Department of Health Care Services

BUDGET NO. 4260

REPORT NO. 1

AB 131 (Committee on the Budget, Chapter 80, Statutes of 2005)- Section 34 un-codified

SEC. 34.

The State Department of Health Services shall provide the fiscal and policy committees of the Legislature with quarterly updates, commencing January 1, 2006, regarding core activities to improve the Medi-Cal Managed Care Program and to expand to the 13 new counties, as directed by the Budget Act of 2005. The quarterly updates shall include key milestones and objectives of progress regarding changes to the existing program, submittal of state plan amendments to the federal Centers for Medicare and Medicaid Services, submittal of any federal waiver documents, and applicable key functions related to the Medi-Cal Managed Care expansion effort.

COMMENTS/RECOMMENDATIONS:

According to the Assembly Health Committee staff, the transfer of Seniors and Person with Disabilities to Managed Care was completed on July 1, 2012. However the Department is continuing to move additional populations into managed care including persons with disabilities, and people with dual eligibility for Medi-Cal and Medicare and at the same time will be expanding the Medi-Cal program with the Affordable Care Act. The Legislature may wish to consider modifying this reporting requirement to maintain strong oversight.

REPORT NO. 2

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 8. Prepaid Plans [14200. - 14499.77.]
(Chapter 8 added by Stats. 1972, Ch. 1366.)
ARTICLE 3. Administration [14300. - 14316.]
(Article 3 repealed and added by Stats. 1974, Ch. 983.)

14301.1.

(a) For rates established on or after August 1, 2007, the department shall pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods and may establish health-plan- and county-specific rates. Notwithstanding any other law, this section shall apply to any managed care organization, licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), that has contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) of Chapter 7 to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS for rates established on or after July 1, 2012. The department shall utilize a county- and model-specific rate methodology to develop Medi-Cal managed care capitation rates for contracts entered into between the department and any entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 that includes, but is not limited to, all of the following:
(k) The department shall report, upon request, to the fiscal and policy committees of the respective houses of the Legislature regarding implementation of this section.

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-203	Committee on Budget	Health.	Chaptered 08/24/2007	08/24/2007 - Chaptered by Secretary of State - Chapter 188, Statutes of 2007.	Secretary of State- Chaptered	Yes	Two Thirds
AB-1164	Tran	Maintenance of the codes.	Chaptered 08/06/2009	08/06/2009 - Chaptered by Secretary of State - Chapter 140, Statutes of 2009.	Secretary of State- Chaptered	No	Majority
AB-1183	Committee on Budget	Health.	Chaptered 09/30/2008	09/30/2008 - Chaptered by Secretary of State - Chapter 758, Statutes of 2008.	Secretary of State- Chaptered	Yes	Two Thirds
AB-1467	Committee on Budget	Health.	Chaptered 06/27/2012	06/27/2012 - Chaptered by Secretary of State - Chapter 23,	Secretary of State- Chaptered	Yes	Majority

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
				Statutes of 2012.			
AB-1468	Committee on Budget	Public social services: Medi-Cal.	Amended Senate 06/25/2012	07/02/2012 - Re-referred to Com. on B. & F.R.	Senate-In Committee Process - Budget and Fiscal Review	Yes	Majority
AB-1613	Committee on Budget	Health.	Amended Senate 10/06/2010	10/08/2010 - Read third time. Urgency clause refused adoption. (Ayes 26. Noes 7. Page 5256.)	Senate-In Floor Process	Yes	Two Thirds
AB-2472	Butler, Bonnie Lowenthal	Medi-Cal: managed care.	Introduced 02/24/2012	05/25/2012 - In committee: Set, second hearing. Held under submission.	Assembly-In Committee Process - Appropriations	Yes	Majority
SB-83	Committee on Budget and Fiscal Review	Health.	Amended Assembly 07/20/2007	11/30/2008 - Died on file.	Legislature-Died	Yes	Two Thirds
SB-853	Committee on Budget and Fiscal Review	Health.	Chaptered 10/19/2010	10/19/2010 - Chaptered by Secretary of State. Chapter 717, Statutes of 2010.	Secretary of State-Chaptered	Yes	Two Thirds
SB-1007	Committee on Budget and Fiscal Review	Health.	Amended Assembly 06/13/2012	06/14/2012 - Withdrawn from committee. (Ayes 47. Noes 25. Page 5301.) 06/14/2012 - Ordered to second reading. 06/14/2012 - Read second time. Ordered to third reading.	Assembly-In Floor Process	Yes	Majority
SB-1008	Committee on Budget and Fiscal Review	Public social services: Medi-Cal.	Chaptered 06/27/2012	06/27/2012 - Chaptered by Secretary of State. Chapter 33, Statutes of 2012.	Secretary of State-Chaptered	Yes	Majority
SB-1077	Committee on Budget and Fiscal Review	Health.	Amended Assembly 09/15/2008	11/30/2008 - From Assembly without further action.	Assembly-Died	Yes	Two Thirds

COMMENTS/RECOMMENDATIONS:

This report to the Legislature is upon request only. The Legislature may wish to consider retaining this option in statute.

REPORT NO. 3

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)
ARTICLE 1. General Provisions [14000. - 14029.8.]
(Article 1 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)

14005.16.

(a) In determining the eligibility of a married individual pursuant to Section 14005.4 or 14005.7, who resides in a nursing facility, and who is in a Medi-Cal family budget unit separate from that of his or her spouse, the community property interest of the noninstitutionalized spouse in the income of the married individual shall not be considered income available to that individual.
(b) For purposes of this section, there shall be a presumption, rebuttable by either spouse, that each spouse has a community property interest in one-half of the total monthly income of both spouses.
(c) (1) This section shall not become operative unless Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is amended to authorize the consideration of state community property laws in determining eligibility or the federal government authorizes the state to apply community property laws in that determination.
(2) The department shall report to the appropriate committees of the Legislature upon the occurrence of the amendment of federal law or the receipt of federal approval, as specified in paragraph (1).
(Amended (as amended by Stats. 1989, Ch. 1430) by Stats. 1990, Ch. 1329, Sec. 7.5. Effective September 26, 1990. Section conditionally operative by its own provisions.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
SB-1413		Medi-Cal.	Chaptered 10/02/1989		-		
SB-1414		Health: skilled nursing and intermediate care facilities.	Chaptered 09/25/1989		-		
SB-1524		Health care.	Chaptered 09/26/1990		-		

COMMNETS/RECOMMENDATIONS:

According to the Department of Health Care Services, this information can be provided to the Legislature upon request, however, the Assembly Health Committee would like to continue receiving this information when federal community property law is modified.

REPORT NO. 4

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)
ARTICLE 1. General Provisions [14000. - 14029.8.]
(Article 1 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)

14007.95.

The department shall report to the Governor and the Legislature any information the department gathers from the California Health Improvement Project, or from any other public or private sources, that may explain the low participation rates in the optional program provided pursuant to Section 14007.9 and any recommendations from the department on actions the state may take to increase participation by eligible persons in a manner that is cost effective for the state and beneficial for the participants.
(Added by Stats. 2002, Ch. 1088, Sec. 7. Effective January 1, 2003.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-925	Aroner	Employment of persons with disabilities.	Chaptered 09/29/2002	09/29/2002 - Chaptered by Secretary of State - Chapter 1088, Statutes of 2002. 09/29/2002 - Approved by the Governor.	-		

COMMNETS/RECOMMENDATIONS:

This report does not have a due date. The Legislature may wish to consider adding the due date of January, 2014 to this requirement.

REPORT NO. 5

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)
ARTICLE 1. General Provisions [14000. - 14029.8.]
(Article 1 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)

14012.5.

(a) By July 1, 2007, the department shall implement a process that allows applicants and beneficiaries to self-certify the amount and nature of assets and income without the need to submit income or asset documentation.
(b) The process shall apply to applicants and beneficiaries in the program described in Section 14005.30, the federal poverty level programs for infants, children and pregnant women, the Medically-Indigent and Medically-Needy Programs for children and families, and other similar programs designated by the department, in order to preserve family unity or simplify administration. The process shall not apply to applicants or beneficiaries whose eligibility is based on their status as aged, blind, or based upon a disability determination unless, to the extent possible, they are members of families in which a child, parent, or spouse of that person is also a Medi-Cal applicant or beneficiary.
(c) The department shall implement the process of self-certification in two phases. The first phase shall be implemented in two counties as established in subdivision (d), and consistent with requirements set forth in this section. The second phase shall be implemented statewide as established in subdivision (h) and subject to the conditions set forth in this section.
(d) The department shall implement the first phase in two counties that have a combined Medi-Cal population of approximately 10 percent of the total statewide Medi-Cal population for the programs described in subdivision (b) as being eligible for the self-certification process. The department shall select the two counties for the initial phase of implementation by considering the following factors:
(1) The county's demonstrated record of completing eligibility determinations and redeterminations accurately and on a timely basis.
(2) The county's demonstrated record of accurately, quickly and successfully implementing programs.
(e) Each county shall agree to meet all federal requirements for income, resource, and other verifications, and to perform determinations and verifications in a timely manner.
(f) Following a two-year implementation of the first phase, the department shall promptly provide the fiscal and policy committees of the Legislature with an evaluation of the self-certification process and its impacts on the Medi-Cal program, including its impact on enrolling and retaining eligible persons, simplifying the program, assuring program and fiscal integrity, administrative costs, and its overall cost-benefit to the state.
(g) The director may modify or terminate the first phase of implementation not sooner than 90 days after providing notification to the Chair of the Joint Legislative Budget Committee. This notification shall articulate the specific reasons for the modification or termination and shall include all relevant data elements which are applicable to document the reasons provided for said modifications or termination. Upon the request of the Chair of the Joint Legislative Budget

Committee, the director shall promptly provide any additional clarifying information regarding the first phase of implementation as requested.
(h) Following two years of operation in two counties and submission of the evaluation to the Legislature, the director, in consultation with the Department of Finance, shall determine whether to implement the self-certification process statewide. This determination shall be based on the outcomes of the evaluation, including the ability to increase enrollment of eligible children and families, and to maintain the overall integrity of the Medi-Cal program. Statewide implementation shall be contingent on a specific appropriation being provided for this purpose in the Budget Act or subsequent legislation.
(i) This section shall be implemented only if that, and to the extent, federal financial participation is available.
(j) 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 all-county letters or similar instructions, without taking any further regulatory action. Thereafter, the department shall adopt regulations, as necessary, to implement this section 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.
(k) The department, in consultation with the Department of Finance, counties, and other interested stakeholders, shall determine which types of assets and income are appropriate for self-certification under this section.
(l) Nothing in this section shall be read to preclude a county from requesting documentation from any applicant or beneficiary regarding any income or asset where a question arises about such income or asset during the county's determination or redetermination of eligibility following receipt of the application or annual redetermination form.
(m) Nothing in this section shall change the ability of the department to self-certify income, assets, or other program information to the extent allowed under state or federal law, waiver, or the state plan.
(n) (1) This section shall not be implemented if the voters approve Proposition 86, the tobacco tax initiative, at the statewide general election on November 7, 2006.
(2) Notwithstanding paragraph (1) if Proposition 86 is approved by the voters at the statewide general election on November 7, 2006, this section shall be implemented during the pendency of any legal action concerning the validity of the proposition.
(Added by Stats. 2006, Ch. 328, Sec. 8. Effective January 1, 2007.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-2875	Lieber	Public social services recipients: Medi-Cal eligibility.	Amended Senate 07/01/2008	11/30/2008 - From Senate committee without further action.	Senate-Died - Appropriations	Yes	Majority
SB-437	Escutia	Health care coverage.	Chaptered 09/19/2006	09/19/2006 - Chaptered by Secretary of State. Chapter 328, Statutes of 2006. 09/19/2006 - Approved by Governor.	-	Yes	Majority

COMMENTS/RECOMMENDATIONS:

According to the Department of Health Care Services, information on the Medi-Cal self-certification program can be provided to the Legislature or public upon request. However, the Assembly Health Committee indicates that self-certification of income will be important aspect of the Affordable Care Act implementation and key to providing oversight.

REPORT NO. 6

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)
ARTICLE 1. General Provisions [14000. - 14029.8.]
(Article 1 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)

14016.55.

(a) It is the intent of the Legislature that Medi-Cal beneficiaries who are required to enroll in a Medi-Cal managed care health plan make an informed choice that is not the result of confusion, lack of information, or understanding of the choices available to them.
(b) It is the intent of the Legislature that the department strive to increase the level of choice of Medi-Cal beneficiaries required to enroll in a Medi-Cal managed care health plan and that default rates be no greater than 20 percent in any participating county.
(c) In any county in which conversion to managed care plan enrollment has taken place and where the default rate, as defined in subdivision (e), is 20 percent or higher in two consecutive months occurring after conversion upon the effective date of this section, the department shall conduct a one-time survey of beneficiaries aimed at determining the reasons why beneficiaries fail to enroll into a managed care plan when required to do so by the department or its health care options contractor.
(d) The department shall submit the results of the survey to the appropriate legislative policy and budget committees within six months of completion, and implement a plan of correction intended to reduce the rate of beneficiary default. The plan of correction may include, but not be limited to, culturally appropriate outreach and education activities, including the use of community based organization.
(e) For purposes of this section, "default rate" refers to the rate of Medi-Cal beneficiaries defaulting into managed care health plan enrollment by virtue of their failure to make an election, as provided for in Section 14016.5.
(Added by Stats. 1998, Ch. 310, Sec. 78. Effective August 19, 1998.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-1309	Emmerson	Medi-Cal.	Introduced 02/27/2009	02/02/2010 - Died at Desk.	Assembly-Died	No	Majority
AB-1512	Garrick	Medi-Cal.	Introduced 01/12/2012	01/13/2012 - From printer. May be heard in committee February 12.	Assembly-Pending Referral	No	Majority
AB-2780		Health services: Budget Act implementation.	Chaptered 08/19/1998		-		

COMMENTS/RECOMMENDATIONS:

It is unclear whether the Department is proposing to delete the survey requirement as well as the reporting requirement. Stakeholders and others have expressed an interest in retaining both requirements.

REPORT NO. 7

WEALFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)
ARTICLE 1. General Provisions [14000. - 14029.8.]
(Article 1 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)

14022.4.

(a) Any nursing facility or any category of intermediate care facility for the developmentally disabled currently certified to participate in the Medi-Cal program may not voluntarily withdraw from the program unless all of the following conditions are met:
(1) The facility shall file with the department a notice of intent to withdraw from the Medi-Cal program.
(2) Except for patients to be transferred or discharged only for medical reasons, or for patients' welfare or that of other patients, or for nonpayment for his or her stay, the facility shall not subsequently evict any Medi-Cal recipient or private pay patient residing in the facility at the time the notice of intent to withdraw from the Medi-Cal program is filed.
(3) Patients admitted to the facility on or after the date of the notice of intent to withdraw from the Medi-Cal program shall be advised orally and in writing of both the following:
(A) That the facility intends to withdraw from the Medi-Cal program.
(B) That notwithstanding Section 14124.7, the facility is not required to keep a new resident who converts from private pay to Medi-Cal.
(b) Subdivision (a) shall not apply to facilities that have filed, prior to May 1, 1987, a notice of intent to withdraw from the Medi-Cal program.
(c) The department shall notify the appropriate substate ombudsmen monthly as to which facilities have filed a notice of intent to withdraw from the Medi-Cal program. This information shall also be made available to the public and noted in facility files available in each district office.
(d) The facility may formally withdraw from the Medi-Cal program when all patients residing in the facility at the time the facility filed the notice of intent to withdraw from the Medi-Cal program no longer reside in the facility.
(e) If a facility that has withdrawn as a Medi-Cal provider pursuant to this section subsequently reapplies to the department to become a Medi-Cal provider, the department shall require as a condition of becoming a Medi-Cal provider that the facility enter into a five-year Medi-Cal provider contract with the department.
(f) (1) This section shall be inoperative in the event federal law or federal or state appellate judicial decisions prohibit implementation or invalidate any part of this section.
(2) In the event of any occurrence which renders this section inoperative pursuant to paragraph (1), the department shall within 30 days, report that information to the Legislature.
(g) (1) This section does not apply to any facility which ceases operations entirely.
(2) For purposes of this subdivision, "ceases operations entirely" means not being in operation for a period of not less than 12 months.

(Amended by Stats. 1990, Ch. 1329, Sec. 14. Effective September 26, 1990. Conditionally inoperative as provided in subd. (f).)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
SB-1414		Health: skilled nursing and intermediate care facilities.	Chaptered 09/25/1989		-		
SB-1524		Health care.	Chaptered 09/26/1990		-		

COMMENTS/RECOMMENDATIONS:

The Department is required to report to the appropriate substate ombudsmen monthly as to which nursing facilities have filed a noticed of intent to withdraw from the Medi-Cal program and make this information available to the public as specified. There is no required report to the Legislature.

REPORT NO. 8

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)
ARTICLE 1.5. Electronic Medical Records [14046. - 14046.8.]
(Article 1.5 added by Stats. 2011, Ch. 433, Sec. 2.)

14046.1.

(a) The program shall be administered in accordance with the State Medicaid Health Information Technology Plan, as developed by the department and approved by the federal Centers for Medicare and Medicaid Services. Upon federal approval, the department shall provide copies of the plan to the appropriate fiscal and policy committees of the Legislature.
(b) The State Medicaid Health Information Technology Plan shall address all of the following:
(1) Identify and establish the planning, policies, and procedures required to operationalize the Medi-Cal Electronic Health Record Incentive Program.
(2) Specify the criteria for enrollment, eligibility, and data collection.
(3) Specify timeframes for technology modifications.
(4) Specify the process for provider outreach and department coordination with established regional extension centers in the state, established to provide technical support to providers.
(5) Establish the audit and appeals processes.
(6) Participate in the National Level Registry.
(Added by Stats. 2011, Ch. 433, Sec. 2. Effective October 2, 2011. Inoperative July 1, 2021. Repealed as of January 1, 2022, pursuant to Section 14046.8.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
SB-945	Committee on Health	Medi-Cal: electronic records.	Chaptered 10/02/2011	10/02/2011 - Chaptered by Secretary of State. Chapter 433, Statutes of 2011.	Senate-Chaptered	Yes	Two Thirds

COMMENTS/RECOMMENDATIONS:

The Assembly Health Committee has expressed an interest in continuing to receive the State Medicaid Information Technology Plan upon federal approval. The technology plan has implications for the efficiency and quality of care provided to people on Medi-Cal.

REPORT NO. 9

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)
ARTICLE 2. Definitions [14050. - 14068.]
(Article 2 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)

14067.

