periodic Screening, Diagnostic, and Treatment service.

(8) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. By July 1, 2018, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Commencing January 1, 2018, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(9) This subdivision shall not be implemented until July 1, 2017.

(ae) (1) No sooner than January 1, 2022, Rapid Whole Genome Sequencing, including individual sequencing, trio sequencing for a parent or parents and their baby, and ultra-rapid sequencing, is a covered benefit for any Medi-Cal beneficiary who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit.

(2) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted.

(3) This subdivision shall be implemented only to the extent that any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized.

(af) (1) Home test kits for sexually transmitted diseases that are deemed medically necessary or appropriate and ordered directly by an enrolled Medi-Cal clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.

(2) For purposes of this subdivision, “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.

(3) 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 Medi-Cal provider to a Medi-Cal-enrolled laboratory with fee based on Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule.

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

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking any further regulatory action.

(ag) (1) Violence prevention services are covered, subject to medical necessity and utilization controls.

(2) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, may implement, interpret, or make specific this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted.

(3) This subdivision shall be implemented only to the extent that any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized.

(4) The department shall post on its internet website the date upon which violence prevention services may be provided and billed pursuant to this subdivision.

(5) “Violence prevention services” means evidence-based, trauma-informed, and culturally responsive preventive services provided to reduce the incidence of violent injury or reinjury, trauma, and related harms and promote trauma recovery, stabilization, and improved health outcomes.

(Amended by Stats. 2025, Ch. 21, Sec. 101. (AB 116) Effective June 30, 2025.)

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.

(Amended by Stats. 2005, Ch. 503, Sec. 1. Effective January 1, 2006.)

14132.02. (a) The department shall seek approval from the United States Secretary of Health and Human Services to provide individuals made eligible pursuant to Section 14005.60 with the alternative benefit package option authorized by Section 1396u-7(b)(1)(D) of Title 42 of the United States Code. Effective January 1, 2014, the alternative benefit package shall provide the same schedule of benefits provided to full-scope Medi-Cal beneficiaries qualifying under the modified adjusted gross income standard pursuant to Section 1396a(e)(14) of Title 42 of the United States Code, except coverage of long-term services and supports shall be excluded unless otherwise required by Section 1396u-7(a)(2) of Title 42 of the United States Code or made available pursuant to subdivision (b). The alternative benefit package shall also include any benefits otherwise required by Section 1396u-7 of Title 42 of the United States Code and any regulations or guidance issued pursuant to that section.

(b) Notwithstanding Section 14005.64, and only to the extent federal approval is obtained, the department shall provide coverage for long-term services and supports to only those individuals who meet the asset requirements imposed under the Medi-Cal program for receipt of the services.

(c) For purposes of this section, long-term services and supports include nursing facility services, a level of care in any institution equivalent to nursing facility services, home- and community-based services furnished under the state plan or a waiver under Section 1315 or 1396n of Title 42 of the United States Code, home health services as described in Section 1396d(a)(7) of Title 42 of the United States Code, and personal care services described in Section 1396d(a)(24) of Title 42 of the United States Code.

(d) The department may seek approval of any necessary state plan amendments or waivers to implement this section.

(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, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 1, 2017, 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 this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(f) This section shall be implemented only to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

(Amended (as added by Stats. 2013, 1st Ex. Sess., Ch. 4, Sec. 28) by Stats. 2013, Ch. 442, Sec. 13. (SB 28) Effective January 1, 2014.)

14132.025. (a) Notwithstanding any other law, emergency services and care necessary for the treatment of an emergency medical condition, as defined in subdivision (b) of Section 1317.1 of the Health and Safety Code, are a covered benefit. For purposes of this section, "emergency services and care" has the same meaning as defined in Section 438.114 of Title 42 of the Code of Federal Regulations and paragraph (1) of, and subparagraph (A) of paragraph (2) of, subdivision (a) of Section 1317.1 of the Health and Safety Code.

(b) For a beneficiary with a psychiatric emergency medical condition, as defined in subdivision (k) of Section 1317.1 of the Health and Safety Code, emergency services and care necessary to relieve or eliminate that condition are covered, regardless of whether the beneficiary is voluntary, or involuntarily detained for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment pursuant to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code).

(c) (1) A Medi-Cal managed care plan, as defined in subdivision (j) of Section 14184.101, shall be responsible for covering, and reimbursing providers furnishing, the emergency services and care described in subdivisions (a) and (b), and any poststabilization care services required under Section 438.114 of Title 42 of the Code of Federal Regulations, for its enrolled Medi-Cal beneficiaries,

excluding any Medi-Cal specialty mental health services provided once an enrolled beneficiary is admitted for inpatient psychiatric care.

(2) This subdivision does not limit or reduce the scope of covered emergency services and care described in subdivisions (a) and (b) for Medi-Cal fee-for-service beneficiaries.

(d) 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-plan letters, information notices, plan or provider bulletins, or similar instructions until the department can promulgate any necessary regulations.

(e) For purposes of this section, emergency services and care includes emergency room professional services and facility charges for emergency room visits.

(f) This section shall be implemented in a manner consistent with federal law and only to the extent federal financial participation is available and not otherwise jeopardized.

(g) The Legislature finds and declares that this section is intended to clarify, and not expand, the scope of Medi-Cal covered benefits.

(Added by Stats. 2024, Ch. 632, Sec. 6. (AB 1316) Effective January 1, 2025.)

14132.03. (a) The following shall be covered Medi-Cal benefits effective January 1, 2014:

(1) Mental health services included in the essential health benefits package adopted by the state pursuant to Section 1367.005 of the Health and Safety Code and Section 10112.27 of the Insurance Code and approved by the United States Secretary of Health and Human Services under Section 18022 of Title 42 of the United States Code. To the extent behavioral health treatment services are considered mental health services pursuant to the essential health benefits package, these services shall only be provided to individuals who receive services through federally approved waivers or state plan amendments pursuant to the Lanterman Developmental Disability Services Act, at Division 4.5 (commencing with Section 4500).

(2) Substance use disorder services included in the essential health benefits package adopted by the state pursuant to Section 1367.005 of the Health and Safety Code and Section 10112.27 of the Insurance Code and approved by the United States Secretary of Health and Human Services under Section 18022 of Title 42 of the United States Code.

(b) The department may seek approval of any necessary state plan amendments to implement this section.

(c) This section shall be implemented only to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

(Added by Stats. 2013, 1st Ex. Sess., Ch. 4, Sec. 29. (SB 1 1x) Effective September 30, 2013.)

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.

(Added by Stats. 2000, Ch. 93, Sec. 90. Effective July 7, 2000.)

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) This section shall not be interpreted to expand the current category of professional health care practitioners permitted to directly bill the Medi-Cal program.

(d) This section is not 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.

(A) The following provisions shall not apply to medical transportation eligible to be billed under this section:

(i) Section 51323(a)(2)(A) of Title 22 of the California Code of Regulations.

(ii) Section 51323(a)(3)(B) of Title 22 of the California Code of Regulations.

(iii) For students whose medical or physical condition does not require the use of a gurney, Section 51231.1(f) of Title 22 of the California Code of Regulations.

(iv) For students whose medical or physical condition does not require the use of a wheelchair, Section 51231.2(e) of Title 22 of the California Code of Regulations.

(B) (i) Subparagraph (A) shall become inoperative on January 1, 2018, or on the date the director executes a declaration stating that the regulations implementing subparagraph (A) and Section 14115.8 have been updated, whichever is later.

(ii) The department shall post the declaration executed under clause (i) on its Internet Web site and transmit a copy of the declaration to the Assembly Committee on Budget and the Senate Committee on Budget and Fiscal Review and the LEA Ad Hoc Workgroup.

(iii) If subparagraph (A) becomes inoperative on January 1, 2018, subparagraph (A) and this subparagraph shall be inoperative on January 1, 2018, unless a later enacted statute enacted before that date, deletes or extends that date.

(iv) If subparagraph (A) becomes inoperative on the date the director executes a declaration as described in clause (i), subparagraph (A) and this subparagraph shall be inoperative on the January 1 immediately following the date subparagraph (A) becomes inoperative, unless a later enacted statute enacted before that date, deletes or extends that date.

(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 regardless of whether the child has 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 charter school, a state special school, a California State University campus, or a University of California campus.

(i) Notwithstanding any other 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.

(j) No later than July 1, 2013, and every year thereafter, the department shall make publicly accessible an annual accounting of all funds collected by the department from federal Medicaid payments allocable to local educational agencies, including, but not limited to, the funds withheld pursuant to subdivision (g) of Section 14115.8. The accounting shall detail amounts withheld from federal

Medicaid payments to each participating local educational agency for that year. One-time costs for the development of this accounting shall not exceed two hundred fifty thousand dollars ($250,000).

(k) (1) If the requirements in paragraphs (2) and (4) are satisfied, the department shall seek federal financial participation for covered services that are provided by a local educational agency pursuant to subdivision (a) to a child who is an eligible Medi-Cal beneficiary, regardless of either of the following:

(A) Whether the child has an IEP or an IFSP.

(B) Whether those same services are provided at no charge to the beneficiary or to the community at large.

(2) The local educational agency shall take all reasonable measures to ascertain and pursue claims for payment of covered services specified in this section against legally liable third parties pursuant to Section 1902(a)(25) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(25)).

(3) If a legally liable third party receives a claim submitted by a local educational agency pursuant to paragraph (2), the legally liable third party shall either reimburse the claim or issue a notice of denial of noncoverage of services or benefits. If there is no response to a claim submitted to a legally liable third party by a local educational agency within 45 days, the local educational agency may bill the Medi-Cal program pursuant to subdivision (b). The local educational agency shall retain a copy of the claim submitted to the legally liable third party for a period of three years.

(4) This subdivision shall not be implemented until the department obtains any necessary federal approvals.

(Amended by Stats. 2016, Ch. 86, Sec. 320. (SB 1171) Effective January 1, 2017.)

14132.07. (a) A Medi-Cal managed care plan shall not restrict the choice of the qualified provider from whom a beneficiary enrolled in the managed care plan may receive family planning services covered by the Medi-Cal program pursuant to subdivision (n) of Section 14132.

(b) The following definitions shall apply for purposes of this section:

(1) “Medi-Cal managed care plan” means an applicable organization or entity that contracts with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(A) Article 2.7 (commencing with Section 14087.3).

(B) Article 2.8 (commencing with Section 14087.5).

(C) Article 2.81 (commencing with Section 14087.96).

(D) Article 2.82 (commencing with Section 14087.98).

(E) Article 2.91 (commencing with Section 14089).

(F) Chapter 8 (commencing with Section 14200).

(2) “Qualified provider” means a provider that is licensed to furnish family planning services, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to an enrollee. A qualified provider may be an out-of-plan or out-of-network provider.

(c) A Medi-Cal managed care plan shall reimburse an out-of-plan or out-of-network qualified provider at the applicable fee-for-service rate.

(d) If federal approval is required to implement this section, the section shall be implemented only to the extent that federal approval is obtained.

(Added by Stats. 2017, Ch. 572, Sec. 3. (SB 743) Effective January 1, 2018.)

14132.09. (a) By July 1, 2024, biomarker testing, as specified in this section, is a covered benefit, subject to utilization controls and medical necessity requirements, as described in Section 14059.5. Biomarker testing shall be covered for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a Medi-Cal beneficiary’s disease or condition to guide treatment decisions. Coverage shall include biomarker tests that meet any of the following:

(1) A labeled indication for a test that has been approved or cleared by the United States Food and Drug Administration (FDA) or is an indicated test for an FDA-approved drug.

(2) A national coverage determination made by the federal Centers for Medicare and Medicaid Services, to the extent allowed under the Medicaid program.

(3) A local coverage determination made by a Medicare Administrative Contractor for California.

(4) Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

(5) Standards set by the National Academy of Medicine.

(b) (1) This section does not preclude any obligation on a Medi-Cal managed care plan subject to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, including any obligations under Section 1363.5 of the Health and Safety Code.

(2) This section does not require coverage of biomarker testing for screening purposes unless otherwise required by this chapter.

(3) The department shall direct, by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, that biomarker testing is to be provided in a manner that limits disruptions in care.

(c) Restricted or denied use of biomarker testing for the purpose of diagnosis, treatment, or ongoing monitoring of any medical condition is subject to grievance and appeal processes under state and federal law.

(d) This section 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.

(e) (1) 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, plan letters, plan or provider bulletins, or similar instructions, without taking any further regulatory action.

(2) An all-county letter, plan letter, plan or provider bulletin, or similar instructions promulgated pursuant to paragraph (1) shall be based at a minimum on evidence-based clinical practice guidelines.

(f) For purposes of this section, the following definitions apply:

(1) “Biomarker” means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention. A biomarker includes, but is not limited to, gene mutations or protein expression.

(2) “Biomarker testing” is the analysis of an individual’s tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes, but is not limited to, single-analyte tests, multiplex panel tests, and whole genome sequencing.

(g) This section is subject to the provisions of Section 1367.665 of the Health and Safety Code as amended by Chapter 605 of the Statutes of 2021 for a Medi-Cal beneficiary with advanced or metastatic stage III or IV cancer covered by a Medi-Cal managed care plan.

(Added by Stats. 2023, Ch. 401, Sec. 3. (SB 496) Effective January 1, 2024.)

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.

(Amended by Stats. 1982, Ch. 328, Sec. 36. Effective June 30, 1982.)

14132.10. (a) (1) 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 health care does not include inpatient long-term care or family respite care.

(2) Pediatric day health care services may be provided at any time of the day and on any day of the week, so long as the total number of authorized hours is not exceeded. Pediatric day health care services may be covered for up to 23 hours per calendar day.

(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 health 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.

(Amended by Stats. 2019, Ch. 64, Sec. 1. (AB 781) Effective January 1, 2020.)

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 Services Administration (HRSA).

(3) A change in costs is not, in and of itself, 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 413.1) 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 (l). 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 both 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, licensed professional clinical counselor, or a visiting nurse. A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a comprehensive perinatal practitioner, as defined in Section 51179.7 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, a dental hygienist in alternative practice, or a marriage and family therapist.

(B) Notwithstanding subdivision (e), if an FQHC or RHC that currently includes the cost of the services of a dental hygienist in alternative practice, or a marriage and family therapist for the purposes of establishing its FQHC or RHC rate chooses to bill these services as a separate visit, the FQHC or RHC 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 or marriage and family therapists 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’s 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, a dental hygienist in alternative practice, or a marriage and family therapist 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 and bill these services as a separate visit, shall process the addition of these services as a change in scope of service pursuant to subdivision (e).

(3) Notwithstanding any other provision of this section, no later than July 1, 2018, a visit shall include a marriage and family therapist.

(4) (A) (i) Subject to subparagraphs (C) and (D), a visit shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, licensed professional clinical counselor, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using video synchronous interaction, when services delivered through that interaction meet the applicable standard of care. A visit described in this clause shall be reimbursed at the applicable FQHC’s or RHC’s per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter. An FQHC or RHC is not precluded from establishing a new patient relationship through video synchronous interaction. An FQHC patient who receives telehealth services shall otherwise be eligible to receive in-person services from that FQHC pursuant to HRSA requirements.

(ii) Subject to subparagraphs (C) and (D), a visit shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, licensed professional clinical counselor, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using audio-only synchronous interaction, when services delivered through that modality meet the applicable standard of care. A visit described in this clause shall be reimbursed at the applicable FQHC’s or RHC’s per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

(iii) Subject to subparagraphs (C) and (D), a visit shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, licensed professional clinical counselor, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using an asynchronous store and forward modality, when services delivered through that modality meet the applicable standard of care. A visit described in this clause shall be reimbursed at the applicable FQHC’s or RHC’s per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

(iv) (I) An FQHC or RHC may not establish a new patient relationship using an audio-only synchronous interaction.

(II) Notwithstanding subclause (I), the department may provide for exceptions to the prohibition established by subclause (I), including, but not limited to, the exceptions described in sub-subclauses (ia) and (ib), which shall be developed in consultation with affected stakeholders and published in departmental guidance.

(ia) Notwithstanding the prohibition in subclause (I) and subject to subparagraphs (C) and (D), an FQHC or RHC may establish a new patient relationship using an audio-only synchronous interaction when the visit is related to sensitive services, as defined in subdivision (n) of Section 56.05 of the Civil Code, and when established in accordance with department-specific requirements and consistent with federal and state laws, regulations, and guidance.

(ib) Notwithstanding the prohibition in subclause (I) and subject to subparagraphs (C) and (D), an FQHC or RHC may establish a new patient relationship using an audio-only synchronous interaction when the patient requests an audio-only modality or attests they do not have access to video, and when established in accordance with department-specific requirements and consistent with federal and state laws, regulations, and guidance.

(v) An FQHC or RHC is not precluded from establishing a new patient relationship through an asynchronous store and forward modality, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, if the visit meets all of the following conditions:

(I) The patient is physically present at the FQHC or RHC, or at an intermittent site of the FQHC or RHC, at the time the service is performed.

(II) The individual who creates the patient records at the originating site is an employee or contractor of the FQHC or RHC, or other person lawfully authorized by the FQHC or RHC to create a patient record.

(III) The FQHC or RHC determines that the billing provider is able to meet the applicable standard of care.

(IV) An FQHC patient who receives telehealth services shall otherwise be eligible to receive in-person services from that FQHC pursuant to HRSA requirements.

(B) (i) Pursuant to an effective date designated by the department that is no sooner than January 1, 2024, an FQHC or RHC furnishing applicable health care services via audio-only synchronous interaction shall also offer those same health care services via video synchronous interaction to preserve beneficiary choice.

(ii) The department may provide specific exceptions to the requirement specified in clause (i), based on an FQHC's or RHC's access to requisite technologies, which shall be developed in consultation with affected stakeholders and published in departmental guidance.

(iii) Effective on the date designated by the department pursuant to clause (i), an FQHC or RHC furnishing services through video synchronous interaction or audio-only synchronous interaction shall also do one of the following:

(I) Offer those services via in-person, face-to-face contact.

(II) Arrange for a referral to, and a facilitation of, in-person care that does not require a patient to independently contact a different provider to arrange for that care.

(iv) In addition to any existing law requiring beneficiary consent to telehealth, including, but not limited to, subdivision (b) of Section 2290.5 of the Business and Professions Code, all of the following shall be communicated by an FQHC or RHC to a Medi-Cal beneficiary, in writing or verbally, on at least one occasion prior to, or concurrent with, initiating the delivery of one or more health care services via telehealth to a Medi-Cal beneficiary: an explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit; an explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future; an explanation of the availability of Medi-Cal coverage for nonmedical transportation services to in-person visits when other available resources have been reasonably exhausted; and the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the FQHC or RHC.

(I) The FQHC or RHC shall document in the patient record the provision of this information and the patient's verbal or written acknowledgment that the information was received.

(II) The department shall develop, in consultation with affected stakeholders, model language for purposes of the communication described in this subparagraph.

(C) The department shall seek any federal approvals it deems necessary to implement this paragraph. This paragraph shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is

available and not otherwise jeopardized.

(D) This paragraph shall be operative on January 1, 2023, or on the operative date or dates reflected in the applicable federal approvals obtained by the department pursuant to subparagraph (C), whichever is later. This paragraph shall not be construed to limit coverage of, and reimbursement for, covered telehealth services provided before the operative date of this paragraph.

(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, and make specific this paragraph by means of all-county letters, plan letters, provider manuals, information notices, provider bulletins, and similar instructions, without taking any further regulatory action.

