DEPARTMENT OF HEALTH SERVICES
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December 1, 1999

MMCD All-Plan Letter 99014

TO:
- [X] County-Organized Health Systems
- [X] Geographic Managed Care Plans
- [X] Prepaid Health Plans
- [X] Two-Plan Model Plans

SUBJECT: SUMMARY OF 1999 CHAPTERED LEGISLATION IMPACTING OR OF INTEREST TO MEDI-CAL MANAGED CARE PLANS

The purpose of this letter is to provide summary information about bills chaptered during 1999 that impact or are of interest to Medi-Cal managed care plans (MCPs). We have enclosed the following:

- *Narrative summary* of chaptered bills. The brief summary of each bill highlights the main provisions of the new law, indicates how Medi-Cal MCPs and other entities are affected, and cites relevant code sections. You may access complete copies of bills through the California State Legislature's website: http://www.leginfo.ca.gov/bilinfo

- *Impact summary table* indicating the effective date for each bill, affected entities, and plan submissions and contract changes that will be required as a result of the legislation.

Please be advised that the chaptered legislation summarized does *not* reflect all changes in State law that may affect the business practices or daily operations of contracting MCPs.

Each MCP is responsible for reviewing and analyzing the impact of chaptered legislation on their operations. Contractors are expected to implement statutory changes as required by the effective date of each chaptered bill and should not delay any required operational changes while the Medi-Cal Managed Care Division (MMCD) processes related contract amendments. In addition, MCPs are responsible for compliance with any regulatory requirements that are enforced by other state or federal entities. (See *General Terms and Conditions* of your contract.)

MCPs are reminded that your contracts require new or revised reports, policies and procedures, provider directories, member informing materials, and subcontracts to be submitted to the Department of Health Services (DHS). DHS review and approval also may be required before policies and procedures are implemented and revised materials are distributed to enrolled Medi-Cal members. Please refer to your specific contract for approval requirements and time frames.

When necessary, MMCD will issue policy letters to clarify the application of some new laws to the Medi-Cal Managed Care Program. Laws that contain provisions specific to Medi-Cal (such as AB 55, SB 59 and SB 189) may require DHS to promulgate new regulations as part of the implementation process. Future policy letters and proposed regulations related to new legislation will be distributed to contracting MCPs as they become available.

If you have questions about how a specific chaptered bill affects your Medi-Cal MCP contract, please contact your DHS contract manager at (916) 657-0977 for assistance.

Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division

Enclosures (2)

1999 CHAPTERED BILLS IMPACTING OR OF INTEREST TO MEDI-CAL MANAGED CARE DIVISION AND CONTRACTED PLANS

(Prepared 10/26/99)

AB 12 (Chapter 531, Statutes of 1999) – AB 12 requires a health care service plan (HCSP) to provide or arrange for a prompt second opinion by an appropriately qualified professional upon request by an enrollee or his/her participating health professional. The second opinion provider may be from the same physician organization or another physician organization, depending on the specific circumstances of the enrollee and nature of medical condition to be evaluated. (Adds Section 1383.15 to the Health and Safety Code and Section 10123.68 to the Insurance Code.)

AB 39 (Chapter 532, Statutes of 1999) – Known as the "Women's Contraceptive Equity Act," AB 39 requires every group and individual HCSP contract, except for specialized HCSPs, to cover federal Food and Drug Administration (FDA) approved prescription contraceptive methods when plan contracts cover outpatient prescription drugs. Religious employers are exempted if providing contraceptive coverage is contrary to their religious beliefs. To qualify as a "religious employer," a nonprofit organization must focus on spreading religious values and primarily employ and serve individuals with the same religious values. Religious employers choosing not to provide prescription contraceptive coverage must notify prospective enrollees prior to plan enrollment. AB 39's provisions take effect January 1, 2000. Medi-Cal managed care plans are not affected because they are already required to cover all FDA-approved prescription contraceptive drugs and devices. Medi-Cal managed care plans are also afforded "conscience protection" by being allowed to subcontract services to which they object to providing on religious grounds. (Adds Section 1367.25 to the Health and Safety Code.) *Note: Another chaptered bill, SB 41, imposes the same requirements on disability insurers.*