(a) The department, in conjunction with the Managed Risk Medical Insurance Board, may develop and conduct a community outreach and education campaign to help families learn about, and apply for, Medi-Cal and the Healthy Families Program of the Managed Risk Medical Insurance Board, subject to the requirements of federal law. In conducting this campaign, the department may seek input from, and contract with, various entities and programs that serve children, including, but not limited to, the State Department of Education, counties, Women, Infants, and Children program agencies, Head Start and Healthy Start programs, and community-based organizations that deal with potentially eligible families and children to assist in the outreach, education, and application completion process. The department shall implement the campaign if funding is provided for this purpose by an appropriation in the annual Budget Act or other statute.
(b) An annual outreach plan shall be submitted to the Legislature by April 1 for each fiscal year for those years for which there is funding in the annual Budget Act or other statute for the outreach and education campaign. The plan shall address both the Medi-Cal program for children and the Healthy Families Program and, at a minimum, shall include the following:
(1) Specific milestones and objectives to be completed for the upcoming year and their anticipated cost.
(2) A general description of each strategy or method to be used for outreach.
(3) Geographic areas and special populations to be targeted, if any, and why the special targeting is needed.
(4) Coordination with other state or county education and outreach efforts.
(5) The results of previous year outreach efforts.
(c) In implementing this section, the department may amend any existing or future media outreach campaign contract that it has entered into pursuant to Section 14148.5. Notwithstanding any other provision of law, any such contract entered into, or amended, as required to implement this section, shall be exempt from the approval of the Director of General Services and from the provisions of the Public Contract Code.
(d) (1) The department, in conjunction with the Managed Risk Medical Insurance Board, may award contracts to community-based organizations to help families learn about, and enroll in, the Medi-Cal program and Healthy Families Program, and other health care programs for low-income children. The department shall implement this subdivision if funding is provided for this purpose by an appropriation in the annual Budget Act or other statute.
(2) Contracts for these outreach and enrollment projects shall be awarded based on, but not limited to, all of the following criteria:

(A) Capacity to reach populations or geographic areas with disproportionately low enrollment rates. If it is not possible to estimate the number of uninsured children in a geographic area who are eligible for the Medi-Cal program or the Healthy Families Program, proxy measures for rates of eligible children may be used. These measures may include, but are not limited to, the number of children in families with gross annual household incomes at or below the federal poverty levels pertinent to the programs.
(B) Organizational capacity and experience, including, but not limited to, any of the following:
(i) Organizational experience in serving low-income families.
(ii) Ability to work effectively with populations that have disproportionately low enrollment rates.
(iii) Organizational experiences in helping families learn about, and enroll in, the Medi-Cal program and Healthy Families Program. Organizations that do not have experience helping families learn about, and enroll in, the Medi-Cal program and Healthy Families Program shall be eligible only to the extent that they support and collaborate with the outreach and enrollment activities of entities with that experience.
(C) Effectiveness of the outreach and education plan, including, but not limited to, all of the following:
(i) Culturally and linguistically appropriate outreach and education strategies.
(ii) Strategies to identify and address barriers to enrollment, such as transportation limitations and community perceptions regarding the Medi-Cal program and Healthy Families Program.
(iii) Coordination with other outreach efforts in the community, including the statewide Healthy Families Program and Medi-Cal program outreach campaign, the state and federally funded county Medi-Cal outreach program, and any other Medi-Cal program and Healthy Families Program outreach projects in the target community.
(iv) Collaboration with other local organizations that serve families of eligible children.
(v) Strategies to ensure that children and families retain coverage and are informed of options for health coverage and services when they lose eligibility for a particular program.
(vi) Plans to inform families about all available health care programs and services.
(Amended by Stats. 2003, 1st Ex. Sess., Ch. 9, Sec. 7. Effective May 5, 2003.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-1107	Cedillo, Escutia, Figueroa, Gallegos, Johnston, Solis, Speier, Vasconcellos, Villaraigosa	Health Care.	Chaptered 07/22/1999	07/22/1999 - Chaptered by Secretary of State - Chapter 146, Statutes of 1999. 07/22/1999 - Approved by the Governor.	-		
AB-2780		Health services: Budget Act implementation.	Chaptered 08/19/1998		-		
SBX1-6	Committee on Budget and Fiscal Review	Health and Human Services: Budget Act trailer.	Amended Assembly 04/28/2003	07/29/2003 - From Assembly without further action.	-	Yes	Two Thirds
SBX1-26	Committee on Budget and Fiscal Review	Health.	Chaptered 05/05/2003	05/05/2003 - Chaptered by Secretary of State. Chapter	-		

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
				9, Statutes of 2003-04 First Extraordinary Session. 05/05/2003 - Approved by Governor.			
SB-391		Health.	Chaptered 08/18/1997		-		
SB-903		Children's health care coverage.	Chaptered 10/03/1997		-		

COMMENTS/RECOMMENDATIONS:

The transfer of the Healthy Families Program to the Department of Health Care Services and the coordinated outreach of the Affordable Care Act may make this report no longer necessary.

REPORT NO. 10

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)
ARTICLE 2.98. California Children's Services Program and Medi-Cal Managed Care Contracts [14094. - 14094.3.]
(Article 2.98 added by Stats. 1994, Ch. 917, Sec. 2.)

14094.3.

(a) Notwithstanding this article or Section 14093.05 or 14094.1, CCS covered services shall not be incorporated into any Medi-Cal managed care contract entered into after August 1, 1994, pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.9 (commencing with Section 14088), Article 2.91 (commencing with Section 14089), Article 2.95 (commencing with Section 14092); or either Article 2 (commencing with Section 14200), or Article 7 (commencing with Section 14490) of Chapter 8, until January 1, 2016, except for contracts entered into for county organized health systems or Regional Health Authority in the Counties of San Mateo, Santa Barbara, Solano, Yolo, Marin, and Napa.
(b) Notwithstanding any other provision of this chapter, providers serving children under the CCS program who are enrolled with a Medi-Cal managed care contractor but who are not enrolled in a pilot project pursuant to subdivision (c) shall continue to submit billing for CCS covered services on a fee-for-service basis until CCS covered services are incorporated into the Medi-Cal managed care contracts described in subdivision (a).
(c) (1) The department may authorize a pilot project in Solano County in which reimbursement for conditions eligible under the CCS program may be reimbursed on a capitated basis pursuant to Section 14093.05, and provided all CCS program's guidelines, standards, and regulations are adhered to, and CCS program's case management is utilized.
(2) During the time period described in subdivision (a), the department may approve, implement, and evaluate limited pilot projects under the CCS program to test alternative managed care models tailored to the special health care needs of children under the CCS program. The pilot projects may include, but need not be limited to, coverage of different geographic areas, focusing on certain subpopulations, and the employment of different payment and incentive models. Pilot project proposals from CCS program-approved providers shall be given preference. All pilot projects shall utilize CCS program-approved standards and providers pursuant to Section 14094.1.
(d) (1) The department shall submit to the appropriate committees of the Legislature an evaluation of pilot projects established pursuant to subdivision (c) based on at least one full year of operation.
(2) The evaluation required by paragraph (1) shall address the impact of the pilot projects on outcomes as set forth in paragraph (4) and, in addition, shall do both of the following:
(A) Examine the barriers, if any, to incorporating CCS covered services into the Medi-Cal managed care contracts described in subdivision (a).

(B) Compare different pilot project models with the fee-for-service system. The evaluation shall identify, to the extent possible, those factors that make pilot projects most effective in meeting the special needs of children with CCS eligible conditions.
(3) CCS covered services shall not be incorporated into the Medi-Cal managed care contracts described in subdivision (a) before the evaluation process has been completed.
(4) The pilot projects shall be evaluated to determine whether:
(A) All children enrolled with a Medi-Cal managed care contractor described in subdivision (a) identified as having a CCS eligible condition are referred in a timely fashion for appropriate health care.
(B) All children in the CCS program have access to coordinated care that includes primary care services in their own community.
(C) CCS program standards are adhered to.
(e) For purposes of this section, CCS covered services include all program benefits administered by the program specified in Section 123840 of the Health and Safety Code regardless of the funding source.
(f) Nothing in this section shall be construed to exclude or restrict CCS eligible children from enrollment with a managed care contractor, or from receiving from the managed care contractor with which they are enrolled primary and other health care unrelated to the treatment of the CCS eligible condition.
(Amended by Stats. 2011, Ch. 460, Sec. 2. Effective January 1, 2012.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-301	Pan	Medi-Cal: managed care.	Chaptered 10/04/2011	10/04/2011 - Chaptered by Secretary of State - Chapter 460, Statutes of 2011.	Secretary of State-Chaptered	Yes	Majority
AB-1107	Cedillo, Escutia, Figueroa, Gallegos, Johnston, Solis, Speier, Vasconcellos, Villaraigosa	Health Care.	Chaptered 07/22/1999	07/22/1999 - Chaptered by Secretary of State - Chapter 146, Statutes of 1999. 07/22/1999 - Approved by the Governor.	-		
AB-2117	Committee on Budget	Budget Act of 2004: health.	Amended Senate 07/27/2004	11/30/2004 - Died on Senate third reading file.	-	Yes	Two Thirds
AB-2379	Chan	Medi-Cal: managed care.	Chaptered 09/19/2006	09/19/2006 - Chaptered by Secretary of State - Chapter 333, Statutes of 2006. 09/19/2006 - Approved by the Governor.	-	Yes	Majority
AB-3049	Committee on Health	Public health.	Chaptered 09/15/2002	09/15/2002 - Chaptered by Secretary of State - Chapter 536, Statutes of 2002.	-		

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
SB-391		Health.	Chaptered 08/18/1997		-		
SB-479	Solis	Medi-Cal: county organized health systems.	Introduced 02/18/1999	11/30/2000 - From Assembly without further action.	-	Yes	Majority
SB-1103	Committee on Budget and Fiscal Review	Budget Act of 2004: health.	Chaptered 08/16/2004	08/16/2004 - Chaptered by Secretary of State. Chapter 228, Statutes of 2004. 08/16/2004 - Approved by Governor.	-		
SB-1371		Child health care.	Chaptered 09/28/1994		-		
SB-1497	Committee on Health and Human Services	Reorganization of the Health and Safety Code: public health.	Chaptered 09/29/1996		-		
SB-1783	Dunn	Medi-Cal: managed care.	Amended Senate 05/18/2004	11/30/2004 - From Assembly without further action. 11/30/2004 - From committee without further action.	-	Yes	Majority

COMMENTS/RECOMMENDATIONS:

The managed care pilot projects have been replaced with new pilot projects rendering this reporting requirement obsolete.

REPORT NO. 11

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)
ARTICLE 3. Administration [14100. - 14124.11.]
(Article 3 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)

14105.42.

(a) The department shall report to the Legislature after the first three major therapeutic categories have been reviewed and contracts executed. The report shall include the estimated savings, number of manufacturers entering negotiations, number of contracts executed, number of drugs added and deleted, and impact on Medi-Cal beneficiaries and providers.
(b) The department shall report to the Legislature, through the annual budget process, on the cost-effectiveness of contracts executed pursuant to Section 14105.33.
(Amended by Stats. 2002, Ch. 1161, Sec. 69. Effective September 30, 2002.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-442	Committee on Budget	Health: budget trailer.	Chaptered 09/30/2002	09/30/2002 - Chaptered by Secretary of State - Chapter 1161, Statutes of 2002. 09/30/2002 - Approved by the Governor.	-		
AB-1107	Cedillo, Escutia, Figueroa, Gallegos, Johnston, Solis, Speier, Vasconcellos, Villaraigosa	Health Care.	Chaptered 07/22/1999	07/22/1999 - Chaptered by Secretary of State - Chapter 146, Statutes of 1999. 07/22/1999 - Approved by the Governor.	-		
AB-2117		Medi-Cal drug formulary.	Chaptered 09/25/1989		-		
AB-2780		Health services: Budget Act implementation.	Chaptered 08/19/1998		-		
AB-2877	Thomson	Public health programs: Budget Act implementation.	Chaptered 07/07/2000	07/07/2000 - Chaptered by Secretary of State - Chapter 93, Statutes of 2000.	-		
AB-3483		Health.	Chaptered 07/22/1996		-		

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-3573		Public assistance.	Chaptered 07/31/1990		-		
AB-4195		Medi-Cal: purchase contracts.	Chaptered 09/30/1990		-		
SB-8	Leslie	Medi-Cal: drugs.	Introduced 12/07/1998	02/01/2000 - Returned to Secretary of Senate pursuant to Joint Rule 56.	-	Yes	Majority
SB-408		State Auditor.	Chaptered 10/06/1997		-		
SB-485		Human services.	Chaptered 09/15/1992		-		
SB-1063		Medi-Cal: list of contract drugs.	Chaptered 09/15/1992		-		
SB-1156		Health care.	Chaptered 09/15/1992		-		
SB-1846	Committee on Budget and Fiscal Review	Health: budget trailer.	Amended Assembly 06/25/2002	11/30/2002 - From Assembly without further action.	-	Yes	Two Thirds
SB-2097		Public assistance.	Chaptered 07/31/1990		-		

COMMENTS/RECOMMENDATIONS:

According the Assembly Health Committee, this report requirement can be considered for elimination.

REPORT NO. 12

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)
ARTICLE 3. Administration [14100. - 14124.11.]
(Article 3 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)

14120.

(a) At the beginning of each fiscal year, for the current fiscal year, the director shall establish a monthly schedule of anticipated total payments and anticipated payments for categories of services, according to the categories established in the Governor's Budget. The schedule will be revised quarterly.
(b) The director shall report actual total payments and payments for categories of services, as set forth in subdivision (a), monthly to the Director of Finance and to the Joint Legislative Budget Committee.
(c) At any time during the fiscal year, if the director has reason to believe that the total cost of the program will exceed available funds, the director may first modify the method or amount of payment for services provided that no amount shall be reduced more than 10 percent and no modification will conflict with federal law. If such modification is not sufficient to bring the program within available funds, the director may postpone elective services in the schedule of benefits. Such postponement of elective services shall be accomplished by changing the standards for approval of requests for prior authorizations. Such changes shall be designed to insure that those recipients most in need of elective services receive them first within the funds available, but that no particular service is completely eliminated.
(d) At any time during the fiscal year, if the total amounts paid since the beginning of the fiscal year exceed by 10 percent the amounts scheduled, the director shall immediately institute the action set forth in subdivision (c).
(e) At any time during the fiscal year, if the total amounts paid for any category of service exceeds by 10 percent the amounts scheduled (other than services for which the method or amount of payment is prescribed by the United States Secretary of Health and Human Services pursuant to Title XIX of the federal Social Security Act), the director shall modify the method or amount of payment for such category of service to assure that the total amount paid for such category of service in the fiscal year shall be less than 10 percent in excess of the total amount scheduled provided the total cost of the program to the State General Fund shall not exceed appropriated state general funds.
(f) Before any of the above actions are taken by the director, he or she shall consult with representatives of concerned provider groups.
(g) Notwithstanding subdivision (c) or (e), the director shall not reduce the amount of payment, under the circumstances described in subdivision (c) or (e), for the ingredient cost component of pharmaceutical services rendered by pharmacist providers in California.
(Amended by Stats. 1988, Ch. 1444, Sec. 1. Effective September 28, 1988.)

NO RELATED LEGISLATION

COMMENTS/RECOMMENDATIONS:

The Legislature may consider asking the Department if removing the reporting requirement would also change their monthly comparison of actual payments against anticipated payments. If they are still performing this analysis and reporting to the Department of Finance, it is appropriate that the Joint Legislative Budget Committee would also receive the same information.

REPORT NO. 13

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(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.)

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.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-3712		Medi-Cal: Rural hospitals.	Chaptered 09/30/1992		-		
SB-1497	Committee on Health and Human Services	Reorganization of the Health and Safety Code: public health.	Chaptered 09/29/1996		-		

COMMENTS/RECOMMENDATIONS:

This report provides an interim evaluation after the first year of a two-year pilot project that allows rural hospitals to perform delegated acute inpatient treatment reviews. Since the Department of Health Care services is authorized to modify or terminate the pilot project upon evaluation, the Legislature may wish to continue receiving this information.

REPORT NO. 14

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(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.)

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.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
ABX4-5	Evans	Health.	Chaptered 07/28/2009	07/28/2009 - Chaptered by Secretary of State. Chapter 5, Statutes of 2009-10 Fourth Extraordinary Session.	Secretary of State-Chaptered	Yes	Two Thirds
ABX3-44	Evans	Health.	Amended Assembly 06/28/2009	10/26/2009 - Died at Desk.	Assembly-Died	Yes	Majority
AB-2118	Committee on Budget	Budget Act of 2004: human services.	Amended Senate 07/27/2004	11/30/2004 - Died on Senate third reading file.	-	Yes	Two Thirds
SB-1104	Committee on Budget and Fiscal Review	Budget Act of 2004: human services.	Chaptered 08/16/2004	08/16/2004 - Chaptered by Secretary of State. Chapter 229, Statutes of	-		

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
				2004. 08/16/2004 - Approved by Governor.			

COMMENTS/RECOMMENDATIONS:

This report provides timely updates to the Legislature on any federal modifications in benefits or eligibility and operational requirements of the In-Home Supportive Services program required for receipt of the IHSS Plus waiver. As the funding challenges continue for this important program, the Legislature may wish to continue receiving this information to help guide state policies.

REPORT NO. 15

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(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.)

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.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
ABX4-5	Evans	Health.	Chaptered 07/28/2009	07/28/2009 - Chaptered by Secretary of State. Chapter 5, Statutes of 2009-10 Fourth Extraordinary Session.	Secretary of State-Chaptered	Yes	Two Thirds
ABX3-44	Evans	Health.	Amended Assembly 06/28/2009	10/26/2009 - Died at Desk.	Assembly-Died	Yes	Majority

COMMENTS/RECOMMENDATIONS:

This report provides timely updates to the Legislature on any federal modifications in benefits or eligibility and operational requirements of the In-Home Supportive Services program required for the Medicaid state plan amendment to become effective. As the funding challenges continue for this important program, the Legislature may wish to continue receiving this information to help guide state policies.

REPORT NO. 16

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 8. Prepaid Plans [14200. - 14499.77.]
(Chapter 8 added by Stats. 1972, Ch. 1366.)
ARTICLE 5. Standards for Prepaid Health Plans [14450. - 14464.]
(Article 5 added by Stats. 1974, Ch. 983.)

14459.5.

(a) As delegated by the federal government, the department has responsibility for monitoring the quality of all medicaid services provided in the state. A key component of this monitoring function is the performance of annual, independent, external reviews of the quality of services furnished under each state contract with a health maintenance organization, as specified by the federal Health Care Financing Administration.
(b) The Legislature finds and declares that the final report obtained from the external reviews will provide valid and reliable information regarding health care outcomes and the overall quality of care delivered by the managed care plans.
(c) The department shall make only the final report of each external review available, within 30 calendar days of completion, to the fiscal and health policy committees of the Legislature, and shall make only the final report available for public viewing upon request by any individual or organization.
(Added by Stats. 1997, Ch. 294, Sec. 77. Effective August 18, 1997.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
SB-391		Health.	Chaptered 08/18/1997		-		

COMMENTS/RECOMMENDATIONS:

The annual independent external review of contracts with HMO's is required by federal law. The Legislature may want to continue receiving the final evaluations in a timely manner to assist in state policy decisions.

REPORT NO. 17

WEALFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 4.7. HEALTH CARE FOR INDIGENTS [16900. - 16996.2.]
(Heading for Part 4.7 (added by Stats. 1989, Ch. 1331) added by Stats. 1990, Ch. 50, Sec. 10.5.)
CHAPTER 5. California Healthcare for Indigents Program [16940. - 16995.1.]
(Chapter 5 added by Stats. 1989, Ch. 1331, Sec. 9.)
ARTICLE 6. County Application [16980. - 16981.]
(Article 6 added by Stats. 1989, Ch. 1331, Sec. 9.)

16981.

