



Department of Health Care Services



LEGISLATIVE SUMMARY 2013

**TOBY DOUGLAS
DIRECTOR**

DEPARTMENT OF HEALTH CARE SERVICES
LEGISLATIVE SUMMARY
2013

Compiled by the
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LEGISLATIVE SUMMARY 2013
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CAPITATED RATES DEVELOPMENT

SB 78 Committee on Budget & Fiscal Review (Chapter 33)
PUBLIC HEALTH: MEDI-CAL MANAGED CARE PLAN TAXES

SB 78, sponsored by the author, implements portions of the 2013-14 Budget Act, as it relates to tax revenues and allocated funding. The bill extends the sunset date for the gross premiums tax imposed on Medi-Cal managed care plans from July 1, 2012 until June 30, 2013, and then replaces it with a permanent managed care organization tax commencing July 1, 2013. This language will also provide the Managed Risk Medical Insurance Board (MRMIB) with General Fund loan authority in 2012-13.

FEE-FOR-SERVICE RATES

AB 10 Alejo (Chapter 351)
MINIMUM WAGE: ANNUAL ADJUSTMENT

AB 10, sponsored by the author, increases the minimum wage for all industries to not less than nine dollars (\$9) per hour, on and after July 1, 2014, and not less than ten dollars (\$10) per hour on and after January 1, 2016. AB 10 increases the state's minimum wage from \$8.00 to \$10.00.

HEALTH POLICY

AB 361 Mitchell (Chapter 642)
MEDI-CAL: HEALTH HOMES FOR MEDI-CAL ENROLLEES AND SECTION 1115 WAIVER DEMONSTRATION POPULATIONS WITH CHRONIC AND COMPLEX CONDITIONS

AB 361, sponsored by the Corporation for Supportive Housing and the Western Center on Law and Poverty, permits DHCS to adopt the optional Medicaid health home benefit as authorized under Section 2703 of the Affordable Care Act (ACA), if DHCS determines that it is operationally viable regarding cost effectiveness, provider network, and eligibility criteria. This optional benefit will be used to provide health home services to Medi-Cal beneficiaries and Section 1115 waiver demonstration populations with chronic conditions.

SBx1 3 Hernandez, E. (Chapter 5)
HEALTH CARE COVERAGE: BRIDGE PLAN

SBx1 3, sponsored by the California Health and Human Services, requires the California Health Benefits Exchange (known as Covered CA) to enter into contracts with and certify as a qualified health plan Medi-Cal managed care plans that offer "bridge plan" products meeting specified requirements;

specifies the populations that would be eligible to purchase a bridge plan product; and requires DHCS to ensure its contracts with Medi-Cal managed care plans meet specified requirements.

LEGISLATIVE AND GOVERNMENTAL AFFAIRS

AB 82 Committee on Budget (Chapter 23)
HEALTH TRAILER BILL

AB 82, sponsored by the author, implements the provisions of the Budget Act for Fiscal Year (FY) 2013-14, as it pertains to DHCS, CDPH, the Mental Health Services Oversight and Accountability Commission (MHSOAC), MRMIB and Department of Managed Health Care.

Sections 1, 6-12, 14, 21, 22, 27-47, 51-54. These sections transfer responsibility for licensing of mental health rehabilitation centers and psychiatric health facilities from California Department of Social Services to DHCS. This transfer further consolidates community mental health facility licensing and program certification functions at DHCS.

Sections 2, 23 and 78. These sections terminate coverage for Access for Infants and Mothers (AIM)-linked infants under the Insurance Code effective October 1, 2013, and transition the administration of the program to DHCS on this date. DHCS will administer the AIM-Linked Infant Program using the same practices for disclosure of records, communications and deliberative processes as MRMIB.

Sections 3-5. These sections clarify notification and county fiscal responsibilities related to the compassionate release and medical probation programs. DHCS is required to adopt regulations and submit an annual report to the Legislature until those regulations are adopted.

Section 13. This section allows the State Controller to transfer funds from the Long-Term Care Quality Assurance Fund to the General Fund (GF), in accordance with Sections 16310 and 16381 of the Government Code, when necessary.

Section 15. This section requires the Every Woman Counts program to include supplemental fiscal information as part of the estimate package it provides during the budget process; no later than January 10 and concurrently with the release of the May Revision each year.

Sections 17- 20. These sections add provisions related to the AIM-Linked Infant Program being transferred to DHCS as it relates to the California Children's Services Program.

Section 48. This section provides that DHCS revises the program elements for prevention and early intervention consistent with regulations from the

MHSOAC. DHCS believes this provision requires clarification about the roles of DHCS and the MHSOAC.

Section 49. This section makes a technical amendment to specify that MHSOAC operates separate and apart from the California Health and Human Services Agency (CHHSA).

Section 50. This section adds provisions for the MHSOAC to adopt regulations for innovative programs and prevention and early intervention. DHCS believes this provision needs clarification about MHSOAC requirements.

Section 55. This section allows all former foster care adolescents who were receiving services on or after July 1, 2013, but no later than December 31, 2013, and lost Medi-Cal coverage as a result of attaining 21 years of age to continue to receive services until January 1, 2014. This aligns the foster care coverage with the ACA which extends coverage to former foster care children until age 26 who aged out of foster at the age of 18, beginning January 1, 2014.

Section 56. This section requires DHCS to post State Plan Amendments, federal waiver applications and requests for new waivers, onto its website as specified.

Section 57. This section requires DHCS to provide the Legislature's fiscal committees supplemental fiscal information regarding the Medi-Cal Specialty Mental Health Services Program. This information shall include: service-type descriptions, children's and adults' caseload and fiscal forecast by service type, a detailed explanation of changes to these forecasts, fiscal charts containing children's and adults' claim costs and unduplicated client counts, and summary fiscal charts with current-year and budget-year proposals. DHCS must make this information available on its website.

Section 58. This section requires DHCS to provide to the Legislature's fiscal committees supplemental fiscal information for the Drug Medi-Cal Program including adult, minor consent, child and perinatal unique client counts and summary fiscal charts for current and budget year proposals. DHCS must make this information available on its website.

Section 59. This section extends the laboratory provider's data submission deadline from 6 months to 11 months; clarifies the current interpretation that laboratory rates cannot exceed 80% of the Medicare rate; and extends the exemption for laboratory services providers from a section of the California Code of Regulations.