AB 55 (Chapter 533, Statutes of 1999) – As of January 1,2000, the Department of Corporations (DOC) is required to establish an Independent Medical Review (IMR) System, funded by an assessment on HCSPs, for the purpose of reviewing medical decisions. A similar IMR system is to be established by the Department of Insurance (DOI) for review of decisions by disability insurers. The IMR system is to review disputed decisions made on or after January 1, 2001. Enrollee requests must be made within six months of the disputed decision, and HCSPs must inform enrollees of the availability of the IMR every time a service is denied, delayed, or modified. Reviews shall be conducted as prescribed within specified time frames, with provision for an expedited review for cause. Decisions shall be binding on the HCSP or disability insurer. The DOC or the DOI shall be the final arbiter concerning the appropriateness of an IMR request. The Department of Health Services (DHS) will promulgate regulations to describe the additional steps that will be necessary when Medi-Cal enrollees request IMRs while also requesting State Fair Hearings concerning the same disputed medical decision. *Note: The IMR system established by DOC will eventually be transferred to the new Department of Managed Care established by AB 78.*

The IMR prescribed by AB 55 will only be available to Medi-Cal beneficiaries enrolled in HCSPs. Plans not licensed under or subject to all of the requirements of the Knox-Keene Act will *not* be required to provide IMR and should not be assessed the fee to support the system. (These include the seven counties served by a county organized health system and two counties that operate the fee-for-service managed care model.) HCSPs must review current policies, procedures and member informing materials and make all changes needed to implement IMR within their organization. HCSPs should also review subcontracts, including those with any entity to which utilization responsibility has been delegated, to assure compliance with the requirements to provide medical records on a timely basis, inform enrollees of their appeal rights, and satisfy other administrative requirements of the IMR system. (Adds Article 5.55 to Chapter 2.2 of Division 2 of the Health and Safety Code and Article 3.5 to Chapter 1 of Part 2 of Division 2 of the Insurance Code.)

AB 78 (Chapter 525, Statutes of 1999) – AB 78 establishes a new Department of Managed Care (DMC), within the Business, Transportation, and Housing Agency, that is specifically devoted to licensing and regulating managed care plans. The DMC is expected to begin operating on July 1, 2000. DOC's oversight functions and any remaining unexpended funds specific to health care regulation will be transferred to DMC. The Governor will appoint the new Director of DMC, subject to Senate confirmation. AB 78 also establishes a new Clinical Advisory Panel on Managed Care and Office of Patient Advocate within the DMC. The head of the Office of Patient Advocate will be appointed by the Governor, subject to Senate confirmation. The Assembly Speaker and the Senate Rules Committee will appoint three members of the Clinical Advisory Panel, and the Governor will appoint the remaining members. The Clinical Advisory Panel will assist and advise the Director, monitor the independent review process, review and reduce clinical errors, and promote patient safety. The Office of Patient Advocate will provide advice and assistance to HCSP enrollees, recommend needed enforcement actions, develop health care rights consumer guides, perform public outreach and education, and issue an annual quality-of-care report card for HCSPs. The DMC Director will have enforcement authority for AB 78's provisions and assessment authority to adjust HCSP fees in Fiscal Year 2000-2001, if necessary, to support the transition to the new department. The Director may also order HCSPs to discontinue violations that threaten irreparable loss and injury to patients. (Amends numerous sections of the Business and Professions Code, Civil Code, Corporations Code, Government Code, Health and Safety Code, Insurance Code, Labor Code, Penal Code, and Welfare and Institutions Code.)