(F) Telehealth modalities authorized pursuant to this paragraph shall be subject to the billing, reimbursement, and utilization management policies imposed by the department.

(G) Services delivered via telehealth modalities described in this paragraph shall comply with the privacy and security requirements contained in the federal Health Insurance Portability and Accountability Act of 1996 found in Parts 160 and 164 of Title 45 of the Code of Federal Regulations, the Medicaid state plan, and any other applicable state and federal statutes and regulations.

(5) For purposes of this section, “physician” shall be interpreted in a manner consistent with the federal 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 physician and surgeon, osteopath, podiatrist, dentist, optometrist, and chiropractor.

(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) Provided that the following entities are not operating as intermittent clinics, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, each entity shall have its reimbursement rate established in accordance with one of the methods outlined in paragraph (2) or (3), as selected by the FQHC or RHC:

(A) An entity that first qualifies as an FQHC or RHC in 2001 or later.

(B) A newly licensed facility at a new location added to an existing FQHC or RHC.

(C) An entity that is an existing FQHC or RHC that is relocated to a new site.

(2) (A) An FQHC or RHC that adds a new licensed location to its existing primary care license under paragraph (1) of subdivision (b) of Section 1212 of the Health and Safety Code may elect to have the reimbursement rate for the new location established in accordance with paragraph (3), or notwithstanding subdivision (e), an FQHC or RHC may choose to have one PPS rate for all locations that appear on its primary care license determined by submitting a change in scope of service request if both of the following requirements are met:

(i) The change in scope of service request includes the costs and visits for those locations for the first full fiscal year immediately following the date the new location is added to the FQHC’s or RHC’s existing licensee.

(ii) The FQHC or RHC submits the change in scope of service request within 90 days after the FQHC’s or RHC’s first full fiscal year.

(B) The FQHC’s or RHC’s single PPS rate for those locations shall be calculated based on the total costs and total visits of those locations and shall be determined based on the following:

(i) An audit in accordance with Section 14170.

(ii) Rate changes based on a change in scope of service request 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 successors.

(iii) 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.

(C) Except as specified in subdivision (j), this paragraph does not apply to a location that was added to an existing primary care clinic license by the State Department of Public Health, whether by a regional district office or the centralized application

unit, prior to January 1, 2017.

(3) If an FQHC or RHC does not elect to have the PPS rate determined by a change in scope of service request, the FQHC or RHC shall have the reimbursement rate established for any of the entities identified in paragraph (1) or (2) in accordance with one of the following methods at the election of 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.

(4) 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.

(5) 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 under its existing provider number until it is informed of its FQHC or RHC enrollment approval, 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) (1) 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, in a mobile unit as defined in subdivision (b) of Section 1765.105 of the Health and Safety Code, or at the election of the FQHC or RHC and subject to paragraph (2), a location added to an existing primary care clinic license by the State Department of Public Health prior to January 1, 2017, shall be billed by and reimbursed at the same rate as the FQHC or RHC that either established the intermittent clinic site or mobile unit, or that held the clinic license to which the location was added prior to January 1, 2017.

(2) If an FQHC or RHC with at least one additional location on its primary care clinic license that was added by the State Department of Public Health prior to January 1, 2017, applies for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC as described in subdivision (e), all locations on the FQHC's or RHC's primary care clinic license shall be subject to a scope-of-service adjustment in accordance with either paragraph (2) or (3) of subdivision (i), as selected by the FQHC or RHC.

(3) This subdivision does not preclude or otherwise limit 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 Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with applicable scope-of-service adjustments as provided in subdivision (e).

(l) Reimbursement for Drug Medi-Cal services shall be provided pursuant to this subdivision.

(1) An FQHC or RHC may elect to have Drug Medi-Cal services reimbursed directly from a county or the department under contract with the FQHC or RHC pursuant to paragraph (4).

(2) (A) For an FQHC or RHC to receive reimbursement for Drug Medi-Cal services directly from the county or the department under contract with the FQHC or RHC pursuant to paragraph (4), costs associated with providing Drug Medi-Cal services shall not be included in the FQHC's or RHC's per-visit PPS rate. For purposes of this subdivision, the costs associated with providing Drug Medi-Cal services shall not be considered to be within the FQHC's or RHC's clinic base PPS rate if in delivering Drug Medi-Cal services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver Drug Medi-Cal services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering Drug Medi-Cal services, including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing Drug Medi-Cal services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the Drug Medi-Cal services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a scope-of-service change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering Drug Medi-Cal services outside of the PPS rate. Notwithstanding subdivision (e), the scope-of-service change request shall include a full fiscal year of activity that does not include Drug Medi-Cal services costs.

(B) An FQHC or RHC may submit requests for scope-of-service change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any scope-of-service change request under this subdivision approved by the department shall be retroactive to the first day that Drug Medi-Cal services were rendered and reimbursement for Drug Medi-Cal services was received outside of the PPS rate, but in no case shall the effective date be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for Drug Medi-Cal services outside of the PPS rate when the FQHC or RHC obtains approval as a Drug Medi-Cal provider and enters into a contract with a county or the department to provide these services pursuant to paragraph (4).

(D) Within 90 days of receipt of the request for a scope-of-service change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for scope-of-service change under this subdivision 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.

(F) For purposes of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and Drug Medi-Cal services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate and the FQHC or RHC is approved as a Drug Medi-Cal provider, an FQHC or RHC shall not bill the PPS rate for any Drug Medi-Cal services provided pursuant to a contract entered into with a county or the department pursuant to paragraph (4).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with the applicable scope-of-service adjustments as provided for in subdivision (e).

(4) Reimbursement for Drug Medi-Cal services shall be determined according to subparagraph (A) or (B), depending on whether the services are provided in a county that participates in the Drug Medi-Cal organized delivery system (DMC-ODS).

(A) In a county that participates in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon contract entered into between the county or county designee and the FQHC or RHC. If the county or county designee refuses to contract with the FQHC or RHC, the FQHC or RHC may follow the contract denial process set forth in the Special Terms and Conditions.

(B) In a county that does not participate in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon contract entered into between the county and the FQHC or RHC. If the county refuses to contract with the FQHC or RHC, the FQHC or RHC may request to contract directly with the department and shall be reimbursed for those services at the Drug Medi-Cal fee-for-service rate.

(5) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments for Drug Medi-Cal services made pursuant to this subdivision.

(6) For purposes of this subdivision, the following definitions apply:

(A) “Drug Medi-Cal organized delivery system” or “DMC-ODS” means the Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services and described in the Special Terms and Conditions.

(B) “Special Terms and Conditions” has the same meaning as set forth in subdivision (o) of Section 14184.10.

(m) Reimbursement for specialty mental health services shall be provided pursuant to this subdivision.

(1) An FQHC or RHC and one or more mental health plans that contract with the department pursuant to Section 14712 may mutually elect to enter into a contract to have the FQHC or RHC provide specialty mental health services to Medi-Cal beneficiaries as part of the mental health plan’s network.

(2) (A) For an FQHC or RHC to receive reimbursement for specialty mental health services pursuant to a contract entered into with the mental health plan under paragraph (1), the costs associated with providing specialty mental health services shall not be included in the FQHC’s or RHC’s per-visit PPS rate. For purposes of this subdivision, the costs associated with providing specialty mental health services shall not be considered to be within the FQHC’s or RHC’s clinic base PPS rate if in delivering specialty mental health services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver specialty mental health services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering specialty mental health services, including costs related to utilizing space in part of the FQHC’s or RHC’s building, that are or were previously calculated as part of the clinic’s base PPS rate.

(3) If the costs associated with providing specialty mental health services are within the FQHC’s or RHC’s clinic base PPS rate, as determined by the department, the specialty mental health services costs shall be adjusted out of the FQHC’s or RHC’s per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a scope-of-service change request to adjust the FQHC’s or RHC’s clinic base PPS rate after the first full fiscal year of rendering specialty mental health services outside of the PPS rate. Notwithstanding subdivision (e), the scope-of-service change request shall include a full fiscal year of activity that does not include specialty mental health costs.

(B) An FQHC or RHC may submit requests for a scope-of-service change under this subdivision only within 90 days following the beginning of the FQHC’s or RHC’s fiscal year. Any scope-of-service change request under this subdivision approved by the department is retroactive to the first day that specialty mental health services were rendered and reimbursement for specialty mental health services was received outside of the PPS rate, but the effective date shall not be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for specialty mental health services outside of the PPS rate when the FQHC or RHC contracts with a mental health plan to provide these services pursuant to paragraph (1).

(D) Within 90 days of receipt of the request for a scope-of-service change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC’s or RHC’s projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for scope-of-service change under this subdivision 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.

(F) For the purpose of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and specialty mental health services.

(G) After the department approves the adjustment to the FQHC’s or RHC’s clinic base PPS rate, an FQHC or RHC shall not bill the PPS rate for any specialty mental health services that are provided pursuant to a contract entered into with a mental health plan pursuant to paragraph (1).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with the applicable scope-of-service adjustments as provided for in subdivision (e).

(4) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments made for specialty mental health services under this subdivision.

(n) The department shall seek any necessary federal approvals and issue appropriate guidance to allow an FQHC or RHC to bill, under a supervising licensed behavioral health practitioner, for an encounter between an FQHC or RHC patient and a psychological associate, associate professional clinical counselor, associate clinical social worker, or associate marriage and family therapist when all of the following conditions are met:

(1) The psychological associate, associate professional clinical counselor, associate clinical social worker, or associate marriage and family therapist is supervised by the designated licensed behavioral health practitioner, as required by their applicable clinical licensing board.

(2) The behavioral health visit is billed under the supervising licensed practitioner of the FQHC or RHC, pursuant to paragraph (1).

(3) The FQHC or RHC is otherwise authorized to bill for services provided by the supervising licensed behavioral health practitioner as a separate visit.

(o) 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.

(p) The department shall 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.

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

(r) Notwithstanding any other law, the director may, without taking regulatory action pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, implement, interpret, or make specific this section by means of a provider bulletin or similar instruction. The department shall notify and consult with interested parties and appropriate stakeholders in implementing, interpreting, or making specific the provisions of this section, including all of the following:

(1) Notifying provider representatives in writing of the proposed action or change. The notice shall occur, and the applicable draft provider bulletin or similar instruction, shall be made available at least 10 business days prior to the meeting described in paragraph (2).

(2) Scheduling at least one meeting with interested parties and appropriate stakeholders to discuss the proposed action or change.

(3) Allowing for written input regarding the proposed action or change, to which the department shall provide summary written responses in conjunction with the issuance of the applicable final written provider bulletin or similar instruction.

(4) Providing at least 60 days advance notice of the effective date of the proposed action or change.

(s) This section shall become inoperative on July 1, 2026, and, as of January 1, 2027, is repealed.

(Amended by Stats. 2025, Ch. 21, Sec. 103. (AB 116) Effective June 30, 2025. Inoperative July 1, 2026, by its own provisions. Repealed as of January 1, 2027, by its own provisions. See later operative version added by Sec. 104 of Stats. 2025, Ch. 21.)

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 that are eligible for federal financial participation 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 Services Administration (HRSA).

(3) A change in costs is not, in and of itself, 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 413.1) 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 (l). 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 both 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, licensed professional clinical counselor, or a visiting nurse that is eligible for federal financial participation. A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a comprehensive perinatal practitioner, as defined in Section 51179.7 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 that is eligible for federal financial participation.

(2) (A) A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist that is eligible for federal financial participation.

(B) Notwithstanding subdivision (e), if an FQHC or RHC that currently includes the cost of the services of a dental hygienist in alternative practice, or a marriage and family therapist for the purposes of establishing its FQHC or RHC rate chooses to bill these services as a separate visit, the FQHC or RHC 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 or marriage and family therapists 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's 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, a dental hygienist in alternative practice, or a marriage and family therapist 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 and bill these services as a separate visit, shall process the addition of these services as a change in scope of service pursuant to subdivision (e).

(3) Notwithstanding any other provision of this section, no later than July 1, 2018, a visit shall include a marriage and family therapist that is eligible for federal financial participation.

(4) (A) (i) Subject to subparagraphs (C) and (D), a visit shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker,

licensed professional clinical counselor, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using video synchronous interaction, when services delivered through that interaction meet the applicable standard of care and are eligible for federal financial participation. A visit described in this clause shall be reimbursed at the applicable FQHC's or RHC's per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter. An FQHC or RHC is not precluded from establishing a new patient relationship through video synchronous interaction. An FQHC patient who receives telehealth services shall otherwise be eligible to receive in-person services from that FQHC pursuant to HRSA requirements.

(ii) Subject to subparagraphs (C) and (D), a visit shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, licensed professional clinical counselor, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using audio-only synchronous interaction, when services delivered through that modality meet the applicable standard of care and are eligible for federal financial participation. A visit described in this clause shall be reimbursed at the applicable FQHC's or RHC's per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

(iii) Subject to subparagraphs (C) and (D), a visit shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, licensed professional clinical counselor, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using an asynchronous store and forward modality, when services delivered through that modality meet the applicable standard of care and are eligible for federal financial participation. A visit described in this clause shall be reimbursed at the applicable FQHC's or RHC's per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

(iv) (I) An FQHC or RHC may not establish a new patient relationship using an audio-only synchronous interaction.

(II) Notwithstanding subclause (I), the department may provide for exceptions to the prohibition established by subclause (I), including, but not limited to, the exceptions described in sub-subclauses (ia) and (ib), which shall be developed in consultation with affected stakeholders and published in departmental guidance.

(ia) Notwithstanding the prohibition in subclause (I) and subject to subparagraphs (C) and (D), an FQHC or RHC may establish a new patient relationship using an audio-only synchronous interaction when the visit is related to sensitive services, as defined in subdivision (n) of Section 56.05 of the Civil Code, and when established in accordance with department-specific requirements and consistent with federal and state laws, regulations, and guidance.

(ib) Notwithstanding the prohibition in subclause (I) and subject to subparagraphs (C) and (D), an FQHC or RHC may establish a new patient relationship using an audio-only synchronous interaction when the patient requests an audio-only modality or attests they do not have access to video, and when established in accordance with department-specific requirements and consistent with federal and state laws, regulations, and guidance.

(v) An FQHC or RHC is not precluded from establishing a new patient relationship through an asynchronous store and forward modality, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, if the visit meets all of the following conditions:

(I) The patient is physically present at the FQHC or RHC, or at an intermittent site of the FQHC or RHC, at the time the service is performed.

(II) The individual who creates the patient records at the originating site is an employee or contractor of the FQHC or RHC, or other person lawfully authorized by the FQHC or RHC to create a patient record.

(III) The FQHC or RHC determines that the billing provider is able to meet the applicable standard of care.

(IV) An FQHC patient who receives telehealth services shall otherwise be eligible to receive in-person services from that FQHC pursuant to HRSA requirements.

(B) (i) Pursuant to an effective date designated by the department that is no sooner than January 1, 2024, an FQHC or RHC furnishing applicable health care services via audio-only synchronous interaction shall also offer those same health care services via video synchronous interaction to preserve beneficiary choice.

(ii) The department may provide specific exceptions to the requirement specified in clause (i), based on an FQHC's or RHC's access to requisite technologies, which shall be developed in consultation with affected stakeholders and published in departmental guidance.

(iii) Effective on the date designated by the department pursuant to clause (i), an FQHC or RHC furnishing services through video synchronous interaction or audio-only synchronous interaction shall also do one of the following:

(I) Offer those services via in-person, face-to-face contact.

(II) Arrange for a referral to, and a facilitation of, in-person care that does not require a patient to independently contact a different provider to arrange for that care.

(iv) In addition to any existing law requiring beneficiary consent to telehealth, including, but not limited to, subdivision (b) of Section 2290.5 of the Business and Professions Code, all of the following shall be communicated by an FQHC or RHC to a Medi-Cal beneficiary, in writing or verbally, on at least one occasion prior to, or concurrent with, initiating the delivery of one or more health care services via telehealth to a Medi-Cal beneficiary: an explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit; an explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future; an explanation of the availability of Medi-Cal coverage for nonmedical transportation services to in-person visits when other available resources have been reasonably exhausted; and the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the FQHC or RHC.

(I) The FQHC or RHC shall document in the patient record the provision of this information and the patient's verbal or written acknowledgment that the information was received.

(II) The department shall develop, in consultation with affected stakeholders, model language for purposes of the communication described in this subparagraph.

(C) The department shall seek any federal approvals it deems necessary to implement this paragraph. This paragraph shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and not otherwise jeopardized.

(D) This paragraph shall be operative on January 1, 2023, or on the operative date or dates reflected in the applicable federal approvals obtained by the department pursuant to subparagraph (C), whichever is later. This paragraph shall not be construed to limit coverage of, and reimbursement for, covered telehealth services provided before the operative date of this paragraph.

(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, and make specific this paragraph by means of all-county letters, plan letters, provider manuals, information notices, provider bulletins, and similar instructions, without taking any further regulatory action.

(F) Telehealth modalities authorized pursuant to this paragraph shall be subject to the billing, reimbursement, and utilization management policies imposed by the department.

(G) Services delivered via telehealth modalities described in this paragraph shall comply with the privacy and security requirements contained in the federal Health Insurance Portability and Accountability Act of 1996 found in Parts 160 and 164 of Title 45 of the Code of Federal Regulations, the Medicaid state plan, and any other applicable state and federal statutes and regulations.

(5) For purposes of this section, "physician" shall be interpreted in a manner consistent with the federal 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 physician and surgeon, osteopath, podiatrist, dentist, optometrist, and chiropractor.

(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) Provided that the following entities are not operating as intermittent clinics, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, each entity shall have its reimbursement rate established in accordance with one of the methods outlined in paragraph (2) or (3), as selected by the FQHC or RHC:

(A) An entity that first qualifies as an FQHC or RHC in 2001 or later.

(B) A newly licensed facility at a new location added to an existing FQHC or RHC.

(C) An entity that is an existing FQHC or RHC that is relocated to a new site.

(2) (A) An FQHC or RHC that adds a new licensed location to its existing primary care license under paragraph (1) of subdivision (b) of Section 1212 of the Health and Safety Code may elect to have the reimbursement rate for the new location established in accordance with paragraph (3), or notwithstanding subdivision (e), an FQHC or RHC may choose to have one PPS rate for all locations that appear on its primary care license determined by submitting a change in scope of service request if both of the following requirements are met:

(i) The change in scope of service request includes the costs and visits for those locations for the first full fiscal year immediately following the date the new location is added to the FQHC's or RHC's existing licensee.

(ii) The FQHC or RHC submits the change in scope of service request within 90 days after the FQHC's or RHC's first full fiscal year.

(B) The FQHC's or RHC's single PPS rate for those locations shall be calculated based on the total costs and total visits of those locations and shall be determined based on the following:

(i) An audit in accordance with Section 14170.

(ii) Rate changes based on a change in scope of service request 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 successors.

(iii) 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.

(C) Except as specified in subdivision (j), this paragraph does not apply to a location that was added to an existing primary care clinic license by the State Department of Public Health, whether by a regional district office or the centralized application unit, prior to January 1, 2017.

(3) If an FQHC or RHC does not elect to have the PPS rate determined by a change in scope of service request, the FQHC or RHC shall have the reimbursement rate established for any of the entities identified in paragraph (1) or (2) in accordance with one of the following methods at the election of 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.

(4) 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.

