ASSEMBLY BILL No. 2073

Introduced by Assembly Member Bonnie Lowenthal
(Coauthors: Assembly Members Beall, Brownley, Eng, Jones, and Swanson)

February 18, 2010

An act to amend Sections 14132, 14522.4, 14525.1, and 14526.2 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 2073, as introduced, Bonnie Lowenthal. Medi-Cal: adult day health care services.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons.

The Adult Day Health Medi-Cal Law establishes adult day health care services as a Medi-Cal benefit for Medi-Cal beneficiaries who meet certain adult day health care eligibility criteria. Existing law provides that certain criteria shall only apply on the date the Director of Health Care Services executes a declaration, as specified. These criteria include requirements that beneficiaries have two or more functional impairments involving activities that include bathing, dressing, and self-feeding and, depending upon the type of beneficiary, the beneficiary either requires substantial human assistance or assistance, as defined, in performing those activities.

This bill would, instead, upon the date the director executes the aforementioned declaration, establish adult day health care services as a Medi-Cal benefit for Medi-Cal beneficiaries who meet certain criteria, including, requiring beneficiaries to have two or more functional

impairments involving the above-described activities and require assistance, as defined, in performing those activities.

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

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

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

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

(a) Outpatient services are covered as follows:

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

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

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

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

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

(3) (A) To the extent required by federal law, the purchase of outpatient prescribed drugs, for which the prescription is executed

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

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

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

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

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses which are lost or destroyed due to circumstances beyond

the beneficiary's control. Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions that preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children Services Program.

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

(A) Periodontal treatment is not a benefit.

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

(C) Laboratory processed crowns are not a benefit.

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

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

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

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

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

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

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

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

modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.

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

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

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

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

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

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

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

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

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

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

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

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

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

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of Section 1482 of the article.

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

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

(s) In-home medical care services are covered when medically appropriate and subject to utilization controls, for beneficiaries who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be

provided to patients placed in shared or congregate living arrangements, if a home setting is not medically appropriate or available to the beneficiary. As used in this section, "in-home medical care service" includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

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

(1) Level of care and cost of care evaluations.

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

(3) Physician fees for home visits.

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

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

(6) Medically related personal services.

(7) Home nursing education.

(8) Emergency maintenance repair.

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

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

(11) Emergency and nonemergency medical transportation.

(12) Medical supplies.

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

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

(15) Special drugs and medications.

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

(17) Therapy services.

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

(19) Modification of medical equipment for home use.

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

(21) Respiratory care practitioner services as defined in Sections 3702 and 3703 of the Business and Professions Code, subject to prescription by a physician and surgeon.

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

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

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

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

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

(w) Hospice service which is Medicare-certified hospice service is covered, subject to utilization controls. Coverage shall be

available only to the extent that no additional net program costs are incurred.

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

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

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

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

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

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

(2) The department shall seek a waiver for a program to provide comprehensive clinical family planning services as described in

paragraph (8). The program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. The services shall be provided under the program only if the waiver is approved by the federal Centers for Medicare and Medicaid Services in accordance with Section 1396n of Title 42 of the United States Code and only to the extent that federal financial participation is available for the services.

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

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

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

(6) In the event that the Department of Finance determines that the program operated under the authority of the waiver described in paragraph (2) is no longer cost effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that

considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

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

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

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

supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

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

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

(i) Psychosocial and medical aspects of contraception.

(ii) Sexuality.

(iii) Fertility.

(iv) Pregnancy.

(v) Parenthood.

(vi) Infertility.

(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

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

(xi) Possible contraceptive consequences and followup.

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

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

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

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

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

SEC. 2. Section 14522.4 of the Welfare and Institutions Code is amended to read:

14522.4. (a) The following definitions shall apply for the purposes of this chapter:

(1) "Activities of daily living (ADL)" means activities performed by the participant for essential living purposes, including bathing, dressing, self-feeding, toileting, ambulation, and transferring.

(2) "Instrumental activities of daily living (IADL)" means functions or tasks of independent living limited to hygiene and medication management.

(3) "Personal health care provider" means the participant's personal physician, physician's assistant, or nurse practitioner, operating within his or her scope of practice.