AB 88 (Chapter 534, Statutes of 1999) – Requires that HCSP contracts or disability insurance policies issued, amended, or renewed after July 1, 2000, provide coverage for the diagnosis and medically necessary treatment of defined biologically-based diseases of the brain of a person of any age or of serious emotional disturbances of a child. This coverage must be provided under the same terms and conditions as coverage of diseases of other organs of the body. HCSPs and indemnity insurers may provide this coverage through separate specialized HCSPs or mental health plans. Contracts between DHS and HCSPs are exempted. (Adds Section 1374.72 to the Health and Safety Code and Section 10144.5 to the Insurance Code.)

AB 215 (Chapter 530, Statutes of 1999) – AB 215 establishes a moratorium on DOC's issuance of Knox-Keene licenses with waivers or limited licenses for two years beginning January 1, 2000, and ending December 31, 2001. Effective January 1, 2000, no HCSP may enter into a contract with a global capitation arrangement unless the subcontractor is a licensed HCSP or a licensed HCSP with waivers. The precise impact of AB 215 on individual Medi-Cal managed care plans, their subcontractors, and their networks is not known. Each Medi-Cal plan should review their individual subcontracting arrangements to assure compliance with these requirements. All Medi-Cal plans are reminded that revised provider directories (including a description of the changes) must be submitted to DHS for review and approval. Any plan amendments to existing subcontracts as a result of AB 260 should be submitted to DHS for approval prior to execution. (Adds Section 1349.3 to the Health and Safety Code.) *Note: AB 215 contains clean-up language to SB 260 with the intent of preventing risk-bearing organizations from marketing directly to self-insured employers.*

AB 285 (Chapter 535, Statutes of 1999) – AB 285 establishes a framework for the registration and regulation of telephone medical advice services (TMAS) that do business in California or provide these services to California residents from an out-of-state location. The Department of Consumer Affairs shall conduct a study of the impact on Californians of allowing out-of-state professionals to provide TMAS. Effective January 1, 2000, HCSPs and certain disability insurers that provide access to TMAS to enrollees must contract only with entities that are registered in California to provide TMAS. To become registered in California, TMAS employees providing advice must be licensed health professionals (registered nurses must be licensed in California regardless of the actual location of the business), have a supervising physician available at all times of operation, pay an annual fee, and meet certain other requirements. HCSPs should review any TMAS contracts to ensure compliance with the new registration requirements. (Adds Chapter 15 to Division 2 of the Business and Professions Code, Section 1348.8 to the Health and Safety Code, and Section 10279 to the Insurance Code.)

AB 416 (Chapter 527, Statutes of 1999) – Prohibits health care providers (including HCSPs and their contractors) from releasing specified medical information regarding an individual's outpatient treatment with a psychotherapist, unless requested in writing as specified. The Confidentiality of Information Act already requires that patient medical records be kept confidential and provides greater protections for medical records related to the treatment of mental health conditions. AB 416 provides greater protections for medical records related to outpatient psychotherapy. (Amends Section 56.35 of the Civil Code and adds Section 56.104.)

AB 435 (Chapter 766, Statutes of 1999) – Limits an existing provision in the Confidentiality of Medical Information Act to prohibit the disclosure of medical information relative to Workers' Compensation claims and a patient being infected with HIV. This information cannot be disclosed without the patient's prior authorization unless the patient is an injured worker claiming to have been infected with HIV through his or her employment. (Adds Section 56.31 to the Civil Code and amends Section 3762 of the Labor Code.)

AB 496 (Chapter 769, Statutes of 1999) – AB 496 exempts from public disclosure certain HCSP records when a county board of supervisors governs the local initiative Medi-Cal managed care plan (such as Contra Costa County). Records related to provider rate or payment determinations, provider payment methodologies, formulae or calculations for provider payments, and provider contract negotiations for alternative rates are exempted from public disclosure for three years after the HCSP contract is fully executed. AB 496 also provides for closed session meetings of the HCSP's governing board when health plan trade secrets are discussed. This bill's provisions are effective January 1, 2000. (Adds Sections 54956.87 and 6254.22 to the Government Code and amends Section 54957.5 of the Government Code.)