(5) 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 under its existing provider number until it is informed of its FQHC or RHC enrollment approval, 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) (1) 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, in a mobile unit as defined in subdivision (b) of Section 1765.105 of the Health and Safety Code, or at the election of the FQHC or RHC and subject to paragraph (2), a location added to an existing primary care clinic license by the State Department of Public Health prior to January 1, 2017, shall be billed by and reimbursed at the same rate as the FQHC or RHC that either established the intermittent clinic site or mobile unit, or that held the clinic license to which the location was added prior to January 1, 2017.

(2) If an FQHC or RHC with at least one additional location on its primary care clinic license that was added by the State Department of Public Health prior to January 1, 2017, applies for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC as described in subdivision (e), all locations on the FQHC's or RHC's primary care clinic license shall be subject to a scope-of-service adjustment in accordance with either paragraph (2) or (3) of subdivision (i), as selected by the FQHC or RHC.

(3) This subdivision does not preclude or otherwise limit 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 Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with applicable scope-of-service adjustments as provided in subdivision (e).

(l) Reimbursement for Drug Medi-Cal services shall be provided pursuant to this subdivision.

(1) An FQHC or RHC may elect to have Drug Medi-Cal services reimbursed directly from a county or the department under contract with the FQHC or RHC pursuant to paragraph (4).

(2) (A) For an FQHC or RHC to receive reimbursement for Drug Medi-Cal services directly from the county or the department under contract with the FQHC or RHC pursuant to paragraph (4), costs associated with providing Drug Medi-Cal services shall not be included in the FQHC's or RHC's per-visit PPS rate. For purposes of this subdivision, the costs associated with providing Drug Medi-Cal services shall not be considered to be within the FQHC's or RHC's clinic base PPS rate if in delivering Drug Medi-Cal services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver Drug Medi-Cal services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering Drug Medi-Cal services, including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing Drug Medi-Cal services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the Drug Medi-Cal services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a scope-of-service change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering Drug Medi-Cal services outside of the PPS rate. Notwithstanding subdivision (e), the scope-of-service change request shall include a full fiscal year of activity that does not include Drug Medi-Cal services costs.

(B) An FQHC or RHC may submit requests for scope-of-service change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any scope-of-service change request under this subdivision approved by the department shall be retroactive to the first day that Drug Medi-Cal services were rendered and reimbursement for Drug Medi-Cal services was received outside of the PPS rate, but in no case shall the effective date be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for Drug Medi-Cal services outside of the PPS rate when the FQHC or RHC obtains approval as a Drug Medi-Cal provider and enters into a contract with a county or the department to provide these services pursuant to paragraph (4).

(D) Within 90 days of receipt of the request for a scope-of-service change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for scope-of-service change under this subdivision 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.

(F) For purposes of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and Drug Medi-Cal services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate and the FQHC or RHC is approved as a Drug Medi-Cal provider, an FQHC or RHC shall not bill the PPS rate for any Drug Medi-Cal services provided pursuant to a contract entered into with a county or the department pursuant to paragraph (4).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with the applicable scope-of-service adjustments as provided for in subdivision (e).

(4) Reimbursement for Drug Medi-Cal services shall be determined according to subparagraph (A) or (B), depending on whether the services are provided in a county that participates in the Drug Medi-Cal organized delivery system (DMC-ODS).

(A) In a county that participates in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon contract entered into between the county or county designee and the FQHC or RHC. If the county or county designee refuses to contract with the FQHC or RHC, the FQHC or RHC may follow the contract denial process set forth in the Special Terms and Conditions.

(B) In a county that does not participate in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon contract entered into between the county and the FQHC or RHC. If the county refuses to contract with the FQHC or RHC, the FQHC or RHC may request to contract directly with the department and shall be reimbursed for those services at the Drug Medi-Cal fee-for-service rate.

(5) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments for Drug Medi-Cal services made pursuant to this subdivision.

(6) For purposes of this subdivision, the following definitions apply:

(A) "Drug Medi-Cal organized delivery system" or "DMC-ODS" means the Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services and described in the Special Terms and Conditions.

(B) "Special Terms and Conditions" has the same meaning as set forth in subdivision (o) of Section 14184.10.

(m) Reimbursement for specialty mental health services shall be provided pursuant to this subdivision.

(1) An FQHC or RHC and one or more mental health plans that contract with the department pursuant to Section 14712 may mutually elect to enter into a contract to have the FQHC or RHC provide specialty mental health services to Medi-Cal beneficiaries as part of the mental health plan's network.

(2) (A) For an FQHC or RHC to receive reimbursement for specialty mental health services pursuant to a contract entered into with the mental health plan under paragraph (1), the costs associated with providing specialty mental health services shall not be included in the FQHC's or RHC's per-visit PPS rate. For purposes of this subdivision, the costs associated with providing specialty mental health services shall not be considered to be within the FQHC's or RHC's clinic base PPS rate if in delivering specialty mental health services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver specialty mental health services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering specialty mental health services, including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing specialty mental health services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the specialty mental health services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a scope-of-service change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering specialty mental health services outside of the PPS rate. Notwithstanding subdivision (e), the scope-of-service change request shall include a full fiscal year of activity that does not include specialty mental health costs.

(B) An FQHC or RHC may submit requests for a scope-of-service change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any scope-of-service change request under this subdivision approved by the department is retroactive to the first day that specialty mental health services were rendered and reimbursement for specialty mental health services was received outside of the PPS rate, but the effective date shall not be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for specialty mental health services outside of the PPS rate when the FQHC or RHC contracts with a mental health plan to provide these services pursuant to paragraph (1).

(D) Within 90 days of receipt of the request for a scope-of-service change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for scope-of-service change under this subdivision 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.

(F) For the purpose of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and specialty mental health services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate, an FQHC or RHC shall not bill the PPS rate for any specialty mental health services that are provided pursuant to a contract entered into with a mental health plan pursuant to paragraph (1).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with the applicable scope-of-service adjustments as provided for in subdivision (e).

(4) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments made for specialty mental health services under this subdivision.

(n) The department shall seek any necessary federal approvals and issue appropriate guidance to allow an FQHC or RHC to bill, under a supervising licensed behavioral health practitioner, for an encounter between an FQHC or RHC patient and a psychological associate, associate professional clinical counselor, associate clinical social worker, or associate marriage and family therapist when all of the following conditions are met:

(1) The psychological associate, associate professional clinical counselor, associate clinical social worker, or associate marriage and family therapist is supervised by the designated licensed behavioral health practitioner, as required by their applicable clinical licensing board.

(2) The behavioral health visit is billed under the supervising licensed practitioner of the FQHC or RHC, pursuant to paragraph (1).

(3) The FQHC or RHC is otherwise authorized to bill for services provided by the supervising licensed behavioral health practitioner as a separate visit.

(o) 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.

(p) The department shall 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.

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

(r) Notwithstanding any other law, the director may, without taking regulatory action pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, implement, interpret, or make specific this section by means of a provider bulletin or similar instruction. The department shall notify and consult with interested parties and appropriate stakeholders in implementing, interpreting, or making specific the provisions of this section, including all of the following:

(1) Notifying provider representatives in writing of the proposed action or change. The notice shall occur, and the applicable draft provider bulletin or similar instruction, shall be made available at least 10 business days prior to the meeting described in paragraph (2).

(2) Scheduling at least one meeting with interested parties and appropriate stakeholders to discuss the proposed action or change.

(3) Allowing for written input regarding the proposed action or change, to which the department shall provide summary written responses in conjunction with the issuance of the applicable final written provider bulletin or similar instruction.

(4) Providing at least 60 days advance notice of the effective date of the proposed action or change.

(s) This section shall become operative on July 1, 2026.

(Repealed (in Sec. 103) and added by Stats. 2025, Ch. 21, Sec. 104. (AB 116) Effective June 30, 2025. Operative July 1, 2026, by its own provisions.)

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.

(Added by Stats. 2005, Ch. 548, Sec. 1. Effective January 1, 2006.)

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.

(Added by Stats. 2005, Ch. 548, Sec. 2. Effective January 1, 2006.)

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.

(Added by Stats. 2004, Ch. 228, Sec. 21. Effective August 16, 2004.)

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.

(Added by Stats. 2004, Ch. 228, Sec. 22. Effective August 16, 2004.)

14132.11. (a) Commencing on July 1, 2024, pharmacogenomic testing shall be a covered benefit under the Medi-Cal program, subject to utilization controls and evidence-based clinical practice guidelines.

(b) "Pharmacogenomic testing" means laboratory genetic testing that includes, but is not limited to, a panel test, to identify how a person's genetics may impact the efficacy, toxicity, and safety of medications.

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

(d) 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, plan letters, plan or provider bulletins, or similar instructions, without taking any further regulatory action.

(Added by Stats. 2023, Ch. 329, Sec. 2. (AB 425) Effective January 1, 2024.)

14132.13. (a) Services provided by a community paramedicine program, triage to alternate destination program, or mobile integrated health program are covered benefits under the Medi-Cal program.

(b) The department shall develop rates of reimbursement for services provided by a community paramedicine program, triage to alternate destination program, or mobile integrated health program in consultation with community paramedicine programs, triage to alternate destination programs, and mobile integrated health programs.

(c) This section shall be implemented only to the extent that the department obtains any necessary federal waivers or other federal approvals and that federal financial participation is available and not otherwise jeopardized.

(d) Implementation of this section shall be subject to an appropriation made by the Legislature for the purpose of this section.

(e) For purposes of this section, the following definitions apply:

(1) "Community paramedicine program" means a program defined in Section 1815 of the Health and Safety Code.

(2) "Mobile integrated health program" means a team of licensed health care practitioners, operating within their scope of practice, who provide mobile health services to support the emergency medical services system.

(3) “Triage to alternate destination program” means a program defined in Section 1819 of the Health and Safety Code.

(Added by Stats. 2024, Ch. 884, Sec. 3. (SB 1180) Effective January 1, 2025.)

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.

(Added by Stats. 1985, Ch. 1360, Sec. 2.)

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.

(Added by Stats. 1987, Ch. 550, Sec. 4.)

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.

(Added by Stats. 1990, Ch. 1279, Sec. 4.)

14132.171. (a) (1) An annual cognitive health assessment for Medi-Cal beneficiaries who are 65 years of age or older is a covered benefit if they are otherwise ineligible for a similar assessment as part of an annual wellness visit under the Medicare Program. Subject to paragraph (3), the department shall provide reimbursement to a Medi-Cal provider who renders this service.

(2) The payment for the cognitive health assessment developed pursuant to paragraph (1) shall only be available upon appropriation by the Legislature for these purposes.

(3) (A) A Medi-Cal provider shall only be eligible to receive the payment for the benefit specified in paragraph (1) if the provider conducts the cognitive health assessment using validated tools, as recommended by the department.

(B) (i) The department shall determine the cognitive health assessment validated tools, as described in subparagraph (A), in consultation with the State Department of Public Health’s Alzheimer’s Disease Program (Article 4 (commencing with Section 125275) of Chapter 2 of Part 5 of Division 106 of the Health and Safety Code), that program’s 10 California Alzheimer’s Disease Centers, representatives of primary care physician specialties, including, but not limited to, family medicine, and the Alzheimer’s Disease and Related Disorders Advisory Committee of the California Health and Human Services Agency (Chapter 3.1 (commencing with Section 1568.15) of Division 2 of the Health and Safety Code).

(ii) With respect to the validated tools, the department shall select multiple tools. To improve overall accessibility of these tools and minimize access barriers, at least one of those tools shall not carry any restrictions on copyright or trademark.

(b) An annual cognitive health assessment shall identify signs of Alzheimer’s disease or dementia, consistent with the standards for detecting cognitive impairment under the federal Centers for Medicare and Medicaid Services and the recommendations by the American Academy of Neurology.

(c) By January 1, 2024, the department shall do both of the following:

(1) Consolidate and analyze the data on the administration of the cognitive health assessment in the Medi-Cal managed care and fee-for-service delivery systems.

(2) Post information on the utilization of, and payment for, this benefit on its internet website.

(d) 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 this section, in whole or in part, by means of all-plan letters, provider bulletins, or similar instructions, without taking any further regulatory action.

(e) This section shall be implemented only to the extent any necessary federal approvals are obtained and federal financial participation is available.

(Amended by Stats. 2025, Ch. 21, Sec. 105. (AB 116) Effective June 30, 2025.)

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.

(Added by Stats. 1991, Ch. 735, Sec. 6. Conditionally inoperative by its own provisions.)

14132.19. (a) (1) The department, in consultation with the State Department of Social Services, county mental health experts, managed care plan experts, behavioral health experts, child welfare experts, and stakeholders, shall convene an advisory working group to update, amend, or develop, if appropriate, tools and protocols for the screening of children for trauma, within the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit, consistent with existing law and this section. The advisory working group shall consider both of the following:

(A) Existing screening tools used in the Medi-Cal program, including, but not limited to, the Staying Healthy Assessment developed by the department, the United States Preventive Services Task Force grade "A" or "B" recommendations, and the American Academy of Pediatrics Bright Futures periodicity schedule and anticipatory guidance.

(B) The efficacy and appropriateness of the types of providers authorized to administer screenings.

(2) The department shall convene the advisory working group by May 1, 2018. The advisory working group shall report its findings and recommendations, as well as any appropriations necessary to implement those recommendations, to the department and to the Legislature's budget subcommittees on health and human services no later than May 1, 2019. The advisory working group shall be disbanded on December 31, 2019.

(3) Findings or recommendations of the advisory working group that cannot be implemented without a subsequent appropriation by the Legislature, as determined by the department, shall not be implemented until the appropriation is made.

(4) On or before May 1, 2019, the department shall identify an existing advisory working group to periodically review and consider the protocols for the screening of trauma in children consistent with subparagraphs (A) and (B) of paragraph (1). The group created pursuant to this section may, as part of its work, recommend to the department an existing group appropriate to conduct this review. The advisory working group identified by department shall review and consider the protocols for the screening of trauma in children at least once every five years, or upon the request of the department.

(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, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action.

(c) This section shall be implemented only if and to the extent that federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is not jeopardized and all necessary federal approvals have been obtained.

(d) "Trauma," as used in this section, means the result of an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning

and physical, social, emotional, or spiritual well-being.

(Added by Stats. 2017, Ch. 700, Sec. 1. (AB 340) Effective January 1, 2018.)

14132.195. (a) Consistent with federal law, screening services provided as an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit pursuant to subdivision (v) of Section 14132 shall include developmental screening services for individuals zero to three years of age, inclusive.

(b) Medi-Cal managed care plans shall ensure, and monitor compliance with, both of the following:

(1) Developmental screening services provided by providers who contract with Medi-Cal managed care plans comply with the periodicity schedule and the standardized and validated developmental screening tools that are established by the Bright Futures Guidelines and Recommendations for Preventive Pediatric Health Care, as established by the American Academy of Pediatrics, and by any future updates to this material.

(2) Developmental screening tools administered by providers who contract with Medi-Cal managed care plans are administered in their entirety, and in adherence to, the specific tools' recommended guidelines.

(c) This section does not limit or restrict the scope of the EPSDT benefit, as required to be provided to eligible Medi-Cal beneficiaries under 21 years of age pursuant to Section 1396d(r) of Title 42 of the United States Code.

(d) This section does not limit or restrict blood lead screenings required under Chapter 5 (commencing with Section 105275) of Part 5 of Division 103 of the Health and Safety Code.

(Added by Stats. 2019, Ch. 387, Sec. 2. (AB 1004) Effective January 1, 2020.)

14132.20. (a) The department shall establish a program to provide continuous skilled nursing care to persons with developmental disabilities as a benefit of the Medi-Cal program, when those services are provided in accordance with an approved federal waiver or Medi-Cal State Plan amendment meeting the requirements of subdivision (b). "Continuous skilled nursing care" means medically necessary care provided by, or under the supervision of, a registered nurse within his or her scope of practice, seven days a week, 24 hours per day, in a facility participating in the program. Continuous skilled nursing care shall include a minimum of eight hours per day provided by or under the direct supervision of a registered nurse. Each facility providing continuous skilled nursing care in the program shall have a minimum of one registered nurse or one licensed vocational nurse awake and in the facility at all times when a consumer is present.

(b) The department shall submit to the federal Centers for Medicare and Medicaid Services, a request, developed in consultation with the State Department of Public Health, the State Department of Developmental Services, and the Association of Regional Center Agencies, to provide continuous skilled nursing care services under a federal waiver pursuant to Section 1915(c) of the federal Social Security Act (42 U.S.C. Sec. 1396n(c)) or pursuant to a Medi-Cal State Plan amendment.

(c) (1) The program shall provide continuous skilled nursing care to persons with developmental disabilities in the least restrictive home-like setting.

(2) Participation in the program shall be restricted to facilities that meet all eligibility requirements. The facilities shall be approved by the department, in consultation with the State Department of Public Health, the State Department of Developmental Services, and the appropriate regional center agencies, and shall meet the requirements of subdivision (f).

(d) Under the program established by this section, a person with developmental disabilities shall be eligible to receive continuous skilled nursing care if all of the following conditions are met:

(1) The person with developmental disabilities meets the criteria specified in the federal waiver or the Medi-Cal State Plan amendment.

(2) The person with developmental disabilities resides in a facility that meets the provider participation criteria as specified in the federal waiver or the Medi-Cal State Plan amendment.

(3) The continuous skilled nursing care services are provided in accordance with the federal waiver or the Medi-Cal State Plan amendment.

(e) The services provided to persons with developmental disabilities under the program, pursuant to Section 1915(c) of the federal Social Security Act (42 U.S.C. Sec. 1396n(c)), shall not result in costs that exceed the fiscal limit established in the federal waiver.

(f) A facility seeking to participate in the program shall provide care for persons with developmental disabilities who require the availability of continuous skilled nursing care in accordance with the terms of the federal waiver or the Medi-Cal State Plan amendment. During participation in the program, the facility shall comply with all the terms and conditions of the federal waiver or the Medi-Cal State Plan amendment.

(g) In implementing this article, the department may enter into contracts for the provision of essential administration 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.

(h) This section shall not become operative unless and until the federal Centers for Medicare and Medicaid Services approve a federal waiver pursuant to Section 1915(c) of the Social Security Act (42 U.S.C. Sec. 1396n(c)) or approve a Medi-Cal State Plan amendment to implement the program authorized by this section. If the federal Centers for Medicare and Medicaid Services provide the aforementioned approval, the Director of Health Care Services shall execute a declaration stating that this approval has been granted. The director shall retain the declaration and this section shall become operative on the date that the director executes a declaration pursuant to this subdivision.

(Added by Stats. 2009, 4th Ex. Sess., Ch. 5, Sec. 44. Effective July 28, 2009. Conditionally operative as provided in subd. (h).)

14132.21. The department 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.

(Amended by Stats. 2013, Ch. 22, Sec. 103. (AB 75) Effective June 27, 2013. Operative July 1, 2013, by Sec. 110 of Ch. 22.)

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.

(Amended by Stats. 2004, Ch. 183, Sec. 386. Effective January 1, 2005.)

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.

(Added by Stats. 2007, Ch. 494, Sec. 1. Effective January 1, 2008. Section operative July 1, 2008, by its own provisions.)

14132.24. (a) No later than April 1, 2023, and until June 30, 2025, the State Department of Health Care Services shall convene a workgroup to examine the implementation of the doula benefit provided under the Medi-Cal program. The workgroup shall be comprised of doulas, health care providers, consumer and community advocates, health plans, county representatives, and other stakeholders with experience with doula services as determined by the department.

(b) The workgroup shall consider all of the following:

(1) Ensuring that doula services are available to Medi-Cal beneficiaries who are eligible for and want doula services.