Section 60. This section removes provisions that reference an obsolete annual legislative report on the specialty pharmacy provider contracting program and remove the sunset date for executing contracts with providers of specialty pharmacy services.

Section 61. This section repeals Welfare & Institutions (W&I) Code section 14131.07 the seven visit limit on physician office and clinic visits per beneficiary, per year, under Medi-Cal.

Sections 62 and 64. These sections restore adult dental benefits, subject to utilization controls, to adults 21 years of age and older. These sections outline the added covered adult dental benefits and the effective date.

Section 63. This section restores enteral nutrition products benefit coverage to levels existing prior to action taken in the 2011 Budget Act that restricted enteral nutrition products for adult beneficiaries to products administered through a feeding tube (specific diagnosis exempted).

Sections 65 and 66. These sections exempt preventive services and adult vaccines from copayment or cost sharing to ensure DHCS can receive enhanced federally matched assistance payments.

Section 67. This section requires DHCS, by February 1, 2014, to convene a stakeholder advisory committee comprised of managed care health plans, advocates of children and families, providers, counties, and the Legislature to develop measures for screening and referring Medi-Cal beneficiaries to mental health services and supports. In addition, DHCS will be required to provide an updated performance outcomes system plan to the fiscal and appropriate policy committees of the Legislature by October 1, 2014, and a proposal by DHCS describing how to implement the updated performance systems outcome plan by January 10, 2015.

Section 68. This section adds general provisions for the DHCS effective October 1, 2013, to transition and administer the AIM-Linked Infant Program and determine eligibility, scope of coverage and subscriber contribution amounts.

Section 69. This section deletes specific language regarding the Centers for Medicare and Medicaid Services (CMS) approval deadline and allows the updated capitation rates to apply until the end of the Low Income Health Program.

Sections 70 and 71. These sections add provisions to allow private foundations to contribute at least \$26.5 million towards the payment of Medi-Cal in-person enrollment assisters and outreach activities. Federal matching funds would also be requested. SB 101 (Committee on Budget and Fiscal Review, Chapter 361, Statutes of 2013) provides a sunset date of June 30, 2018, for these outreach and enrollment efforts.

Section 72. This section requires DHCS to convene a series of stakeholder meetings to receive input from clients, family members, providers, counties, and representatives of the Legislature concerning the development of the Behavioral Health Services Plan, as required by paragraph 25.d of the

Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Medicaid Demonstration.

Section 75. This section requires DHCS, in support of the ACA, to analyze the fiscal impacts of the ACA for Medi-Cal eligibles whose income eligibility is subject to the use of the Modified Adjusted Gross Income (MAGI) income standard. DHCS will consult with the Legislature's fiscal and policy staff regarding the details of the policy change.

Section 76. This section re-appropriates \$1,058,000 of federal authority from FY 2012-13 to FY 2013-14 for contractual and personnel services to ensure the activities of the federal Consumer Assistance Program grant are completed.

SB 98

Committee on Budget and Fiscal Review (Chapter 358)

PUBLIC HEALTH

SB 98, sponsored by the author, makes technical corrections to fully implement AB 85 (Committee on Budget, Chapter 24, Statutes of 2013), which provided a mechanism for the State to redirect State health realignment funding that will no longer be needed for indigent care when the indigent population becomes eligible for coverage through Medi-Cal or the Exchange. The bill also makes numerous technical corrections that clarifies and eases the implementation of other health and human services budget trailer bills associated with the 2013-14 Budget.

Section 5. This section makes a technical correction to W&I Code section 14186.11, which contained an incorrect citation.

Section 6. This section makes a technical correction to W&I Code section 14199.1, which contained an incorrect citation.

Sections 8, 9, 19 and 24. These sections propose a one month extension for DHCS and the counties to determine the historical amounts. These historical amounts are calculated for FYs 2008-09 through 2011-12 and are used annually in calculating the redirected realignment amount. These sections also limit the amount of realignment funding that is redirected to the Family Support Subaccount in 2013-14 to the lesser of \$300 million or the adjusted savings estimate amount provided by DHCS in the FY 2013-14 May revision of the state budget; further clarify the appeals process; and propose various technical, non-substantive changes to ensure proper code section references, correct grammatical errors, and add clarifying language to avoid potential confusion.

Section 17. This section codifies the historical allocation methodology agreed upon by DHCS and the counties and submitted to the Legislature on August 1, 2013.

Sections 14, 16, 20, 21-23, and 25. These sections make technical, non-substantive changes necessary to clarify the implementation of AB 85.

Section 18. This section repeals existing law which dictated how the historical county funding allocation was to be determined since the historical allocation methodology has been determined through agreement by DHCS and the counties and is being added to statute in SEC 17 of this bill.

SB 101 Committee on Budget and Fiscal Review (Chapter 361)
HEALTH

SB 101, sponsored by the author, made technical changes to provisions contained in AB 82 (Committee on Budget, Chapter 32, Statutes of 2013) related to the allocation of the Department of Alcohol and Drug Program (DADP) prior years' funding encumbrances. AB 75 transferred all remaining functions under the former DADP to DHCS, and did not include this specificity. The bill ensures that DHCS has authority to spend DADP funds to cover DADP expenditures. SB 101 also specifies how funds provided by the California Endowment to DHCS are to be used and created a Special Deposit Fund and specified the amount of funding and positions to be allocated to DHCS for administration of the outreach and enrollment program.

Section 1. This section makes technical amendments to allow DHCS, until July 1, 2017, to liquidate the prior years' encumbrances previously obligated to the former DADP. It provides specific budget item numbers associated with encumbrances of the former DADP.

Sections 4 and 5. These sections amend provisions contained in AB 82 that required DHCS to accept a grant from the California Endowment for the management and funding of Medi-Cal outreach and enrollment activities. The technical amendments specify in more detail the appropriation of the funding of \$14,000,000 and \$12,500,000 from both the Federal Trust Fund and the Health Care Outreach and Medi-Cal Enrollment Account to DHCS; create a Special Deposit Fund to collect and allocate the funds; and specify the amount of funding and positions to be allocated to DHCS for the administration of the outreach and enrollment program.