(a) The department shall conduct fiscal and program reviews to ensure county compliance with the provisions of this part, and shall report annually the results of these reviews to the Legislature. The department may withhold funds, up to the total amount of funds allocated under this chapter, if a county fails to correct deficiencies in the program after receiving written notice of noncompliance from the department.
(b) The department shall recoup funds which were provided pursuant to this chapter and Chapter 4 (commencing with Section 16930) if they were not encumbered or expended according to the requirements of this chapter or Chapter 4 respectively within the fiscal year according to procedures and reports required by the department. The funds shall revert to the CHIP Account or Rural Health Services Account respectively.
(Amended by Stats. 1994, Ch. 195, Sec. 49. Effective July 12, 1994.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-75		Health care.	Chaptered 10/02/1989		-		
AB-816		Health care.	Chaptered 07/12/1994		-		
SB-99		Health care.	Chaptered 10/14/1991		-		

COMMENTS/RECOMMENDATIONS:

Since the Department of Health Care Services would still be required to conduct a fiscal and program review to ensure county compliance with health care provisions for the indigent, the Legislature may wish to continue receiving this information annually to assist state policy decisions.

REPORT NO. 18

SB 853 (COMMITTEE ON BUDGET AND FISCAL REVIEW, CHAPTER 717, STATUTES OF 2010) SENTION 173, UN-CODIFIED

SEC. 173.

The State Department of Health Care Services shall provide the fiscal and appropriate policy committees of the Legislature with semiannual updates regarding all of California's Medicaid waivers to be provided in March and October of each year. At a minimum, the semiannual updates shall include a listing of all Medicaid waivers with all of the following information for each waived:
(a) Description of what federal laws or regulations are being waived.
(b) Description of the purpose of the wavier.
(c) Description of whom the waiver serves and the number of enrollees.
(d) Status of the waiver, including its expiration date and pending renewal dates where applicable.
(e) State plan amendment number listing and date that is applicable to the waiver.
(f) Department that administers the program.
(g) Any other information deemed useful by the department, including any separate attachments or reports on a particular waiver.

COMMENTS/RECOMMENDATIONS:

The Legislative may wish to consider requiring the Department of Health Care Services to continue to provide this information on their internet website.

REPORT NO. 19

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 1.75. STATEWIDE ELIGIBILITY AND ENROLLMENT PROCESSING [10200. - 10205.]
(Part 1.75 added by Stats. 2009, 4th Ex. Sess., Ch. 7, Sec. 1.)

10200. Subdivision 9

(a) (1) The State Department of Health Care Services and the State Department of Social Services shall develop a statewide eligibility and enrollment determination process for the California Work Opportunity and Responsibility to Kids (CalWORKs) program, the Medi-Cal program, and the Supplemental Nutrition Assistance Program (SNAP), in accordance with this part. It is the intent of the Legislature that the development of this process shall achieve all of the following outcomes:
(A) Facilitate better access to services and aid for eligible clients.
(B) Lower the costs of enrolling persons into CalWORKs, Medi-Cal, and SNAP without reducing access.
(C) Improve consistency of eligibility determination and enrollment approach and processes statewide.
(D) Create an efficient process that eliminates redundancies and inefficiencies.
(E) Employ state-of-the-art technology to improve efficiency of the eligibility determination process.
(F) Minimize the number of technology systems that the state shall support in preforming the eligibility process.
(2) The development of the statewide eligibility and enrollment determination process and the comprehensive plan required in subdivision (b) shall be accomplished in consultation with a stakeholder steering committee established pursuant to subdivision (h).
(b) The State Department of Health Care Services and the State Department of Social Services shall develop a comprehensive plan, which shall include, at a minimum, all of the following components:
(1) Project description.
(2) Business case.
(3) Business and technical requirements.
(4) Cost benefit analysis, including all aspects as traditionally provided in a feasibility study report for information technology projects, including, but not limited to, the following components:
(A) An analysis of the benefits and drawbacks of procuring a new statewide eligibility and enrollment determination process and contracting out eligibility functions as compared to building upon existing enrollment and eligibility determination systems.
(B) An assessment of risks, including an analysis of other states in automating and contracting out centralized eligibility determinations and the state's history and experience in other procurement efforts.
(C) An analysis of the state and local staffing and costs, and any program impacts resulting from any new statewide eligibility and enrollment system.
(5) Project timelines, including key milestones.

(6) Recommendations of other health or social services programs that should be added to the process, if any.
(7) Description of any federal waivers and any state statutory changes that may be needed for full, phased-in implementation of the process.
(8) Project budget, including necessary budget proposal documents.
(9) Competitive procurement strategy and process.
(10) Transition plan for phasing in any new statewide eligibility and enrollment system.
(11) Strategy to inform the public and beneficiaries of any new statewide eligibility and enrollment system.
(12) Description of stakeholder steering committee involvement in the development of the comprehensive plan.
(c) The State Department of Health Care Services and the State Department of Social Services may utilize a contractor to develop and complete the comprehensive plan as specified.
(d) The State Department of Health Care Services and the State Department of Social Services shall submit the comprehensive plan to the fiscal and applicable policy committees of the Legislature, including the Joint Legislative Budget Committee, at least 45 days prior to a request for an appropriation.
(e) Contingent upon legislative approval of the comprehensive plan and an appropriation for this purpose, the State Department of Health Care Services and the State Department of Social Services may proceed with procurement activities consistent with the approved plan, including any request for proposals being issued and the utilization of a performance-based contract model, or subsequent process as identified in the comprehensive plan, to implement a statewide eligibility and enrollment determination process. Any contractor, county consortia, nonprofit providers, or any partnerships shall be authorized to compete for any aspect of this process. At a minimum, an entity shall be required to comply with all of the following requirements:
(1) Make accurate determinations and redeterminations of eligibility for CalWORKs, Medi-Cal, and SNAP.
(2) Coordinate with community-based organizations to assist individuals with the application process, in various languages, as specified by the State Department of Health Care Services and the State Department of Social Services and as required in state and federal law and regulation.
(3) Represent the departments as applicable in fair hearings arising out of eligibility determinations and redeterminations.
(4) Assist applicants and recipients requiring assistance for program eligibility, enrollment, and redeterminations for enrollment.
(5) Applicable state and federal technology standards, inclusive of the alignment with Medicaid Information Technology Architecture requirements or applicable successor framework promulgated by the federal Centers for Medicare and Medicaid Services.
(6) Applicable privacy and security requirements, including, but not limited to, the protection of personal health information, as defined by applicable federal and state regulations.
(7) Rules and regulations governing the federal Health Insurance Portability and Accountability Act (HIPAA; Public Law 104-191).
(8) State and federal disability accessibility laws and standards, including Section 508 of the federal Rehabilitation Act as referenced in Section 11135 of the Government Code and the Information Organization, Usability, Currency, and Accessibility Working Group accessibility recommendations from the Office of the Chief Information Officer.
(f) Contingent on the Legislature's approval of the comprehensive plan and an appropriation for this purpose, pursuant to subdivision (e), the State Department of Health Care Services and the State Department of Social Services shall have the authority necessary to implement this part,

including the authority to enter into contract amendments, change orders, or change requests and project or system development notices as consistent with the approved plan.
(g) The State Department of Health Care Services and the State Department of Social Services may contract with another state department or agency for project management services of any statewide enrollment process developed or enhanced as a result of the comprehensive plan developed in accordance with subdivision (b).
(h) (1) The State Department of Health Care Services and the State Department of Social Services shall convene a stakeholder steering committee for consultation in the development of the statewide eligibility and enrollment determination process and comprehensive plan. As appropriate, subcommittees may be formed to facilitate work product development and outcomes. The stakeholder steering committee shall include representatives of advocacy organizations representing clients and consumers, county employees, county human services agencies, the California State Association of Counties, and legislative staff. Other representatives may be included as deemed appropriate by the State Department of Health Care Services and the State Department of Social Services. At a minimum, the stakeholder steering committee shall advise on all of the following matters:
(A) Program eligibility and enrollment simplifications without increasing program costs.
(B) Revisions to program applications and procedures for making eligibility and enrollment determinations, including notices of action and other forms processing.
(C) Development of new processes and procedures for making eligibility determinations and for enrolling eligible individuals.
(D) Beneficiary needs to ensure access to services and transition to any new system.
(E) Development of a public outreach campaign to inform people of any new system.
(F) Other issues as applicable for the development of the implementation plan and any ongoing efforts.
(2) The stakeholder steering committee shall remain in place to advise on any issues regarding the implementation of any new or revised statewide eligibility and enrollment determination process for the CalWORKs program, the Medi-Cal program, and SNAP.
(i) This part shall be implemented only if, and to the extent that, federal financial participation is available for this purpose.
(j) The State Department of Health Care Services and the State Department of Social Services may seek a federal waiver or waivers and state plan amendments to the extent necessary to implement the eligibility determination process as specified in the approved implementation plan.
(Added by Stats. 2009, 4th Ex. Sess., Ch. 7, Sec. 1. Effective October 23, 2009.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
ABX4-7	Evans	Public social services: statewide enrollment process.	Chaptered 07/28/2009	07/28/2009 - Chaptered by Secretary of State. Chapter 7, Statutes of 2009-10 Fourth Extraordinary Session.	Secretary of State- Chaptered	Yes	Majority

COMMENTS/RECOMMENDATIONS: According to the Department of Health Care Services, this workgroup and its efforts have been suspended to focus on federal health care reform. The Legislature may wish to consider suspending or modifying this requirement.

REPORT NO. 20

HEALTH AND SAFETY CODE

DIVISION 106. PERSONAL HEALTH CARE (INCLUDING MATERNAL, CHILD, AND ADOLESCENT) [123100. - 125850.]
(Division 106 added by Stats. 1995, Ch. 415, Sec. 8.)
PART 4. PRIMARY HEALTH CARE [124400. - 124945.]
(Part 4 added by Stats. 1995, Ch. 415, Sec. 8.)
CHAPTER 2. Primary Clinic Revolving Fund [124475. - 124525.]
(Chapter 2 added by Stats. 1995, Ch. 415, Sec. 8.)
ARTICLE 1. General Provisions [124475. - 124485.]
(Article 1 added by Stats. 1995, Ch. 415, Sec. 8.)

124485.

(a) The department shall prepare and transmit to the Legislature a report of the department's activities relating to the utilization of clinics to provide comprehensive health services pursuant to the following programs:
(1) Health of seasonal agricultural and migratory workers and their families program.
(2) American Indian health services program.
(3) Rural health services program.
(4) Grants-in-aid to clinic program.
(5) California health services corps program.
(b) A report shall be transmitted to the Legislature by July 1, 1992, and by July 1 of every fourth year thereafter.
(c) The report shall also include any grant funds expended and the resources allocated to the programs by the department, including staff, travel, and support services.
(d) The report shall reflect activities, resources, and expenditures by fiscal year.
(Added by Stats. 1995, Ch. 415, Sec. 8. Effective January 1, 1996.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
SB-1360	Committee on Health and Human Services	Reorganization of the Health and Safety Code: public health.	Chaptered 08/11/1995		-		

COMMENTS/RECOMMENDATIONS:

This every four-year reporting requirement began in 1992 and the last report was submitted in 2008. The Assembly Health Committee has expressed an interest in continuing to receive information about these vulnerable populations regardless of whether the Department has fulfilled its obligation in the past.

REPORT NO. 21

AB 131 (COMMITTEE ON BUDGET, CHAPTER 80, STATUTES OF 2005) SECTION 37

SEC. 37.

On an annual basis, the State Department of Health Services and the California Medical Assistance Commission shall provide fiscal information to the Joint Legislative Audit Committee and the Joint Legislative Budget Committee on the funds provided to the contract hospitals participating in the Medi-Cal program, and the health plans participating in the Medi-Cal Managed Care Program, for implementation of nurse-to-patient ratios.

COMMENTS/RECOMMENDATIONS:

The California Medical Assistance Commission was scheduled to be dissolved 6-30-12. The Legislature may wish to continue requiring the Department to report on any funds provided to hospitals and health plans for the implementation of nurse-to-patient ratios.

REPORT NO. 22

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 8.7. Adult Day Health Care Programs [14520. - 14590.]
(Heading of Chapter 8.7 renumbered from Chapter 8.5 (as added by Stats. 1977, Ch. 1066) by Stats. 1978, Ch. 429.)
ARTICLE 1. General Provisions [14520. - 14522.4.]
(Article 1 added by Stats. 1977, Ch. 1066.)

14521.1. (a)

(a) Effective January 1, 2007, the department shall report annually to the relevant policy and fiscal committees of the Legislature, as part of the budget submitted by the Governor to the Legislature each January, on the implementation of changes made to the adult day health care program by the act adding this section, including the impact of those changes on the number of centers and participants.

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
SB-1755	Chesbro	Medi-Cal: adult day health care services.	Chaptered 09/29/2006	09/29/2006 - Chaptered by Secretary of State. Chapter 691, Statutes of 2006. 09/29/2006 - Approved by Governor.	-	Yes	Majority

COMMENTS/RECOMMENDATIONS:

The Adult Day Health Care Program was eliminated in 2011 due to revenue shortfalls, however, it has been reconstituted by Court Order. There is a replacement program that is under Court supervision with reporting requirements that supersede this one.

REPORT NO. 23

HEALTH AND SAFETY CODE

DIVISION 106. PERSONAL HEALTH CARE (INCLUDING MATERNAL, CHILD, AND ADOLESCENT) [123100. - 125850.]
(Division 106 added by Stats. 1995, Ch. 415, Sec. 8.)
PART 4. PRIMARY HEALTH CARE [124400. - 124945.]
(Part 4 added by Stats. 1995, Ch. 415, Sec. 8.)
CHAPTER 4. American Indian Health Services [124575. - 124595.]
(Chapter 4 added by Stats. 1995, Ch. 415, Sec. 8.)

124590.

The Legislature finds and declares that the health status of many American Indians in California is not adequate.
It is, therefore, the intent of the Legislature to insure that in addition to funding provided pursuant to the American Indian Health Service program, sufficient funding is provided to American Indians from other programs in order to substantially improve their access to health services. These programs include, but are not limited to, the following:
(a) Rural health services.
(b) Mental health services.
(c) Developmental disability programs.
(d) Maternal and child health programs.
(e) Alcoholism programs.
(f) Programs for the aging.
(g) Environmental health programs.
The department shall report to the Legislature by July 1, 1984, and every two years thereafter, with respect to the extent to that funding for these programs is allocated to grantees receiving funding from the department pursuant to Section 124585.
(Added by Stats. 1995, Ch. 415, Sec. 8. Effective January 1, 1996.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
SB-1360	Committee on Health and Human Services	Reorganization of the Health and Safety Code: public health.	Chaptered 08/11/1995		-		

COMMENTS/RECOMMENDATIONS:

Due to revenue shortfalls, American Indian Health Service programs were de-funded in July, 2009.

REPORT NO. 24

HEALTH AND SAFETY CODE

DIVISION 106. PERSONAL HEALTH CARE (INCLUDING MATERNAL, CHILD, AND ADOLESCENT) [123100. - 125850.]
(Division 106 added by Stats. 1995, Ch. 415, Sec. 8.)
PART 4. PRIMARY HEALTH CARE [124400. - 124945.]
(Part 4 added by Stats. 1995, Ch. 415, Sec. 8.)
CHAPTER 7. Grants in Aid for Clinics [124875. - 124945.]
(Chapter 7 added by Stats. 1995, Ch. 415, Sec. 8.)
ARTICLE 2. Primary Care [124900. - 124945.]
(Article 2 added by Stats. 1995, Ch. 415, Sec. 8.)

124925.

The department shall submit a report on its activities under this article to the Legislature no later than January 1, 1991, and annually thereafter.
(Added by Stats. 1995, Ch. 415, Sec. 8. Effective January 1, 1996.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
SB-1360	Committee on Health and Human Services	Reorganization of the Health and Safety Code: public health.	Chaptered 08/11/1995		-		

COMMENTS/RECOMMENDATIONS:

According to the Department of Managed Care, Grant funds for Primary Care Clinics have not been provided in the budget for several years.

REPORT NO. 25

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)
ARTICLE 1. General Provisions [14000. - 14029.8.]
(Article 1 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)

14005.30.

(a) (1) To the extent that federal financial participation is available, Medi-Cal benefits under this chapter shall be provided to individuals eligible for services under Section 1396u-1 of Title 42 of the United States Code, including any options under Section 1396u-1(b)(2)(C) made available to and exercised by the state.
(2) The department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code to adopt less restrictive income and resource eligibility standards and methodologies to the extent necessary to allow all recipients of benefits under Chapter 2 (commencing with Section 11200) to be eligible for Medi-Cal under paragraph (1).
(3) To the extent federal financial participation is available, the department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code authorizing the state to disregard all changes in income or assets of a beneficiary until the next annual redetermination under Section 14012. The department shall implement this paragraph only if, and to the extent that the State Child Health Insurance Program waiver described in Section 12693.755 of the Insurance Code extending Healthy Families Program eligibility to parents and certain other adults is approved and implemented.
(b) To the extent that federal financial participation is available, the department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary to expand eligibility for Medi-Cal under subdivision (a) by establishing the amount of countable resources individuals or families are allowed to retain at the same amount medically needy individuals and families are allowed to retain, except that a family of one shall be allowed to retain countable resources in the amount of three thousand dollars ($3,000).
(c) To the extent federal financial participation is available, the department shall, commencing March 1, 2000, adopt an income disregard for applicants equal to the difference between the income standard under the program adopted pursuant to Section 1931(b) of the federal Social Security Act (42 U.S.C. Sec. 1396u-1) and the amount equal to 100 percent of the federal poverty level applicable to the size of the family. A recipient shall be entitled to the same disregard, but only to the extent it is more beneficial than, and is substituted for, the earned income disregard available to recipients.
(d) For purposes of calculating income under this section during any calendar year, increases in social security benefit payments under Title II of the federal Social Security Act (42 U.S.C. Sec. 401 and following) arising from cost-of-living adjustments shall be disregarded commencing in the month that these social security benefit payments are increased by the cost-of-living adjustment through the month before the month in which a change in the federal poverty level requires the department to modify the income disregard pursuant to subdivision (c) and in which new income limits for the program established by this section are adopted by the department.