(2) Minimizing barriers and delays in payments to a Medi-Cal doula or in reimbursement to Medi-Cal recipients for doula services received.

(3) Making recommendations for outreach efforts so that all Medi-Cal recipients within the eligible and other target populations are aware of the option to use doula services.

(c) (1) No later than July 1, 2025, the department shall publish a report that provides the number of Medi-Cal recipients utilizing doula services, broken down by race, ethnicity, primary language, health plan, and county. The report shall also identify any barriers that impede access to doula services in the prenatal, labor and delivery, and postpartum periods and make recommendations to the department and the Legislature to reduce any identified barriers.

(2) The report shall provide a numerical comparison in the birthing outcomes of Medi-Cal recipients who receive doula services with those who do not, including, but not limited to, rates of cesarean delivery births, maternal or infant mortality, other maternal morbidity, and, to the extent available through information voluntarily provided by the Medi-Cal recipient, breast and chest feeding outcomes.

(3) The report shall utilize standard public health reporting practices for accurate dissemination of these data elements, especially with regard to the reporting of small numbers so as to avoid inadvertently risking a breach of confidentiality or other disclosure.

(4) The department shall post this report on the department's internet website.

(d) This section shall remain in effect only until January, 1, 2026, and as of that date is repealed. The repeal of this section shall not prevent the department from continuing to convene the workgroup referenced in subdivision (a) or issuing reports referenced in subdivision (c), should the department determine that either activity is helpful or necessary in order to monitor, evaluate, or expand access to Medi-Cal doula services.

(Amended by Stats. 2023, Ch. 42, Sec. 144. (AB 118) Effective July 10, 2023. Repealed as of January 1, 2026, by its own provisions.)

14132.25. (a) On or before July 1, 1983, the State Department of Health Care 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 health facilities who meet subacute care criteria. Subacute care may be provided by any facility designated by the director as meeting the subacute care criteria that has an approved provider participation agreement with the department.

(b) The department shall develop a rate of reimbursement for this subacute care program. Reimbursement rates shall be determined in accordance with methodology developed by the department, 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.

(c) Reimbursement at subacute care rates, as specified in subdivision (b), shall only be implemented if funds are available for this purpose pursuant to the annual Budget Act.

(d) The department may negotiate and execute an agreement with any health facility that 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.

(e) For the purposes of this section, pediatric subacute services are the health care services needed by a person under 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function.

(f) Medical necessity for pediatric subacute care services shall be substantiated in any one of the following ways:

(1) A tracheostomy with dependence on mechanical ventilation for a minimum of six hours each day.

(2) Dependence on tracheostomy care requiring suctioning at least every six hours, and room air mist or oxygen as needed, and dependence on one of the five treatment procedures listed in subparagraphs (B) to (F), inclusive:

(A) Dependence on intermittent suctioning at least every eight hours and room air mist and oxygen as needed.

(B) Dependence on continuous intravenous therapy, including administration of a therapeutic agent necessary for hydration or of intravenous pharmaceuticals, or intravenous pharmaceutical administration of more than one agent, via a peripheral or central line, without continuous infusion.

(C) Dependence on peritoneal dialysis treatments requiring at least four exchanges every 24 hours.

(D) Dependence on tube feeding by means of a nasogastric or gastrostomy tube.

(E) Dependence on other medical technologies required continuously, which, in the opinion of the attending physician and the Medi-Cal consultant, require the services of a professional nurse.

(F) Dependence on biphasic positive airway pressure at least six hours a day, including assessment or intervention every three hours and lacking either cognitive or physical ability of the patient to protect his or her airway.

(3) Dependence on total parenteral nutrition or other intravenous nutritional support, and dependence on one of the treatment procedures specified in subparagraphs (A) to (F), inclusive, of paragraph (2).

(4) Dependence on skilled nursing care in the administration of any three of the six treatment procedures specified in subparagraphs (A) to (F), inclusive, of paragraph (2).

(5) Dependence on biphasic positive airway pressure or continuous positive airway pressure at least six hours a day, including assessment or intervention every three hours and lacking either cognitive or physical ability of the patient to protect his or her airway and dependence on one of the five treatment procedures specified in subparagraphs (A) to (E), inclusive, of paragraph (2).

(g) The medical necessity determination outlined in subdivision (f) is intended solely for the evaluation of a patient who is potentially eligible and meets the criteria to be transferred from an acute care setting to a subacute level of care.

(Amended by Stats. 2011, Ch. 294, Sec. 2. (AB 667) Effective January 1, 2012.)

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.

(Amended by Stats. 2002, Ch. 1161, Sec. 84. Effective September 30, 2002.)

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.

(Added by Stats. 2003, Ch. 230, Sec. 71. Effective August 11, 2003.)

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.

(Added by Stats. 2003, Ch. 443, Sec. 1. Effective January 1, 2004.)

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.

(Added by Stats. 2003, Ch. 443, Sec. 2. Effective January 1, 2004.)

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.

(Added by Stats. 1982, Ch. 421, Sec. 2.)

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.

(Added by Stats. 1988, Ch. 956, Sec. 3. Effective September 19, 1988.)

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.

(Added by Stats. 1985, Ch. 1360, Sec. 3.)

14132.36. (a) Community health worker services are a covered Medi-Cal benefit.

(b) For purposes of this section, the following definitions apply:

(1) "Community health worker" means a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. A community health worker is a frontline health worker either trusted by, or who has a close understanding of, the community served. Community health workers include Promotores, Promotores de Salud, Community Health Representatives, navigators, and other nonlicensed health workers, including violence prevention professionals. A community health worker's lived experience shall align with and provide a connection to the community being served.

(2) "Supervising provider" is an enrolled Medi-Cal provider that is authorized to supervise a community health worker pursuant to the federally approved Medicaid state plan amendment and that ensures that a community health worker meets the qualifications as required by the department. The supervising provider directly or indirectly oversees community health workers and the services that they deliver to Medi-Cal members.

(c) A Medi-Cal managed care plan shall engage in outreach and education efforts to enrollees in a form and manner as directed by the department. At a minimum, the department shall require a Medi-Cal managed care plan to provide the following information to an enrollee:

(1) A description of the community health worker services benefit, including eligibility and coverage criteria.

(2) A list of providers that are authorized to refer an enrollee to community health worker services, and an explanation of how to request a referral.

(3) A list of contracted community health worker entities, including community-based organizations, community clinics, local health jurisdictions, licensed providers, clinics, or hospitals available to provide community health worker services, updated at least annually.

(4) An email address, internet website, and telephone number for an enrollee to access to request additional information regarding community health worker services.

(d) The outreach and education efforts conducted by a Medi-Cal managed care plan pursuant to subdivision (c) shall meet cultural and linguistic appropriateness standards, as determined by the department.

(e) The Medi-Cal managed care plan shall notify providers about the community health worker services benefit, as set forth by the department.

(f) (1) No later than July 1, 2025, a Medi-Cal managed care plan shall adopt policies and procedures to effectuate a billing pathway for supervising providers, including contracted hospitals, to claim for the provision of community health worker services to enrollees during an emergency department visit and an outpatient followup to an emergency department visit, that are consistent with guidance developed by the department pursuant to paragraph (2).

(2) No later than July 1, 2025, the department shall, consistent with subdivision (g), develop guidance on policies and procedures to effectuate a billing pathway for supervising providers, including contracted hospitals, to claim for the provision of community health worker services to Medi-Cal members under the fee-for-service delivery system during an emergency department visit and as an outpatient followup to an emergency department visit.

(g) The department shall, through existing and regular stakeholder processes, inform stakeholders about, and accept input from stakeholders on, implementation of the community health worker services benefit.

(h) This section 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.

(i) 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 policy letters, provider bulletins, or other similar instructions, without taking any further regulatory action.

(Amended by Stats. 2025, Ch. 21, Sec. 102. (AB 116) Effective June 30, 2025.)

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.

(Added by Stats. 1993, Ch. 1280, Sec. 6. Effective January 1, 1994.)

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.

(Added by Stats. 1982, Ch. 327, Sec. 229. Effective June 30, 1982.)

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.

(Amended by Stats. 2006, Ch. 719, Sec. 1. Effective January 1, 2007.)

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.

(Added by Stats. 1998, Ch. 652, Sec. 4. Effective January 1, 1999.)

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 local governmental agency may contract with the department to provide TCM services. The department shall not contract with local education agencies to provide case management services under this section.

(c) A local governmental agency may contract with any private or public entity to provide TCM services on its behalf under the conditions specified by the department in regulations.

(d) Each local governmental agency that provides TCM services 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) Subject to the requirements of federal law and regulations, a local governmental agency or an entity under contract with a local governmental agency 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 reimbursement, submit an annual cost report as prescribed by the department that certifies all of the following:

(A) The expenditure of 100 percent of the costs incurred 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.

(3) (A) A city that is not a local governmental agency, or any other local public entity that contracts with a local governmental agency pursuant to subdivision (c) and that is located within a county that is a participating local governmental agency pursuant to this section, may submit certification to the local governmental agency of amounts expended for TCM services in accordance with Section 433.51 of Title 42 of the Code of Federal Regulations.

(B) A city or other local public entity that submits certification pursuant to this paragraph shall comply with the requirements of paragraph (1), with other requirements applicable to local governmental agencies that the department determines, in regulations, to be applicable, and with all applicable federal requirements.

(C) The local governmental agency shall forward the city's or local public entity's certification to the department for purposes of claiming federal financial participation.

(D) As applicable, the local governmental agency shall obtain and retain appropriate certifications from the expending city or local public entity, together with documentation of the underlying expenditures, as required by the department.

(g) Except as otherwise provided in paragraph (3) of subdivision (f), only a local governmental agency may submit TCM service claims to the department for the performance of TCM services.

(h) 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, Centers for Medicare and Medicaid Services, 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 expenditures.

(i) (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, 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, 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 an entity 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, for the disallowed claim.

(j) The expenditure of local 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.

(k) Subject to the requirements of federal law and regulations, TCM services are services which assist beneficiaries to gain access to needed medical, social, educational, and other services. Services provided by local governmental agencies, 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.

(l) 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.

(m) For the purposes of this section a “local governmental agency” means a county or chartered city.

(n) Nothing in this section or in Section 14132.47 shall be construed to prevent any state agency from providing TCM services or from contracting with others to provide these services.

(Amended by Stats. 2008, Ch. 464, Sec. 1. Effective January 1, 2009.)

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.

(Added by Stats. 1988, Ch. 1555, Sec. 8.)

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.

(Added by Stats. 1989, Ch. 532, Sec. 1.)

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 1903a of the federal Social Security Act (42 U.S.C. Sec. 1396b(a)), and this activity shall be known as the Administrative Claiming process.

(c) (1) Subject to the requirements of paragraph (2) of subdivision (f), 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 reimbursement, enter into a contract with the department and shall certify to the department the total amount the local governmental agency or each local educational consortium expended on the allowable administrative activities.

(2) The department shall deny the claim if it determines that the certification is not adequately supported, or does not otherwise comply with federal requirements, for purposes of claiming federal financial participation.

(d) Each participating local governmental agency or local educational consortium may subcontract with private or public 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) (1) The department shall require that each participating local governmental agency or each local educational consortium certify to the department both of the following:

(A) The expenditure of 100 percent 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.

(B) 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.

(2) (A) (i) A city that is not a participating local governmental agency, or any other local public entity, that contracts with a local governmental agency pursuant to subdivision (d) and that is located within a county that is a participating local governmental agency pursuant to this section, may submit certification to the local governmental agency of amounts expended for Administrative Claiming services in accordance with Section 433.51 of Title 42 of the Code of Federal Regulations.

(ii) A city or other local public entity that submits certification pursuant to this paragraph shall comply with the requirements of paragraph (1), with other requirements applicable to local governmental agencies that the department determines, in

regulations, to be applicable, and with all applicable federal requirements.

(iii) The local governmental agency shall forward the city's or local public entity's certification to the department for the purposes of claiming federal financial participation.

(iv) As applicable, the local governmental agency shall obtain and retain appropriate certifications from the expending city or local public entity, together with documentation of the underlying expenditures, as required by the department.

(B) A tribe or tribal organization, as defined in subdivision (n), that is not participating in Administrative Claiming process activities as a local governmental agency, may contract with, and submit to a tribe or tribal organization that is contracting with, the department pursuant to subdivision (b) amounts expended for Administrative Claiming process activities that it is certifying in accordance with Section 433.51 of Title 42 of the Code of Federal Regulations and other applicable federal law and regulations. The tribe or tribal organization receiving the certification shall forward it to the department for purposes of claiming federal financial participation. The certification shall comply with all of the requirements for certification set forth in subparagraph (A).

(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, 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, 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 an 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, for the disallowed claim.

(h) The use of local 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 governmental 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) To the extent consistent with federal law and regulations, 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) 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.

(n) (1) 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).

(2) Each participating Native American Indian tribe, tribal organization, or subgroup of a Native American Indian tribe or tribal organization may claim, as a Medi-Cal Administrative Activity, facilitating Medi-Cal applications, which includes, but is not limited to, using the California Healthcare Eligibility, Enrollment, and Retention System.

(o) 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.

(p) (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).

(q) (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.

(r) (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.

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

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

(u) 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.

(v) 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.

(w) Nothing in this section or Section 14132.44 shall be construed to prevent any state agency from participating in the Administrative Claiming process or from contracting with others to engage in these activities.

(Amended by Stats. 2013, Ch. 306, Sec. 1. (AB 1233) Effective September 9, 2013.)

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.

(Added by Stats. 1994, Ch. 147, Sec. 27. Effective July 11, 1994.)

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.

(Amended by Stats. 1992, Ch. 123, Sec. 1. Effective January 1, 1993.)

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 (c) of Section 2532.2 of the Business and Professions Code.

(Amended by Stats. 2014, Ch. 316, Sec. 36. (SB 1466) Effective January 1, 2015.)

14132.56. (a) (1) Only to the extent required by the federal government and effective no sooner than required by the federal government, behavioral health treatment (BHT) shall be a covered Medi-Cal service for individuals under 21 years of age.

(2) It is the intent of the Legislature that, to the extent the federal government requires BHT to be a covered Medi-Cal service, the department shall seek statutory authority to implement this new benefit in Medi-Cal.

(3) For purposes of this section, "behavioral health treatment" or "BHT" means professional services and treatment programs, including applied behavior analysis (ABA) and evidence-based intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and are administered by the department as described in the approved state plan.

(b) The department shall implement, or continue to implement, this section only after all of the following occurs or has occurred:

(1) The department receives all necessary federal approvals to obtain federal funds for the service.

(2) The department seeks an appropriation that would provide the necessary state funding estimated to be required for the applicable fiscal year.

(3) The department consults with stakeholders.

(c) The department shall develop and define eligibility criteria, provider participation criteria, utilization controls, and delivery system structure for services under this section, subject to limitations allowable under federal law, in consultation with stakeholders.

(d) (1) The department, commencing on the effective date of the act that added this subdivision until March 31, 2017, inclusive, may make available to individuals described in paragraph (2) contracted services to assist those individuals with health insurance enrollment, without regard to whether federal funds are available for the contracted services.

(2) The contracted services described in paragraph (1) may be provided only to an individual under 21 years of age whom the department identifies as no longer eligible for Medi-Cal solely due to the transition of BHT coverage from the waiver program under Section 1915(c) of the federal Social Security Act to the Medi-Cal state plan in accordance with this section and who meets all of the following criteria:

(A) They were enrolled in the home and community-based services waiver for persons with developmental disabilities under Section 1915(c) of the Social Security Act as of January 31, 2016.

(B) They were deemed to be institutionalized in order to establish eligibility under the terms of the waiver.

(C) They have not been found eligible under any other federally funded Medi-Cal criteria without a spend down of excess income.

(D) They have received a BHT service from a regional center for persons with developmental disabilities as provided in Chapter 5 (commencing with Section 4620) of Division 4.5.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until regulations are adopted. The department shall adopt regulations by July 1, 2017, 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. Notwithstanding Section 10231.5 of the Government Code, beginning six months after the effective date of this section, the department shall provide semiannual status reports to the Legislature, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(f) For the purposes of implementing this section, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis, including contracts for the purpose of obtaining subject matter expertise or other technical assistance. Contracts may be statewide or on a more limited geographic basis. Contracts entered into or amended under this subdivision shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of the Government Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(g) The department may seek approval of any necessary state plan amendments or waivers to implement this section. The department shall make any state plan amendments or waiver requests public at least 30 days prior to submitting to the federal Centers for Medicare and Medicaid Services, and the department shall work with stakeholders to address the public comments in the state plan amendment or waiver request.

(h) This section shall be implemented only to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

(Amended by Stats. 2023, Ch. 42, Sec. 145. (AB 118) Effective July 10, 2023.)

14132.57. (a) (1) The department shall seek all necessary federal approvals to exercise the option described in Section 1396w-6 of Title 42 of the United States Code, to provide qualifying community-based mobile crisis intervention services to eligible Medi-Cal beneficiaries experiencing a mental health or substance use disorder crisis.

(2) Qualifying community-based mobile crisis intervention services shall be available to eligible Medi-Cal beneficiaries exclusively through a Medi-Cal behavioral health delivery system.

(b) The department shall comply with any federal requirements and conditions for receipt of the increased federal medical assistance percentage described in Section 1396w-6(c) of Title 42 of the United States Code and any associated federal regulations or guidance for qualifying community-based mobile crisis intervention services.

(c) Subject to obtaining the federal approvals described in subdivision (a), the department shall do all of the following:

(1) Establish requirements for the receipt of qualifying community-based mobile crisis intervention services by eligible Medi-Cal beneficiaries experiencing a mental health or substance use disorder crisis, including, but not limited to, utilization controls.

(2) Establish requirements for authorized providers of qualifying community-based mobile crisis intervention services.

(3) Oversee and enforce the requirements and guidelines developed pursuant to this section.

(d) For the purposes of implementing this section, including, but not limited to, providing training and technical assistance, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(e) Subject to federal approval, this section shall be implemented no sooner than January, 1, 2023, and shall be implemented up to the end of the five-year period specified in Section 1396w-6 of Title 42 of the United States Code.

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

(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, interpret, or make specific this section, in whole or in part, by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions, without taking any further regulatory action. To the extent practicable, the department shall consult with interested stakeholders when issuing guidance pursuant to this subdivision.

(h) For purposes of this section, the following definitions apply:

(1) “Medi-Cal behavioral health delivery system” has the same meaning as set forth in subdivision (i) of Section 14184.101.

(2) “Qualifying community-based mobile crisis intervention services” has the same meaning as set forth in Section 1396w-6(b) of Title 42 of the United States Code.

(Added by Stats. 2022, Ch. 47, Sec. 97. (SB 184) Effective June 30, 2022.)

14132.58. (a) The department shall file all necessary state plan amendments, as set forth in Section 457.40 of Title 42 of the Code of Federal Regulations, to exercise the health services initiative (HSI) option made available under the Children’s Health Insurance Program (CHIP), established under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.), as that option is described in Section 1397ee(a)(1)(D)(ii) of Title 42 of the United States Code, and as HSI is defined in Section 457.10 of Title 42 of the Code of Federal Regulations, to cover vision services provided to low-income children statewide through a mobile optometric office, as defined in Section 3070.2 of the Business and Professions Code and in accordance with subdivision (g) of Section 14043.15 and with Section 14043.26.