LONG TERM CARE

AB 753 Lowenthal (Chapter 708)
COGNITIVELY IMPAIRED ADULTS: CAREGIVER RESOURCE CENTERS

AB 753, sponsored by the Association of California Caregiver Resource Centers (CRC), repeals and recasts statutes related to CRCs which includes the recent transfer of oversight of the CRC program from the former Department of Mental Health to DHCS. This bill requires DHCS to contract with regionally-based non-profit CRCs to ensure an array of programs and services for caregivers of cognitively impaired adults. This bill includes a Public Contract Code exception to allow the Director of DHCS to enter into

exclusive or nonexclusive contracts with CRCs on a bid or negotiated basis. This bill also removed a requirement for DHCS to submit an annual report to the Legislature on the effectiveness of the CRCs. CRCs are required only to submit data to DHCS.

SB 67 Committee on Budget and Fiscal Review (Chapter 4)
IN-HOME SUPPORTIVE SERVICES

SB 67, sponsored by the author, resolves three class-action lawsuits affecting the In-Home Supportive Services (IHSS) program, *Oster v. Lightbourne, et al.*, (both Oster I and II) and *Dominguez v. Brown, et al.* Specifically, this bill codifies the settlement agreement reached between plaintiffs and the state that repeals previous budget reductions to the IHSS program and replaces those reductions with an eight percent reduction in FY 2013-14, and then with a seven percent reduction beginning in July, 2014.

The ongoing seven percent reduction may be partially or fully offset by GF savings resulting from a new assessment on home care services, including home health care and IHSS. This assessment, still undefined, needs to be approved by the Legislature and CMS. According to the settlement agreement, legislation must be passed no later than May 24, 2013, and enacted by June 1, 2013, or the Parties to the agreement would need to meet and confer on next steps.

SB 94 Committee on Budget and Fiscal Review (Chapter 37)
**MEDI-CAL: MANAGED CARE: LONG-TERM SERVICES AND SUPPORTS:
IN-HOME SUPPORTIVE SERVICES**

SB 94, sponsored by the author, permits the mandatory enrollment of persons eligible for Medicare and Medi-Cal (Duals) into Medi-Cal managed care; the integration of Long-Term Supports and Services into managed care plans operating in the eight Coordinated Care Initiative (CCI) counties to proceed separately from the CCI Duals Demonstration (Cal MediConnect). This bill allows each component of the CCI program to continue separately from others as long as adequate savings are generated. However, the bill also specifies that if the CCI does not provide net savings to the state General Fund, then all components of the CCI will become inoperative.

LOW-INCOME HEALTH PROGRAM

SB 249 Leno (Chapter 445)
PUBLIC HEALTH: HEALTH RECORDS: CONFIDENTIALITY

SB 249, sponsored by the AIDS Legal Referral Panel, the Conference of California Bar Associations, the Los Angeles Gay & Lesbian Center, and the San Francisco Acquired Immune Deficiency Syndrome (AIDS) Foundation, allows California Department of Public Health (CDPH) and qualified entities, as defined in the bill, to share with each other public health records relating to people living with HIV and AIDS, who are beneficiaries enrolled in the federal

Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White), for the purpose of coordinating care for patients transitioning to other sources of health care through the ACA. The bill also clarifies that both the local health officer and CDPH are authorized to access reports of HIV infection that are electronically submitted by laboratories, instead of requiring laboratories, upon request by CDPH, to report cases of HIV infection by name directly. If DHCS chooses to receive the HIV data specified in this bill, the data would need to be treated separately from other healthcare records and could only be released pursuant to Health and Safety Code Section 121025, the Confidentiality of Medical Information Act, the Insurance Information and Privacy Protection Act, and any additional statutes referenced in SB 249.

MEDI-CAL BENEFITS

AB 446 Mitchell (Chapter 589)
HIV TESTING

AB 446, sponsored by the AIDS Healthcare Foundation, requires primary care clinics to offer patients a Human Immunodeficiency Virus (HIV) test when the clinic performs a blood draw consistent with the United States Preventive Services Task Force recommendation for screening for HIV infection. The bill requires the person administering the test to record the patient's oral or written informed consent, except when a person independently requests an HIV test from an HIV counseling and testing site, as specified. It also authorizes disclosure of HIV test results by internet posting or other electronic means, if the result is posted on a secure website and can only be viewed with use of a secure personal code.

MEDI-CAL ELIGIBILITY

AB 422 Nazarian (Chapter 440)
SCHOOL LUNCH PROGRAM APPLICATIONS: HEALTH CARE NOTICE

AB 422, sponsored by the California Pan-Ethnic Health Network and St. John's Well Child and Family Center, adds a new requirement for school districts participating in the optional Express Enrollment pilot project, to update the National School Lunch Program (NSLP) information form, which is only used by the counties participating in the Medi-Cal pilot project, to include details about eligibility for the Covered California reduced cost health care options available as a result of the ACA. Alternately, school districts may choose to provide this health coverage information outside of the NSLP application packet and place it in the notifications provided to parents annually at the beginning of the school term. Further, the bill eliminates a notification process county welfare departments are currently required to provide when a parent mistakenly applies for Medi-Cal on the school lunch application and is determined by the county welfare department already to be enrolled in Medi-Cal.

AB 720

Skinner (Chapter 646)

INMATES: HEALTH CARE ENROLLMENT

AB 720, sponsored by the Californians for Safety and Justice, authorizes county boards of supervisors (BOS) to designate an entity or entities to assist county inmates with applying for a health insurance affordability program; authorizes an entity or entities to act on behalf of an inmate for purposes of applying for, or determinations of, Medi-Cal eligibility for acute inpatient hospital services provided while the individual is an inmate; requires that the county sheriff only be designated as the “entity” if he/she agrees to perform the function of the “entity;” requires that the county jail administrator or his/her designee approve the designation, if the BOS wants to designate a community based organization as the “entity;” amends current Medi-Cal suspension rules to expand the suspension process to include all inmates, not just juvenile inmates; requires DHCS to implement the new inmate suspension rules, if FFP is not jeopardized; and allows the state to implement the bill by means of ACWDLs.