(4) "Care coordination" means the process of obtaining information from, or providing information to, the participant, the participant's family, the participant's personal health care provider, or social services agencies to facilitate the delivery of services designed to meet the needs of the participant, as identified by one or more members of the multidisciplinary team.

(5) "Facilitated participation" means an interaction to support a participant's involvement in a group or individual activity, whether or not the participant takes active part in the activity itself.

(6) "Group work" means a social work service in which a variety of therapeutic methods are applied within a small group setting to promote participants' self-expression and positive adaptation to their environment.

(7) "Professional nursing" means services provided by a registered nurse or licensed vocational nurse functioning within his or her scope of practice.

(8) "Psychosocial" means a participant's psychological status in relation to the participant's social and physical environment.

(9) "Assistance" means verbal or physical prompting or aid, including cueing, supervision, stand-by assistance, or hands-on support to ~~complete the task correctly~~ *perform the essential elements of the ADL and the IADL*.

~~(10) "Substantial human assistance" means direct, hands-on assistance provided by a qualified caregiver, which entails physically helping the participant perform the essential elements of the ADLs and IADLs. It entails more than cueing, supervision, or stand-by assistance to perform the ADLs and IADLs. It also includes the performance of the entire ADL or IADL for participants totally dependent on human assistance.~~

~~(11)~~

(10) (a) "Cognitive impairment" means the loss or deterioration of intellectual capacity characterized by impairments in short- or long-term memory, language, concentration and attention, orientation to people, place, or time, visual-spatial abilities or executive functions, or both, including, but not limited to, judgment, reasoning, or the ability to inhibit behaviors that interfere with social, occupational, or everyday functioning due to conditions, including, but not limited to, mild cognitive impairment, Alzheimer's disease or other form of dementia, or brain injury.

(b) Upon the date of execution of the declaration described under subdivision ~~(g)~~ *(f)* of Section 14525.1, this section shall become operative and Section 14522.3 shall become inoperative and on that date is repealed.

SEC. 3. Section 14525.1 of the Welfare and Institutions Code is amended to read:

14525.1. (a) Except as provided in subdivisions (b) and (c), any adult eligible for benefits under Chapter 7 (commencing with Section 14000) shall be eligible for adult day health care services if that person meets all of the following criteria:

(1) The person is 18 years of age or older and has one or more chronic or postacute medical, cognitive, or mental health conditions, and a physician, nurse practitioner, or other health care provider has, within his or her scope of practice, requested adult day health care services for the person.

(2) The person has two or more functional impairments involving ambulation, bathing, dressing, self-feeding, toileting, transferring, medication management, and hygiene, *and the person requires assistance in performing those activities*.

~~(3) (A) Except as provided under subparagraph (B), the person requires substantial human assistance in performing these activities.~~

~~(B) The persons described in subdivisions (b) and (c) shall only require assistance in performing these activities.~~

~~(4)~~

(3) The person requires ongoing or intermittent protective supervision, assessment, or intervention by a skilled health or mental health professional to improve, stabilize, maintain, or minimize deterioration of the medical, cognitive, or mental health condition.

~~(5)~~

(4) The person requires adult day health care services, as defined in Section 14550, that are individualized and planned, including, when necessary, the coordination of formal and informal services outside of the adult day health care program to support the individual and his or her family or caregiver in the living arrangement of his or her choice and to avoid or delay the use of institutional services, including, but not limited to, hospital emergency department services, inpatient acute care hospital services, inpatient mental health services, or placement in a nursing facility or a nursing or intermediate care facility for the developmentally disabled providing continuous nursing care.

~~(6)~~

(5) The person meets the level of care set forth in Section 51120 of Title 22 of the California Code of Regulations.

(b) A resident of an intermediate care facility for the developmentally disabled-habilitative shall be eligible for adult day health care services if that resident meets the criteria set forth in paragraphs (1) to ~~(5)~~ *(4)*, inclusive, of subdivision (a) and has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through adult day health care, placement to a more costly institutional level of care would be likely to occur.

~~(c) Persons having chronic mental illness or moderate to severe Alzheimer's disease or other cognitive impairments shall be eligible for adult day health care services if they meet the criteria established in paragraphs (1) to (5), inclusive, of subdivision (a).~~

~~(d)~~

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

~~(e)~~

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

~~(f)~~

(e) Prior to implementing this section, the department shall meet and confer with provider representatives, including, but not limited to, adult day health care, home- and community-based services, and nursing facilities for the purpose of presenting and discussing

information and evidence to assist the department as it determines the methods and procedures necessary to implement this section.