(b) (1) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available. The federal financial participation shall be limited to no more than 3 percent of the total federal dollars available for expenditures not used for Medicaid or health insurance assistance, as described in Section 1397ee(c)(2)(A) of Title 42 of the United States Code.

(2) This section shall be implemented by January 1, 2025, or the date that any necessary federal approvals have been obtained, whichever date is later.

(c) (1) The Vision Services CHIP-HSI Special Fund is hereby created in the State Treasury.

(2) All revenues derived pursuant to paragraph (1) of subdivision (d) and federal financial participation provided for in this section shall be deposited in the State Treasury to the credit of the Vision Services CHIP-HSI Special Fund. Moneys in that fund shall be available to cover vision services, as described in subdivision (a), upon appropriation by the Legislature in the annual Budget Act. Commencing with the first fiscal year in which the department requests funds for this purpose and annually thereafter, the department shall report on projected and actual federal and nonfederal resources and expenditures through the budget estimate process.

(d) (1) The department shall seek to fund the implementation of this section, subject to subdivision (c), with funding other than General Fund moneys, including gifts, donations, bequests, or grants of funds from private sources and public agencies, designated for any of the purposes of this section.

(2) This section shall continue to be implemented only if no General Fund moneys are used for this section.

(e) 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 section by means of an all-county letter or similar instruction, without taking any further regulatory action, until regulations are adopted.

(Added by Stats. 2023, Ch. 487, Sec. 2. (SB 502) Effective January 1, 2024.)

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.

(Amended by Stats. 1989, Ch. 1398, Sec. 4. Effective October 2, 1989.)

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.

(Added by Stats. 1998, Ch. 788, Sec. 4. Effective January 1, 1999. Section operative July 1, 1999, by its own provisions.)

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.

(Added by Stats. 1996, Ch. 1009, Sec. 1. Effective January 1, 1997. Repealed conditionally by its own provisions.)

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.

(Added by Stats. 2007, Ch. 300, Sec. 3. Effective January 1, 2008.)

14132.70. (a) A Medi-Cal beneficiary shall remain eligible to receive Medi-Cal coverage for antirejection medication for up to two years following an organ transplant, unless during that period the beneficiary becomes eligible for Medicare or private health insurance that would cover the medication.

(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, without taking any further regulatory action.

(Added by Stats. 2010, Ch. 676, Sec. 1. (AB 2352) Effective January 1, 2011.)

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.

(Added by Stats. 2007, Ch. 300, Sec. 5. Effective January 1, 2008.)

14132.72. (a) For purposes of this section, the definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code shall apply.

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

(c) In-person contact between a health care provider and a patient shall not be required under the Medi-Cal program for services appropriately provided through telehealth, subject to reimbursement policies adopted by the department to compensate a licensed health care provider who provides health care services through telehealth that are otherwise reimbursed pursuant to the Medi-Cal program. Nothing in this section or the Telehealth Advancement Act of 2011 shall be construed to conflict with or supersede the provisions of Section 14091.3 of this code or any other existing state laws or regulations related to reimbursement for services provided by a noncontracted provider.

(d) The department shall not require a health care provider to document a barrier to an in-person visit for Medi-Cal coverage of services provided via telehealth.

(e) For the purposes of payment for covered treatment or services provided through telehealth, the department shall not limit the type of setting where services are provided for the patient or by the health care provider.

(f) Nothing in this section shall be interpreted to authorize the department to require the use of telehealth when the health care provider has determined that it is not appropriate.

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

(Amended by Stats. 2011, Ch. 547, Sec. 9. (AB 415) Effective January 1, 2012.)

14132.723. (a) (1) Notwithstanding any other law, neither face-to-face contact nor a patient's physical presence on the premises shall be required for services provided by an enrolled community clinic to a Medi-Cal beneficiary during or immediately following a state of emergency, as described in Section 8628.5 of the Government Code.

(2) Notwithstanding any other law, the department may apply paragraph (1) to services provided by another enrolled fee-for-service Medi-Cal provider, clinic, or facility during or immediately following a state of emergency.

(b) For purposes of this section, the following terms have the following meanings:

(1) (A) "Enrolled community clinic" means a community clinic licensed under subdivision (a) of Section 1204 of the Health and Safety Code, an intermittent clinic exempt from licensure under subdivision (h) of Section 1206 of the Health and Safety Code, a clinic operated by the state or any of its political subdivisions, including, but not limited to, the University of California or a city or county that is exempt from licensure under subdivision (b) of Section 1206 of the Health and Safety Code, a tribal clinic exempt from licensure under subdivision (c) of Section 1206 of the Health and Safety Code, or an outpatient setting conducted, maintained, or operated by a federally recognized Indian tribe, tribal organization, or urban Indian organization, as defined in Section 1603 of Title 25 of the United States Code, that is certified, as applicable, and enrolled in good standing as a Medi-Cal provider or, in the case of an intermittent site, is added to a parent clinic's provider master file under Section 14043.15.

(B) An outpatient setting that operates as a federally qualified health center (FQHC) or a rural health center (RHC) shall qualify as an enrolled community clinic, regardless of its license type or license-exempt status.

(2) "Immediately following" means up to 90 calendar days, as deemed appropriate by the department, following the termination of the proclaimed state of emergency, as described in Section 8629 of the Government Code. Under extraordinary circumstances, including, but not limited to, the destruction of an enrolled location, as described in subdivision (a), the department may extend, in its discretion or at the direction of the Governor, the period of time immediately following the termination of a state of emergency beyond 90 calendar days and for as long as is necessary for the health and safety of the public.

(3) (A) "Premises" means either of the following, as applicable:

(i) A site located within the four walls of the enrolled community clinic, and at the address listed either on the primary care clinic license or in the provider master file.

(ii) A site located within the four walls of the enrolled fee-for-service Medi-Cal provider, clinic, or facility, and at the address listed either on its license or in the provider master file.

(B) For purposes of an FQHC or RHC, "premises" include a site located outside of the four walls of the FQHC or RHC, and at an address other than the address listed on its license or in the provider master file, but within the boundaries of the proclamation declaring the state of emergency.

(4) "Telehealth" has the same meaning as provided in Section 2290.5 of the Business and Professions Code.

(5) "Telephonic services" means health services provided via telephone with audio component only.

(c) The following services shall be reimbursable when provided by an enrolled community clinic, an enrolled fee-for-service Medi-Cal program provider, clinic, or facility approved by the department pursuant to paragraph (2) of subdivision (a) during or immediately following a state of emergency for any dates of service on or after the date that the department obtains federal approvals and federal matching funds to implement these provisions pursuant to subdivision (f).

(1) Telehealth services, including services provided by the enrolled community clinic or approved enrolled provider, clinic, or facility at a distant site location, whether on or off the premises, to a Medi-Cal beneficiary located at an originating site, which includes the beneficiary's home, temporary shelter, or any other location, if the services are provided somewhere located within the boundaries of the proclamation declaring the state of emergency.

(2) Telephonic services.

(3) Covered benefit services that are otherwise reimbursable to an FQHC or RHC, but that are provided somewhere off the premises, including, but not limited to, at a temporary shelter, a Medi-Cal beneficiary's home, or any location other than the premises, but within the boundaries of the proclamation declaring the state of emergency.

(d) For purposes of paragraph (1) of subdivision (c), and consistent with Section 14132.72, the department shall ensure its reimbursement policies reflect the intent of the Legislature to authorize reimbursement for telehealth services appropriately provided by an enrolled community clinic, or, if approved by the department pursuant to paragraph (2) of subdivision (a), by an enrolled fee-for-service Medi-Cal provider, clinic, or facility, respectively, during or immediately following a state of emergency. This subdivision does not limit reimbursement for, or coverage of, or reduce access to, services provided through telehealth on or before the enactment of this section.

(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, and make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action.

(f) This section shall be implemented only to the extent that both of the following occur:

(1) The department obtains any federal approvals necessary to implement this section.

(2) The department obtains federal matching funds to the extent permitted by federal law.

(Added by Stats. 2019, Ch. 829, Sec. 1. (AB 1494) Effective January 1, 2020.)

14132.724. (a) On or before July 1, 2020, the department shall issue, and shall publish on its internet website, guidance for enrolled community clinics and other enrolled fee-for-service Medi-Cal providers, clinics, or facilities that are subject to Section 14132.723 in order to facilitate reimbursement for services provided pursuant to Section 14132.723, whether those services are provided at a health facility, a shelter, the Medi-Cal beneficiary's home, or any other location within the boundaries of the emergency proclamation for the state of emergency, as described in Section 8628.5 of the Government Code. This guidance shall include, at a minimum, all of the following information:

(1) Instructions, including examples, describing how enrolled community clinics and other enrolled fee-for-service Medi-Cal providers, clinics, or facilities submit claims for telehealth or telephonic services, as described in Section 14132.723, to Medi-Cal beneficiaries located outside the premises of the enrolled community clinic or other enrolled fee-for-service Medi-Cal provider, clinic, or facility during or immediately following a state of emergency.

(2) Direction to Medi-Cal managed care plans on paying any claims submitted in accordance with the guidance issued under this section, including that Medi-Cal managed care plans contracting with the department under the Medi-Cal program are responsible for ensuring their delegated payers comply with all applicable federal and state laws, regulations, contract requirements, and any department-issued guidance related to the provision of services by enrolled community clinics or other providers, clinics, or facilities during or immediately following a state of emergency.

(3) (A) Identification of services, provided during or immediately following a state of emergency, that may be provided solely through a telephonic visit, and identification of services that require other forms of telehealth, such as a live, synchronous video interaction, asynchronous store and forward, or an interactive telecommunications system.

(B) Identification of telephonic, facsimile, email, or remote patient monitoring devices that may be used and reimbursed as part of a Medi-Cal covered service, including, but not limited to, laboratory, x-ray, or physician services, subject to any required federal approvals or waivers sought under subdivision (d).

(4) Policies for ensuring prompt payment of claims submitted by enrolled community clinics or other enrolled fee-for-service Medi-Cal providers, clinics, or facilities for services provided during or immediately following a state of emergency, including, but not limited to, the temporary waiver of documentation requirements and streamlined billing or appeal processes for commonly owned entities.

(b) For purposes of this section, the following terms have the following meanings:

(1) “Asynchronous store and forward” has the same meaning as provided in Section 2290.5 of the Business and Professions Code.

(2) “Immediately following” has the same meaning as provided in Section 14132.723.

(3) “Interactive telecommunications system” has the same meaning as provided in Section 410.78 of Title 42 of the Code of Federal Regulations.

(4) “Premises” has the same meaning as provided in Section 14132.723.

(5) “Telehealth” has the same meaning as provided in Section 2290.5 of the Business and Professions Code.

(c) The department shall seek federal approval of any necessary state plan amendments or waivers to implement this section, including, but not limited to, any demonstration program or similar opportunities allowing a telephonic visit to be used as a substitute for other forms of telehealth, such as synchronous video interaction, asynchronous store and forward, or an interactive telecommunications system.

(d) 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, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. The department shall adopt regulations by January 1, 2024, 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.

(Added by Stats. 2019, Ch. 829, Sec. 2. (AB 1494) Effective January 1, 2020.)

14132.725. (a) For purposes of this section, the following definitions apply:

(1) “Border community” means border areas adjacent to the State of California where it is customary practice for California residents to use medical resources in adjacent areas outside the state. Under these circumstances, program controls and limitations are the same as for services rendered by health care providers within the state.

(2) “Health care provider” has the same meaning as set forth in paragraph (3) of subdivision (a) of Section 2290.5 of the Business and Professions Code, and shall be either enrolled as a Medi-Cal rendering provider, or a nonphysician medical practitioner affiliated with an enrolled Medi-Cal provider group. “Health care provider” also includes any provider type designated by the department pursuant to subparagraph (A) of paragraph (2) of subdivision (b). The enrolled Medi-Cal provider or provider group for which the health care provider renders services via telehealth shall meet all Medi-Cal requirements and shall be located in the state or a border community.

(3) “Health care service plan” has the same meaning as set forth in subdivision (f) of Section 1345 of the Health and Safety Code.

(4) “Medi-Cal managed care plan” has the same meaning as set forth in subdivision (j) of Section 14184.101.

(5) “Network provider” has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(6) “Telehealth” has the same meaning as set forth in paragraph (6) of subdivision (a) of Section 2290.5 of the Business and Professions Code.

(b) (1) Subject to subdivision (k), in-person, face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for covered health care services and provider types designated by the department, when provided by video synchronous interaction, asynchronous store and forward, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet the applicable standard of care and meet the requirements of the service code being billed.

(2) (A) In implementing this section, the department shall designate and periodically update the covered health care services and provider types, including required licensing and credentialing criteria, as applicable, which may be appropriately delivered via the telehealth modalities described in this subdivision.

(B) Applicable health care services appropriately provided through video synchronous interaction, asynchronous store and forward, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities are subject to billing, reimbursement, and utilization management policies imposed by the department. Subject to subdivision (k), utilization management protocols adopted by the department pursuant to this section shall be consistent with, and no more restrictive than, those authorized for health care service plans pursuant to Section 1374.13 of the Health and Safety Code.

(c) (1) (A) Pursuant to an effective date designated by the department that is no sooner than January 1, 2024, a Medi-Cal provider furnishing applicable health care services via audio-only synchronous interaction shall also offer those same health care services via video synchronous interaction to preserve beneficiary choice.

(B) (i) The department may provide specific exceptions to the requirement specified in subparagraph (A), based on a Medi-Cal provider’s access to requisite technologies, which shall be developed in consultation with affected stakeholders and published in departmental guidance.

(ii) In making exceptions to the requirement specified in subparagraph (A), in addition to the provisions in clause (i), the department may also take into consideration the availability of broadband access based on speed standards set by the Federal Communications Commission, pursuant to Section 706 of the Telecommunications Act of 1996 (Pub. L. No. 104-104) or other applicable federal law or regulation.

(2) Effective on the date designated by the department pursuant to paragraph (1), a provider furnishing services through video synchronous interaction or audio-only synchronous interaction shall also maintain and follow protocols to do one of the following:

(A) Offer those services via in-person, face-to-face contact.

(B) (i) Arrange for a referral to, and a facilitation of, in-person care that does not require a patient to independently contact a different provider to arrange for that care.

(ii) Clause (i) does not require a provider to schedule an appointment with a different provider on behalf of a patient.

(3) In implementing this subdivision, the department shall consider additional recommendations from affected stakeholders regarding the need to maintain access to in-person services without unduly restricting access to telehealth services.

(4) A health care provider may establish a new patient relationship with a Medi-Cal beneficiary via video synchronous interaction consistent with any requirements imposed by the department.

(5) (A) A health care provider shall not establish a new patient relationship with a Medi-Cal beneficiary via asynchronous store and forward, telephonic (audio-only) synchronous interaction, remote patient monitoring, or other virtual communication modalities, except as set forth in paragraph (4) of subdivision (g) of Section 14132.100.

(B) Notwithstanding the prohibition in subparagraph (A), the department may provide for specific exceptions to this prohibition, the department may provide for specific exceptions described in clauses (i) and (ii), which shall be developed in consultation with affected stakeholders and published in departmental guidance.

(i) Notwithstanding the prohibition in subparagraph (A), a health care provider may establish a new patient relationship using an audio-only synchronous interaction when the visit is related to sensitive services, as defined in subdivision (p) of Section 56.05 of the Civil Code, and when established in accordance with department-specific requirements and consistent with federal and state law, regulations, and guidance.

(ii) Notwithstanding the prohibition in subparagraph (A), a health care provider may establish a new patient relationship using an audio-only synchronous interaction when the patient requests an audio-only modality or attests they do not have access to video, and when established in accordance with department-specific requirements and consistent with federal and state laws, regulations, and guidance.

(6) Subject to subdivision (k), the department may establish separate fee schedules for applicable health care services delivered via remote patient monitoring or other permissible virtual communication modalities.

(7) This subdivision does not apply to Medi-Cal covered services delivered by providers via any telehealth modality to eligible inmates in state prisons, county jails, or youth correctional facilities.

(d) In addition to any existing law requiring beneficiary consent to telehealth, including, but not limited to, subdivision (b) of Section 2290.5 of the Business and Professions Code, all of the following shall be communicated by a health care provider to a Medi-Cal beneficiary, in writing or verbally, on at least one occasion prior to, or concurrent with, initiating the delivery of one or more health care services via telehealth to a Medi-Cal beneficiary: an explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit; an explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future; an explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted; and the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider.

(1) The provider shall document in the patient record the provision of this information and the patient's verbal or written acknowledgment that the information was received.

(2) The department shall develop, in consultation with affected stakeholders, model language for purposes of the communication described in this subdivision.

(3) This subdivision does not apply to Medi-Cal covered services delivered by providers via any telehealth modality to eligible inmates in state prisons, county jails, or youth correctional facilities.

(e) (1) The department shall develop, in consultation with affected stakeholders, an informational notice to be distributed to fee-for-service Medi-Cal beneficiaries and for use by Medi-Cal managed care plans in communicating to their enrollees. Information in the notice shall include, but not be limited to, all of the following:

(A) The availability of Medi-Cal covered telehealth services.

(B) The beneficiary's right to access all medically necessary covered services through in-person, face-to-face visits, and a provider's and Medi-Cal managed care plan's responsibility to offer or arrange for that in-person care, as applicable.

(C) An explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn by the Medi-Cal beneficiary at any time without affecting their ability to access covered Medi-Cal services in the future.

(D) An explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted.

(E) Notification of the beneficiary's right to make complaints about the offer of telehealth services in lieu of in-person care or about the quality of care delivered through telehealth.

(2) The informational notice shall be translated into threshold languages determined by the department pursuant to subdivision (b) of Section 14029.91 and provided in a format that is culturally and linguistically appropriate.

(3) This subdivision does not apply to Medi-Cal covered services delivered by providers via any telehealth modality to eligible inmates in state prisons, county jails, or youth correctional facilities.

(f) (1) Subject to subdivision (k), the department shall reimburse health care providers of applicable health care services delivered via video synchronous interaction, synchronous audio-only modality, or asynchronous store and forward, as applicable, at payment amounts that are not less than the amounts the provider would receive if the services were delivered via in-person, face-to-face contact, so long as the services or settings meet the applicable standard of care and meet the requirements of the service code being billed.

(2) Subject to subdivision (k), for applicable health care services appropriately provided by a network provider via video synchronous interaction, audio-only synchronous interaction modality, or asynchronous store and forward, as applicable, to an enrollee of a Medi-Cal managed care plan, the Medi-Cal managed care plan shall reimburse the network provider at payment amounts that are not less than the amounts the network provider would have received if the services were delivered via in-person,

face-to-face contact, unless the Medi-Cal managed care plan and network provider mutually agree to reimbursement in different amounts.

(g) On or before January 1, 2023, the department shall develop a research and evaluation plan that does all of the following:

(1) Proposes strategies to analyze the relationship between telehealth and the following: access to care, access to in-person care, quality of care, and Medi-Cal program costs, utilization, and program integrity.

(2) Examines issues using an equity framework that includes stratification by available geographic and demographic factors, including, but not limited to, race, ethnicity, primary language, age, and gender, to understand inequities and disparities in care.

(3) Prioritizes research and evaluation questions that directly inform Medi-Cal policy.

(h) Applicable health care services provided through asynchronous store and forward, video synchronous interaction, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities as described in this section shall comply with the privacy and security requirements contained in the federal Health Insurance Portability and Accountability Act of 1996 found in Parts 160 and 164 of Title 45 of the Code of Federal Regulations, the Medicaid State Plan, and any other applicable state and federal statutes and regulations.