ABx1 1

Pérez, J. (Chapter 3)

MEDI-CAL: ELIGIBILITY

ABx1 1, sponsored by the author, authorizes DHCS to implement various Medicaid provisions of the ACA. This is a companion bill to SBX1 1 and is operative only to the extent SBX1 1 is enacted. Specifically, ABX1 1 implements the new “adult group” in California; transitions current Low-Income Health Program (LIHP) beneficiaries to Medi-Cal January 1, 2014; implements the use of the MAGI methodology as prescribed in ACA for determining Medi-Cal eligibility for select coverage groups; simplifies the annual renewal and change in circumstance processes for Medi-Cal beneficiaries; requires DHCS to use electronic verifications of eligibility criteria both at initial application and redeterminations of eligibility; permits Covered California to make Medi-Cal eligibility determinations in limited situations; and establishes performance standards for DHCS, Covered California, and SAWS.

Sections 5 and 22. W&I Code sections 14005.36 and 14016.6

These sections require DHCS to adopt emergency regulations by July 1, 2015.

Sections 9, 11, 15-17, and 24.

These sections provide authority for all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. Thereafter, DHCS is required to adopt regulations, and beginning six months after the effective date of the section, DHCS is required to provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

Section 7 – W&I Code Section 14005.37

- Requires DHCS, in consultation with the counties and representatives of eligibility workers and consumers, to develop a prepopulated form for annual eligibility redetermination for use with beneficiaries whose eligibility is determined using MAGI-based financial methods.
- Requires DHCS to develop prepopulated renewal forms for use with beneficiaries whose eligibility is not determined using MAGI-based financial methods by January 1, 2015.
- Requires DHCS, in consultation with the counties, representatives or consumers, and eligibility workers to develop a prepopulated form for use in the case of a redetermination due to change in circumstances.
- Requires DHCS to seek federal approval to extend the annual redetermination date for a three-month period for those Medi-Cal beneficiaries whose annual redeterminations are scheduled to occur between January 1, 2014, and March 31, 2014.

Section 10 – W&I Code Section 14005.61

- Transitions current LIHP beneficiaries who are at or below 133 percent of the federal poverty level to the Medi-Cal program on January 1, 2014. Except as specified, individuals eligible for Medi-Cal will be enrolled into Medi-Cal managed care health plans. In counties where no Medi-Cal managed care health plans are available, LIHP enrollees will be transitioned into fee-for-service Medi-Cal.

Section 11 – W&I Code Section 14005.64

- Requires DHCS to establish income eligibility thresholds for those Medi-Cal eligibility groups whose eligibility will be determined using MAGI-based financial methods.
- DHCS shall report to the Legislature on the expected changes in income eligibility thresholds using the chosen methodology for individuals whose income is determined on the basis of a converted dollar amount or federal poverty level percentage. DHCS shall convene stakeholders, including the Legislature, counties, and consumer advocates regarding the results of the converted standards and shall review with them the information used for the specific calculations before adopting its final methodology for the equivalent income eligibility threshold level.

Section 15 – W&I Code Section 14013.3

- DHCS shall develop, and update as it is modified, a verification plan describing the verification policies and procedures adopted by DHCS to verify eligibility information. If DHCS determines that any state or federal agencies or programs not previously identified in the verification plan are useful in determining an individual's eligibility for Medi-Cal benefits or for potential eligibility, for an insurance affordability program offered through Covered California, DHCS shall update the verification plan to identify those additional agencies or programs. The development and modification of the verification plan shall be undertaken in consultation with representatives from county human services departments, legal aid

advocates, and the Legislature. The verification plan shall conform to all federal requirements and shall be posted on DHCS's Internet Web site.

Section 17 – W&I Code Section 14015.7

- Requires DHCS, Covered California, and each county consortia to jointly enter into an interagency agreement that specifies the operational parameters and performance standards pertaining to the workflow transfer protocol. After consulting with counties, consumer advocates, and labor organizations that represent employees of the customer service center operated by Covered California and employees of county customer service centers, DHCS and Covered California shall determine and implement the performance standards that shall be incorporated into these agreements.
- Prior to October 1, 2014, DHCS and Covered California, in consultation with counties, consumer advocates, and labor organizations that represent employees of the customer service center operated by Covered California and employees of county customer service centers, shall review and determine the efficacy of the specified enrollment procedures.

Section 20 – W&I Code Section 14016.5

- Requires DHCS to establish standards for the: 1) maximum distances a beneficiary is required to travel to obtain primary care services from the managed care plan, FFS case management provider, or pilot project in which the beneficiary is enrolled; 2) conditions under which a primary care service site shall be accessible by public transportation; and 3) conditions under which a managed care plan, FFS case management provider, or pilot project shall provide nonmedical transportation to a primary care service site.
- Requires DHCS to consult with a group of stakeholders through either a group currently in existence or convened for training purposes that includes representatives of plans, providers, consumer advocates, counties, eligibility workers, California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), Covered California, and the Legislature, to review process, timelines, scripts, training curricula, monitoring and oversight plans, and plan marketing and informational materials.

Section 22 – W&I Code Section 14016.6

- Requires DHCS to develop a program that allows individuals or their authorized representatives to select Medi-Cal managed care plans via CalHEERS and to provide information and assistance to enable Medi-Cal beneficiaries to understand and successfully use the services of the Medi-Cal managed care plans in which they enroll.

Section 24 – W&I Code Section 14102.5

- Requires DHCS, in collaboration with Covered California, the counties, consumer advocates, and the Statewide Automated Welfare System (SAWS) consortia, to develop and prepare one or more reports to be

issued on at least a quarterly basis and shall be made publicly available within 30 days following the end of each quarter, for the purpose of informing the California Health and Human Services Agency, Covered California, the Legislature, and the public about the enrollment process for all insurance affordability programs.

Section 25 – W&I Code Section 14103

- If the federal medical assistance percentage (FMAP) payable to the state under the ACA for the optional expansion of Medi-Cal benefits to adults is reduced below 90 percent, ABX1 1 requires that reduction to be addressed in a timely manner through the annual state budget or legislative process. Upon receiving notification of any reduction in federal assistance as specified, the Director of Finance shall immediately notify the Chairperson of the Senate and Assembly Health Committees and the Chairperson of the Joint Legislative Budget Committee.
- If prior to January 1, 2018, the FMAP payable to the state under the ACA for the optional expansion of Medi-Cal benefits to adults is reduced to 70 percent or less, ABX1 1 requires the implementation of any provision as specified authorizing the optional expansion of Medi-Cal benefits to adults to cease 12 months after the effective date of the federal law or other action reducing the federal medical assistance percentage.