~~(g)~~

(f) Upon the determination of the director that all necessary methods and procedures described in subdivision ~~(f)~~ *(e)* have been ascertained and are sufficient to implement the purposes of this section, the director shall execute and retain a declaration indicating that this determination has been made. Subdivisions (a) to ~~(e)~~ *(d)*, inclusive, shall be inoperative, until the date of execution of the declaration. Upon the date of execution of such a declaration, subdivisions (a) to ~~(e)~~ *(d)*, inclusive of this section shall become operative and Section 14525 shall become inoperative.

SEC. 4. Section 14526.2 of the Welfare and Institutions Code is amended to read:

14526.2. (a) Initial and subsequent treatment authorization requests may be granted for up to six calendar months, initial and subsequent treatment authorization requests may, at the discretion of the department, be granted for up to 12 calendar months.

(b) Treatment authorization requests shall be initiated by the adult day health care center, and shall include all of the following:

(1) A complete history and physical form, including a request for adult day health care services signed by the participant's personal health care provider shall be obtained annually. A copy of the history and physical form shall be submitted with an initial treatment authorization request and maintained in the participant's health record. This history and physical form shall be developed by the department and published in the inpatient/outpatient provider manual.

(2) The participant's individual plan of care, pursuant to Section 54211 of Title 22 of the California Code of Regulations.

(c) Whenever a subsequent treatment authorization request is submitted, the adult day health care center shall obtain and submit an updated history and physical form from the participant's personal health care provider using a standard update form that shall be maintained in the participant's health record. This update form shall be developed by the department for that use and shall be published in the inpatient/outpatient provider manual.

(d) Authorization or reauthorization of an adult day health care treatment authorization request shall be granted only if the participant meets all of the following medical necessity criteria:

(1) The participant has one or more chronic or post acute medical, cognitive, or mental health conditions that are identified by the participant's personal health care provider as requiring one or more of the following, without which the participant's condition will likely deteriorate and require emergency department visits, hospitalization, or other institutionalization:

(A) Assessment and monitoring.

(B) Treatment.

(C) Intervention.

(2) The participant has a condition or conditions resulting in both of the following:

(A) Two or more functional impairments involving ambulation, bathing, dressing, self-feeding, toileting, transferring, medication management, and hygiene.

(B) As set forth in ~~subparagraph (A) and (B) of paragraph (3)~~ *paragraph (2)* of subdivision (a) of Section 14525.1, the need for assistance ~~or substantial human assistance~~ in performing the activities identified in subparagraph (A) as related to the condition or conditions specified in paragraph (1). That assistance ~~or substantial human assistance~~ shall be in addition to any other nonadult day health care support the participant is currently receiving in his or her place of residence.

(3) Except for participants residing in an intermediate care facility/developmentally disabled-habilitative, the participant's network of nonadult day health care center supports is insufficient to maintain the individual in the community, demonstrated by at least one of the following:

(A) The participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision.

(B) The participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the participant.

(4) A high potential exists for the deterioration of the participant's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if adult day health care services are not provided.

(5) The participant's condition or conditions require adult day health care services specified in subdivisions (a) to (d), inclusive, of Section 14550.6, on each day of attendance, that are

individualized and designed to maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization.

(e) When determining whether a provider has demonstrated that a participant meets the medical necessity criteria, the department may enter an adult day health care center and review participants' medical records and observe participants receiving care identified in the individual plan of care in addition to reviewing the information provided on or with the TAR.

(f) Reauthorization of an adult day health care treatment authorization request shall be granted when the criteria specified in subdivision (d) or (g), as appropriate, have been met and the participant's condition would likely deteriorate if the adult day health care services were denied.

(g) For individuals residing in an intermediate care facility/developmentally disabled-habilitative, authorization or reauthorization of an adult day health care treatment authorization request shall be granted only if the resident has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through adult day health care, placement to a more costly institutional level of care would be likely to occur.

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

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

(j) Upon the date of execution of the declaration described under subdivision ~~(g)~~ *(f)* of Section 14525.1, this section shall become operative and Section 14526.1 shall become inoperative and on that date is repealed.

O