(e) Subdivision (b) shall be applied retroactively to January 1, 1998.
(f) 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, without taking regulatory action, subdivisions (a) and (b) of this section by means of an all county letter or similar instruction. Thereafter, 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. Beginning six months after the effective date of this section, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.
(Amended by Stats. 2001, Ch. 171, Sec. 31. Effective August 10, 2001.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
ABX1-1	Nunez	Health care reform.	Amended Senate 01/16/2008	02/25/2008 - From Senate committee without further action pursuant to Joint Rule 62(a).	Senate-Died - Health	Yes	Majority
ABX1-2		Health care reform.	Amended Assembly 11/08/2007	11/30/2008 - From committee without further action.	Assembly-Died - Health	Yes	Majority
AB-8	Nunez	Health care.	Enrolled 09/10/2007	03/05/2008 - Last day to consider Governor's veto pursuant to Joint Rule 58.5.	Assembly-Died	Yes	Majority
AB-32	Richman, Chan, Figueroa	Health care coverage: Cal-Health Program.	Amended Senate 08/30/2001	11/30/2002 - From Senate committee without further action.	-	Yes	Majority
AB-430	Cardenas	Health: budget implementation.	Chaptered 08/10/2001	08/10/2001 - Chaptered by Secretary of State - Chapter 171, Statutes of 2001.	-		
AB-1107	Cedillo, Escutia, Figueroa, Gallegos, Johnston, Solis, Speier, Vasconcellos, Villaraigosa	Health Care.	Chaptered 07/22/1999	07/22/1999 - Chaptered by Secretary of State - Chapter 146, Statutes of 1999. 07/22/1999 - Approved by the Governor.	-		
AB-1239	Chan	Medi-Cal: self-certification of assets.	Amended Assembly 03/29/2005	01/31/2006 - From committee: Filed with the Chief Clerk pursuant to Joint Rule 56. Died pursuant to Art. IV, Sec. 10(c) of the Constitution.	-	Yes	Majority

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-1542		Welfare reform.	Chaptered 08/11/1997		-		
AB-1722	Gallegos	Medi-Cal: eligibility.	Enrolled 08/31/2000	09/28/2000 - Vetoed by Governor.	-		
AB-1806	Richman	Medi-Cal: eligibility: resources.	Amended Senate 06/24/2002	11/30/2002 - From Senate committee without further action.	-	Yes	Majority
AB-2780		Health services: Budget Act implementation.	Chaptered 08/19/1998		-		
AB-2877	Thomson	Public health programs: Budget Act implementation.	Chaptered 07/07/2000	07/07/2000 - Chaptered by Secretary of State - Chapter 93, Statutes of 2000.	-		
SB-708	Committee on Budget and Fiscal Review	Human services.	Chaptered 07/22/1999	07/22/1999 - Chaptered by Secretary of State. Chapter 148, Statutes of 1999. 07/22/1999 - Approved by Governor.	-		
SB-1414	Speier	Health care coverage.	Amended Senate 05/13/2002	11/30/2002 - From committee without further action.	-	Yes	Two Thirds
SB-1459	Yee	Health care coverage: Cal-Health Act.	Amended Senate 05/13/2008	11/30/2008 - From committee without further action.	Senate-Died - Appropriation s	Yes	Majority
SB-1567	Chesbro	Medi-Cal.	Introduced 02/20/2002	11/30/2002 - From committee without further action.	-	Yes	Majority
SB-1631	Figueroa	Cal-Health Program.	Amended Senate 04/20/2004	11/30/2004 - From committee without further action.	-	Yes	Majority
SB-1836	Peace	Medi-Cal: benefits.	Amended Senate 08/21/2002	11/30/2002 - Died on file.	-	Yes	Two Thirds

COMMENTS/RECOMMENDATIONS:
According to the Department of Health Care Services, this information is available in other forms and there is no continued stakeholder or public interest in a report on regulations. The Affordable Care Act provides new reporting requirements rendering this report obsolete.

REPORT NO. 26

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(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.)

14133.9.

The implementation of prior authorization permitted by subdivision (a) of Section 14133 shall be subject to all of the following provisions:
(a) The department shall secure a toll free phone number for the use of providers of Medi-Cal services listed in Section 14132. For providers, the department shall provide access to an individual knowledgeable in the program to provide Medi-Cal providers with information regarding available services. Access shall include a toll-free phone number that provides reasonable access to that person. The number shall be operated 24 hours a day, seven days a week.
(b) For major categories of treatment subject to prior authorization, the department shall publicize and continue to develop its list of objective medical criteria that indicate when authorization should be granted. Any request meeting these criteria, as determined by the department, shall be approved, or deferred as authorized in subdivision (e) by specific medical information.
(c) The objective medical criteria required by subdivision (d) shall be adopted and published in accordance with the Administrative Procedure Act, and shall be made available at appropriate cost.
(d) When a proposed treatment meets objective medical criteria, and is not contraindicated, authorization for the treatment shall be provided within an average of five working days. When a treatment authorization request is not subject to objective medical criteria, a decision on medical necessity shall be made by a professional medical employee or contractor of the department within an average of five working days.
(e) Notwithstanding the provisions of subdivisions (c) and (d), the department shall adopt, by emergency regulations as provided by this subdivision, a list of elective services that the director determines may be nonurgent. In determining these services, the department shall be guided by commonly accepted medical practice parameters. Authorization for these services may be deferred for a period of up to 90 days. In making determinations regarding these referrals, the department may use criteria separate from, or in addition to, those specified in subdivision (c). These deferrals shall be determined through the treatment authorization request process. When a proposed service is on the list of elective services that the director determines may be considered nonurgent, authorization for the service shall be granted or deferred within an average of 10 working days. The State Department of Health Services may adopt emergency regulations to implement this subdivision in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The initial adoption of emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace,

health and safety or general welfare. Initial emergency regulations and the first readoption of those regulations shall be exempt from review by the Office of Administrative Law. The emergency regulations authorized by this subdivision shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations and shall remain in effect for no more than 120 days.
(f) The department shall submit to the Legislature, every three months, its treatment authorization request status report.
(g) Final decisions of the department on denial of requests for prior authorization for inpatient acute hospital care shall be reviewable upon request of a provider by a Professional Standards Review Organization established pursuant to Public Law 92-603, or a successor organization if either of the following applies:
(1) The original decision on the request was not performed by a Professional Standards Review Organization, or its successor organization.
(2) The original decision on the request was performed by a Professional Standards Review Organization, or its successor organization, and the original decision was reversed by the department. The department shall contract with one or more of these organizations to, among other things, perform the review function required by this subdivision. The review performed by the contracting organization shall result in a finding that the department's decision is either appropriate or unjustified, in accordance with existing law, regulation, and medical criteria. The cost of each review shall be borne by the party that does not prevail.
The decision of this body shall be reviewable by civil action.
(h) This section, and any amendments made to Section 14103.6 by Assembly Bill 2254 of the 1985–86 Regular Legislative Session, shall not apply to treatment or services provided under contracts awarded by the department under which the contractor agrees to assume the risk of utilization or costs of services.
(Amended by Stats. 1993, Ch. 69, Sec. 56. Effective June 30, 1993.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-613	Beall	Medi-Cal: treatment authorization requests.	Amended Assembly 05/05/2009	02/02/2010 - From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.	Assembly-Died - Appropriations	Yes	Majority
AB-2795	Salinas	Medi-Cal: prior authorization.	Enrolled 08/28/2002	09/22/2002 - Vetoed by Governor.	-		

COMMENTS/RECOMMENDATIONS:

According to the Department of Health Care Services, this reporting requirement is outdated and no longer necessary. However, the Assembly Health Committee has expressed an interest in continuing to receive this information.

REPORT NO. 27

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)
ARTICLE 4.8. Perinatal Outreach, Coordination, and Expansion Services [14148.9. - 14148.98.]
(Article 4.8 added by Stats. 1991, Ch. 278, Sec. 14.)

14148.91.

(a) No later than March 15 of each year, the department shall report to the appropriate committees of the Legislature and the Governor, on a statewide and county-by-county basis, the most recent data on all of the following:
(1) The number of live births to women receiving prenatal care in the first trimester, in the second trimester, and in the third trimester, as well as an analysis of barriers to care to the extent available.
(2) The number of maternal deaths by race and ethnic group.
(3) The number of live births by county, race, and ethnic group.
(4) The number of fetal deaths of infants over 20 weeks' gestation by race and ethnic group.
(5) The number of infant deaths by county, race, and ethnic group from birth to 28 days postpartum.
(6) The number of infant deaths by county, race, and ethnic group from 29 days postpartum to one year.
(7) The number of live births under 2,500 grams and over 4,500 grams by race and ethnic group.
(8) The number of live births under 1,500 grams by race and ethnic group.
(9) The number of women eligible for prenatal, delivery, or postpartum care under Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code in the past year.
(10) The source of payment for prenatal care and delivery.
(b) No later than March 15 of each year, the department shall report to the appropriate committees of the Legislature and the Governor on a statewide basis, to the extent data are available, all of the following:
(1) The number of infants eligible for services under Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.
(2) The number of newborn babies screened or diagnosed with Fetal Alcohol Syndrome.
(3) The number of babies born with drug dependencies, HIV infection, and sexually transmitted diseases.
(4) Whether the mother smoked, consumed alcoholic beverages, or used controlled substances without a prescription, during pregnancy.
(c) (1) The department, in consultation with the Legislative Analyst, shall contract, using appropriate state administrative funds, with an appropriate entity for a one-time, statistical survey of the income of mothers, utilizing a statistically valid sample linked to the birth certificate.
(2) The State Department of Health Services shall not use more than one hundred thousand dollars ($100,000) of administrative funds for the survey required by paragraph (1).

(3) The income information required by paragraph (1) shall be categorized according to the following income categories:
(A) Persons whose family income does not exceed 150 percent of the official federal poverty line.
(B) Persons whose family income exceeds 150 percent of the official federal poverty line but does not exceed 185 percent of the official federal poverty line.
(C) Persons whose family income exceeds 185 percent of the official federal poverty line but does not exceed 200 percent of the official federal poverty line.
(D) Persons whose family income exceeds 200 percent of the official federal poverty line but does not exceed 225 percent of the official federal poverty line.
(E) Persons whose family income exceeds 225 percent of the official federal poverty line.
(F) Persons whose family income exceeds 250 percent of the official federal poverty line level but does not exceed 300 percent of the official federal poverty line.
(d) The department shall, in addition to the information required by subdivision (a), report on trends in private insurance coverage of maternity care, to the extent the data is available.
(Amended by Stats. 2004, Ch. 183, Sec. 388. Effective January 1, 2005.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-99		Health care.	Chaptered 07/30/1991		-		
AB-3082	Committee on Judiciary	Maintenance of the codes.	Chaptered 07/20/2004	07/20/2004 - Chaptered by Secretary of State - Chapter 183, Statutes of 2004.	-		

COMMENTS/RECOMMENDATIONS:

Alternative Birthing Centers never provided the necessary information to the Department of Health Care Services to complete this reporting requirement. The Legislature may wish to consider modifying this requirement to achieve the desired information.

REPORT NO. 28 and 29

WEALFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)
ARTICLE 5. Fiscal Provisions [14150. - 14164.]
(Article 5 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)

14161.

Carriers and providers of Medi-Cal benefits shall be required to utilize uniform accounting and cost-reporting systems as shall be developed and adopted by the department. If any other provision of law provides for uniform accounting and cost-reporting systems for hospitals, the department shall adopt these systems.
Carriers and providers of Medi-Cal benefits shall provide cost information to the department as is necessary in order to conduct studies to determine payment for services provided under this chapter, including but not limited to copies of any Medicare cost reports and settlements, and any Medicare audit reports.
Failure to comply with the provisions of this section shall be cause for suspension from participation under this chapter.
The department shall conduct such studies as necessary to determine payments for services provided under this chapter. The results of or progress reports concerning such studies shall be submitted to the Legislature by January 31 of each year.
The department shall submit an annual report to the Governor and the Legislature by January 31 of each year setting forth a comprehensive description of its activities and the operation and administration of the Medi-Cal program including, but not limited to, a fiscal accounting of expenditures, an evaluation of the relative cost and effectiveness of the various plans in accomplishing the desired goals, results of demonstration or pilot programs, and its recommendations as to legislation and other action as is necessary for carrying out the purposes of this chapter.
(Amended by Stats. 1995, Ch. 305, Sec. 22. Effective August 3, 1995.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-911		Health services.	Chaptered 08/03/1995		-		

COMMENTS/RECOMMENDATIONS:
Stakeholders and others have indicated that the information contained in the reports required by this code section relating to Medi-Cal is important for proper oversight and evaluation.

REPORT NO. 30

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 8. Prepaid Plans [14200. - 14499.77.]
(Chapter 8 added by Stats. 1972, Ch. 1366.)
ARTICLE 5. Standards for Prepaid Health Plans [14450. - 14464.]
(Article 5 added by Stats. 1974, Ch. 983.)

14459.7.

(a) The department shall implement a Management Information System/Decision Support System (MIS/DSS) for the Medi-Cal Program, that shall integrate data from managed care plans to monitor and evaluate the quality of care provided to beneficiaries, including access to services, establish provider rates, and analyze ways to improve both the managed care and fee-for-service systems.
(b) The department shall provide the fiscal and health policy committees of the Legislature with an annual progress and status report on the implementation of the MIS/DSS. The annual progress and status report shall include a description of the current status of the project, including a list of the specific project objectives that have and have not been met at the time of the report and a comparison of the actual progress of the project with the most recent project schedule approved by the Legislature. The report also shall include estimated expenditures and staffing for the current fiscal year and proposed expenditures and staffing for the next fiscal year as well as a summary of cumulative total project expenditures to date and a projection of future expenditures necessary to complete the project.
(c) The department shall provide system or information access to the fiscal and health policy committees of the Legislature, with the most cost-effective technology available, by the conclusion of the third phase of this multiphase project. Access shall include both the management information system and ad hoc report systems, or their equivalent, with safeguards to block access to individual patient identities. Public access shall be provided to at least the management information system summary presentation, or an equivalent, by the time of project completion.
(Added by Stats. 1997, Ch. 294, Sec. 78. Effective August 18, 1997.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
SB-391		Health.	Chaptered 08/18/1997		-		

COMMENTS/RECOMMENDATIONS:
Stakeholders and others have indicated that the information contained in the report required by this code section relating to the Management Information System/Decision Support System is important for proper oversight and evaluation. The Department is regularly complying with this requirement which provides the Legislature and public the information necessary for oversight and accountability.

REPORT NO. 31

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 4.7. HEALTH CARE FOR INDIGENTS [16900. - 16996.2.]
(Heading for Part 4.7 (added by Stats. 1989, Ch. 1331) added by Stats. 1990, Ch. 50, Sec. 10.5.)
CHAPTER 6. Children's Hospitals [16996. - 16996.2.]
(Chapter 6 added by Stats. 1989, Ch. 1331, Sec. 9.)

16996.2.

(a) As a condition of receiving funds under Section 16996.1, a hospital shall provide medically necessary inpatient treatment, including prescription drugs, for any condition detected as part of a child health and disability prevention screen for any child eligible for services under Section 104395 of the Health and Safety Code. Inpatient hospital services shall be provided at no cost upon referral by a child health and disability prevention program provider, whether that provider is a physician, a county, or a primary care clinic, unless the child is eligible to receive care with no share of cost under the Medi-Cal program, is covered under another publicly funded program, or the services are payable under private insurance coverage.
(b) The department shall report to the Legislature on the distribution and use of funds provided to hospitals under Section 16996.1 on an annual basis.
(Amended by Stats. 1996, Ch. 1023, Sec. 498. Effective September 29, 1996.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-75		Health care.	Chaptered 10/02/1989		-		
AB-1154		Health services.	Chaptered 04/18/1990		-		
SB-1412		Health care.	Chaptered 04/18/1990		-		
SB-1497	Committee on Health and Human Services	Reorganization of the Health and Safety Code: public health.	Chaptered 09/29/1996		-		

COMMENTS/RECOMMENDATIONS:

Stakeholders and others have indicated that the information contained in the reports required by this code section relating to children's health services is important for proper oversight and evaluation.

REPORT NO. 32

AB 36 (CHAPTER 1030 OF THE STATUTES 1993) SECTION 3

SEC. 3.

(a) (1) The State Department of Health Services shall convene a workgroup to address the policy issues related to the development of a pediatric service continuum. The workgroup shall seek input from clinicians and other interested and knowledgeable parties, and shall develop emergency regulations and a reimbursement structure for services to technology dependent children with special needs no later than April 1, 1994.
(2) The department shall continue the efforts of the workgroup beyond April 1, 1994, to address the policy issues related to the development of other services necessary to define and provide a pediatric service continuum that addresses the needs of other children with special health care needs. Those services, subject to the availability of federal financial participation, may include, but are not limited to, the provision of pediatric day health and respite care facility services, as defined in Section 1760.2 of the Health and Safety Code, and congregate living health facility services, as defined in subdivision (i) of Section 1250 of the Health and Safety Code.
(b) The State Department of Health Services shall report the results of the workgroup to the appropriate committees of the Legislature upon development of the regulations and reimbursement structure pursuant to subdivision (a).

COMMENTS/RECOMMENDATIONS:

According to the Department of Health Care Services, this information can be provided to the Legislature upon request. This reporting requirement is obsolete and has been superseded by statutory enactments of the workgroup recommendations.

REPORT NO. 33

AB 430 (CHAPTER 171 OF THE STATUTES OF 2001) SECTION 51

SEC. 51.

The State Department of Health Services shall provide the fiscal and policy committees of the Legislature and the local Los Angeles County 1115 Waiver Oversight Committee, upon their individual request, with copies of all reports and updates provided to the federal Centers for Medicare and Medicaid Services as contained in the Los Angeles County waiver document, including the state's monitoring plan, the annual administrative budget report, quarterly status reports, independent audits, the worker retraining plan, and the quality assurance and improvement plan.

COMMENTS/RECOMMENDATIONS:

According to the Department of Health Care Services, copies of this information can be provided to the Legislature upon request. According to the Assembly Health Committee, this is an obsolete requirement.

REPORT NO. 34

AB 430 (CHAPTER 171 OF THE STATUTES OF 2001) SECTION 54

SEC. 54.

The State Department of Health Services shall provide the fiscal and policy committees of the Legislature with a copy of the independent assessment of the state's Home and Community Based Waiver, as administered by the State Department of Health Services and the State Department of Developmental Services, upon its completion and submission to the federal Centers for Medicare and Medicaid Services and by no later than September 1, 2001.

COMMENTS/RECOMMENDATIONS:

Stakeholders and others have indicated that the information contained in the report and is required by this code section relating to the Home and Community Based Wavier program is important for proper oversight and evaluation.

REPORT NO. 35

AB 131 (COMMITTEE ON THE BUDGET, CHAPTER 80, STATUTES OF 2005) SECTION 34, UN-CODIFIED

SEC. 34.

The State Department of Health Services shall provide the fiscal and policy committees of the Legislature with quarterly updates, commencing January 1, 2006, regarding core activities to improve the Medi-Cal Managed Care Program and to expand to the 13 new counties, as directed by the Budget Act of 2005. The quarterly updates shall include key milestones and objectives of progress regarding changes to the existing program, submittal of state plan amendments to the federal Centers for Medicare and Medicaid Services, submittal of any federal waiver documents, and applicable key functions related to the Medi-Cal Managed Care expansion effort.

COMMENTS/RECOMMENDATIONS:

According to the Department of Health Care Services, the managed care expansion has been completed. The Department is regularly providing quarterly reports required by federal law.

REPORT NO. 36

SB 72 (COMMITTEE ON THE BUDGET & FISCAL REVIEW, CHAPTER 8, STATUTES OF 2011) SECTION 37

SEC. 37. Section 14132.957 is added to the Welfare and Institutions Code, to read:

WELFARE AND INSTITUTIONS CODE

14132.957.