(i) 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, plan letters, provider bulletins, and similar instructions, without taking any further regulatory action.

(j) Consistent with the requirements of this section and subject to subdivision (k), a PACE organization approved by the department pursuant to Chapter 8.75 (commencing with Section 14591) may use video telehealth to conduct initial assessments and annual reassessments for eligibility for enrollment in the PACE program.

(k) The department shall seek any federal approvals it deems necessary to implement this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(l) This section shall be operative on January 1, 2023, or on the operative date or dates reflected in the applicable federal approvals obtained by the department pursuant to subdivision (k), whichever is later.

(m) This section does not apply to health care services provided via telehealth in an FQHC or RHC visit as described in paragraph (4) of subdivision (g) of Section 14132.100.

(Amended by Stats. 2023, Ch. 172, Sec. 1. (AB 1241) Effective January 1, 2024. Conditionally operative on or after January 1, 2023, by its own provisions.)

14132.73. The State Department of Health Care Services shall allow psychiatrists to receive fee-for-service Medi-Cal reimbursement for services provided through telehealth in accordance with the Medicaid state plan.

(Amended by Stats. 2012, Ch. 782, Sec. 13. (AB 1733) Effective January 1, 2013.)

14132.731. (a) A county that enters into a Drug Medi-Cal Treatment Program contract with the department in accordance with Section 14124.20, or the department if entering into a Drug Medi-Cal Treatment Program contract directly with providers or as otherwise described in Section 14124.21, shall reimburse Drug Medi-Cal certified providers for medically necessary Drug Medi-Cal reimbursable services, as defined in Section 14124.24, provided by a licensed practitioner of the healing arts, or a registered or certified alcohol or other drug counselor or other individual authorized by the department to provide Drug Medi-Cal reimbursable services when those services meet the standard of care, meet the requirements of the service code being billed, and are delivered through video synchronous interaction or audio-only synchronous interaction.

(b) A Drug Medi-Cal certified provider shall not establish a new patient relationship with a Medi-Cal beneficiary via asynchronous store and forward, audio-only synchronous interaction, remote patient monitoring, or other virtual communication modalities, except as set forth in paragraph (4) of subdivision (g) of Section 14132.100. Notwithstanding this prohibition, the department may provide for specific exceptions to this prohibition, which shall be developed in consultation with affected stakeholders and published in departmental guidance.

(c) Drug Medi-Cal reimbursable services provided through a video synchronous interaction or an audio-only synchronous interaction pursuant to subdivision (a) shall be subject to billing, reimbursement, and utilization management policies imposed by the department.

(d) Drug Medi-Cal reimbursable services provided through a video synchronous interaction or an audio-only synchronous interaction shall be provided in compliance with the privacy and security requirements contained in the federal Health Insurance Portability and Accountability Act of 1996 found in Parts 160 and 164 of Title 45 of the Code of Federal Regulations, Part 2 of Title 42 of the Code of Federal Regulations, the Medicaid State Plan, and any other applicable state and federal statutes and regulations.

(e) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available.

(f) The department shall adopt regulations by July 1, 2024, to implement this section 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).

(g) Notwithstanding the rulemaking provisions of the Administrative Procedure Act, the department may, if it deems it appropriate, implement, interpret, or make specific this section by means of provider bulletins, written guidelines, or similar instructions from the department, until regulations are adopted.

(Repealed and added by Stats. 2022, Ch. 47, Sec. 101. (SB 184) Effective June 30, 2022.)

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.

(Added by Stats. 2006, Ch. 330, Sec. 2. Effective January 1, 2007.)

14132.75. (a) In enacting this section, it is the intent of the Legislature that palliative care include, but not be limited to, all of the following:

(1) Specialized medical care and emotional and spiritual support for people with serious advanced illnesses.

(2) Relief of symptoms, pain, and stress of serious illness.

(3) Improvement of quality of life for both the patient and family.

(4) Appropriate care for any age and for any stage of serious illness, along with curative treatment.

(b) The department, in consultation with interested stakeholders, shall establish standards and provide technical assistance for Medi-Cal managed care plans to ensure delivery of palliative care services.

(c) Covered services shall include, but are not limited to, those types of services that are available through the Medi-Cal hospice benefit. These services shall include the following, regardless of whether these 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 establish guidance on the medical conditions and prognoses that render a beneficiary eligible for the palliative care services.

(e) Providers authorized to provide services shall include licensed hospice agencies and home health agencies licensed to provide hospice care that are contracted with Medi-Cal managed care plans to provide palliative care services.

(f) The department shall, to the extent practicable, ensure that the delivery of palliative care services under this section is provided in a manner that is cost neutral to the General Fund on an ongoing basis.

(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 all plan letters or similar instructions, without the adoption of regulations. The department shall notify stakeholders and the fiscal and appropriate policy committees of the Legislature of its intent to issue all plan letters or other similar instructions 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.

(2) This section shall not affect an individual's eligibility to receive, concurrently with the services 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.

(Added by Stats. 2014, Ch. 574, Sec. 1. (SB 1004) Effective January 1, 2015.)

14132.755. (a) Commencing no sooner than July 1, 2022, dyadic behavioral health visits shall be a covered benefit under the Medi-Cal program, subject to utilization controls.

(b) The dyadic services benefit is a family- and caregiver-focused model of care intended to address developmental and behavioral health conditions of children as soon as they are identified, and that fosters access to preventive care for children, rates of immunization completion, coordination of care, child social-emotional health and safety, developmentally appropriate parenting, and maternal mental health. Dyadic behavioral health visits are provided for the child and caregiver or parent at medical visits, providing screening for behavioral health problems, interpersonal safety, tobacco and substance misuse and social determinants of health, such as food insecurity and housing instability, and referrals for appropriate followup care.

(c) This section shall be implemented only to the extent any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized.

(d) 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, in whole or in part, by means of provider bulletins, plan letters, information notices, or other similar instructions, without taking any further regulatory action.

(Added by Stats. 2021, Ch. 143, Sec. 392. (AB 133) Effective July 27, 2021.)

14132.76. (a) An individual who is determined to be eligible to receive hospice services prior to 21 years of age may continue to receive hospice services after 21 years of age when certified as eligible by a physician in accordance with section 1905(o) of the Social Security Act (42 U.S.C. Sec. 1396d(o)).

(b) An individual who is determined to be eligible to receive palliative care services prior to 21 years of age may continue to receive medically necessary palliative care services after 21 years of age when determined to be eligible by the recipient's treating health care provider.

(c) The department shall seek any federal approvals it deems necessary to implement this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and

not otherwise jeopardized.

(Added by Stats. 2023, Ch. 814, Sec. 3. (AB 847) Effective January 1, 2024.)

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.

(Added by Stats. 1993, Ch. 460, Sec. 1. Effective January 1, 1994.)

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.

(Amended by Stats. 1996, Ch. 1023, Sec. 477. Effective September 29, 1996.)

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.

(Amended by Stats. 1986, Ch. 258, Sec. 1.)

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.

(Added by Stats. 1989, Ch. 1082, Sec. 2.)

14132.85. (a) For purposes of this section, the following definitions apply:

(1) “Complex needs patient” means an individual with a diagnosis or medical condition that results in significant physical impairment or functional limitation. “Complex needs patient” includes, but is not limited to, individuals with spinal cord injury, traumatic brain injury, cerebral palsy, muscular dystrophy, spina bifida, osteogenesis imperfecta, arthrogryposis, amyotrophic lateral sclerosis, multiple sclerosis, demyelinating disease, myelopathy, myopathy, progressive muscular atrophy, anterior horn cell disease, post-polio syndrome, cerebellar degeneration, dystonia, Huntington’s disease, spinocerebellar disease, and the types of amputation, paralysis, or paresis that result in significant physical impairment or functional limitation. “Complex needs patient” does not negate the requirement that an individual meet medical necessity requirements under authority rules to qualify for receiving complex rehabilitation technology.

(2) “Complex rehabilitation technology” means items classified within the federal Medicare Program as of January 1, 2021, as durable medical equipment that are individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living identified as medically necessary. These items include, but are not limited to, complex rehabilitation manual and power wheelchairs, power seat elevation or power standing components of power wheelchairs, seating and positioning items, other specialized equipment such as adaptive bath equipment, standing frames, gait trainers, and specialized strollers, and related options and accessories.

(3) “Complex rehabilitation technology services” includes the application of enabling systems designed and assembled to meet the needs of a patient experiencing any permanent or long-term loss or abnormality of physical or anatomical structure or function with respect to mobility or other function or need. These services include, but are not limited to, all of the following:

(A) Evaluating the needs of a patient with a disability, including an assessment of the patient for the purpose of ensuring that the proposed equipment is appropriate.

(B) Documenting medical necessity.

(C) Selecting, fitting, customizing, maintaining, assembling, repairing, replacing, picking up and delivering, and testing equipment and parts.

(D) Training the patient who will use the technology or any individual who assists the patient in using the complex rehabilitation technology.

(4) “Qualified health care professional” means an individual who has no financial relationship to the provider of complex rehabilitation technology and is any of the following:

(A) A physical therapist licensed pursuant to Chapter 5.7 (commencing with Section 2600) of Division 2 of the Business and Professions Code.

(B) An occupational therapist licensed pursuant to Chapter 5.6 (commencing with Section 2570) of Division 2 of the Business and Professions Code.

(C) Other licensed health care professional, approved by the department, and who performs specialty evaluations within the professional’s scope of practice.

(5) “Qualified rehabilitation technology professional” means an individual who meets either of the following:

(A) Holds the credential of Assistive Technology Professional (ATP) from the Rehabilitation Engineering and Assistive Technology Society of North America.

(B) Holds the credential of Certified Complex Rehabilitation Technology Supplier (CRTS) from the National Registry of Rehabilitation Technology Suppliers.

(b) A provider of complex rehabilitation technology to a Medi-Cal beneficiary shall comply with all of the following:

(1) Meet the supplier and quality standards established for a durable medical equipment supplier under the federal Medicare Program and be enrolled as a provider in the Medi-Cal program.

(2) Be accredited by a recognized accrediting organization as a supplier of complex rehabilitation technology.

(3) Employ at least one qualified rehabilitation technology professional as a W-2 employee (receiving a W-2 tax form from the provider) for each distribution location.

(4) Have the qualified rehabilitation technology professional physically present for the evaluation, either in person or remotely if necessary, directly involved in determining the specific complex rehabilitation technology appropriate for the patient, and directly involved with, or closely supervised in, the final fitting and delivery of the complex rehabilitation technology.

(5) Maintain a reasonable supply of parts, adequate physical facilities, and qualified service or repair technicians, and provide patients with prompt services and repair for all complex rehabilitation technology supplied.

(6) Provide written information at the time of delivery of complex rehabilitation technology regarding how the patient may receive services and repair.

(c) For complex needs patients receiving a complex rehabilitation manual wheelchair, power wheelchair, or seating component, the patient shall be evaluated, either in person or remotely if necessary, by both of the following:

(1) A qualified health care professional.

(2) A qualified rehabilitation technology professional.

(d) A medical provider shall conduct a physical examination of an individual, either in person or remotely if necessary, before prescribing a power wheelchair or scooter for a Medi-Cal beneficiary. The medical provider shall complete a certificate of medical necessity that documents the medical condition that necessitates the power wheelchair or scooter, and verifies that the patient is capable of using the wheelchair or scooter safely.

(e) The department may adopt utilization controls, including a specialty evaluation by a qualified health care professional, as defined in paragraph (4) of subdivision (a). The department may adopt any other additional utilization controls for complex rehabilitation technology, as appropriate.

(f) The department shall seek any necessary federal approvals for the implementation of this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(Added by Stats. 2021, Ch. 143, Sec. 393. (AB 133) Effective July 27, 2021.)

14132.86. (a) Notwithstanding subdivision (ab) of Section 14132, effective May 1, 2014, purchase of prescribed enteral nutrition products is covered, subject to the Medi-Cal list of enteral nutrition products pursuant to Section 14105.8 and utilization controls pursuant to Section 14105.395.

(b) 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 section by means of a provider bulletin or similar instruction, without taking regulatory action.

(c) This section shall only be implemented to the extent permitted by federal law.

(d) The department shall seek approval for federal financial participation and coverage of the service specified in subdivision (a) under the Medi-Cal program.

(Added by Stats. 2013, Ch. 23, Sec. 63. (AB 82) Effective June 27, 2013.)

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 a covered benefit when medically necessary to restore a posterior tooth back to normal function based on the criteria specified in the Medi-Cal Dental Manual of Criteria.

(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) Covered dental benefits and accompanying criteria for receipt of those dental benefits under the Medi-Cal program shall be identified in the Medi-Cal Dental Manual of Criteria. Notwithstanding subdivision (h) of Section 14132, the department shall evaluate all covered dental benefits, including those listed in this section and in the Medi-Cal Dental Manual of Criteria, for evidence-based practices consistent with the American Academy of Pediatric Dentistry and the American Dental Association guidelines.

(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 may implement, interpret, or make specific this section, in whole or in part, by means of provider bulletins, plan letters, or other similar instructions, without taking regulatory action.

(g) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available.

(Amended by Stats. 2022, Ch. 47, Sec. 102. (SB 184) Effective June 30, 2022.)

14132.89. (a) Notwithstanding subdivision (h) of Section 14132, effective May 1, 2014, or the effective date of any necessary federal approvals as required by subdivision (d), all of the following are covered benefits for persons 21 years of age or older, subject to utilization controls and medically necessary services:

(1) Examinations, radiographs/photographic images, prophylaxis, and fluoride treatments.

(2) Amalgam and composite restorations.

(3) Stainless steel, resin, and resin window crowns.

(4) Anterior root canal therapy.

(5) Complete dentures, including immediate dentures.

(6) Complete denture adjustments, repairs, and relines.

(7) Emergency procedures are also covered in the above categories of service.

(b) This section shall only be implemented to the extent permitted by federal law.

(c) 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 section by means of a provider bulletin or similar instruction, without taking regulatory action.

(d) The department shall seek approval for federal financial participation and coverage of services specified in subdivision (a) under the Medi-Cal program.

(Added by Stats. 2013, Ch. 23, Sec. 64. (AB 82) Effective June 27, 2013.)

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.

(Added by Stats. 1975, Ch. 958.)

14132.905. (a) 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) This section shall become operative on July 1, 2013.

(Added by Stats. 2013, Ch. 22, Sec. 106. (AB 75) Effective June 27, 2013. Adding action operative July 1, 2013, by Sec. 110 of Ch. 22. Section operative July 1, 2013, by its own provisions.)

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.

(Added by Stats. 2000, Ch. 93, Sec. 94. Effective July 7, 2000.)

14132.915. (a) (1) The department shall establish a list of performance measures to ensure the dental fee-for-service program meets quality and access criteria required by the department. The performance measures shall be designed to evaluate utilization, access, availability, and effectiveness of preventive care and treatment.

(2) Prior to establishing the quality and access criteria described in paragraph (1), the department shall consult with stakeholders, including representatives from counties, local dental societies, nonprofit entities, legal aid entities, and other interested parties.

(3) The performance measures established by the department to monitor the dental fee-for-service program for children shall include, but not be limited to, all of the following:

(A) Overall utilization of dental services.

(B) For each provider, all of the following:

(i) Number of annual dental visits.

(ii) Number of annual preventive dental services.

(iii) Number of annual dental treatment services.

(iv) Number of annual examinations and oral health evaluations.

(C) Number of applications of dental sealants and fluoride varnishes.

(D) Continuity of care and overall utilization over an extended period of time.

(E) All of the following ratios:

(i) Sealant to restoration.

(ii) Filling to preventive services.

(iii) Treatment to caries prevention.

(F) No sooner than January 1, 2018, number of beneficiaries requiring general anesthesia to perform procedures.

(4) The performance measures established by the department to monitor the dental fee-for-service program for adults shall include, but not be limited to, all of the following:

(A) Overall utilization of dental services.

(B) For each provider, all of the following:

(i) Number of annual dental visits.

(ii) Number of annual preventive dental services.

(iii) Number of annual dental treatment services.

(iv) Number of annual examinations and oral health evaluations.

(C) Treatment to caries prevention ratio.

(5) The performance measures shall be reported as aggregate numbers and as percentages, if appropriate, using standards that are as equivalent to those used by managed care entities as feasible. Performance measures for the dental fee-for-service program for children shall be reported by age groupings if appropriate.

(b) The department shall include the initial list of performance measures in any dental contract entered into between the department and a fee-for-service contractor on or after enactment of this section.

(c) To ensure that the dental health needs of Medi-Cal beneficiaries are met, the department shall, when evaluating performance measures for retention on, addition to, or deletion from, the list of performance measures, consider all of the following criteria:

(1) Annual and multiyear Medi-Cal dental fee-for-service trended data.

(2) Other state and national dental program performance and quality measures.

(3) Other state and national performance ratings.

(d) On October 1, 2014, for the 2013 calendar year, and on or before October 1, 2016, for the 2015 calendar year, the list of performance measures established by the department along with the data of the dental fee-for-service program performance shall be posted on the department's Internet Web site.

(e) Commencing January 31, 2017, for the 2015–16 fiscal year, and annually on or before January 31 for each preceding fiscal year thereafter, the list of performance measures established by the department along with the data of the dental fee-for-service program shall be posted on the department's Internet Web site.

(f) Commencing April 30, 2017, for the July 2016 to September 2016, inclusive, fiscal quarter, and quarterly thereafter on or before April 30, July 31, October 31, and January 31 for the fiscal quarter ending seven months prior, the data of the dental fee-for-service program performance shall be posted on the department's Internet Web site.

(g) The department may amend or remove performance measures and establish additional performance measures in accordance with all of the following:

(1) The department shall consider performance measures established by other states, the federal government, and national organizations developing dental program performance and quality measures.

(2) The department shall notify a fee-for-service contractor, at least 30 days prior to the implementation date, of any updates or changes to performance measures. The department shall also post these updates or changes on its Internet Web site at least 30 days prior to implementation in order to maintain transparency to the public.

(3) In establishing the performance measures, the department shall consult with stakeholders, including representatives from counties, local dental societies, nonprofit entities, legal aid entities, and other interested parties.

(h) The department shall annually prepare a summary report of the nature and types of complaints and grievances regarding access to, and quality of, dental services, including the outcome. Commencing January 31, 2017, for the prior fiscal year, and annually thereafter, for each preceding fiscal year, this report shall be posted on the department's Internet Web site.

(i) The department shall ensure, to the greatest degree possible, that the categories of data and performance measures selected under this section are consistent with the categories of data and performance measures selected under Section 14459.6.

(j) No sooner than July 1, 2019, the department shall annually publish utilization data from the preceding calendar year and post this material on its Internet Web site. The utilization data shall be made publicly available for both the dental fee-for-service and dental managed care programs. The utilization data shall include all of the following information:

(1) Number of patients seen on a per-provider basis.

(2) Number of annual preventative dental services, dental treatment services, examinations, and oral health evaluations rendered by each provider during each calendar year.

(3) Number of beneficiaries who received general anesthesia services.

(Amended by Stats. 2016, Ch. 613, Sec. 1. (AB 2207) Effective January 1, 2017.)

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.

(Added by Stats. 2000, Ch. 804, Sec. 1. Effective September 28, 2000.)