Section 26 – W&I Code Section 15926

- Requires DHCS, until January 1, 2016, to instruct counties to not reject an application that was in existence prior to January 1, 2014, but to accept the application and request any additional information needed from the applicant in order to complete the eligibility determination process. DHCS is to work with counties and consumer advocates to develop the supplemental questions.

SB 28

E. Hernandez and Steinberg. (Chapter 442)

CALIFORNIA HEALTH BENEFIT EXCHANGE

SB 28, sponsored by the authors, requires MRMIB to provide Covered California with contact information for MRMIB subscribers, so Covered California can provide outreach to these individuals regarding their potential eligibility for Covered California products or the Medi-Cal program. SB 28 also includes cleanup language to SB x1 1 and AB x1 1, as agreed upon by the administration, the Legislature, and stakeholders. These clean up provision include: 1) permitting DHCS to implement various provisions of the ACA using ACWDLs until regulations are developed no later than July 1, 2017; and a new budgeting methodology for Medi-Cal county administrative costs for conducting Medi-Cal eligibility determinations and case maintenance activities. This new budgeting methodology is required to be implemented no sooner than the 2015-16 FY.

Section 14 – W&I Code Section 14154

- Requires DHCS to develop and implement, in consultation with county program and fiscal representatives, a new budgeting methodology for

Medi-Cal county administrative costs that reflects the impact of ACA implementation on county administrative work. The new budgeting methodology shall be implemented no sooner than the 2015-16 FY.

- Requires DHCS to provide the new budgeting methodology to the legislative fiscal committee by March 1 of the FY immediately preceding the first FY year of implementation of the new budgeting methodology.

SB 346

Beall (Chapter 658)

PUBLIC SOCIAL SERVICES: RECORDS

SB 346, sponsored by the County of Santa Clara Board of Supervisors, clarifies existing law regarding the sharing of confidential information by public social services programs. In addition, this bill updates existing law to exempt the sharing of data for the Medi-Cal Managed Care Program and newly transitioned Medi-Cal beneficiaries from the Healthy Families Program (HFP).

SB 800

Lara (Chapter 448)

HEALTH CARE COVERAGE PROGRAMS: TRANSITION

SB 800, sponsored by the Service Employees International Union, transfers MRMIB civil service employees assigned to HFP, Access for Infants and Mothers Program (AIM), the County Health Initiative Matching Fund, and the Major Risk Medical Insurance Program to DHCS in the event a statute dissolves or terminates MRMIB. The bill also requires DHCS to report to the Legislature on the transfer of employees or any functions transferred to DHCS by February 1 of the year following the year in which employees are transferred and if necessary, updated reports in each of the following two years; and instructs DHCS to assist Covered California with conducting outreach to specified individuals that are not enrolled in Medi-Cal, who may be eligible for insurance affordability programs. Finally, SB 800 establishes the transfer of civil service employees assigned to the Federal Temporary High Risk Pool to Covered California.

SBx1 1

E. Hernandez and Steinberg (Chapter 4)

MEDI-CAL: ELIGIBILITY

SBx1 1, sponsored by the author, authorizes DHCS to implement various Medicaid provisions of the ACA. This is a companion bill to ABX1 1 and is operative only to the extent SBx1 1 is enacted. Specifically, SBx1 1 requires the provision of mental health services, within the context of the essential health benefits, to be provided by Medi-Cal managed care plans for covered beneficiaries; provides for enhanced substance use disorder services, within the context of the essential health benefits, for covered beneficiaries; outlines coverage options for newly eligible adult legal immigrants; implements former foster youth Medi-Cal expansion as required by the ACA; establishes new state residency requirements; permits DHCS to use projected annual increases and predictable future increases and decreases for income eligibility; establishes provisions for authorized representatives; requires DHCS to seek federal waivers for streamlining income eligibility

determinations for newly eligible individuals who are served by other public programs; and establishes provisions for implementing the use of presumptive eligibility by hospitals.

Section 5 – W&I Code Section 14005.28

- Requires DHCS to develop procedures to identify and enroll individuals in foster care that meet the criteria for Medi-Cal eligibility, including, but not limited to, former foster care adolescents who were in foster care on their 18th birthday and who lost Medi-Cal coverage as a result of attaining 21 years of age.
- Requires DHCS to develop and implement a simplified redetermination form for foster care individuals.
- Requires DHCS to seek federal approval to institute a renewal process that allows a foster care individual to remain on Medi-Cal after a redetermination form is returned as undeliverable and the county is otherwise unable to establish contact.

Section 7 – W&I Code Section 14005.31

- Requires DHCS, in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers to prepare a simple, clear, consumer-friendly notice to be used by the counties to inform Medi-Cal beneficiaries whose eligibility for cash aid under specified statute has ended, but whose eligibility for benefits continues pursuant to specified statute, and their benefits will continue.

Section 9 – W&I Code Section 14005.32

- Requires DHCS, in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers to prepare a simple, clear, consumer-friendly notice to be used by the counties to inform beneficiaries that their Medi-Cal benefits have been transferred and to inform them about the program to which they have been transferred.

Section 22 – W&I Code Section 14011.66

- Requires DHCS to establish a process for determining whether a hospital should be disqualified from being able to make presumptive eligibility determinations as specified.

Section 26 – W&I Code Section 14103

- If the FMAP payable to the state under the ACA for the optional expansion of Medi-Cal benefits to adults is reduced below 90 percent, ABX1 1 requires that reduction to be addressed in a timely manner through the annual state budget or legislative process. Upon receiving notification of any reduction in federal assistance as specified, the Director of Finance shall immediately notify the Chairperson of the Senate and Assembly Health Committees and the Chairperson of the Joint Legislative Budget Committee.
- If prior to January 1, 2018, the FMAP payable to the state under the ACA for the optional expansion of Medi-Cal benefits to adults is reduced to 70

percent or less, ABX1 1 requires the implementation of any provision as specified authorizing the optional expansion of Medi-Cal benefits to adults to cease 12 months after the effective date of the federal law or other action reducing the FMAP.

Section 28 – W&I Code Section 14132.02

- Requires DHCS to seek approval from the United States Secretary of Health and Human Services to provide individuals made eligible under specified statute with the alternative benefit package option authorized under the United States Code as specified.