AB 724 (Chapter 784, Statutes of 1999) – Known as the "Year 2000 Problem Good Government Omnibus Act of 1999," this bill made a variety of temporary statutory changes to allow the state to deal effectively with Year 2000 (Y2K) problems. Pharmacists may refill any prescription during the period of December 1, 1999, through February 1, 2000, upon request of the person on whose behalf the prescription was written, subject to the number and terms of authorized refills. This provision becomes inoperative on February 1, 2000. AB 724 also specifies terms for reimbursement of claims to Medi-Cal providers in the case of computing or accounting failure related to Y2K. This bill was effective immediately upon signing. (Amends, adds, or repeals various sections of the Business and Professions Code, Civil Code, Government Code, Public Contract Code, and Public Utilities Code.)

AB 784 (Chapter 993, Statutes of 1999) – Enhances the Medi-Cal fraud initiative contained in Governor Davis' 1999-2000 Budget by requiring Medi-Cal providers of equipment and supplies to provide a bond or other security of at least $25,000, giving DHS financial protection against losses due to provider fraud and billing abuses. AB 784 also provides DHS with the authority to audit the records of Medi-Cal providers and suppliers to ensure invoices submitted and reimbursed are valid. (Amends Sections 14170.8 and 14171.6 of the Welfare and Institutions Code and adds Section 14100.75.)

AB 892 (Chapter 528, Statutes of 1999) – Includes hospice care as a basic healthcare service to be provided by HCSPs as of January 1, 2002. This hospice care must be equivalent to the level of coverage provided through Medicare. The Commissioner of Corporations must adopt regulations for hospice care coverage and report annually on changes in federal regulations that will require a change in state regulations. The Medi-Cal program and Medi-Cal managed care plan contracts are not affected because hospice care is already included in the Medi-Cal uniform schedule of health care benefits. (Amends Sections 1345 and 1368.2 of the Health and Safety Code.)

SB 5 (Chapter 537, Statutes of 1999) – SB 5 restates and affirms the services and coverage to be provided by HCSPs for breast cancer screening, diagnosis, and treatment. Similar changes are made concerning disability insurers that provide comprehensive medical service coverage. Additionally, specific minimum coverage of mammography for women ages 35 and over is established for disability insurance policies. SB 5's provisions are effective January 1, 2000. Medi-Cal managed care plans are not affected because this law is consistent with current Medi-Cal benefits.

(Amends Sections 1367.6 and 1367.65 of the Health and Safety Code and Sections 10123.8 and 10123.81 of the Insurance Code.)

SB 19 (Chapter 526, Statutes of 1999) – Known as the "Confidentiality of Medical Information Act," SB 19 establishes patient confidentiality protections. Providers, HCSPs, and contractors are prohibited from intentionally sharing, selling, using or disclosing any medical information unrelated to a patient's health care without the patient's authorization, unless the disclosure is legally compelled. Every provider, HCSP, or contractor handling medical records must preserve patient confidentiality. Any violator who knowingly or willingly obtains, discloses, uses, or destroys medical information in violation of this Act is subject to enforcement measures. SB 19 also establishes the parameters of a valid patient authorization for HCSPs and providers when releasing medical information. Individuals have the right to bring action against any entity that releases confidential information without valid authorization and the right to recover damages. Providers, HCSPs, and contractors may not require patients, as a condition for securing healthcare services, to sign an authorization, release, consent, or waiver that permits the disclosure of medical information that otherwise could not be disclosed under this Act or another law. On or before July 1, 2001, HCSPs must file policies and procedures with the Director of DMC for protecting the security of their members' medical information in compliance with this Act. By July 1, 2001, HCSPs must provide enrollees, upon request, with a written statement describing how the confidentiality of medical information is maintained, in accordance with the requirements established in this bill. (Amends Sections 56.05, 56.10, 56.11, 56.12, 56.14, 56.30, 56.36, and 56.37 and adds Section 56.101 to the Civil Code. Also amends Section 1386 and adds Sections 1364.5 1367.25 to the Health and Safety Code and amends Section 791.02 of the Insurance Code.)