(a) (1) It is the intent of the Legislature to adopt measures that will assist individuals who are living in the community to remain within their home environment and avoid unnecessary emergency room usage and hospital and nursing facility admissions due to those individuals not taking medications as prescribed.
(2) The Legislature finds and declares that certain seniors, persons with disabilities, and other Medi-Cal recipients are at high risk of not taking medications as prescribed and that measures to assist them in taking prescribed medications will advance the state's objectives to save lives, reduce health care costs, and assist individuals to continue living independently in their homes.
(3) The Legislature has determined that the achievement of these objectives will result in a net annual savings of one hundred forty million dollars ($140,000,000) to the General Fund, after fully offsetting costs for implementing and administrating the pilot project.
(4) The Legislature therefore authorizes the establishment of the Home and Community Based Medication Dispensing Machine Pilot Project for utilization of an automated medication dispensing machine with associated monitoring and telephonic reporting services to assist Medi-Cal recipients with taking prescribed medications. All Medi-Cal recipients who participate in the pilot project shall do so voluntarily and shall be selected using criteria that demonstrates their susceptibility to not taking their medications as prescribed without monitoring or assistance.
(b) On and after the effective date of this section, the department, in consultation with the State Department of Social Services, shall begin implementation of the pilot project described in subdivision (a) and shall do all of the following:
(1) Establish criteria to identify at-risk Medi-Cal recipients who demonstrate susceptibility to not taking medications as prescribed. These criteria shall be based on Medi-Cal, In-Home Supportive Services program and Medicare data and may include factors such as age, disability, multiple prescribed medications, and experience with or a high risk of experience with, numerous emergency department visits or hospital or nursing facility admissions within a specified time period as a result of not taking medications as prescribed.
(2) Identify an at-risk portion of Medi-Cal recipients of a sufficient number to achieve the intended savings. Recipients identified for this pilot project shall be limited to individuals who obtain Medi-Cal benefits through fee for service, who are not required to be enrolled on a mandatory basis in a Medi-Cal managed care health plan, and who are able to manage the medication dispensing machine independently or with the assistance of a family member or care provider and have a home environment capable of supporting the machine and associated telephonic reporting service that includes an active telephone line.
(3) To the extent necessary, the department shall do all of the following:

(A) Select and procure the automated medication dispensing machines, including costs for installation in a participant's home, as well as monitoring and repair services associated with operation of the machines.
(B) Provide an in-home, automated medication dispensing machine with telephonic reporting service for monitoring and assisting with taking medication, including installation, maintenance, alerts, training, and supplies at no cost to the recipient.
(4) Seek federal funding from the Centers for Medicare and Medicaid Services Innovation Center for the cost of the demonstration and other expenses, and to receive Medicare shared savings realized from the pilot project.
(5) Assess the potential for federal financial participation for these machines and any other expenses associated with this pilot project as well as receipt of federal reimbursement for savings accrued to the Medicare program. If the department determines that federal financial participation is available under Title XI or XIX of the federal Social Security Act, the department shall seek a waiver or other federal approval, or submit a Medicaid State Plan amendment to implement the pilot project.
(c) (1) The department shall provide quarterly reports, beginning October 1, 2011, to the Department of Finance and the appropriate fiscal and policy committees of the Legislature, describing the number of recipients participating in the pilot project, the number of medication dispensing machines in use, costs of implementing and administering the pilot project, and any available data regarding medical and pharmacy utilization.
(2) The department shall also conduct an evaluation of the pilot project, including effects on service utilization, spending, outcomes, projected savings to the Medi-Cal program and the federal Medicare program, recommendations for improving the pilot project and maximizing savings to the state, and identification of other means of General Fund savings related to improving quality and cost-effectiveness of care, and shall report the evaluation to the appropriate policy and fiscal committees of the Legislature by December 31, 2013.
(3) (A) If the Department of Finance determines that the quarterly reports do not demonstrate the ability of the pilot project to achieve at least the estimated net annual savings of one hundred forty million dollars ($140,000,000) to the General Fund, after fully offsetting implementation and administrative costs, the Director of Finance shall notify the Chair of the Senate Committee on Budget and Fiscal Review and the Chair of the Assembly Committee on Budget of this determination, in writing, by April 10, 2012. Within 10 days following this notification, the Department of Finance shall convene a meeting with legislative staff to review the estimates related to its determination.
(B) Subsequent to the meeting pursuant to subparagraph (A), the Department of Finance shall request that the Legislature enact legislation on or before July 1, 2012, to either modify the pilot project, if necessary, or provide alternative options to achieve the balance of the net annual savings of one hundred forty million dollars ($140,000,000) to the General Fund, after fully offsetting implementation and administrative costs, or both.
(d) (1) Notwithstanding any other provision of law, if the Department of Finance determines after July 1, 2012, that the actions pursuant to subdivisions (b) and (c) will fail to achieve the net annual savings of one hundred forty million dollars ($140,000,000) to the General Fund, after fully offsetting implementation and administrative costs, the Department of Finance shall notify the State Department of Social Services and the department, and the State Department of Social Services, in consultation with the department, shall implement a reduction in authorized hours for in-home supportive services recipients beginning October 1, 2012, in accordance with Section 12301.03, to achieve a net annual savings of one hundred forty million dollars ($140,000,000) to the General Fund, after fully offsetting implementation and administrative

costs of the pilot project and after taking into account any savings achieved pursuant to subdivisions (b) and (c).
(2) No earlier than 30 days after submission of the evaluation required by paragraph (2) of subdivision (c), the Department of Finance may adjust the amount of the reduction to meet net annual savings of one hundred forty million dollars ($140,000,000) to the General Fund after fully offsetting implementation and administrative costs and after taking into account any savings achieved pursuant to subdivisions (b) and (c). The calculations shall be based on updated data contained in the evaluation.
(e) For the purpose of implementing this section, the director may enter into exclusive or nonexclusive contracts on a bid or negotiated basis, or utilize existing provider enrollment or payment mechanisms. Any contract, contract amendment, or change order entered into for the purpose of implementing this section shall be exempt from Chapter 5.6 (commencing with Section 11545) of Part 1 of Division 3 of Title 2 of the Government Code, the Public Contract Code, and any associated policies, procedures, or regulations under these provisions, and shall be exempt from review or approval by any division of the Department of General Services and the California Technology Agency.
(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 this section through all-county letters, provider bulletins, or similar instructions, without taking regulatory action.
(g) (1) Notwithstanding paragraph (2) of subdivision (c), the department may terminate operation of the pilot project if and to the extent that any of the following events occurs:
(A) Funding to implement and administer the pilot project is not appropriated in the 2012–13 fiscal year or annually thereafter.
(B) The Director of Finance notifies the Legislature that the pilot project is not projected to achieve a net annual savings or results in an overall increased cost.
(C) The pilot project conflicts with one or more provisions of state or federal law necessary to implement the pilot project.
(D) The department is unable to obtain from the Medicare program the data necessary to implement this pilot project, and the high-risk Medi-Cal only population is insufficient to conduct the pilot project.
(E) The department receives substantiated reports of adverse clinical outcomes indicating that continuing the pilot project poses unacceptable health risks to participants.
(2) Termination of the pilot project pursuant to paragraph (1) does not provide the department or the State Department of Social Services with authority to implement a reduction in authorized hours pursuant to Section 12301.03. Any reduction in authorized hours pursuant to Section 12301.03 shall comply with the requirements of subdivision (d).
(3) The department shall notify the appropriate fiscal and policy committees of the Legislature 30 days prior to terminating the pilot project.

COMMENTS/RECOMMENDATIONS:

According to the Department of Health Care Services, the Administration has decided not to pursue this program. The Legislature may wish to require that the Department produce a report explaining how that decision was determined.

REPORT NO. 37

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)
ARTICLE 1. General Provisions [14000. - 14029.8.]
(Article 1 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)

14021.31.

(a) The department, in collaboration with the State Department of Alcohol and Drug Programs, shall develop an administrative and programmatic transition plan to guide the transfer of the Drug Medi-Cal program to the department effective July 1, 2012.
(1) Commencing no later than July 15, 2011, the department, together with the State Department of Alcohol and Drug Programs, shall convene stakeholders to receive input from consumers, family members, providers, counties, and representatives of the Legislature concerning the transfer of the administration of Drug Medi-Cal functions currently performed by the State Department of Alcohol and Drug Programs to the department. This consultation shall inform the creation of an administrative and programmatic transition plan that shall include, but is not limited to, the following components:
(A) Plans for how to review monthly billing from counties to monitor and prevent any disruptions of service to Drug Medi-Cal beneficiaries during and immediately after the transition, and a description of how the department intends to approach the longer-term development of measures for access and quality of service.
(B) A detailed description of the Drug Medi-Cal administrative functions currently performed by the State Department of Alcohol and Drug Programs.
(C) Explanations of the operational steps, timelines, and key milestones for determining when and how each of these functions will be transferred. These explanations shall also be developed for the transition of position and staff serving the Drug Medi-Cal program and how these will relate to and align with positions for the Medi-Cal program at the department. The department shall consult with the Department of Personnel Administration in developing this aspect of the transition plan.
(D) A list of any planned or proposed changes or efficiencies in how the functions will be performed, including the anticipated fiscal and programmatic impacts of the changes.
(E) A detailed organization chart that reflects the planned staffing at the department, taking into account the requirements of subparagraphs (A) to (C), inclusive, and includes focused, high-level leadership for behavioral health issues.
(F) A description of how stakeholders were included in the initial planning process to formulate the transition plan, and a description of how their feedback will be taken into consideration after transition activities are underway.
(2) The department, together with the State Department of Alcohol and Drug Programs, shall convene and consult with stakeholders at least once following production of a draft of the transition plan and before submission of that plan to the Legislature. Continued consultation with stakeholders shall occur in accordance with the requirement in subparagraph (F) of paragraph (1).

(3) The department shall provide the transition plan described in paragraph (1) to all fiscal committees and appropriate policy committees of the Legislature by October 1, 2011, and shall provide additional updates to the Legislature during budget subcommittee hearings after that date, as necessary.
(b) The requirement for submitting a report imposed under paragraph (3) of subdivision (a) is inoperative on October 1, 2015, pursuant to Section 10231.5 of the Government Code.
(Added by Stats. 2011, Ch. 32, Sec. 64. Effective June 29, 2011.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-106	Committee on Budget	Human services.	Chaptered 06/29/2011	06/28/2011 - Chaptered by Secretary of State - Chapter 32, Statutes of 2011.	Secretary of State- Chaptered	Yes	Majority

COMMENTS/RECOMMENDATIONS:

This one-time report was submitted to the Legislature.

REPORT NO. 38

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)
ARTICLE 2.7. Contracts for Medi-Cal Services and Case Management [14087.3. - 14087.48.]
(Heading of Article 2.7 amended by Stats. 1992, Ch. 722, Sec. 73.)

14087.305.

(a) In areas specified by the director for expansion of the Medi-Cal managed care program under Section 14087.3 and where the department is contracting with a prepaid health plan that is contracting with, governed, owned or operated by a county board of supervisors, a county special commission or county health authority authorized by Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.96, a Medi-Cal or California Work Opportunity and Responsibility for Kids (CalWORKs) applicant or beneficiary shall be informed of the health care options available regarding methods of receiving Medi-Cal benefits. The county shall ensure that each beneficiary is informed of these options and informed that a health care options presentation is available.
(b) The managed care options information described in subdivision (a) shall include the following elements:
(1) Each beneficiary or eligible applicant shall be provided, at a minimum, with the name, address, telephone number, and specialty, if any, of each primary care provider, by specialty, or clinic, participating in each managed care health plan option through a personalized provider directory for that beneficiary or applicant. This information shall be presented under the geographic area designations, by the name of the primary care provider and clinic and shall be updated based on information electronically provided monthly by the health care plans to the department, setting forth any changes in the health care plan's provider network. The geographic areas shall be based on the applicant's residence address, the minor applicant's school address, the applicant's work address, or any other factor deemed appropriate by the department, in consultation with health plan representatives, legislative staff, and consumer stakeholders. In addition, directories of the entire service area of the local initiative and commercial plan provider networks, including, but not limited to, the name, address, and telephone number of each primary care provider and hospital, shall be made available to beneficiaries or applicants who request them from the health care options contractor. Each personalized provider directory shall include information regarding the availability of a directory of the entire service area, provide telephone numbers for the beneficiary to request a directory of the entire service area, and include a postage-paid mail card to send for a directory of the entire service area. The personalized provider directory shall be implemented as a pilot project in Los Angeles County pursuant to this article, and in Sacramento County (Geographic Managed Care Model) pursuant to Article 2.91 (commencing with Section 14089). The content, form, and the geographic areas used in the personalized provider directories shall be determined by the department, in consultation with a workgroup to include health plan representatives, legislative staff, and consumer stakeholders, with an emphasis on the inclusion of stakeholders from Los Angeles and Sacramento Counties. The personalized provider directories may include a section for each health plan. Prior to

implementation of the pilot project, the department, in consultation with consumer stakeholders, legislative staff, and health plans, shall determine the parameters, methodology, and evaluation process of the pilot project. The pilot project shall thereafter be in effect for a minimum of two years. Three months prior to the end of the first two years of the pilot project, the department shall promptly provide the fiscal and policy committees of the Legislature with an evaluation of the personalized provider directory pilot project and its impact on the Medi-Cal managed care program, including whether the pilot project resulted in a reduction of default assignments and a more informed choice process for beneficiaries, and its overall cost-benefit to the state. Following two years of operation as a pilot project in two counties and submission of the evaluation to the Legislature, the department, in consultation with consumer stakeholders, legislative staff, and health plans, shall determine whether to implement personalized provider directories as a permanent program statewide. This determination shall be based on the outcomes set forth in the evaluation provided to the Legislature. If necessary, the pilot project shall continue beyond the initial two-year period until this determination is made. This pilot project shall only be implemented to the extent that it is budget neutral to the department.
(2) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in a managed care option, if his or her treating provider is a primary care provider or clinic contracting with any of the prepaid health plan options available and has available capacity and agrees to continue to treat that beneficiary or applicant.
(3) Each beneficiary or eligible applicant shall be informed that if he or she fails to make a choice, he or she shall be assigned to, and enrolled in, a prepaid health plan.
(c) No later than 30 days following the date a Medi-Cal or CalWORKs beneficiary or applicant is determined eligible for Medi-Cal, the beneficiary shall indicate his or her choice, in writing, from among the available prepaid health plans in the region and his or her choice of primary care provider or clinic contracting with the selected prepaid health plan. Notwithstanding the 30-day deadline set forth in this subdivision, if a beneficiary requests a directory for the entire service area within 30 days of receiving an enrollment form, the deadline for choosing a plan shall be extended an additional 30 days from the date of the request.
(d) At the time the beneficiary or eligible applicant selects a prepaid health plan, the department shall, when applicable, encourage the beneficiary or eligible applicant to also indicate, in writing, his or her choice of primary care provider or clinic contracting with the selected prepaid health plan.
(e) In areas specified by the director for expansion of the Medi-Cal managed care program under Section 14087.3, and where the department is contracting with a prepaid health plan that is contracting with, governed, owned or operated by a county board of supervisors, a county special commission or county health authority authorized by Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.96, a Medi-Cal or CalWORKs beneficiary who does not make a choice of managed care plans, shall be assigned to and enrolled in an appropriate Medi-Cal prepaid health plan providing service within the area in which the beneficiary resides.
(f) If a beneficiary or eligible applicant does not choose a primary care provider or clinic, or does not select any primary care provider who is available, the prepaid health plan that was selected by or assigned to the beneficiary shall ensure that the beneficiary selects a primary care provider or clinic within 30 days after enrollment or is assigned to a primary care provider within 40 days after enrollment.
(g) Any Medi-Cal or CalWORKs beneficiary dissatisfied with the primary care provider or prepaid health plan shall be allowed to select or be assigned to another primary care provider within the same prepaid health plan. In addition, the beneficiary shall be allowed to select or be

assigned to another prepaid health plan contracted for pursuant to this article that is in effect for the geographic area in which he or she resides, in accordance with Section 1903(m)(2)(F)(ii) of the Social Security Act.
(h) The department or its contractor shall notify a prepaid health plan when it has been selected by or assigned to a beneficiary. The prepaid health plan that has been selected by or assigned to a beneficiary shall notify the primary care provider that has been selected or assigned. The prepaid health plan shall also notify the beneficiary of the prepaid health plan and primary care provider or clinic selected or assigned.
(i) (1) The managed health care plan shall have a valid Medi-Cal contract, adequate capacity, and appropriate staffing to provide health care services to the beneficiary.
(2) The department shall establish standards for all of the following:
(A) The maximum distances a beneficiary is required to travel to obtain primary care services from the managed care plan, in which the beneficiary is enrolled.
(B) The conditions under which a primary care service site shall be accessible by public transportation.
(C) The conditions under which a managed care plan shall provide nonmedical transportation to a primary care service site.
(3) In developing the standards required by paragraph (2) the department shall take into account, on a geographic basis, the means of transportation used and distances typically traveled by Medi-Cal beneficiaries to obtain fee-for-service primary care services and the experience of managed care plans in delivering services to Medi-Cal enrollees. The department shall also consider the provider's ability to render culturally and linguistically appropriate services.
(j) To the extent possible, the arrangements for carrying out subdivision (e) shall provide for the equitable distribution of Medi-Cal beneficiaries among participating prepaid health plans, or managed care plans.
(k) This section shall be implemented in a manner consistent with any federal waiver required to be obtained by the department in order to implement this section.
(Amended by Stats. 2007, Ch. 188, Sec. 52. Effective August 24, 2007.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-203	Committee on Budget	Health.	Chaptered 08/24/2007	08/24/2007 - Chaptered by Secretary of State - Chapter 188, Statutes of 2007.	Secretary of State-Chaptered	Yes	Two Thirds
AB-3483		Health.	Chaptered 07/22/1996		-		
SB-83	Committee on Budget and Fiscal Review	Health.	Amended Assembly 07/20/2007	11/30/2008 - Died on file.	Legislature-Died	Yes	Two Thirds
SB-835		Medi-Cal: health care providers.	Chaptered 10/13/1995		-		
SB-2093		Medi-Cal: managed care.	Chaptered 08/13/1998		-		

COMMENTS/RECOMMENDATIONS:

This one-time report was submitted to the Legislature.

REPORT NO. 39

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)
ARTICLE 2.91. Geographic Managed Care Pilot Project [14089. - 14089.8.]
(Heading of Article 2.91 amended by Stats. 1991, Ch. 95, Sec. 7.)

14089.