MEDI-CAL MANAGED CARE

AB 776 Yamada (Chapter 298)
MEDI-CAL

AB 776, sponsored by the California Association of Area Agencies on Aging and the California Commission on Aging, redefines the term “stakeholder” for the purpose of the CCI as including AAAs and ILCs. The bill specifically adds AAAs and ILCs to key DHCS CCI stakeholder groups and will require that AAAs and ILCs be consulted prior to issuance of APLs and other provider bulletins or instructions related to CCI.

SB 208 Lara (Chapter 656)
PUBLIC SOCIAL SERVICES: CONTRACTING

SB 208, sponsored by the California Association of Physician Groups, Health Net, and L.A. Care Health Plan, allows MCPs to enter into a subcontract in which consideration will be determined by a percentage of a MCP’s payment from DHCS, unless DHCS objects.

SB 494 Monning (Chapter 684)
HEALTH CARE PROVIDERS

SB 494, sponsored by the California Academy of Physician Assistants and the California Association of Physician Groups, ensures there is at least one full-time equivalent primary care physician (PCP) for every 2,000 enrollees in a health care plan, MCP, and authorizes the assignment of up to 1,000 additional enrollees for each non-physician medical practitioner supervised by a PCP. The bill also redefines primary care provider to be inclusive of non-physician medical practitioners, as applicable, and requires DHCS to include non-physician medical practitioners in its plan readiness evaluations.

MENTAL HEALTH

AB 1054 Chesbro (Chapter 303)
MENTAL HEALTH: SKILLED NURSING FACILITY: REIMBURSEMENT RATE

AB 1054, sponsored by the California Mental Health Directors Association, reduces the automatic rate increases that counties are required to reimburse Institutions for Mental Disease (IMD) that are licensed as Skilled Nursing Facilities (SNF) from 4.7 percent annually, to 3.5 percent annually, effective July 1, 2014. The bill also expresses the intent of the Legislature that the annual rate increases be utilized by the SNF-IMDs to meet direct service costs and, to the extent possible, improve the quality of care rendered to residents in the facilities. The purpose of the bill is to align the annual rate increase with the actual cost of providing these services, while maintaining a predictable mechanism for county and facility budgeting.

SB 82 Committee on Budget and Fiscal Review (Chapter 34)
INVESTMENT IN MENTAL HEALTH WELLNESS ACT OF 2013

SB 82, sponsored by the author, establishes the Investment in Mental Health Wellness Act of 2013 and provides the necessary statutory references to enact mental health related provisions of the 2013-14 Budget. The bill authorizes the California Health Facilities Financing Authority and the Mental Health Services Oversight and Accountability Commission to develop programs to award funds to counties or counties acting jointly for the purpose of increasing community-based mental health treatment options. The bill also increases authorization for state administrative costs for the Mental Health Services Act (MHSA) from the current 3.5 percent maximum to a 5 percent maximum of annual revenues.

SB 364 Steinberg (Chapter 567)
MENTAL HEALTH

SB 364, sponsored by the author, broadens the types of facilities that may be designated by a county for 72-hour mental health evaluation and treatment under W&I Code Section 5150 of the Lanterman-Petris-Short Act, and authorizes county mental health directors to develop procedures for the designation and training of professionals who will be authorized to perform certain functions under Section 5150.

SB 585 Steinberg (Chapter 288)
MENTAL HEALTH: MENTAL HEALTH SERVICES FUND

SB 585, sponsored by the author, allows mental health services provided under the Assisted Outpatient Treatment (AOT) Demonstration Project Act of 2002, also known as Laura's Law, to be funded with the Local Revenue Fund, the Local Revenue Fund 2011, or the Mental Health Services Fund. This bill

specifically adds AOT services to the list of exceptions to voluntary treatment under the Adult and Older Adult Mental Health System of Care Act provided the client has had the opportunity to voluntarily participate in a treatment plan. Lastly, this bill makes clear that a county may use MHSA funds for AOT services when the county includes AOT programs in its three-year program and expenditure plan and annual updates. The purpose of the bill is to remove uncertainty about counties' ability to use MHSA funds for outpatient mental health treatment for those who do not voluntarily access local mental health services.

OFFICE OF MEDI-CAL PROCUREMENT

AB 906 Pan (Chapter 744)
PERSONAL SERVICES CONTRACT

AB 906, sponsored by the American Federation of State, County and Municipal Employees, and the Service Employees International Union, prohibits the execution of proposed personal services contracts, as specified, until the State agency proposing to execute the contract has notified all organizations that represent State employees who perform the type of work to be contracted. A full copy of the proposed contract is to be provided with the notification. The bill also requires the Department of General Services to establish a process to certify notifications.

SAFETY NET FINANCING

AB 85 Committee on Budget (Chapter 24)
HEALTH AND HUMAN SERVICES

AB 85, sponsored by the author, is the 1991 Realignment/California Work Opportunity and Responsibility to Kids (CalWORKs) trailer bill, which contains statutory and technical changes necessary to implement the Budget Act of 2013 that relate to sales tax and county reimbursement for health and human services. Sections 2, 3, 9, 20, and 21, directly apply to DHCS. This bill also implements a mechanism for counties to share savings, which result from implementation of the federal ACA, with the state. The bill requires specified percentages of newly eligible Medi-Cal beneficiaries under Medi-Cal expansion to be assigned to public hospital health systems in an eligible county, until the county public hospital health system (county public hospital) meets its enrollment target, as defined. The bill also requires Medi-Cal managed care plans serving newly eligible beneficiaries to pay county public hospitals for services provided to newly eligible beneficiaries in amounts that are no less than the cost of providing those services, as specified. It requires DHCS to pay Medi-Cal managed care plans rate range increases at a minimum level of 75 percent of the rate range available for enrollees who are newly eligible Medi-Cal beneficiaries. It defines the realignment options for the three county groups—the 34 County Medical Services Program counties; the 12 public hospital counties in Alameda, Contra Costa, Kern, Los Angeles,

Monterey, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, and Ventura; and a 12-county group of Fresno, Merced, Orange, Placer, Sacramento, San Diego, San Luis Obispo, Santa Barbara, Santa Cruz, Stanislaus, Tulare, and Yolo. It specifies the formula based approach to calculating the redirected realignment amount for the public hospital counties starting in the 2013-14 FY, with alternate formula components for Los Angeles County. It specifies the formula based approach to calculating the redirected realignment amount to the twelve-county group of Fresno, Merced, Orange, Placer, Sacramento, San Diego, San Luis Obispo, Santa Barbara, Santa Cruz, Stanislaus, Tulare, and Yolo.