SB 21 (Chapter 536, Statutes of 1999) – Known as the "Managed Health Care Insurance Accountability Act," SB 21 makes HCSPs and managed care entities liable for substantial harm caused by their failure to exercise ordinary care in authorizing or denying healthcare services. Individuals may not seek a cause of action against an HCSP until they have exhausted the IMR system, unless substantial harm has occurred or will imminently occur prior to completion of the review. HCSPs and managed care entities may not seek damages from a provider for liability resulting from the provisions of SB 21. This bill becomes effective January 1, 2001, and may result in increased exposure to liability for Medi-Cal managed care plans. (Adds Section 3428 to the Civil Code.)

SB 59 (Chapter 539, Statutes of 1999) – SB 59 defines the term "utilization review" (UR) and establishes standards for the UR processes used by HCSPs, disability insurers, and their subcontracting provider networks. Administrative penalties are specified for failure to meet the standards. The new performance standards include:

- Written policies and procedures for the UR process specifying that decisions will be made within specified timeframes, that verbal and/or written notices will be sent to requesting providers and covered enrollees, and that all written notices will contain sufficient detail to meet legal requirements.

- Employment of a California-licensed health professional as a director responsible for ensuring that the UR process meets legal requirements.
- Clinical guidelines used to make UR decisions will be disclosed to contracting providers, enrollees, and the public upon request.

SB 59 also requires DHS to develop a simple form to be used by all Medi-Cal managed care plans to inform a Medi-Cal enrollee of a denial, termination, delay or modification in benefits. The use of this form shall be required as a condition of participation in the Medi-Cal managed care program. This requirement affects HCSPs, COHSs, GMC plans, PHPs, PCCMs, and other managed care contractors. The provisions of SB 59 are effective January 1, 2000. HCSPs should review their current UR policies and procedures, as well as the policies and procedures of any subcontracting entity to which they delegate UR responsibility, to assure compliance with the new requirements. MMCD will amend all affected current contracts to require the use of the new form when it is available. (Adds new Sections 1367.01 and 1363.5 to the Health and Safety Code, Section 10123.135 to the Insurance Code, and Section 14087.41 to the Welfare and Institutions Code.)

SB 64 (Chapter 540, Statutes of 1999) – SB 64 requires all HCSP contracts and certain disability policies issued, amended, or renewed on or after January 1, 2000, to include coverage for the management and treatment of diabetes. This coverage must include medically necessary equipment, supplies, prescription drugs, and training and educational services. This bill exempts vision-only, dental-only, accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, and disability income insurance. Medi-Cal managed care plans are not affected because they are already required to cover all medically necessary equipment, supplies, drugs, training, and health education services related to the treatment of diabetes. (Adds Section 1367.51 to the Health and Safety Code and Section 10176.61 to the Insurance Code.)

SB 148 (Chapter 541, Statutes of 1999) – Requires HCSP contracts and specified disability insurance policies to cover the testing and medically necessary treatment of phenylketonuria (PKU) as of July 1, 2000. Specialized HCSP contracts are exempted. Medi-Cal managed care plan contracts are not affected because this coverage is already a Medi-Cal benefit. (Adds Section 1374.56 to the Health and Safety Code and Section 10123.89 to the Insurance Code.)

SB 189 (Chapter 542, Statutes of 1999) – SB 189 modifies existing grievance procedures required of HCSPs. The $250,000 penalty cap is removed for cases involving repeated failure to process grievances properly and timely. Additional provisions relate to the IMR system to be established by AB 55 and coordination of the new IMR system with the existing IMR provided under the Friedman-Knowles Act that concerns requests for coverage of experimental treatment for terminal conditions. SB 189 requires:

- Written responses to grievances with specific minimum content, including information about the IMR system.