(a) The purpose of this article is to provide a comprehensive program of managed health care plan services to Medi-Cal recipients residing in clearly defined geographical areas. It is, further, the purpose of this article to create maximum accessibility to health care services by permitting Medi-Cal recipients the option of choosing from among two or more managed health care plans or fee-for-service managed case arrangements, including, but not limited to, health maintenance organizations, prepaid health plans, and primary care case management plans. Independent practice associations, health insurance carriers, private foundations, and university medical centers systems, not-for-profit clinics, and other primary care providers, may be offered as choices to Medi-Cal recipients under this article if they are organized and operated as managed care plans, for the provision of preventive managed health care plan services.
(b) The department may seek proposals and then shall enter into contracts based on relative costs, extent of coverage offered, quality of health services to be provided, financial stability of the health care plan or carrier, recipient access to services, cost-containment strategies, peer and community participation in quality control, emphasis on preventive and managed health care services and the ability of the health plan to meet all requirements for both of the following:
(1) Certification, where legally required, by the Director of the Department of Managed Health Care and the Insurance Commissioner.
(2) Compliance with all of the following:
(A) The health plan shall satisfy all applicable state and federal legal requirements for participation as a Medi-Cal managed care contractor.
(B) The health plan shall meet any standards established by the department for the implementation of this article.
(C) The health plan receives the approval of the department to participate in the pilot project under this article.
(c) (1) (A) The proposals shall be for the provision of preventive and managed health care services to specified eligible populations on a capitated, prepaid, or postpayment basis.
(B) Enrollment in a Medi-Cal managed health care plan under this article shall be voluntary for beneficiaries eligible for the federal Supplemental Security Income for the Aged, Blind, and Disabled Program (Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code).
(2) The cost of each program established under this section shall not exceed the total amount that the department estimates it would pay for all services and requirements within the same geographic area under the fee-for-service Medi-Cal program.
(d) (1) An eligible beneficiary shall be entitled to enroll in any health care plan contracted for pursuant to this article that is in effect for the geographic area in which he or she resides. The

department shall make available to recipients information summarizing the benefits and limitations of each health care plan available pursuant to this section in the geographic area in which the recipient resides. A Medi-Cal or CalWORKs applicant or beneficiary shall be informed of the health care options available regarding methods of receiving Medi-Cal benefits. The county shall ensure that each beneficiary is informed of these options and informed that a health care options presentation is available.
(2) No later than 30 days following the date a Medi-Cal or CalWORKs recipient is informed of the health care options described in paragraph (1), the recipient shall indicate his or her choice, in writing, of one of the available health care plans and his or her choice of primary care provider or clinic contracting with the selected health care plan. Notwithstanding the 30-day deadline set forth in this paragraph, if a beneficiary requests a directory for the entire service area within 30 days of the date of receiving an enrollment form, the deadline for choosing a plan shall be extended an additional 30 days from the date of that request.
(3) The health care options information described in this subdivision shall include the following elements:
(A) Each beneficiary or eligible applicant shall be provided, at a minimum, with the name, address, telephone number, and specialty, if any, of each primary care provider, by specialty or clinic participating in each managed health care plan option through a personalized provider directory for that beneficiary or applicant. This information shall be presented under the geographic area designations by the name of the primary care provider and clinic, and shall be updated based on information electronically provided monthly by the health care plans to the department, setting forth changes in the health care plan provider network. The geographic areas shall be based on the applicant's residence address, the minor applicant's school address, the applicant's work address, or any other factor deemed appropriate by the department, in consultation with health plan representatives, legislative staff, and consumer stakeholders. In addition, directories of the entire service area, including, but not limited to, the name, address, and telephone number of each primary care provider and hospital, of all Geographic Managed Care health plan provider networks shall be made available to beneficiaries or applicants who request them from the health care options contractor. Each personalized provider directory shall include information regarding the availability of a directory of the entire service area, provide telephone numbers for the beneficiary to request a directory of the entire service area, and include a postage-paid mail card to send for a directory of the entire service area. The personalized provider directory shall be implemented as a pilot project in Sacramento County pursuant to this article, and in Los Angeles County (Two-Plan Model) pursuant to Article 2.7 (commencing with Section 14087.305). The content, form, and geographic areas used shall be determined by the department in consultation with a workgroup to include health plan representatives, legislative staff, and consumer stakeholders, with an emphasis on the inclusion of stakeholders from Los Angeles and Sacramento Counties. The personalized provider directories may include a section for each health plan. Prior to implementation of the pilot project, the department, in consultation with consumer stakeholders, legislative staff, and health plans, shall determine the parameters, methodology, and evaluation process of the pilot project. The pilot project shall thereafter be in effect for a minimum of two years. Three months prior to the end of the first two years of the pilot project, the department shall promptly provide the fiscal and policy committees of the Legislature with an evaluation of the personalized provider directory pilot project and its impact on the Medi-Cal managed care program, including whether the pilot project resulted in a reduction of default assignments and a more informed choice process for beneficiaries, and its overall cost-benefit to the state. Following two years of operation as a pilot project in two counties and submission of the evaluation to the Legislature,

the department, in consultation with consumer stakeholders, legislative staff, and health plans, shall determine whether to implement personalized provider directories as a permanent program statewide. This determination shall be based on the outcomes set forth in the evaluation provided to the Legislature. If necessary, the pilot project shall continue beyond the initial two-year period until this determination is made. This pilot project shall only be implemented to the extent that it is budget neutral to the department.
(B) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in a managed care option, if his or her treating provider is a primary care provider or clinic contracting with any of the health plans available and has the available capacity and agrees to continue to treat that beneficiary or eligible applicant.
(C) Each beneficiary or eligible applicant shall be informed that if he or she fails to make a choice, he or she shall be assigned to, and enrolled in, a health care plan.
(4) At the time the beneficiary or eligible applicant selects a health care plan, the department shall, when applicable, encourage the beneficiary or eligible applicant to also indicate, in writing, his or her choice of primary care provider or clinic contracting with the selected health care plan.
(5) Commencing with the implementation of a geographic managed care project in a designated county, a Medi-Cal or CalWORKs beneficiary who does not make a choice of health care plans in accordance with paragraph (2), shall be assigned to and enrolled in an appropriate health care plan providing service within the area in which the beneficiary resides.
(6) If a beneficiary or eligible applicant does not choose a primary care provider or clinic, or does not select a primary care provider who is available, the health care plan selected by or assigned to the beneficiary shall ensure that the beneficiary selects a primary care provider or clinic within 30 days after enrollment or is assigned to a primary care provider within 40 days after enrollment.
(7) A Medi-Cal or CalWORKs beneficiary dissatisfied with the primary care provider or health care plan shall be allowed to select or be assigned to another primary care provider within the same health care plan. In addition, the beneficiary shall be allowed to select or be assigned to another health care plan contracted for pursuant to this article that is in effect for the geographic area in which he or she resides in accordance with Section 1903(m)(2)(F)(ii) of the Social Security Act.
(8) The department or its contractor shall notify a health care plan when it has been selected by or assigned to a beneficiary. The health care plan that has been selected or assigned by a beneficiary shall notify the primary care provider that has been selected or assigned. The health care plan shall also notify the beneficiary of the health care plan and primary care provider selected or assigned.
(9) This section shall be implemented in a manner consistent with any federal waiver that is required to be obtained by the department to implement this section.
(e) A participating county may include within the plan or plans providing coverage pursuant to this section, employees of county government, and others who reside in the geographic area and who depend upon county funds for all or part of their health care costs.
(f) Funds may be provided to prospective contractors to assist in the design, development, and installation of appropriate programs. The award of these funds shall be based on criteria established by the department.
(g) In implementing this article, the department may enter into contracts for the provision of essential administrative and other services. Contracts entered into under this subdivision may be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(h) Notwithstanding any other provision of law, on and after the effective date of the act adding this subdivision, the department shall have exclusive authority to set the rates, terms, and conditions of geographic managed care contracts and contract amendments under this article. As of that date, all references to this article to the negotiator or to the California Medical Assistance Commission shall be deemed to mean the department.
(i) Notwithstanding subdivision (q) of Section 6254 of the Government Code, a contract or contract amendments executed by both parties after the effective date of the act adding this subdivision shall be considered a public record for purposes of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) and shall be disclosed upon request. This subdivision includes contracts that reveal the department's rates of payment for health care services, the rates themselves, and rate manuals.
(Amended by Stats. 2010, Ch. 717, Sec. 144. Effective October 19, 2010.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-78	Gallegos	Health care coverage: Department of Managed Health Care.	Chaptered 09/28/1999	09/28/1999 - Chaptered by Secretary of State - Chapter 525, Statutes of 1999.	-		
AB-203	Committee on Budget	Health.	Chaptered 08/24/2007	08/24/2007 - Chaptered by Secretary of State - Chapter 188, Statutes of 2007.	Secretary of State- Chaptered	Yes	Two Thirds
AB-336		Health care.	Chaptered 06/30/1991		-		
AB-426		Medi-Cal: managed care.	Chaptered 09/30/1998		-		
AB-469	Papan	Medi-Cal: managed care plans.	Enrolled 09/09/1999	03/02/2000 - Last day to consider Governor's veto pursuant to Joint Rule 58.5.	-		
AB-1613	Committee on Budget	Health.	Amended Senate 10/06/2010	10/08/2010 - Read third time. Urgency clause refused adoption. (Ayes 26. Noes 7. Page 5256.)	Senate-In Floor Process	Yes	Two Thirds
AB-2729		Medi-Cal: managed care provider payment rates.	Chaptered 09/25/1998		-		
AB-2903	Committee on Health	Health care coverage: telephone medical advice services.	Chaptered 09/29/2000	09/29/2000 - Chaptered by Secretary of State - Chapter 857, Statutes of 2000.	-		
SB-83	Committee on Budget and Fiscal Review	Health.	Amended Assembly 07/20/2007	11/30/2008 - Died on file.	Legislature- Died	Yes	Two Thirds
SB-420	Figueroa	Managed care.	Amended Senate 04/14/1999	02/01/2000 - Returned to Secretary of	-	Yes	Majority

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
				Senate pursuant to Joint Rule 56.			
SB-485		Human services.	Chaptered 09/15/1992		-		
SB-835		Medi-Cal: health care providers.	Chaptered 10/13/1995		-		
SB-853	Committee on Budget and Fiscal Review	Health.	Chaptered 10/19/2010	10/19/2010 - Chaptered by Secretary of State. Chapter 717, Statutes of 2010.	Secretary of State- Chaptered	Yes	Two Thirds
SB-856	Brulte	Medi-Cal: reimbursement: dental services.	Enrolled 09/10/1999	01/10/2000 - Stricken from Senate file. Veto sustained.	-		
SB-2093		Medi-Cal: managed care.	Chaptered 08/13/1998		-		

COMMENTS/RECOMMNEDATIONS:

This one-time report was submitted to the Legislature.

REPORT NO. 40

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)
ARTICLE 2.91. Geographic Managed Care Pilot Project [14089. - 14089.8.]
(Heading of Article 2.91 amended by Stats. 1991, Ch. 95, Sec. 7.)

14089.05.

(a) (1) The department may implement a multiplan project in the County of San Diego, upon approval of the Board of Supervisors of the County of San Diego, for the provision of benefits under this chapter to eligible Medi-Cal recipients. The multiplan project implemented in San Diego County pursuant to this section shall provide diagnostic, therapeutic, and preventive services provided under the Medi-Cal program, and additional benefits including, but not limited to, medical-related transportation, comprehensive patient management, and referral to other support services.
(2) The County of San Diego shall be eligible to receive funds transferred pursuant to paragraph (1) of subdivision (p) of Section 14163 for the development and implementation of this section. These funds in the amount allocated by the department for the County of San Diego shall be paid by the department upon the enactment of this section to the County of San Diego to reimburse a portion of the costs of the development of the project. To the full extent permitted by state and federal law, these funds shall be distributed by the department for expenditure by the County of San Diego in a manner that qualifies for federal financial participation under the Medicaid Program and the department shall expedite the payment of the federal funds to the County of San Diego. The department shall seek additional state, federal, and other funds to pay for costs that are incurred by the County of San Diego to develop the multiplan project in excess of the payment required by this section, and the department shall assist the county in obtaining the additional funds.
(b) (1) The County of San Diego may establish two advisory boards, one of which shall be composed of consumer representatives and the other of which shall be composed of health care professional's representatives. Each board shall advise the Department of Health Services of the County of San Diego and review and comment on all aspects of the implementation of the multiplan project. At least one of the members of each advisory board shall be appointed by the board of supervisors. The board of supervisors shall establish a number of members to serve on each advisory board, with each supervisor to appoint an equal number of members from his or her district. Each advisory board shall vote on all pilot project policies and issues that are submitted to the board of supervisors.
(2) Notwithstanding any other provision of law, a member of an advisory board established pursuant to this section shall not be deemed to be interested in a contract entered into by the department within the meaning of Article 4 (commencing with Section 1090) of Chapter 1 of Division 4 of Title 1 of the Government Code if the member is a Medi-Cal recipient or if all of the following apply:
(A) The member was appointed to represent the interests of physicians, health care practitioners, hospitals, pharmacies, or other health care organizations.

(B) The contract authorizes the member or the organization the member represents to provide Medi-Cal services under the multiplan project.
(C) The contract contains substantially the same terms and conditions as contracts entered into with other individuals or organizations the member was appointed to represent.
(D) The member does not influence or attempt to influence the joint advisory board or another member of the joint advisory board to recommend that the department enter into the contract in which the member is interested.
(E) The member discloses the interest to the joint advisory board and abstains from voting on any recommendation on the contract.
(F) The advisory board notes the member's disclosure and abstention in its official records.
(3) Members of the advisory boards shall not be paid compensation for activities relating to their duties as members, but members who are Medi-Cal recipients shall be reimbursed an appropriate amount by the County of San Diego for travel and child care expenses incurred in performing their duties under this section.
(c) At the discretion of the department, the County of San Diego, the department, or other appropriate entities may perform any of the following in a manner that accomplishes the integration of the intake of eligible beneficiaries to the project, the assessment of beneficiary individual and family needs and circumstances, and the timely referral of beneficiaries to health care and other services to respond to their individual and family needs:
(1) Determine the eligibility of Medi-Cal applicants and recipients in a manner and environment that is accessible to the recipients and applicants.
(2) Perform enrollment activities in a manner that ensures that recipients be given the opportunity to select the provider of their choice in a manner and environment that is accessible to the recipients.
(3) The department may negotiate and amend its contract with the county to provide for specified quality improvement activities, and may require each of the health plans to participate in those activities. The department shall also participate in the county's quality improvement activities.
(d) Notwithstanding Section 14089 or any other provision of law, the County of San Diego, when contracting with the department pursuant to this section or subdivision (d), (i), or (j) of Section 14089, shall not be liable for damages for injury to persons or property arising out of the actions or inactions of the department, the department's other contractors, or providers of health care or other services, or Medi-Cal recipients. This section shall not relieve the County of San Diego from liability arising out of its actions or inactions.
(e) The County of San Diego, when contracting with the department pursuant to Section 14089 or this section, shall have no legal duty to provide health care or other services to Medi-Cal recipients, and shall have no financial responsibility for the department's other contractors or providers of health care or other services, except to the extent specifically set forth in contracts between the department and the county.
(f) Notwithstanding Section 14089.6, the department may terminate any existing managed care contract with either a prepaid health plan or a primary care case management plan for services in the County of San Diego in accordance with the terms and conditions set forth in the existing contract, at any time that the department determines that termination is in the best interest of the state. The department shall notify an existing prepaid health plan at least 90 days prior to termination. The department shall notify a primary care case management plan at least 30 days prior to termination.
(g) All contracts entered into by the department and the County of San Diego pursuant to Section 14089 or this section shall not be for the benefit of any third party, and no third-party beneficiary

relationship shall be established between the county and any other party, except as may be specifically set forth in contracts between the department and the County of San Diego.
(h) The department shall report to the appropriate committees of the Legislature on the project implemented pursuant to this section.
(i) (1) For purposes of this section, "multiplan project" means a program authorized by this section in which a number of Knox-Keene licensed health plans designated by the county and approved by the department shall be the only Medi-Cal managed care health plans authorized to operate within San Diego County, with the exception of special projects approved by the department.
(2) Designated health plans shall include, but not be limited to, health plans sponsored by traditional Medi-Cal physicians, neighborhood health centers, community clinics, health systems, including hospitals and other providers, or a combination thereof.
(3) Participating health plans shall first be designated by the county for approval by the department. Health plans approved by the department shall be eligible to contract with the department. Designation by the county and approval by the department provides the health plan only with the opportunity to compete for a contract and does not guarantee a contract with the state.
(4) Designation requirements imposed by the county shall not conflict with the requirements imposed by the department, the federal Medicaid Program, and the Medi-Cal program, and may not impose stricter requirements, without the department's approval, than those imposed by the department, the federal Medicaid Program, and the Medi-Cal program.
(5) Designation of health plans by the county will continue for the term of the Medi-Cal contract.
(j) Nothing in this section relieves the county of duties or liabilities imposed by Part 5 (commencing with Section 17000) or which it has assumed through contract with entities other than the department.
(k) Indian health facilities in San Diego County may contract directly with the department as Medi-Cal fee-for-service case management providers apart from the geographic managed care program or may participate in the network of one or more of the geographic managed care plans. Indian health service facilities that contract with the department as fee-for-service case management providers may enroll Medi-Cal recipients, including, but not limited to, recipients who are in any of the geographic managed care mandatory enrollment aid codes.
(Amended by Stats. 2010, Ch. 717, Sec. 145. Effective October 19, 2010.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-1613	Committee on Budget	Health.	Amended Senate 10/06/2010	10/08/2010 - Read third time. Urgency clause refused adoption. (Ayes 26. Noes 7. Page 5256.)	Senate-In Floor Process	Yes	Two Thirds
AB-2178		Medi-Cal.	Chaptered 09/20/1994		-		
SB-853	Committee on Budget and Fiscal Review	Health.	Chaptered 10/19/2010	10/19/2010 - Chaptered by Secretary of State. Chapter 717, Statutes of 2010.	Secretary of State-Chaptered	Yes	Two Thirds
SB-2139		Medi-Cal: San Diego County project.	Chaptered 09/23/1996		-		

COMMENTS/RECOMMENDATIONS:
This one-time report was submitted to the Legislature.

REPORT NO. 41

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)
ARTICLE 2.93. Payments to Hospitals [14091.3. - 14091.3.]
(Article 2.93 added by Stats. 2008, Ch. 758, Sec. 42.)

14091.3.

(a) For purposes of this section, the following definitions shall apply:
(1) "Medi-Cal managed care plan contracts" means those contracts entered into with the department by any individual, organization, or entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), or Article 2.91 (commencing with Section 14089) of this chapter, or Article 1 (commencing with Section 14200) or Article 7 (commencing with Section 14490) of Chapter 8, or Chapter 8.75 (commencing with Section 14591).
(2) "Medi-Cal managed care health plan" means an individual, organization, or entity operating under a Medi-Cal managed care plan contract with the department under this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591).
(b) The department shall take all appropriate steps to amend the Medicaid State Plan, if necessary, to carry out this section. This section shall be implemented only to the extent that federal financial participation is available.
(c) (1) Any hospital that does not have in effect a contract with a Medi-Cal managed care health plan, as defined in paragraph (2) of subdivision (a), that establishes payment amounts for services furnished to a beneficiary enrolled in that plan shall accept as payment in full, from all these plans, the following amounts:
(A) For outpatient services, the Medi-Cal fee-for-service (FFS) payment amounts.
(B) For emergency inpatient services, the average per diem contract rate specified in paragraph (2) of subdivision (b) of Section 14166.245, except that the payment amount shall not be reduced by 5 percent, until July 1, 2013, and thereafter, the average contract rate specified in Section 1396u-2(b)(2) of Title 42 of the United States Code. For the purposes of this subparagraph, this payment amount shall apply to all hospitals, including hospitals that contract with the department under the Medi-Cal Selective Provider Contracting Program described in Article 2.6 (commencing with Section 14081), and small and rural hospitals specified in Section 124840 of the Health and Safety Code.
(C) For poststabilization services following an emergency admission, payment amounts shall be consistent with Section 438.114(e) of Title 42 of the Code of Federal Regulations. This paragraph shall only be implemented to the extent that contract amendment language providing for these payments is approved by CMS. For purposes of this subparagraph, this payment amount shall apply to all hospitals, including hospitals that contract with the department under the Medi-Cal Selective Provider Contracting Program pursuant to Article 2.6 (commencing with Section 14081).