AB 498 Chávez. (Chapter 672)
MEDI-CAL

AB 498, sponsored by the District Hospital Leadership Forum, authorizes DHCS to seek federal Safety Net Care Pool (SNCP) funding and implement a CPE supplemental payment program to distribute SNCP funds to Non-designated public hospitals who voluntarily choose to participate, for FY 2013-14 and FY 2014-15. The bill also allows eligible Distinct Part Nursing Facilities to claim supplemental federal reimbursement up to the federal limit. AB 498 also clarifies that the supplemental payments are subject to a reconciliation process to ensure that the supplemental payments are not in excess of allowable costs.

AB 1233 Chesbro, (Chapter 306)
MEDI-CAL: ADMINISTRATIVE CLAIMING PROCESS

AB 1233, sponsored by the California Rural Indian Health Board, authorizes a Native American Indian tribe, a tribal organization, or a subgroup of a Native American Indian tribe or tribal organization to claim, as a Medi-Cal Administrative Activity (MAA), facilitating Medi-Cal applications; which includes, but is not limited to, using CalHEERS.

SB 239 Hernandez, E. (Chapter 657)
MEDI-CAL: HOSPITALS: QUALITY ASSURANCE FEES: DISTINCT PART SKILLED NURSING FACILITIES

SB 239, sponsored by the California Hospital Association, enacts the Medi-Cal Hospital Reimbursement Improvement Act of 2013, and establishes a new Hospital Quality Assurance Fee (QAF) program effective from January 1, 2014, through December 31, 2016. The Act also establishes the platform and structure for continuation of the program should subsequent legislation or constitutional amendments be enacted. SB 239 also enacts the Medi-Cal Hospital Reimbursement Improvement and Restoration Act of 2013, which eliminates the rate freeze and rate reductions to DP/NFs on a prospective basis, effective October 1, 2013. Lastly, SB 239 reestablishes state authority to continue making payments to select hospitals using intergovernmental transfer payments from public entities and to reimburse hospitals participating in the construction renovation reimbursement program previously authorized

under the Medi-Cal Selective Provider Contracting Program, which became inoperative on June 30, 2013.

SUBSTANCE USE DISORDER PREVENTION, TREATMENT & RECOVERY

AB 75 Committee on Budget (Chapter 22) **ALCOHOL AND DRUG PROGRAMS**

AB 75, sponsored by the author, transfers all rights and responsibilities of DADP to DHCS, with the exception of all rights and responsibilities of the Office of Problem Gambling (OPG) transferring to CDPH, effective July 1, 2013. The bill requires, until July 1, 2018, CDPH and DHCS to report annually to specified legislative committees on the effects of the transfer of DADP programs. AB 75 implements the Governor's plan to integrate primary care, mental health, and substance use disorder delivery systems to facilitate California's implementation of national health care reform.

Sections 1, 2, 4-6, 16-19, 22, 27, 31-33, 40, 45, 53, 59, 65, 66, 70, 72, 73, 75-77, 79-89, 94-96, 101-103, and 107-108: deletes the mention of ADP and adds DHCS. These amendments provide DHCS with all authority and power, upon the enactment of the Budget Act of 2013, to administer all of the duties, powers, functions, and jurisdiction of ADP. This proposal is a continuing effort to transfer programs as part of the elimination of DADP and transfer of its functions to other departments within CHHSA by July 1, 2013, pursuant to SB 1014 (Chapter 36, Statutes. of 2012), which transferred responsibility for the Drug Medi-Cal Program to DHCS.

Sections 3, 8, 97-99 delete the mention of DADP and adds CDPH. The purpose of OPG is to provide awareness, prevention and treatment services to problem and pathological gamblers in California. There is an identified public health role and benefit to Californians to reduce the amount of problem and pathological gambling in the state to provide treatment services to those Californians that exhibit these behaviors.

Section 7 deletes DADP from the list of agencies that may adopt regulations stating the procedures to be followed when making its records available. A Legislative Counsel drafting error, acknowledged by legislative staff, deleted the Office of Statewide Health Planning and Development and mention of DADP from the list. Government Code Section 6253.4 on page 10, line 12, restores the Office of Statewide Health Planning and Development to, and restores and strikes DADP from the list of agencies. This change may be made through and a trailer bill clean-up bill.

Section 9 updates department names and lists departments currently under CHHSA, respectively.

Sections 10-15 delete DADP; DHCS is already in statute.

Section 20 transfers all functions and resources related to substance use disorder services from DADP to DHCS effective July 1, 2013. This section states multiple objectives for the transfer, including ensuring appropriate state oversight by consolidating into one department, DHCS, the two primary public funding sources for California's substance use disorder system, which are the Substance Abuse Prevention and Treatment Block Grant and the Drug Medi-Cal Treatment Program. This continues and completes the reorganization of the state substance use disorder programs and functions that began with passage of AB 106 (Chapter 32, Statutes of 2011), which authorized the transfer of the Drug Medi-Cal program from DADP to DHCS effective July 1, 2012.

AB 635

Ammiano (Chapter 707)

DRUG OVERDOSE TREATMENT: LIABILITY

AB 635, sponsored by the California Society of Addiction Medicine and the Harm Reduction Coalition, expands the existing pilot project that authorizes licensed health care providers in seven counties in California to prescribe and dispense or distribute the opioid antagonist, defined as naloxone hydrochloride, to those in a position to assist individuals at risk of an opiate-related overdose without criminal and/or civil liability. The bill removes the restriction to seven counties, removes the January 1, 2016 sunset date, and removes other pilot project reporting requirements.