14132.925. (a) (1) Notwithstanding any other provision of law or regulation to the contrary, to the extent federal financial participation is available, in furtherance of Section 14105.06 and subdivisions (a) and (c) of Section 14132.92, effective July 1, 2007, a licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled shall be responsible for providing day treatment and transportation services consistent with Section 14105.06 and subdivision (a) of Section 14132.92, that are selected and authorized through the individual program plan process pursuant to Sections 4646 and 4646.5 and applicable regulations, for each beneficiary receiving those services who resides in that licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled.

(2) (A) The services described in paragraph (1) shall be arranged by the regional center pursuant to Sections 4646 and 4646.5 and applicable regulations.

(B) The licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled shall reimburse the regional center for the full costs of making the disbursements to day treatment and transportation service providers.

(3) Nothing in this section shall authorize the licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled to substitute day treatment or transportation services not selected and authorized through the individual program plan process pursuant to Sections 4646 and 4646.5 and applicable regulations.

(b) (1) The State Department of Developmental Services shall be responsible for reimbursing a licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled for the costs of reimbursing the regional center for the full cost of making disbursements for day treatment and transportation services, plus a coordination fee which will include an administrative fee and reimbursement for increased costs associated with the quality assurance fee. This payment shall be a supplement to the Medi-Cal payment from the State Department of Health Care Services described in Sections 14105.06 and 14132.92.

(2) A licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled may authorize the regional center to invoice the State Department of Developmental Services on its behalf for the services described in subdivision (a).

(3) (A) The licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled shall reimburse the regional center for the full costs of making disbursements for day treatment and transportation services within 30 days of receipt of payment from the State Department of Developmental Services pursuant to instructions from the State Department of Developmental Services.

(B) If there is a failure to reimburse the regional center within 30 days of receipt of payment from the State Department of Developmental Services, for all or part of the costs associated with disbursement for day treatment and transportation services, the outstanding amount shall be recovered by any of the following methods:

(i) Lump sum payment by the provider.

(ii) Offset against current payments due to the provider from the State of California.

(iii) A repayment agreement between the provider and the State of California.

(c) (1) A licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled shall report the costs incurred pursuant to subdivision (a) according to instructions from the State Department of Health Care Services.

(2) 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 this subdivision by means of a provider bulletin or similar instruction.

(d) (1) If the services meeting the conditions of subdivision (a) have been provided to a Medi-Cal beneficiary on or after July 1, 2007, and, notwithstanding Section 14115, a licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled may authorize the regional center to invoice the State Department of Developmental Services on its behalf for arranging for the services described in subdivision (a). The licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled shall reimburse the regional center the full cost of making disbursements for day treatment and transportation services within 30 days of receipt of payment from the State Department of Developmental Services pursuant to instruction from the State Department of Developmental Services. If a licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled fails to reimburse the regional center within 30 days of receipt of payment from the State Department of Developmental Services, for all or part of the costs associated with the day treatment and transportation services, the outstanding amount shall be recovered by any of the following methods:

(A) Lump sum payment by the provider.

(B) Offset against current payments due to the provider from the State of California.

(C) A repayment agreement between the provider and the State of California.

(2) The department shall seek federal financial participation, including any moneys available pursuant to the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), pursuant to a federally approved state plan amendment authorizing reimbursement for costs incurred pursuant to subdivision (a) for day treatment and transportation services provided on or after July 1, 2007.

(3) Upon approval of the state plan amendment, the reimbursement payments made pursuant to this section by the State Department of Developmental Services to a licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled shall be subject to the quality assurance fee imposed upon designated intermediate care facilities pursuant to Article 7.5 (commencing with Section 1324) of Chapter 2 of Division 2 of the Health and Safety Code.

(4) If federal financial participation is not made available for day treatment and transportation services provided on or after July 1, 2007, the services nonetheless shall be reimbursed from the General Fund by the State Department of Developmental Services.

(e) The State Department of Health Care Services shall request approval from the federal Centers for Medicare and Medicaid Services for the implementation of this section. The Director of Health Care Services, with the concurrence of the Director of Developmental Services, may alter the methodology specified in this section to the extent necessary to meet the requirements of federal law or regulations or to obtain federal approval. If after seeking federal approval, federal approval is not obtained or federal financial participation is no longer available, this section and Section 4646.55 shall not be implemented or shall become inoperative.

(Added by Stats. 2010, Ch. 717, Sec. 157. (SB 853) Effective October 19, 2010. Conditionally inoperative as provided in subd. (e).)

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.

(Added by Stats. 2000, Ch. 804, Sec. 2. Effective September 28, 2000.)

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.

(Added by Stats. 2003, Ch. 112, Sec. 1. Effective January 1, 2004.)

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 spend down of excess income if they elect to accept payment for services on an arrears rather than an advance payment basis.

(l) 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 their own provider.

(m) The county welfare department shall inform in writing any individual who is potentially eligible for services under this section of their 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.

(Amended by Stats. 2023, Ch. 42, Sec. 146. (AB 118) Effective July 10, 2023.)

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. 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.

(Amended by Stats. 2009, 4th Ex. Sess., Ch. 5, Sec. 45. Effective July 28, 2009.)

14132.952. (a) The department shall seek approval of an amendment to the Medicaid state plan pursuant to Section 1396n(j) of Title 42 of the United States Code to provide self-directed personal assistance services under the state plan in order that the services available under Article 7 (commencing with Section 12300) of Chapter 3, known as the In-Home Supportive Services (IHSS) program, may be provided as a Medi-Cal benefit under this chapter, to the extent that federal financial participation is available. This program shall be known as the "IHSS Plus option."

(b) To the extent feasible, the IHSS Plus option shall incorporate the eligibility requirements, benefits, and operational requirements of the In-Home Supportive Services program pursuant to Article 7 (commencing with Section 12300) of Chapter 3. The director shall have the discretion to modify these eligibility requirements, benefits, and operational requirements to the extent necessary to secure federal approval of the Medicaid state plan amendment.

(c) The services available through the IHSS Plus waiver pursuant to Section 14132.951 shall be furnished as benefits under the IHSS Plus option to the extent that federal financial participation is available to persons who meet the eligibility requirements of the IHSS Plus option. Upon implementation of the IHSS Plus option, a person who is eligible for services under the IHSS Plus option shall no longer be eligible to receive services under Section 14132.951.

(d) Upon implementation of the IHSS Plus option:

(1) A person who is eligible for the IHSS Plus option shall not be eligible to receive services under the In-Home Supportive Services program pursuant to Article 7 (commencing with Section 12300) of Chapter 3 to the extent those services are available through the IHSS Plus option.

(2) A person shall not be eligible to receive services pursuant to the IHSS Plus option 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 State Department of Public Health, 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 under the IHSS Plus option 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 and approval 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) (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 the federal Centers for Medicare and Medicaid Services' approval of the Medicaid state plan amendment known as the "IHSS Plus option," the director shall notify the Legislature of any modifications in benefits or eligibility and operational requirements of the In-Home Supportive Services program required for that Medicaid state plan amendment to become effective.

(Added by Stats. 2009, 4th Ex. Sess., Ch. 5, Sec. 46. Effective July 28, 2009.)

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.

(Added by Stats. 2002, Ch. 1088, Sec. 9. Effective January 1, 2003.)

14132.956. (a) The department shall assess and determine whether it would be cost efficient for the state to exercise the option made available under Section 1915(k) of the federal Social Security Act (42 U.S.C. Sec. 1396n(k)). When performing this assessment, the department shall collaborate and consult with the State Department of Social Services, the State Department of Developmental Services, the California Department of Aging, and any other state agency that the department believes can assist in its determination whether it would be cost efficient for the state to exercise this option. If the department determines that it would be cost efficient for the state to exercise the federal option, it shall seek a Medi-Cal State Plan amendment to provide home- and community-based attendant services and supports that include assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks pursuant to Section 1915(k) of the federal Social Security Act (42 U.S.C. Sec. 1396n(k)).

(b) If the department determines that it would be cost efficient to exercise the option made available under Section 1915(k) of the federal Social Security Act (42 U.S.C. Sec. 1396n(k)), the department shall establish a development and implementation council that shall include, as a majority of its members, persons with disabilities and elderly individuals, and their representatives. The department shall consult and collaborate with the council when developing and implementing a Medi-Cal State Plan amendment to exercise this option.

(c) Services and supports pursuant to this section may be rendered under the administrative direction of other state departments in accordance with the Medi-Cal State Plan amendment and subject to the department's authority as the designated single state agency for the administration or supervision of the administration of the Medi-Cal program.

(d) (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, and any other state department pursuant to subdivision (c), may implement this section through all-county letters or similar instructions from the director, until regulations are adopted.

(2) The department, and any other state department rendering services and supports pursuant to subdivision (c), shall adopt emergency regulations implementing this section within 24 months from the date federal approval pursuant to this section is received. 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 and approval 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.

(Added by Stats. 2011, Ch. 8, Sec. 36. (SB 72) Effective March 24, 2011.)

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.

(Added by Stats. 1995, Ch. 307, Sec. 17. Effective August 3, 1995.)

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.

(Added by Stats. 2007, Ch. 376, Sec. 7. Effective January 1, 2008.)

14132.968. (a) (1) Pharmacist services are a benefit under the Medi-Cal program, subject to approval by the federal Centers for Medicare and Medicaid Services.

(2) The department shall establish a fee schedule for the list of pharmacist services.

(3) The rate of reimbursement for pharmacist services shall be at 85 percent of the fee schedule for physician services under the Medi-Cal program, except for medication therapy management (MTM) pharmacist services as described in Section 14132.969.

(b) (1) The following services are covered pharmacist services that may be provided to a Medi-Cal beneficiary:

(A) Furnishing travel medications, as authorized in clause (3) of subparagraph (A) of paragraph (10) of subdivision (a) of Section 4052 of the Business and Professions Code.

(B) Furnishing naloxone hydrochloride, as authorized in Section 4052.01 of the Business and Professions Code.

(C) Furnishing self-administered hormonal contraception, as authorized in subdivision (a) of Section 4052.3 of the Business and Professions Code.

(D) Initiating and administering immunizations, as authorized in Section 4052.8 of the Business and Professions Code.

(E) Providing tobacco cessation counseling and furnishing nicotine replacement therapy, as authorized in Section 4052.9 of the Business and Professions Code.

(F) Initiating and furnishing preexposure prophylaxis, as authorized in Section 4052.02 of the Business and Professions Code.

(G) Initiating and furnishing postexposure prophylaxis, as authorized in Section 4052.03 of the Business and Professions Code.

(H) Providing MTM pharmacist services in conjunction with the dispensing of qualified specialty drugs, as described in Section 14132.969.

(2) Covered pharmacist services shall be subject to department protocols and utilization controls.

(c) A pharmacist shall be enrolled as an ordering, referring, and prescribing provider under the Medi-Cal program prior to rendering a pharmacist service that is submitted by a Medi-Cal pharmacy provider for reimbursement pursuant to this section.

(d) (1) The director shall seek any necessary federal approvals to implement this section. This section shall not be implemented until the necessary federal approvals are obtained and shall be implemented only to the extent that federal financial participation is available.

(2) This section neither restricts nor prohibits any services currently provided by pharmacists as authorized by law, including, but not limited to, this chapter, or the Medicaid state plan.

(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, and any applicable federal waivers and state plan amendments, by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. By July 1, 2021, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Commencing July 1, 2017, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(Amended by Stats. 2024, Ch. 1, Sec. 4. (SB 339) Effective February 6, 2024.)

14132.969. (a) Subject to an annual appropriation for this express purpose, the department shall implement a medication therapy management (MTM) reimbursement methodology for covered pharmacist services related to the dispensing of qualified specialty drugs by an eligible pharmacy contracted with the department pursuant to subdivision (c). MTM reimbursement pursuant to this section is intended to supplement Medi-Cal payments made to eligible pharmacies for MTM pharmacist services provided in conjunction with certain specialty drug therapy categories, as identified by the department pursuant to paragraph (2) of subdivision (b).

(b) In implementing this section, the department shall do all of the following:

(1) Establish and maintain protocols and utilization controls for covered MTM pharmacist services.

(2) Establish and maintain a list of covered specialty drug therapy categories for which MTM pharmacist services reimbursement is available.

(3) Establish and maintain rates of reimbursement for covered MTM pharmacist services under contracts with participating pharmacies pursuant to subdivision (c).

(4) Establish and maintain the eligibility criteria and conditions for receipt of MTM pharmacist services reimbursement pursuant to this section.

(c) (1) MTM pharmacist services reimbursement pursuant to this section shall only be available to a Medi-Cal enrolled pharmacy that enters into an MTM pharmacist services contract with the department.

(2) For purposes of implementing this section, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(d) (1) This section shall apply to dates of service on or after July 1, 2021, or to dates of service on or after the effective date reflected in any necessary federal approvals obtained by the department pursuant to paragraph (2), whichever is later.

(2) The department shall seek any necessary federal approvals to implement this section.

(3) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(e) This section neither restricts nor prohibits any services currently provided by pharmacists as authorized by law, including, but not limited to, this chapter, or the Medicaid state plan.

(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, in whole or in part, by means of provider bulletins or other similar instructions, without taking any further regulatory action.

(g) For purposes of this section, the following definitions apply:

(1) “Medication therapy management” or “MTM” means a distinct service or group of services, as determined by the department, that are provided by pharmacists to improve health outcomes of beneficiaries who are at risk of treatment failure due to noncompliance, nonadherence, or other factors found to negatively affect drug therapy outcomes.

(2) “Specialty drugs” has the same meaning as set forth in paragraph (13) of subdivision (a) of Section 14105.45.

(Added by Stats. 2021, Ch. 143, Sec. 395. (AB 133) Effective July 27, 2021.)

14132.97. (a) (1) 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.

(2) Waiver personal care services shall satisfy all of the following criteria:

(A) The services shall be defined in the nursing and model nursing facility waivers.

(B) The services shall differ in scope from services that may be authorized under Section 14132.95 or 14132.952.

(C) The services shall not replace any hours of services authorized or that may be authorized under Section 14132.95 or 14132.952.

(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 services that the individual is authorized to receive under Section 14132.95 or 14132.952 at the time he or she becomes eligible for waiver personal care services.

(2) Determine the individual’s eligibility for services under Section 14132.95 or 14132.952 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) (A) 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. A county is not 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 and personal care services programs may pay providers for the delivery of waiver personal care services if it chooses to do so. In that 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.

(B) For purposes of subparagraph (A) and to the extent the department obtains any federal approvals it deems necessary to implement this subparagraph, "payment" includes wages and benefits. Payments provided pursuant to subparagraph (A) shall be available for service dates on or after the effective date specified in the applicable federal approval obtained by the department and only after the Case Management Information and Payroll System (CMIPS) system has been modified to accommodate these payments, or on July 1, 2019, whichever is sooner.

(e) Waiver personal care services shall not be included as alternative resources in a county's determination of the amount of services an individual may receive under Section 14132.95 or 14132.952.

(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.

(Amended by Stats. 2018, Ch. 35, Sec. 33. (AB 1811) Effective June 27, 2018.)

14132.971. (a) The county, or the public authority or nonprofit consortium established pursuant to Section 12301.6, shall be deemed to be the employer to meet and confer in good faith, in accordance with Chapter 10 (commencing with Section 3500) of Division 4 of Title 1 of the Government Code, regarding wages, benefits, and other terms and conditions of employment of individuals providing waiver personal care services pursuant to Section 14132.97. For purposes of this section, bargaining unit placement pursuant to Section 3507.1 of the Government Code, and waiver personal care services, individuals providing waiver personal care services shall be deemed a part of the established bargaining unit of in-home supportive services providers of an employer of record described in Section 12301.6 in the county in which the individual delivers waiver personal care services.

(b) Recipients shall retain the right to hire, fire, and supervise the work of any waiver personal care services personnel providing services to them.

(c) For service dates on or after the effective date specified in the applicable federal approval obtained by the department pursuant to subdivision (e), wages, benefits, and all other terms and conditions of employment for individuals providing waiver personal care services pursuant to Section 14132.97 shall be equal to the wages, benefits, and other terms and conditions of employment in the respective county for the individual provider mode of services in the In-Home Supportive Services (IHSS) program pursuant to Article 7 (commencing with Section 12300) of Chapter 3.

(d) If eligibility for benefits requires a provider to work a threshold number of hours, eligibility shall be determined based on the aggregate number of monthly hours worked between IHSS and waiver personal care services.

(e) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and not otherwise jeopardized.

(Added by Stats. 2018, Ch. 35, Sec. 34. (AB 1811) Effective June 27, 2018.)

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 or for any other qualifying clinical trial, as defined by Section 1396d(gg)(2) of Title 42 of the United States Code, 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) In accordance with Section 1396d(gg)(1) of Title 42 of the United States Code, "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 items or services that, except for the fact that they are being provided in a clinical trial, are not otherwise covered 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 qualifying clinical trial, which means a clinical trial, in any clinical phase of development, that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition and is described in Section 1396d(gg)(2)(A) of Title 42 of the United States Code.

(d) This section does not 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.

(f) This section shall be implemented only to the extent that any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized.

(g) The amendments made to this section by the act that added this subdivision shall become effective on July 1, 2022.

(Amended by Stats. 2022, Ch. 47, Sec. 103. (SB 184) Effective June 30, 2022.)

14132.985. 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 of this code shall be provided by state-only funds if federal financial participation is not available.

(Added by renumbering Section 14132.99 (as amended by Stats. 2002, Ch. 664, Sec. 237) by Stats. 2015, Ch. 303, Sec. 615. (AB 731) Effective January 1, 2016.)

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 long-term care patient liability. The term "facility residents" also includes individuals who are hospitalized and who are or will be waiting for transfer to a nursing facility.

(b) 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.

(c) The Nursing Facility/Acute Hospital Transition and Diversion Waiver shall include 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.

(d) (1) (A) Notwithstanding paragraphs (1) and (2) of subdivision (d) of Section 12300.4, the department shall grant an exemption, as described in paragraph (2), to a provider of an applicant or participant of the Nursing Facility/Acute Hospital Transition and Diversion Waiver or the In-Home Operations Waiver, or their successors, who was enrolled in either waiver on January 31, 2016, and whose medical or behavioral needs require that the services to the applicant or participant be provided by the requested provider, if any of the following circumstances exists:

(i) The provider lives in the same home as the waiver applicant or participant, even if the provider is not a family member.

(ii) The provider currently provides care to the waiver participant, and has done so for two or more years continuously.

(iii) The waiver applicant or participant is unable to find a local caregiver who speaks the same language as the applicant or participant, resulting in the applicant or participant being unable to direct their own care.

(B) For a waiver participant who enrolls in either waiver after January 31, 2016, the department shall grant a provider an exemption from the workweek requirements described in paragraphs (1) and (2) of subdivision (d) of Section 12300.4 on a case-by-case basis pursuant to paragraph (5).

(2) A provider of in-home supportive services or waiver personal care services who is granted an exemption pursuant to paragraph (1) may work up to a total of 12 hours per day, and up to 360 hours per month combined for the in-home supportive services and waiver personal care services that they provide, not to exceed each waiver participant's monthly authorized hours.

(3) On a one-time basis upon implementation of this paragraph, the department shall mail an informational notice and an exemption request form to all providers who may be eligible for an exemption pursuant to this subdivision and to the waiver participants to whom the providers provide services.

(4) At the time of initial application, and at least annually, the department shall inform all waiver applicants or participants whose providers may be eligible for an exemption pursuant to this subdivision and their providers about the exemptions and the application process.