(2) The rates established in paragraph (1) for emergency inpatient services and poststabilization services shall remain in effect only until the department implements the payment methodology based on diagnosis-related groups pursuant to Section 14105.28.
(3) Upon implementation of the payment methodology based on diagnosis-related groups pursuant to Section 14105.28, any hospital described in paragraph (1) shall accept as payment in full for inpatient hospital services, including both emergency inpatient services and poststabilization services related to an emergency medical condition, the payment amount established pursuant to the methodology developed under Section 14105.28.
(d) Medi-Cal managed care health plans that, pursuant to the department's encouragement in All Plan Letter 07003, have been paying out-of-network hospitals the most recent California Medical Assistance Commission regional average per diem rate as a temporary rate for purposes of Section 1932(b)(2)(D) of the federal Social Security Act (SSA), which became effective January 1, 2007, shall make reconciliations and adjustments for all hospital payments made since January 1, 2007, based upon rates published by the department pursuant to Section 1932(b)(2)(D) of the SSA and effective January 1, 2007, to June 30, 2008, inclusive, and, if applicable, provide supplemental payments to hospitals as necessary to make payments that conform with Section 1932(b)(2)(D) of the SSA. In order to provide managed care health plans with 60 working days to make any necessary supplemental payments to hospitals prior to these payments becoming subject to the payment of interest, Section 1300.71 of Title 28 of the California Code of Regulations shall not apply to these supplemental payments until 30 working days following the publication by the department of the rates.
(e) (1) The department shall provide a written report to the policy and fiscal committees of the Legislature on October 1, 2009, and May 1, 2010, on the implementation and impact made by this section, including the impact of these changes on access to hospitals by managed care enrollees and on contracting between hospitals and managed care health plans, including the increase or decrease in the number of these contracts.
(2) Not later than August 1, 2010, the department shall report to the Legislature on the implementation of this section. The report shall include, but not be limited to, information and analyses addressing managed care enrollee access to hospital services, the impact of this section on managed care health plan capitation rates, the impact of this section on the extent of contracting between managed care health plans and hospitals, and fiscal impact on the state.
(3) For the purposes of preparing the status reports and the final evaluation report required pursuant to this subdivision, Medi-Cal managed care health plans shall provide the department with all data and documentation, including contracts with providers, including hospitals, as deemed necessary by the department to evaluate the impact of the implementation of this section. In order to ensure the confidentiality of managed care health plan proprietary information, and thereby enable the department to have access to all of the data necessary to provide the Legislature with accurate and meaningful information regarding the impact of this section, all information and documentation provided to the department pursuant to this section shall be considered proprietary and shall be exempt from disclosure as official information pursuant to subdivision (k) of Section 6254 of the Government Code as contained in the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).
(f) 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, interpret, or make specific this section and 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. Prior to issuing any letter or

similar instrument authorized pursuant to this section, the department shall notify and consult with stakeholders, including advocates, providers, and beneficiaries.
(g) This section shall become inoperative on July 1, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.
(Amended by Stats. 2012, Ch. 23, Sec. 81. Effective June 27, 2012. Inoperative July 1, 2013. Repealed as of January 1, 2014, by its own provisions.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-97	Committee on Budget	Health care services.	Chaptered 03/24/2011	03/24/2011 - Chaptered by Secretary of State - Chapter 3, Statutes of 2011.	Secretary of State-Chaptered	Yes	Two Thirds
AB-574	Bonnie Lowenthal	Program of All-Inclusive Care for the Elderly.	Chaptered 09/30/2011	09/30/2011 - Chaptered by Secretary of State - Chapter 367, Statutes of 2011.	Secretary of State-Chaptered	Yes	Majority
AB-1164	Tran	Maintenance of the codes.	Chaptered 08/06/2009	08/06/2009 - Chaptered by Secretary of State - Chapter 140, Statutes of 2009.	Secretary of State-Chaptered	No	Majority
AB-1183	Committee on Budget	Health.	Chaptered 09/30/2008	09/30/2008 - Chaptered by Secretary of State - Chapter 758, Statutes of 2008.	Secretary of State-Chaptered	Yes	Two Thirds
AB-1467	Committee on Budget	Health.	Chaptered 06/27/2012	06/27/2012 - Chaptered by Secretary of State - Chapter 23, Statutes of 2012.	Secretary of State-Chaptered	Yes	Majority
AB-1613	Committee on Budget	Health.	Amended Senate 10/06/2010	10/08/2010 - Read third time. Urgency clause refused adoption. (Ayes 26. Noes 7. Page 5256.)	Senate-In Floor Process	Yes	Two Thirds
SB-853	Committee on Budget and Fiscal Review	Health.	Chaptered 10/19/2010	10/19/2010 - Chaptered by Secretary of State. Chapter 717, Statutes of 2010.	Secretary of State-Chaptered	Yes	Two Thirds
SB-1007	Committee on Budget and Fiscal Review	Health.	Amended Assembly 06/13/2012	06/14/2012 - Withdrawn from committee. (Ayes 47. Noes 25. Page 5301.) 06/14/2012 - Ordered to second reading.	Assembly-In Floor Process	Yes	Majority

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
				06/14/2012 - Read second time. Ordered to third reading.			
SB-1077	Committee on Budget and Fiscal Review	Health.	Amended Assembly 09/15/2008	11/30/2008 - From Assembly without further action.	Assembly-Died	Yes	Two Thirds

COMMENTS/RECOMMENDATIONS:

The required reports were submitted to the Legislature.

REPORT NO. 42

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(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.)

14132.

The following is the schedule of benefits under this chapter:
(a) Outpatient services are covered as follows:
Physician, hospital or clinic outpatient, surgical center, respiratory care, optometric, chiropractic, psychology, podiatric, occupational therapy, physical therapy, speech therapy, audiology, acupuncture to the extent federal matching funds are provided for acupuncture, and services of persons rendering treatment by prayer or healing by spiritual means in the practice of any church or religious denomination insofar as these can be encompassed by federal participation under an approved plan, subject to utilization controls.
(b) Inpatient hospital services, including, but not limited to, physician and podiatric services, physical therapy and occupational therapy, are covered subject to utilization controls.
(c) Nursing facility services, subacute care services, and services provided by any category of intermediate care facility for the developmentally disabled, including podiatry, physician, nurse practitioner services, and prescribed drugs, as described in subdivision (d), are covered subject to utilization controls. Respiratory care, physical therapy, occupational therapy, speech therapy, and audiology services for patients in nursing facilities and any category of intermediate care facility for the developmentally disabled are covered subject to utilization controls.
(d) (1) Purchase of prescribed drugs is covered subject to the Medi-Cal List of Contract Drugs and utilization controls.
(2) Purchase of drugs used to treat erectile dysfunction or any off-label uses of those drugs are covered only to the extent that federal financial participation is available.
(3) (A) To the extent required by federal law, the purchase of outpatient prescribed drugs, for which the prescription is executed by a prescriber in written, nonelectronic form on or after April 1, 2008, is covered only when executed on a tamper resistant prescription form. The implementation of this paragraph shall conform to the guidance issued by the federal Centers of Medicare and Medicaid Services but shall not conflict with state statutes on the characteristics of tamper resistant prescriptions for controlled substances, including Section 11162.1 of the Health and Safety Code. The department shall provide providers and beneficiaries with as much flexibility in implementing these rules as allowed by the federal government. The department shall notify and consult with appropriate stakeholders in implementing, interpreting, or making specific this paragraph.
(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instructions without taking regulatory action.

(4) (A) (i) For the purposes of this paragraph, nonlegend has the same meaning as defined in subdivision (a) of Section 14105.45.
(ii) Nonlegend acetaminophen-containing products, with the exception of children's acetaminophen-containing products, selected by the department are not covered benefits.
(iii) Nonlegend cough and cold products selected by the department are not covered benefits. This clause shall be implemented on the first day of the first calendar month following 90 days after the effective date of the act that added this clause, or on the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later.
(iv) Beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment Program shall be exempt from clauses (ii) and (iii).
(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instruction without taking regulatory action.
(e) Outpatient dialysis services and home hemodialysis services, including physician services, medical supplies, drugs and equipment required for dialysis, are covered, subject to utilization controls.
(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetist services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and X-ray services are covered, subject to utilization controls. Nothing in this subdivision shall be construed to require prior authorization for anesthesiologist services provided as part of an outpatient medical procedure or for portable X-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.
(g) Blood and blood derivatives are covered.
(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses which are lost or destroyed due to circumstances beyond the beneficiary's control. Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions that preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children Services Program.
(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:
(A) Periodontal treatment is not a benefit.
(B) Endodontic therapy is not a benefit except for vital pulpotomy.
(C) Laboratory processed crowns are not a benefit.
(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.
(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.
(F) Notwithstanding the conditions specified in subparagraphs (A) to (E), inclusive, the department may approve services for persons with special medical disorders subject to utilization review.
(3) Paragraph (2) shall become inoperative July 1, 1995.

(i) Medical transportation is covered, subject to utilization controls.
(j) Home health care services are covered, subject to utilization controls.
(k) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.
Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated, is covered subject to utilization controls. When there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.
Therapeutic shoes and inserts are covered when provided to beneficiaries with a diagnosis of diabetes, subject to utilization controls, to the extent that federal financial participation is available.
(l) Hearing aids are covered, subject to utilization controls. Utilization controls shall allow replacement of hearing aids necessary because of loss or destruction due to circumstances beyond the beneficiary's control.
(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls shall allow the replacement of durable medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary's control. The utilization controls shall allow authorization of durable medical equipment needed to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian, subject to the availability of federal financial participation. The department shall adopt emergency regulations to define and establish criteria for assistive durable medical equipment in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).
(n) Family planning services are covered, subject to utilization controls.
(o) Inpatient intensive rehabilitation hospital services, including respiratory rehabilitation services, in a general acute care hospital are covered, subject to utilization controls, when either of the following criteria are met:
(1) A patient with a permanent disability or severe impairment requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to develop function beyond the limited amount that would occur in the normal course of recovery.
(2) A patient with a chronic or progressive disease requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to maintain the patient's present functional level as long as possible.
(p) (1) Adult day health care is covered in accordance with Chapter 8.7 (commencing with Section 14520).
(2) Commencing 30 days after the effective date of the act that added this paragraph, and notwithstanding the number of days previously approved through a treatment authorization request, adult day health care is covered for a maximum of three days per week.
(3) As provided in accordance with paragraph (4), adult day health care is covered for a maximum of five days per week.

(4) As of the date that the director makes the declaration described in subdivision (g) of Section 14525.1, paragraph (2) shall become inoperative and paragraph (3) shall become operative.
(q) (1) Application of fluoride, or other appropriate fluoride treatment as defined by the department, other prophylaxis treatment for children 17 years of age and under, are covered.
(2) All dental hygiene services provided by a registered dental hygienist in alternative practice pursuant to Sections 1768 and 1770 of the Business and Professions Code may be covered as long as they are within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental hygienist in alternative practice.
(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of Section 1482 of the article.
(2) All providers enrolled under this subdivision shall satisfy all applicable statutory and regulatory requirements for becoming a Medi-Cal provider.
(3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.
(s) In-home medical care services are covered when medically appropriate and subject to utilization controls, for beneficiaries who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be provided to patients placed in shared or congregate living arrangements, if a home setting is not medically appropriate or available to the beneficiary. As used in this section, “in-home medical care service” includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.
As used in this subdivision, in-home medical care services, include, but are not limited to:
(1) Level of care and cost of care evaluations.
(2) Expenses, directly attributable to home care activities, for materials.
(3) Physician fees for home visits.
(4) Expenses directly attributable to home care activities for shelter and modification to shelter.
(5) Expenses directly attributable to additional costs of special diets, including tube feeding.
(6) Medically related personal services.
(7) Home nursing education.
(8) Emergency maintenance repair.
(9) Home health agency personnel benefits which permit coverage of care during periods when regular personnel are on vacation or using sick leave.
(10) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.
(11) Emergency and nonemergency medical transportation.
(12) Medical supplies.
(13) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.
(14) Utility use directly attributable to the requirements of home care activities which are in addition to normal utility use.
(15) Special drugs and medications.
(16) Home health agency supervision of visiting staff which is medically necessary, but not included in the home health agency rate.
(17) Therapy services.

(18) Household appliances and household utensil costs directly attributable to home care activities.
(19) Modification of medical equipment for home use.
(20) Training and orientation for use of life-support systems, including, but not limited to, support of respiratory functions.
(21) Respiratory care practitioner services as defined in Sections 3702 and 3703 of the Business and Professions Code, subject to prescription by a physician and surgeon.
Beneficiaries receiving in-home medical care services are entitled to the full range of services within the Medi-Cal scope of benefits as defined by this section, subject to medical necessity and applicable utilization control. Services provided pursuant to this subdivision, which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with a home- and community-based services waiver.
(t) Home- and community-based services approved by the United States Department of Health and Human Services may be covered to the extent that federal financial participation is available for those services under waivers granted in accordance with Section 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and community-based services approvable under Section 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers.
(u) Comprehensive perinatal services, as provided through an agreement with a health care provider designated in Section 14134.5 and meeting the standards developed by the department pursuant to Section 14134.5, subject to utilization controls.
The department shall seek any federal waivers necessary to implement the provisions of this subdivision. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained or for which waivers are not required shall be implemented notwithstanding any inability to obtain federal waivers for the other provisions. No provision of this subdivision shall be implemented unless matching funds from Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are available.
(v) Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.
(w) Hospice service which is Medicare-certified hospice service is covered, subject to utilization controls. Coverage shall be available only to the extent that no additional net program costs are incurred.
(x) When a claim for treatment provided to a beneficiary includes both services which are authorized and reimbursable under this chapter, and services which are not reimbursable under this chapter, that portion of the claim for the treatment and services authorized and reimbursable under this chapter shall be payable.
(y) Home- and community-based services approved by the United States Department of Health and Human Services for beneficiaries with a diagnosis of AIDS or ARC, who require intermediate care or a higher level of care.
Services provided pursuant to a waiver obtained from the Secretary of the United States Department of Health and Human Services pursuant to this subdivision, and which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with the waiver, and subject to the terms, conditions, and duration of the waiver. These services shall be provided to

individual beneficiaries in accordance with the client’s needs as identified in the plan of care, and subject to medical necessity and applicable utilization control.
The director may under this section contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to eligible beneficiaries. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract Code.
(z) Respiratory care when provided in organized health care systems as defined in Section 3701 of the Business and Professions Code, and as an in-home medical service as outlined in subdivision (s).
(aa) (1) There is hereby established in the department, a program to provide comprehensive clinical family planning services to any person who has a family income at or below 200 percent of the federal poverty level, as revised annually, and who is eligible to receive these services pursuant to the waiver identified in paragraph (2). This program shall be known as the Family Planning, Access, Care, and Treatment (Family PACT) Program.
(2) The department shall seek a waiver in accordance with Section 1315 of Title 42 of the United States Code, or a state plan amendment adopted in accordance with Section 1396a(a)(10)(A)(ii)(XXI)(ii)(2) of Title 42 of the United States Code, which was added to Section 1396a of Title 42 of the United States Code by Section 2303(a)(2) of the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), for a program to provide comprehensive clinical family planning services as described in paragraph (8). Under the waiver, the program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. Under the state plan amendment, which shall replace the waiver and shall be known as the Family PACT successor state plan amendment, the program shall be operated only in accordance with this subdivision and the statutes and regulations in paragraph (4). The state shall use the standards and processes imposed by the state on January 1, 2007, including the application of an eligibility discount factor to the extent required by the federal Centers for Medicare and Medicaid Services, for purposes of determining eligibility as permitted under Section 1396a(a)(10)(A)(ii)(XXI)(ii)(2) of Title 42 of the United States Code. To the extent that federal financial participation is available, the program shall continue to conduct education, outreach, enrollment, service delivery, and evaluation services as specified under the waiver. The services shall be provided under the program only if the waiver and, when applicable, the successor state plan amendment are approved by the federal Centers for Medicare and Medicaid Services and only to the extent that federal financial participation is available for the services. Nothing in this section shall prohibit the department from seeking the Family PACT successor state plan amendment during the operation of the waiver.
(3) Solely for the purposes of the waiver or Family PACT successor state plan amendment and notwithstanding any other provision of law, the collection and use of an individual’s social security number shall be necessary only to the extent required by federal law.
(4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005, and 24013, and any regulations adopted under these statutes shall apply to the program provided for under this subdivision. No other provision of law under the Medi-Cal program or the State-Only Family Planning Program shall apply to the program provided for under this subdivision.
(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, without taking regulatory action, the provisions of the waiver after its approval by the federal Health Care Financing Administration and the provisions of this section by means of an all-county letter or similar instruction to providers. Thereafter, the department shall adopt regulations to implement this section and the approved waiver in accordance with the requirements of Chapter 3.5

(commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of the act adding this subdivision, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.
(6) In the event that the Department of Finance determines that the program operated under the authority of the waiver described in paragraph (2) or the Family PACT successor state plan amendment is no longer cost effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.
(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no share of cost, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a share of cost or if they are otherwise eligible under Section 24003.
(8) For purposes of this subdivision, “comprehensive clinical family planning services” means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, natural family planning, abstinence methods, and basic, limited fertility management. Comprehensive clinical family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Comprehensive clinical family planning services shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that is not incident to the diagnosis of pregnancy. Comprehensive clinical family planning services shall be subject to utilization control and include all of the following:
(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.
(B) All United States Department of Agriculture, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.
(C) Culturally and linguistically appropriate health education and counseling services, including informed consent, that include all of the following:
(i) Psychosocial and medical aspects of contraception.
(ii) Sexuality.
(iii) Fertility.
(iv) Pregnancy.
(v) Parenthood.