2013 ENROLLED BILLS

BILL NUMBER	AUTHOR	FINAL STATUS	CHAPTER	PROGRAM*	PAGE NUMBER
AB 10	Alejo	Sign	351	FR	1
AB 50	Pan	Veto	---	ME	---
AB 75	Committee on Budget	Sign	22	PT	19
AB 82	Committee on Budget	Sign	23	LA	2
AB 85	Committee on Budget	Sign	24	SF	17
AB 361	Mitchell	Sign	642	HP	1
AB 411	Pan	Veto	---	MC	---
AB 422	Nazarian	Sign	440	ME	8
AB 446	Mitchell	Sign	589	MB	8
AB 498	Chávez	Sign	672	SF	18
AB 635	Ammiano	Sign	707	PT	20
AB 720	Skinner	Sign	646	ME	9
AB 753	Lowenthal	Sign	708	LT	6
AB 776	Yamada	Sign	298	MC	15
AB 906	Pan	Sign	744	OP	17
AB 1054	Chesbro	Sign	303	MH	15
AB 1208	Pan	Veto	---	ME	---
AB 1233	Chesbro	Sign	306	SF	18
AB 1263	Pérez, J.	Veto	---	MB	---
ABx1 1	Pérez, J.	Sign	3	ME	9
SB 28	Hernandez, E.	Sign	442	ME	12
SB 67	Committee on Budget and Fiscal Review	Sign	4	LT	7
SB 78	Committee on Budget and Fiscal Review	Sign	33	RD	1
SB 82	Committee on Budget and Fiscal Review	Sign	34	MH	16
SB 94	Committee on Budget and Fiscal Review	Sign	37	LT	7
SB 98	Committee on Budget and Fiscal Review	Sign	358	LA	5
SB 101	Committee on Budget and Fiscal Review	Sign	361	LA	6
SB 208	Lara	Sign	656	MC	15
SB 239	Hernandez, E.	Sign	657	SF	18
SB 249	Leno	Sign	445	LH	7
SB 346	Beall	Sign	658	ME	13
SB 364	Steinberg	Sign	567	MH	16
SB 494	Monning	Sign	684	MC	15
SB 585	Steinberg	Sign	288	MH	16
SB 800	Lara	Sign	448	ME	13
SBx1 1	Hernandez, E.	Sign	4	ME	13
SBx1 3	Hernandez, E.	Sign	5	HP	1

PROGRAM ASSIGNMENTS AND ACRONYMS

PROGRAM	Acronym
Fee-for-Service Rate Development	FR
Health Policy	HP
Legislative and Governmental Affairs, Office of	LA
Low Income Health Program	LH
Long-Term Care	LT
Medi-Cal Benefits	MB
Medi-Cal Managed Care	MC
Medi-Cal Eligibility	ME
Mental Health Services	MH
Medi-Cal Procurement, Office of	OP
Capitated Rates Development	RD
Substance Use Disorder Prevention, Treatment & Recovery	PT
Safety Net Financing	SF

SIGN MESSAGES

(No Sign messages recorded.)

VETO MESSAGES

<u>BILL#</u>	<u>AUTHOR</u>	<u>SUBJECT</u>	<u>DIV</u>
AB 50	Pan	Health Care Coverage: Medi-Cal: eligibility	ME
AB 411	Pan	Medi-Cal: performance measures	MC
AB 1208	Pan	Insurance affordability programs: application form	ME
AB 1263	Pérez	Medi-Cal: CommuniCal	MB



OFFICE OF THE GOVERNOR

OCT 09 2013

To the Members of the California State Assembly:

Assembly Bill 50 would provide “full-scope” health care coverage for pregnant women between 60 and 100 percent of federal poverty level, during the first and second trimesters of pregnancy, if they otherwise meet Medi-Cal eligibility requirements. Currently, pregnant women in this and higher income groups (up to 200 percent of the federal poverty level), receive all medically necessary services related to their pregnancy.

While I support this policy, I can’t support this bill.

Through the 2013 Budget Act and AB 1 and SB 1 in this year’s special session, we enacted a historic expansion of our state’s Medi-Cal program. Many trade-offs were made in determining our ultimate policy direction. Expanding coverage options for pregnant women, however, remained unresolved.

Rather than enacting a piecemeal change, further discussion should take place on the entire category of pregnancy-only coverage, not just women between 60-100 percent of the federal poverty level.

The development of the 2014-15 budget is underway. I am directing the Department of Health Care Services to work on a more complete proposal for January.

Sincerely,


Edmund G. Brown Jr.



OFFICE OF THE GOVERNOR

OCT 08 2013

To the Members of the California State Senate:

I am returning Assembly Bill 411 without my signature.

Nothing in current law prevents the Department of Health Care Services from requiring its external quality review organization to provide more detailed data by geography, race, ethnicity, or other demographic attribute.

If the department sees a need or benefit that justifies the costs of procuring this additional data, I am confident that they will procure it.

Sincerely,


Edmund G. Brown Jr.



OFFICE OF THE GOVERNOR

OCT 11 2013

To the Members of the California State Assembly:

I am returning Assembly Bill 1208 without my signature.

AB 1208 would mandate that the single, standardized application for health insurance affordability programs include questions related to race, ethnicity, primary language, disability status, sexual orientation, gender identity and expression, so that applicants can voluntarily report this information beginning in 2015.

We don't need to mandate these requirements in law. The Department of Health Care Services and Covered California already have the authority to modify these types of questions on the form, and they can work constructively with stakeholders to decide what is necessary to change for 2015 and beyond.

Sincerely,


Edmund G. Brown Jr.



OFFICE OF THE GOVERNOR

OCT 13 2013

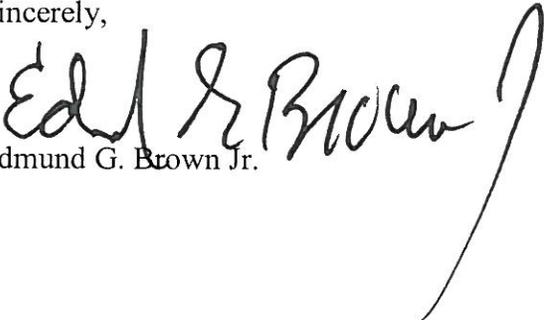
To the Members of the California State Assembly:

I am returning Assembly Bill 1263 without my signature.

The bill would require the Department of Health Care Services to establish the CommuniCal program to certify and restructure current interpreter services provided under Medi-Cal.

California has embarked on an unprecedented expansion to add more than a million people to our Medi-Cal program. Given the challenges and the many unknowns the state faces in this endeavor, I don't believe it would be wise to introduce yet another complex element.

Sincerely,


Edmund G. Brown Jr.