(5) (A) The department shall review the requests for consideration for an exemption described in subparagraph (B) of paragraph (1) pursuant to a process developed by the department with input from stakeholders. The department shall consider whether the waiver applicant or participant meets the criteria described in subparagraph (A) of paragraph (1) in making its determination.

(B) Within 30 days of receiving an application for an exemption described in subparagraph (B) of paragraph (1) from a provider and from a waiver applicant or participant on behalf of a provider, the department shall mail a written notification letter to the provider and the waiver applicant or participant for whom the provider provides services of its approval or denial of the exemption. If the department denies the exemption, the department shall also explain in the notification letter the reason for the denial. The department shall use a standardized notification letter, developed by the department in consultation with stakeholders, for purposes of providing the notification letter that is required by this subparagraph.

(6) The department shall record the number of requests for exemptions that are received and the number of requests approved or denied. These numbers shall be posted no later than every three months on the department's internet website.

(e) 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.

(Amended by Stats. 2023, Ch. 42, Sec. 147. (AB 118) Effective July 10, 2023.)

14132.991. (a) When renewing the Nursing Facility/Acute Hospital Transition and Diversion Waiver, as authorized by subdivision (t) of Section 14132, the director may take the following actions, among others:

(1) Contract with one or more organizations, referred to as a care management contractor, qualified to provide or arrange for delivery of care management and waiver services, including, but not limited to, personal needs assessments, and arranging for

services available through public and private agencies, including services available under the waiver, for the waiver participants and applicants. The contract with the care management contractor, the care management contract, may require the care management contractor or their subcontractor, or both, to do all of the following, among other things:

(A) Provide, arrange for, or subcontract with community-based providers for the provision of, waiver services to waiver participants.

(B) Recognize program and service linkages, coordinate service delivery mechanisms and promote prevention of avoidable institutional placement, emergency room visits or inpatient hospital stays, or both, and coordination between health, social, and long-term services and supports by person-centered care planning.

(C) Provide or arrange for, care management to each waiver participant to stabilize their health care, and provide access to home- and community-based services, including managing and anticipating episodes of medical crisis in which transitional care management is needed.

(D) Carry out the waiver's person-centered model of care, pursuant to the requirements set forth in Sections 441.720, 441.725, and 441.540 of Title 42 of the Code of Federal Regulations.

(E) Submit all information and reports required by the department, including, but not limited to, annual financial statements in the timeframe specified by the department.

(F) Pay any providers of waiver services who are not directly employed by or contracted with the care management contractor no less than the rates specified in the waiver or the department's fee schedule, whichever is less, for the provider type.

(G) Bill the department, at the rate established by the state, for all services the care management contractor provides to waiver participants, directly or through a subcontractor or other direct service provider.

(H) Comply with the requirements of the waiver, including any other requirements established by the department regarding waiver operations, including, but not limited to, requirements regarding care coordination. These requirements may be set forth in the care management contract, care management manual, all-county letters, plan letters, plan or provider bulletins or policy letters, or similar instructions.

(2) Propose that the waiver provide for achievement of annual cost neutrality in the aggregate to allow enrollment and authorization of waiver services based on the medical necessity of the waiver services on a case-by-case basis.

(3) Expand the number of waiver slots up to 5,000 additional slots, the director may seek federal approval to amend the waiver to add additional slots or make changes to the waiver model with approval from the Department of Finance.

(4) Require care management contractors to enroll at least 60 percent of all total annual enrollments from either of the following:

(A) Hospital, nursing facility, or other institutional settings assisting members with transitions back to the home or community, or both, setting.

(B) Individuals who had been continuously receiving in home care services, of the type offered under the waiver, under the Early and Periodic Screening, Diagnosis, and Treatment State Plan benefit, California Children Services or Pediatric Palliative Care programs for children, for at least the prior three months but have at the time of transition exceeded the age limit for that benefit.

(5) If the director determines that the care management contractor is not fiscally solvent, or is in danger of becoming fiscally insolvent, the director has the option to immediately terminate the contract with the care management contractor.

(6) Terminate or refuse to renew, in whole or in part, a care management contract when the director determines that the action is necessary to protect the health of the beneficiaries or funds appropriated to 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, in whole or in part, by means of all-county letters, plan letters, plan or provider bulletins, policy letters, or other similar instructions, without taking regulatory action.

(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 entered into or amended pursuant to this section shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and shall be exempt from the review or approval of any division of the Department of General Services.

(d) The department shall implement this section only to the extent it can demonstrate federal cost neutrality as required under the terms of the waiver, and only to the extent any necessary federal approvals are obtained and federal financial participation is

available.

(Added by Stats. 2017, Ch. 52, Sec. 49. (SB 97) Effective July 10, 2017.)

14132.993. (a) This section applies to the Home- and Community-Based Alternatives Waiver (HCBA), the Assisted Living Waiver (ALW), and, to the extent that the dependent child or spouse of an active duty military service member is deemed eligible for the Medi-Cal program, the Home- and Community-Based Services for the Developmentally Disabled (HCBS-DD) 1915(c) waiver programs, pursuant to state law and Section 1915(c) of the federal Social Security Act (42 U.S.C. Sec. 1396n(c)).

(b) (1) If a dependent child or spouse of an active duty military service member is currently included on the waiting list for a waiver program specified in subdivision (a) and transfers out of state with the military service member on official military orders, the dependent child or spouse shall retain their place on the waiting list for the applicable waiver program if the child or spouse subsequently reestablishes residence in this state. The dependent child's or spouse's place on the waiting list shall advance as the waiting list advances during the time they are out of the state.

(A) In order for the place on the waiting list to be saved after the dependent child or spouse leaves the state, the dependent child or spouse shall notify the department or its designee that they are leaving the state due to the military service member's transfer orders and that they are requesting to remain on the waiver program's waiting list.

(B) While the dependent child or spouse resides out of state and is in the first place on the waiver program's waiting list, and has not informed the department or its designee that the military service member has received official military orders to relocate back to the state, waiver applicants with places farther down the waiting list shall continue to be processed for intake into the waiver program without regard to the dependent child's or spouse's place on the waiting list.

(C) If a dependent child or spouse who is on the waiver program's waiting list informs the department or its designee that the military service member has received official military orders to return to the state and that the dependent child or spouse would like to enroll in the waiver program, the department or its designee shall take action on the dependent child's or spouse's waiver program application in accordance with their place on the waiver program's waiting list.

(2) If a dependent child or spouse of an active duty military service member enrolled in a waiver program specified in subdivision (a) transfers out of state with the military service member on official military orders, and then returns to the state with the military service member on official military orders, the dependent child or spouse shall be reenrolled in the applicable waiver program if there is an open slot in the waiver program, or shall be placed in the first place on the waiver program's waiting list if there is no open slot in the waiver program, subject to the dependent child or spouse meeting all of the following conditions:

(A) The dependent child or spouse reestablishes residence in this state.

(B) The dependent child or spouse submits an application for enrollment in the waiver program and is found to be eligible for the applicable waiver program.

(i) If no more than three years have passed since the dependent child or spouse left the waiver program, they may apply for reenrollment in the waiver program using an abbreviated waiver program enrollment form developed by the department.

(ii) If more than three years have passed since the dependent child or spouse left the waiver program, they shall apply for reenrollment in the waiver program using the standard waiver program enrollment form for that waiver program.

(iii) The dependent child or spouse shall follow the regular Medi-Cal eligibility and enrollment processes to obtain Medi-Cal enrollment.

(c) An individual applying for a waiver program specified in subdivision (a) who is a dependent child or spouse of an active duty military service member and is residing out of state with that military service member may submit the individual's application to enroll in that waiver program as soon as the military service member receives official military orders to transfer to this state and before moving to this state. A copy of the order shall be submitted with the application for the Medi-Cal program and the applicable waiver program. The department or its designee may work with the dependent child or spouse, or their family, prior to their actual relocation to the state in order to evaluate the waiver program application with the goal of having medically necessary waiver program services in place as soon as possible when the family relocates to the state.

(d) (1) This section is not intended to authorize the provision of services to a dependent child or spouse of an active duty military service member through a waiver program specified in subdivision (a) while the dependent child or spouse is transferred to, and living, out of state with the military service member, or has not yet transferred to this state. Waiver program services provided to a dependent child or spouse under this section shall only be provided upon their establishing residence in this state and enrolling in Medi-Cal and the waiver program.

(2) This section is not intended to prevent another individual from receiving services through a waiver program described in subdivision (a) due to lack of space in the applicable waiver program on the sole basis that a dependent child or spouse described in this section is placed on the waiting list for that waiver program while the dependent child or spouse is transferred to, and living, out of state with the military service member, or has not yet transferred to this state.

(e) For purposes of this section, “dependent child” means an individual, whether a minor or an adult, who is a dependent of a parent or guardian.

(f) (1) This section shall be implemented only to the extent that any necessary federal approvals have been obtained and that federal financial participation is available.

(2) The department may seek amendments to the waiver programs specified in subdivision (a), or take other action, as necessary to implement this section.

(3) 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, in whole or in part, by means of letters or other similar instructions, without taking regulatory action.

(Added by Stats. 2019, Ch. 846, Sec. 1. (SB 289) Effective January 1, 2020.)

14132.994. A Medi-Cal managed care plan, as defined in subdivision (j) of Section 14184.101, shall cover COVID-19 screening, testing, immunizations, and therapeutics in accordance with applicable statutes, regulations, all plan letters, the Medi-Cal provider manual, Medi-Cal managed care plan contracts with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), and other guidance.

(Added by Stats. 2025, Ch. 21, Sec. 106. (AB 116) Effective June 30, 2025.)

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.

(Added by Stats. 1989, Ch. 1221, Sec. 1.)

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.

(Amended by Stats. 1979, Ch. 373.)

14133.01. (a) Notwithstanding any other 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 the methodology 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 the methodology 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) (1) By July 1, 2016, or a subsequent date determined by the department, treatment authorization requests, excluding treatment authorization requests submitted by dental providers enrolled in the Medi-Cal Dental program, shall be submitted in an electronic format determined by the department and shall be submitted via the department's Internet Web site or other electronic means designated by the department. The department may implement this requirement in phases.

(2) The department shall consider the capacity of independent sole practitioners, small independent provider-owned clinics, and rural providers to comply with the requirements of this section, and shall implement the electronic submission process in a manner that offers these providers both of the following:

(A) Reasonable time to establish the infrastructure necessary for the generation of electronic treatment authorization requests.

(B) An opportunity to participate in education and training regarding the generation and submission of electronic treatment authorization requests provided by the department or its agents.

(3) The department shall designate an alternate format for submitting requests for authorization of services when the department's Internet Web site or other electronic means designated in paragraph (1) are unavailable due to a system disruption.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may, without taking regulatory action, implement, interpret, or make specific, this section and any applicable waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions. Thereafter, the department shall adopt regulations by July 1, 2017, 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. The department shall consult with interested parties and appropriate stakeholders in implementing this section.

(Amended by Stats. 2014, Ch. 849, Sec. 3. (SB 1457) Effective January 1, 2015.)

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.

(Added by Stats. 2000, Ch. 93, Sec. 95. Effective July 7, 2000.)

14133.07. (a) A doctor of podiatric medicine shall not be required to submit prior authorization for podiatric services rendered in either an outpatient or inpatient basis if a physician and surgeon providing the same services would not be required to submit prior authorization to the department.

(b) A doctor of podiatric medicine acting within their scope of practice and providing services pursuant to subdivision (a) is subject to the same Medi-Cal billing and services policies as required for a physician and surgeon, including, but not limited to, a maximum numerical service limitation in any one calendar month.

(Repealed and added by Stats. 2019, Ch. 433, Sec. 2. (AB 678) Effective January 1, 2020.)

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 reinstituted 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 reinstitution 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.

(Amended by Stats. 1986, Ch. 775, Sec. 1.)

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.

(Added by Stats. 1992, Ch. 722, Sec. 122. Effective September 15, 1992.)

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.

(Added by Stats. 1999, Ch. 845, Sec. 2. Effective January 1, 2000. Conditionally operative by its own provisions.)

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.

(Added by Stats. 1997, Ch. 294, Sec. 72. Effective August 18, 1997.)

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.

(Added by Stats. 1985, Ch. 425, Sec. 4.)

14133.16. (a) Notwithstanding subdivision (l) 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.

(Added by Stats. 2002, Ch. 704, Sec. 1. Effective January 1, 2003.)

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 a compendia listed in Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8).

(Amended by Stats. 2009, Ch. 479, Sec. 6. (AB 830) Effective January 1, 2010.)

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.

(Added by Stats. 2005, Ch. 469, Sec. 3. Effective October 4, 2005.)

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 in 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.

(Amended by Stats. 2006, Ch. 24, Sec. 1. Effective May 15, 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.

(Amended by Stats. 1982, Ch. 1594, Sec. 60. Effective September 30, 1982.)

14133.3. (a) The director shall require fully documented medical justification from providers that the requested services are medically necessary or a medical necessity, as defined in Section 14059.5, 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.

(Amended by Stats. 2018, Ch. 855, Sec. 2. (SB 1287) Effective January 1, 2019.)

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.

(Added by Stats. 1991, Ch. 563, Sec. 2.)

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.

(Amended by Stats. 1990, Ch. 1329, Sec. 30. Effective September 26, 1990.)

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.

(Added by Stats. 2003, Ch. 321, Sec. 1. Effective January 1, 2004.)

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.

(Added by Stats. 1981, Ch. 1081, Sec. 1.)

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.

(Added by Stats. 1985, Ch. 863, Sec. 1.)

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.

(Added by Stats. 1981, Ch. 1164, Sec. 5.)

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.

(Amended by Stats. 2007, Ch. 300, Sec. 6. Effective January 1, 2008.)

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 that violates federal law.

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

(c) This section shall become inoperative on July 1, 2026, and, as of January 1, 2027, is repealed.

(Amended by Stats. 2025, Ch. 21, Sec. 107. (AB 116) Effective June 30, 2025. Inoperative July 1, 2026, by its own provisions. Repealed as of January 1, 2027, by its own provisions.)

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) 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.

(g) 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.

(Amended by Stats. 2012, Ch. 728, Sec. 206. (SB 71) Effective January 1, 2013.)

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.

(Amended by Stats. 1981, Ch. 1163, Sec. 17. Effective October 2, 1981.)

14134.25. (a) Tobacco cessation services are covered benefits under the Medi-Cal program, subject to utilization controls. Tobacco cessation services shall include all intervention recommendations, as periodically updated, assigned a grade A or B by the United States Preventive Services Task Force. Tobacco cessation services shall include quit attempts based on medical necessity, as defined in Section 14059.5, and consistent with United States Preventive Services Task Force grade A and B recommendations, with no required break between attempts, for all beneficiaries 18 years of age and older who use tobacco. For beneficiaries under 18 years of age, tobacco cessation services shall be provided in accordance with both the American Academy of Pediatrics Bright Futures periodicity schedule and anticipatory guidance as periodically updated, as well as services assigned a grade A or B by the United States Preventive Services Task Force.

(b) For purposes of this section, in addition to the services described in subdivision (a) and only to the extent consistent with the intervention recommendations, as periodically updated, assigned a grade A or B by the United States Preventive Services Task Force, tobacco cessation services for beneficiaries 18 years of age and older shall include all of the following:

(1) At least four tobacco cessation counseling sessions per quit attempt that may be conducted in person or by telephone and individually or as part of a group, at the beneficiary's option.

(2) (A) A tobacco cessation treatment regimen of any medication approved by the federal Food and Drug Administration, and that is a covered Medi-Cal benefit, for tobacco cessation, including prescription and over-the-counter medications, in accordance with United States Preventive Services Task Force grade A and B recommendations.

(B) A prescription from a provider with authority to prescribe and proof of Medi-Cal coverage shall be sufficient documentation to fill a prescription for over-the-counter tobacco cessation medications.

(c) Beneficiaries who are covered under this section shall not be required to receive a particular form of tobacco cessation service as a condition of receiving any other form of tobacco cessation service.

(d) Effective January 1, 2017, the department shall seek any federal approvals that the department determines are necessary to implement this section.

(e) This section 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.

(Amended by Stats. 2017, Ch. 561, Sec. 283. (AB 1516) Effective January 1, 2018.)

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

(a) “Comprehensive perinatal provider” means any general practice physician, family physician and surgeon, obstetrician-gynecologist, pediatrician, certified nurse-midwife, a group, any of whose members is one of the above-named providers, 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 former Department of Health Services Obstetrical Access Pilot Program provided or coordinated by a comprehensive perinatal provider.

(d) The comprehensive perinatal provider shall schedule visits with appropriate providers and 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 breastfeeding.

(3) Health, childbirth, and parenting education.

(e) (1) 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:

(A) Physicians, including a general practitioner, a family physician and surgeon, a pediatrician, or an obstetrician-gynecologist.

(B) Certified nurse-midwives.

(C) Licensed midwives.

(D) Nurses.

(E) Nurse practitioners.

(F) Physician assistants.

(G) Social workers.

(H) Health and childbirth educators.

(I) Registered dietitians.

(2) The department shall adopt regulations that 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 that 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 Public Health, in consultation with the California Conference of Local Health Officers, shall establish standards for health care providers and 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 utilize, to the extent feasible, and to the extent funding for administrative costs is available, local health departments in the administration of the perinatal program. If these funds are unavailable, the department shall use alternative means to implement the community perinatal program.

(h) (1) It is the intent of the Legislature that the department shall establish a method for reimbursement of comprehensive perinatal providers that shall include a fee for coordinating services and 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 that patients receive.

(2) 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 that are not related to perinatal care shall not be subject to the requirements 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 the monitoring and oversight of the comprehensive perinatal services provided in this section. The monitoring shall include, but shall not be limited to, the 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.

(k) The amendments made to this section by the act that added this subdivision do not revise or expand the scope of practice of licensed midwives, as defined in Article 24 (commencing with Section 2505) of Chapter 5 of Division 2 of the Business and Professions Code.

(l) Notwithstanding subdivision (a), on the effective date of the regulations adopted by the Medical Board of California pursuant to Section 2507 of the Business and Professions Code, a licensed midwife shall be eligible to serve as a comprehensive perinatal provider.

(m) For purposes of this section, “family physician” means a primary care physician and surgeon who renders continued comprehensive and preventative health care services to individuals and families, and who has received specialized training in an approved family medicine residency for three years after graduation from an accredited medical school.

(Amended by Stats. 2019, Ch. 632, Sec. 17. (AB 1622) Effective January 1, 2020.)

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.

(Added by Stats. 2007, Ch. 460, Sec. 5. Effective January 1, 2008.)

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.

(Added by Stats. 1984, Ch. 1628, Sec. 2.)

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.

(Added by Stats. 1974, Ch. 1240.)

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.

(Amended by Stats. 1988, Ch. 695, Sec. 1.)

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.

(Added by Stats. 1980, Ch. 1075, Sec. 2.)

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.

(Amended by Stats. 1990, Ch. 1329, Sec. 31. Effective September 26, 1990.)

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.

(Added by Stats. 1982, Ch. 1372, Sec. 1.)

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.

(Added by Stats. 1982, Ch. 645, Sec. 1.)

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.

(Added by Stats. 1984, Ch. 746, Sec. 1.)

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.

(Added by renumbering Section 14149 by Stats. 1986, Ch. 248, Sec. 271.)

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.

(Added by Stats. 1989, Ch. 1197, Sec. 2.)

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.

(Added by Stats. 1992, Ch. 442, Sec. 2. Effective January 1, 1993.)

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.

(Amended by Stats. 1996, Ch. 1023, Sec. 478. Effective September 29, 1996.)