(vi) Infertility.
(vii) Reproductive health care.
(viii) Preconception and nutrition counseling.
(ix) Prevention and treatment of sexually transmitted infection.
(x) Use of contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies.
(xi) Possible contraceptive consequences and followup.
(xii) Interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.
(D) A comprehensive health history, updated at the next periodic visit (between 11 and 24 months after initial examination) that includes a complete obstetrical history, gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.
(E) A complete physical examination on initial and subsequent periodic visits.
(F) Services, drugs, devices, and supplies deemed by the federal Centers for Medicare and Medicaid Services to be appropriate for inclusion in the program.
(9) In order to maximize the availability of federal financial participation under this subdivision, the director shall have the discretion to implement the Family PACT successor state plan amendment retroactively to July 1, 2010.
(ab) (1) Purchase of prescribed enteral nutrition products is covered, subject to the Medi-Cal list of enteral nutrition products and utilization controls.
(2) Purchase of enteral nutrition products is limited to those products to be administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube. Beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment Program shall be exempt from this paragraph.
(3) Notwithstanding paragraph (2), the department may deem an enteral nutrition product, not administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube, a benefit for patients with diagnoses, including, but not limited to, malabsorption and inborn errors of metabolism, if the product has been shown to be neither investigational nor experimental when used as part of a therapeutic regimen to prevent serious disability or death.
(4) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement the amendments to this subdivision made by the act that added this paragraph by means of all-county letters, provider bulletins, or similar instructions, without taking regulatory action.
(5) The amendments made to this subdivision by the act that added this paragraph shall be implemented June 1, 2011, or on the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later.
(ac) Diabetic testing supplies are covered when provided by a pharmacy, subject to utilization controls.
(Amended by Stats. 2011, Ch. 3, Sec. 101. Effective March 24, 2011.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
ABX4-5	Evans	Health.	Chaptered 07/28/2009	07/28/2009 - Chaptered by Secretary of State. Chapter	Secretary of State- Chaptered	Yes	Two Thirds

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
				5, Statutes of 2009-10 Fourth Extraordinary Session.			
ABX3-44	Evans	Health.	Amended Assembly 06/28/2009	10/26/2009 - Died at Desk.	Assembly-Died	Yes	Majority
AB-97	Committee on Budget	Health care services.	Chaptered 03/24/2011	03/24/2011 - Chaptered by Secretary of State - Chapter 3, Statutes of 2011.	Secretary of State-Chaptered	Yes	Two Thirds
AB-131	Committee on Budget	Budget Act of 2005: omnibus health trailer bill.	Chaptered 07/19/2005	07/19/2005 - Chaptered by Secretary of State - Chapter 80, Statutes of 2005. 07/19/2005 - Approved by the Governor.	-	Yes	Two Thirds
AB-224		Medi-Cal: respiratory care.	Chaptered 10/02/1989		-		
AB-442	Committee on Budget	Health: budget trailer.	Chaptered 09/30/2002	09/30/2002 - Chaptered by Secretary of State - Chapter 1161, Statutes of 2002. 09/30/2002 - Approved by the Governor.	-		
AB-560		Dentistry: registered dental hygienist in alternative practice.	Chaptered 10/07/1997		-		
AB-1107	Cedillo, Escutia, Figueroa, Gallegos, Johnston, Solis, Speier, Vasconcellos, Villaraigosa	Health Care.	Chaptered 07/22/1999	07/22/1999 - Chaptered by Secretary of State - Chapter 146, Statutes of 1999. 07/22/1999 - Approved by the Governor.	-		
AB-1298	Firebaugh, Cardenas	Medi-Cal: benefits: hearing tests.	Amended Assembly 04/15/1999	02/03/2000 - From committee: Filed with the Chief Clerk pursuant to Joint Rule 56. Died pursuant to Art. IV, Sec. 10(c) of the Constitution.	-	Yes	Majority
AB-1423	Thomson	Mental health.	Amended Assembly 04/17/2001	11/30/2002 - From Senate committee without further action.	-	Yes	Majority

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-1480	Aanestad, Aroner	Medi-Cal reimbursement.	Amended Assembly 04/26/2001	02/07/2002 - From committee: Filed with the Chief Clerk pursuant to Joint Rule 56. Died pursuant to Art. IV, Sec. 10(c) of the Constitution.	-	Yes	Majority
AB-1613	Committee on Budget	Health.	Amended Senate 10/06/2010	10/08/2010 - Read third time. Urgency clause refused adoption. (Ayes 26. Noes 7. Page 5256.)	Senate-In Floor Process	Yes	Two Thirds
AB-1803	Mitchell	Medi-Cal: emergency medical conditions.	Amended Senate 06/12/2012	06/25/2012 - In committee: Placed on APPR. suspense file.	Senate-In Committee Process - Appropriations	Yes	Majority
AB-1981	Cedillo	Medi-Cal: outpatient services.	Introduced 02/18/2000	11/30/2000 - From committee without further action.	-	Yes	Majority
AB-2073	Bonnie Lowenthal	Medi-Cal: adult day health care services.	Introduced 02/18/2010	11/30/2010 - From committee without further action.	Assembly-Died	Yes	Majority
AB-2152	Aroner	Medi-Cal: durable medical equipment.	Chaptered 09/15/2000	09/15/2000 - Chaptered by Secretary of State - Chapter 453, Statutes of 2000.	-		
AB-2742	Nava	Family planning: Medi-Cal: Family PACT program.	Enrolled 09/15/2006	09/29/2006 - Vetoed by Governor.	-	Yes	Majority
AB-2775	Daucher	Medi-Cal: dental services: anesthesia.	Amended Assembly 05/02/2006	05/25/2006 - In committee: Set, second hearing. Held under submission.	-	Yes	Majority
AB-2885	Plescia	Medi-Cal: benefits: prescribed drugs.	Chaptered 07/20/2006	07/20/2006 - Chaptered by Secretary of State - Chapter 95, Statutes of 2006. 07/20/2006 - Approved by the Governor.	-	Yes	Two Thirds
AB-3573		Public assistance.	Chaptered 07/31/1990		-		
SBX1-6	Committee on Budget and Fiscal Review	Health and Human Services: Budget Act trailer.	Amended Assembly 04/28/2003	07/29/2003 - From Assembly without further	-	Yes	Two Thirds

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
				action.			
SBX1-26	Committee on Budget and Fiscal Review	Health.	Chaptered 05/05/2003	05/05/2003 - Chaptered by Secretary of State. Chapter 9, Statutes of 2003-04 First Extraordinary Session. 05/05/2003 - Approved by Governor.	-		
SB-400	Corbett	Medi-Cal: outpatient prescription drugs.	Chaptered 07/17/2008	07/17/2008 - Chaptered by Secretary of State. Chapter 134, Statutes of 2008.	Secretary of State-Chaptered	Yes	Two Thirds
SB-853	Committee on Budget and Fiscal Review	Health.	Chaptered 10/19/2010	10/19/2010 - Chaptered by Secretary of State. Chapter 717, Statutes of 2010.	Secretary of State-Chaptered	Yes	Two Thirds
SB-1191	Speier	State and local reporting requirements.	Chaptered 10/12/2001	10/12/2001 - Chaptered by Secretary of State. Chapter 745, Statutes of 2001.	-		
SB-1414		Health: skilled nursing and intermediate care facilities.	Chaptered 09/25/1989		-		
SB-1524		Health care.	Chaptered 09/26/1990		-		
SB-1525	Speier	Health care: breast cancer and cervical cancer screening services: family planning services.	Enrolled 08/23/2004	11/30/2004 - Died on file.	-		
SB-1846	Committee on Budget and Fiscal Review	Health: budget trailer.	Amended Assembly 06/25/2002	11/30/2002 - From Assembly without further action.	-	Yes	Two Thirds

COMMENTS/RECOMMENDATIONS:

Regulations were adopted and no outstanding reporting requirement exists.

REPORT NO. 43

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 7. Basic Health Care [14000. - 14198.2.]
(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)
ARTICLE 5.2. Medi-Cal Hospital Care/Uninsured Hospital Care Demonstration Project Act [14166. - 14166.26.]
(Article 5.2 added by Stats. 2005, Ch. 560, Sec. 1.)

14166.245.

(a) The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditures to avoid reducing vital government services necessary for the protection of the health, safety, and welfare of the citizens of the State of California.
(b) (1) Notwithstanding any other provision of law, except as provided in Article 2.93 (commencing with Section 14091.3), for hospitals that receive Medi-Cal reimbursement from the State Department of Health Care Services and that are not under contract with the State Department of Health Care Services pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3 of Division 9, the amounts paid as interim payments for inpatient hospital services provided on and after July 1, 2008, shall be reduced by 10 percent.
(2) (A) Beginning on October 1, 2008, amounts paid that are calculated pursuant to paragraph (1) shall not exceed the applicable regional average per diem contract rate for tertiary hospitals and for all other hospitals established as specified in subparagraph (C), reduced by 5 percent, multiplied by the number of Medi-Cal covered inpatient days for which the interim payment is being made.
(B) This paragraph shall not apply to small and rural hospitals specified in Section 124840 of the Health and Safety Code, or to hospitals in open health facility planning areas that were open health facility planning areas on October 1, 2008, unless either of the following apply:
(i) The open health facility planning area at any time on or after July 1, 2005, was a closed health facility planning area as determined by the California Medical Assistance Commission.
(ii) The open health facility planning area has three or more hospitals with licensed general acute care beds. State-owned or operated hospitals shall not be included in determining whether this clause shall apply.
(C) (i) For purposes of this subdivision and subdivision (c), the average regional per diem contract rates shall be derived from unweighted average contract per diem rates that are publicly available on June 1 of each year, trended forward based on the trends in the California Medical Assistance Commission's Annual Report to the Legislature. For tertiary hospitals, and for all other hospitals, the regional average per diem contract rates shall be based on the geographic regions in the California Medical Assistance Commission's Annual Report to the Legislature. The applicable average regional per diem contract rates for tertiary hospitals and for all other hospitals shall be published by the department on or before October 1, 2008, and these rates shall be updated annually for each state fiscal year and shall become effective each July 1, thereafter. Supplemental payments shall not be included in this calculation.

(ii) For purposes of clause (i), both the federal and nonfederal share of the designated public hospital cost-based rates shall be included in the determination of the average contract rates by multiplying the hospital's interim rate, established pursuant to Section 14166.4 and that is in effect on June 1 of each year, by two.
(iii) For the purposes of this section, a tertiary hospital is a children's hospital specified in Section 10727, or a hospital that has been designated as a Level I or Level II trauma center by the Emergency Medical Services Authority established pursuant to Section 1797.1 of the Health and Safety Code.
(D) For purposes of this section, the terms "open health facility planning area" and "closed health facility planning area" shall have the same meaning and be applied in the same manner as used by the California Medical Assistance Commission in the implementation of the hospital contracting program authorized in Article 2.6 (commencing with Section 14081).
(c) (1) Notwithstanding any other provision of law, for hospitals that receive Medi-Cal reimbursement from the State Department of Health Care Services and that are not under contract with the State Department of Health Care Services, pursuant to Article 2.6 (commencing with Section 14081), the reimbursement amount paid by the department for inpatient services provided to Medi-Cal recipients for dates of service on and after July 1, 2008, shall not exceed the amount determined pursuant to paragraph (3).
(2) For purposes of this subdivision, the reimbursement for inpatient services includes the amounts paid for all categories of inpatient services allowable by Medi-Cal. The reimbursement includes the amounts paid for routine services, together with all related ancillary services.
(3) When calculating a hospital's cost report settlement for a hospital's fiscal period that includes any dates of service on and after July 1, 2008, the settlement for dates of service on and after July 1, 2008, shall be limited to the lesser of the following:
(A) Ninety percent of the hospital's audited allowable cost per day for those services multiplied by the number of Medi-Cal covered inpatient days in the hospital's fiscal year on or after July 1, 2008.
(B) Beginning for dates of service on and after October 1, 2008, the applicable average regional per diem contract rate established as specified in subparagraph (A) of paragraph (2) of subdivision (b), reduced by 5 percent, multiplied by the number of Medi-Cal covered inpatient days in the hospital's fiscal year, or portion thereof. This subparagraph shall not apply to small and rural hospitals specified in Section 124840 of the Health and Safety Code, or to hospitals in open health facility planning areas that were open health facility planning areas on July 1, 2008, unless either of the following apply:
(i) The open health facility planning area at any time on or after July 1, 2005, was a closed health facility planning area as determined by the California Medical Assistance Commission.
(ii) The open health facility planning area has three or more hospitals with licensed general acute care beds. State-owned or operated hospitals shall not be included in determining whether this clause shall apply.
(d) Except as provided in Article 2.93 (commencing with Section 14091.3), hospitals that participate in the Selective Provider Contracting Program pursuant to Article 2.6 (commencing with Section 14081) and designated public hospitals under Section 14166.1, except Los Angeles County Martin Luther King, Jr./Charles R. Drew Medical Center and Tuolumne General Hospital, shall be exempt from the limitations required by this section.
(e) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement and administer this section by means of provider bulletins, or other similar instructions, without taking regulatory action.

(f) The director shall promptly seek all necessary federal approvals in order to implement this section, including necessary amendments to the state plan.
(g) (1) Notwithstanding any other provision of this section, small and rural hospitals, as defined in Section 124840 of the Health and Safety Code, shall be exempt from the payment reductions set forth in this section for dates of service on and after November 1, 2008, through and including June 30, 2009. On and after July 1, 2009, small and rural hospitals as defined in this paragraph shall be subject to the reductions set forth in paragraph (1) of subdivision (b) and subparagraph (A) of paragraph (3) of subdivision (c), but shall be exempt from the provisions of subparagraph (A) of paragraph (2) of subdivision (b) and subparagraph (B) of paragraph (3) of subdivision (c).
(2) Notwithstanding any other provision of this section, hospitals that are certified by Medicare as Medical Critical Access Providers or as Rural Referral Centers shall be exempt from the payment reductions set forth in this section for dates of service on and after July 1, 2009.
(h) For hospitals that are subject to clauses (i) and (ii) of subparagraph (B) of paragraph (2) of subdivision (b) and that choose to contract pursuant to Article 2.6 (commencing with Section 14081), the California Medical Assistance Commission shall negotiate rates taking into account factors specified in Section 14083.
(i) In January 2010 and in January 2011, the department and the California Medical Assistance Commission shall submit a written report to the policy and fiscal committees of the Legislature on the implementation and impact of the changes made by this section, including, but not limited to, the impact of those changes on the number of hospitals that are contract and noncontract, patient access, and cost savings to the state.
(j) Commencing on the effective date of the act that added this subdivision, all of the following shall occur:
(1) Subdivisions (a) to (d), inclusive, and subdivisions (g) to (h), inclusive, shall no longer be applicable to fee-for-service hospital rates but shall continue to be applicable under subdivision (c) of Section 14091.3, in the same manner and to the same extent as if this section continued to be applicable to fee-for-service hospital rates.
(2) Medi-Cal reimbursement for inpatient hospital services for hospitals that receive Medi-Cal reimbursement from the department and that are not under contract with the department pursuant to Article 2.6 (commencing with Section 14081) for inpatient hospital services shall be determined in accordance with the applicable provisions in state law and the California Code of Regulations, and the applicable provisions of the California Medicaid State Plan that have been approved by the federal Centers for Medicare and Medicaid Services without application of subdivisions (a) to (d), inclusive, and subdivisions (g) to (h), inclusive.
(k) The reimbursement reductions and limits set forth in, or adopted pursuant to, Section 14105.192 do not apply to payments for inpatient hospital services furnished on a fee-for-service basis under Medi-Cal to hospitals that are not under contract with the department pursuant to Article 2.6 (commencing with Section 14081) for inpatient services provided to Medi-Cal beneficiaries.
(l) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date.
(Amended (as amended by Stats. 2009, 4th Ex., Ch. 5) by Stats. 2011, Ch. 19, Sec. 4. Effective April 13, 2011. Repealed as of January 1, 2013, by its own provisions. Note: See conditional termination provisions in Sections 14166.2 and 14166.26.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
ABX3-5	Committee on Budget	Public health programs.	Chaptered 02/16/2008	02/16/2008 - Chaptered by Secretary of State. Chapter 3, Statutes of 2007-08 Third Extraordinary Session.	Secretary of State- Chaptered	Yes	Two Thirds
ABX4-5	Evans	Health.	Chaptered 07/28/2009	07/28/2009 - Chaptered by Secretary of State. Chapter 5, Statutes of 2009-10 Fourth Extraordinary Session.	Secretary of State- Chaptered	Yes	Two Thirds
ABX3-44	Evans	Health.	Amended Assembly 06/28/2009	10/26/2009 - Died at Desk.	Assembly- Died	Yes	Majority
AB-75	Huffman	Medi-Cal.	Amended Assembly 03/26/2009	11/30/2010 - From Senate committee without further action pursuant to Joint Rule 62(a).	Senate-Died	Yes	Two Thirds
AB-728	Nielsen	Medi-Cal: hospitals: reimbursements.	Introduced 02/26/2009	02/01/2010 - From committee without further action pursuant to Joint Rule 62(a).	Assembly- Died - Health	Yes	Two Thirds
AB-1183	Committee on Budget	Health.	Chaptered 09/30/2008	09/30/2008 - Chaptered by Secretary of State - Chapter 758, Statutes of 2008.	Secretary of State- Chaptered	Yes	Two Thirds
AB-2784	La Malfa	Medi-Cal: hospitals: reimbursements.	Enrolled 09/17/2008	09/30/2008 - Vetoed by Governor.	Assembly- Vetoed	Yes	Two Thirds
SBX3-3	Committee on Budget and Fiscal Review	Public health programs.	Amended Senate 02/13/2008	10/01/2008 - Died on file.	Senate-Died	Yes	Two Thirds
SB-90	Steinberg	Health: hospitals: Medi-Cal.	Chaptered 04/13/2011	04/13/2011 - Chaptered by Secretary of State. Chapter 19, Statutes of 2011.	Secretary of State- Chaptered	Yes	Two Thirds
SB-1077	Committee on Budget and Fiscal Review	Health.	Amended Assembly 09/15/2008	11/30/2008 - From Assembly without further action.	Assembly- Died	Yes	Two Thirds

COMMENTS/RECOMMENDATIONS:
Required reports were submitted to the Legislature.

REPORT NO. 44

WELFARE AND INSTITUTIONS CODE

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]
(Division 9 added by Stats. 1965, Ch. 1784.)
PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]
(Part 3 added by Stats. 1965, Ch. 1784.)
CHAPTER 8.9. Transition of Community-Based Medi-Cal Mental Health [14700. - 14726.]
(Chapter 8.9 added by Stats. 2011, Ch. 29, Sec. 20.)

14701.

(a) The State Department of Health Care Services, in collaboration with the State Department of Mental Health and the California Health and Human Services Agency, shall create a state administrative and programmatic transition plan, either as one comprehensive transition plan or separately, to guide the transfer of the Medi-Cal specialty mental health managed care and the EPSDT Program to the State Department of Health Care Services effective July 1, 2012.
(1) Commencing no later than July 15, 2011, the State Department of Health Care Services, together with the State Department of Mental Health, shall convene a series of stakeholder meetings and forums to receive input from clients, family members, providers, counties, and representatives of the Legislature concerning the transition and transfer of Medi-Cal specialty mental health managed care and the EPSDT Program. This consultation shall inform the creation of a state administrative transition plan and a programmatic transition plan that shall include, but is not limited to, the following components:
(A) Plan shall ensure it is developed in a way that continues access and quality of service during and immediately after the transition, preventing any disruption of services to clients and family members, providers and counties and others affected by this transition.
(B) A detailed description of the state administrative functions currently performed by the State Department of Mental Health regarding Medi-Cal specialty mental health managed care and the EPSDT Program.
(C) Explanations of the operational steps, timelines, and key milestones for determining when and how each function or program will be transferred. These explanations shall also be developed for the transition of positions and staff serving Medi-Cal specialty mental health managed care and the EPSDT Program, and how these will relate to, and align with, positions at the State Department of Health Care Services. The State Department of Health Care Services and the California Health and Human Services Agency shall consult with the Department of Personnel Administration in developing this aspect of the transition plan.
(D) A list of any planned or proposed changes or efficiencies in how the functions will be performed, including the anticipated fiscal and programmatic impacts of the changes.
(E) A detailed organization chart that reflects the planned staffing at the State Department of Health Care Services in light of the requirements of subparagraphs (A) through (C) and includes focused, high-level leadership for behavioral health issues.
(F) A description of how stakeholders were included in the various phases of the planning process to formulate the transition plans and a description of how their feedback will be taken into consideration after transition activities are underway.
(2) The State Department of Health Care Services, together with the State Department of Mental Health and the California Health and Human Services Agency, shall convene and consult with stakeholders at least twice following production of a draft of the transition plans and before

submission of transition plans to the Legislature. Continued consultation with stakeholders shall occur in accordance with the requirement in subparagraph (F) of paragraph (1).
(3) The State Department of Health Care Services shall provide the transition plans described in paragraph (1) to all fiscal committees and appropriate policy committees of the Legislature no later than October 1, 2011. The transition plans may also be updated by the Governor and provided to all fiscal and applicable policy committees of the Legislature upon its completion, but no later than May 15, 2012.
(Added by Stats. 2011, Ch. 29, Sec. 20. Effective June 29, 2011. Conditionally inoperative as provided in Section 14721.)

Bill	Lead Authors	Subject	Latest Bill Version	Last History Action	Status	Fiscal Committee	Vote Required
AB-102	Committee on Budget	Health.	Chaptered 06/29/2011	06/28/2011 - Chaptered by Secretary of State - Chapter 29, Statutes of 2011.	Secretary of State-Chaptered	Yes	Majority
SB-1171	Harman	Maintenance of the codes.	Enrolled 07/09/2012	07/11/2012 - Enrolled and presented to the Governor at 10:45 a.m.	Governor-Enrolled	No	Majority

COMMENTS/RECOMMENDATIONS:

This one-time report was submitted to the Legislature.