- Resolution of grievances within 30 days for HCSPs and DOC, instead of the current 60 days, with additional provision for expedited resolution within 3 days under specific circumstances.
- Investigation and enforcement by DMC (or DOC).
- Integration of the existing IMR system for experimental and investigative procedures with the new IMR system.
- A report to the Legislature on March 1, 2002, on the implementation of the new IMR system.

SB 189 affects *only* HCSPs contracting with the Medi-Cal program (*not* COHSs or other entities not licensed as HCSPs). DHS anticipates that all affected HCSPs currently contracting with the Medi-Cal program will be able to comply with the new grievance requirements. Because the IMR proposed by AB 55 makes specific provisions concerning its application to Medi-Cal enrollees, DHS does not foresee a problem with the IMR provisions of SB 189. (Amends Section 1358.01 and adds Sections 1368, 1368.03, 1368.04, 1370.4, 1374.34, and 1374.3 6 to the Health and Safety Code. Also adds Section 10145.3 to the Insurance Code.)

SB 205 (Chapter 543, Statutes of 1999) – SB 205 requires HCSPs and disability insurers to cover "generally medically accepted" cancer screening tests on any contract or policy issued, amended or renewed on or after January 1, 2000, subject to applicable terms and conditions. Specialized HCSPs (such as dental or mental health plans) and disability insurance policies or contracts with specified exceptions (such as vision-only, dental-only, long-term care, etc.) are exempted. SB 205 does not result in any additional coverage for Medi-Cal managed care plans. (Adds Section 1367.665 to the Health and Safety Code and Section 10123.20 to the Insurance Code.)

SB 260 (Chapter 529, Statutes of 1999) – SB 260 establishes a Financial Solvency Board in DMC to review financial solvency requirements and standards for health plans and their risk-bearing contractors. Health plan contracts issued after July 1, 2000, must contain provisions assessing a risk-bearing organization's administrative and financial capacity, adopting regulations governing the exchange of financial information between plans and risk-bearing organizations, and prohibiting plan contracting with risk-bearing organizations unless the provisions relating to the rates or methods of payment have been negotiated and agreed upon by both parties. SB 260 also places a moratorium on limited Knox-Keene licenses for risk-bearing entities. Medi-Cal managed care plans may need to increase their fiscal data collection and monitoring efforts to meet the requirements of this bill. (Adds Sections 1347.15, 1349.3, 1375.4, 1375.5, and 1375.6, to the Health and Safety Code.) *Note: AB 215 contains clean-up language for SB 260.*

SB 349 (Chapter 544, Statutes of 1999) – Clarifies the definition of emergency services and care to include additional screening, examination, and evaluation needed to determine if a psychiatric emergency medical condition exists. This bill does not add a new responsibility. Although SB 349 does not impact the Medi-Cal program, DHS recommended that this bill be signed because it is consistent with the recently enacted prudent layperson standard for emergency services. Screening, examination and evaluation to determine if a psychiatric emergency medical condition exists are Medi-

Cal benefits and are reimbursed through a local mental health plan; a Medi-Cal managed care plan, or the Medi-Cal fee-for-service program. (Amends Section 1317.1 of the Health and Safety Code.)

SB 559 (Chapter 545, Statutes of 1999) – SB 559 imposes disclosure requirements on every contracting agent that sells, leases, assigns or otherwise transfers a list of contracted providers and their rates to other payors. (Contracting agents and payors may include HCSPs, specialized HCSPs, preferred provider organizations, independent practice associations and others.) Agents must disclose this sale or transfer to contracted providers. Providers must be informed if and how the "payor" will actively encourage beneficiary use of contracted providers. Providers may decline to be included in these transactions if the payor does not actively encourage beneficiary use of contracted providers. Payors must pay provider claims within 30 days of receipt of claim or forfeit their right to the discounted rate. Upon initial signing of the contract for use of the provider list or within 30 days of any provider request, payors must provide a list of all payors currently eligible to claim the provider's discounted rate. This bill is effective July 1, 2000. Although SB 559 will not affect Medi-Cal managed care plan contract provisions, contracted plans will be subject to SB 559's requirements. (Adds Section 511.1 to the Business and Professions Code, Section 1395.6 to the Health and Safety Code, Section 10178.3 to the Insurance Code, and Section 4609 to the Labor Code.)

Note: The complete text of chaptered bills is available through the California State Legislature's website: http://www.leginfo.ca.gov/bilinfo

Prepared by MMCD Policy Unit
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1999 CHAPTERED BILLS IMPACT SUMMARY
(Updated 11/3/99)

BILL INFO		SUBJECT	EFFECTIVE DATE		AFFECTS HCSPs OR OTHERS		PLAN SUBMISSIONS: CONTRACT MONITORING ACTIVITIES			CONTRACT ACTIVITIES	
Bill No.	Chap	Main focus of bill	1/1/2000	Other	HCSPs	Other	New/Rev Policy	New/Rev Procedure	Mmbr Notice[a]	Amend DHS contract	Plan amend subcntrcts
AB 12	531	Second opinions	X		X		X	X	X		As needed
AB 39	532	Contraceptive coverage	X		X						
AB 55	533	Independent medical review		1/1/2001	X		X	X	X	X	X
AB 78	525	Dept of Managed Care		7/1/2000	X		Re: IMR	Re: IMR	Re: IMR	X	X
AB 88	534	Mental health parity		7/1/2000	X						
AB 215	530	Financial solvency	X		X						X
AB 285	535	Telephone medical advice services	X		X		X	X		X	X
AB 416	527	Confidentiality re: outpatient mental health treatment	X		X	Providers					
AB 435	766	Confidentiality re: HIV & workers compensation	X		X	Providers					
AB 496	769	Confidentiality of local initiative plan rates (re: Contra Costa County)	X		X						
AB 724	784	Y2K re: prescriptions		10/10/99	X	Providers					

[a] Member notice may involve changes to member informing materials, form changes and/or special mailings. See specific bill for member notice requirements.
[b] Some provisions of SB 59 (see pg. 2 of this table) affect *only* HCSPs, while others affect *all* Medi-Cal managed care models. See complete bill text for further details.

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Bill No.	Chap	Main focus of bill	1/1/2000	Other	HCSPs	Other	New/Rev Policy	New/Rev Procedure	Mmbr Notice[a]	Amend DHS contract	Plan amend subcntrcts
AB 784	993	Fraud re: providers & suppliers	X			Providers					
AB 892	528	Hospice care		1/1/2002	X						
SB 5	537	Breast cancer screening, diagnosis & treatment	X		X						
SB 19	526	Confidentiality of medical information		7/1/2001	X	Providers	X	X	X	X	X
SB 21	536	Health plan liability		1/1/2001	X		X	X	X		
SB 59	539	Utilization review; new denial form	X		X[b]	COHS, GMC, PHP, PCCM, any other entity doing UR[b]	X	X	X	X	X
SB 64	540	Diabetes coverage	X		X						
SB 148	541	PKU coverage	X		X						
SB 189	542	Grievance procedures		1/1/2001	X		X	X	X	X	X
SB 205	543	Cancer screening coverage	X		X						
SB 260	529	Financial solvency		7/1/2000	X	Any risk-bearing contractors				X	X

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Bill No.	Chap	Main focus of bill	1/1/2000	Other	HCSPs	Other	New/Rev Policy	New/Rev Procedure	Mmbr Notice[a]	Amend DHS contract	Plan amend subcntrcts
SB 349	544	Psychiatric ER services	X		X	Providers					
SB 559	545	Disclosure requirements re: transfer of provider rates		7/1/2000	X	PPOs, IPAs & others					

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