Department of Health Care Services

LEGISLATIVE SUMMARY 2012

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DEPARTMENT OF HEALTH CARE SERVICES

LEGISLATIVE SUMMARY
2012

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ADMINISTRATION

AB 2508 Bonilla (Chapter 824)
PUBLIC CONTRACTS: PUBLIC HEALTH AGENCIES

AB 2508, sponsored by the California Labor Federation and the Western Center of Law and Poverty, prohibits state agencies from contracting for call center services with a contractor or subcontractor unless that contractor or subcontractor certifies in his or her bid that the work will be performed solely with workers employed in California. The bill establishes a civil penalty to be imposed upon any contractor knowingly providing false information in that certification. The bill also requires the call center service contracts to include a clause providing a right by the state to terminate the contract for non-compliance if the contractor or subcontractor performs the contract or subcontracts with workers outside of California during the life of the contract.

FEE-FOR-SERVICE RATES

AB 969 Atkins (Chapter 738)
MEDI-CAL: CLINICAL LABORATORY SERVICES

AB 969, sponsored by the California Primary Care Association prohibits donations of, or discounts for, clinical laboratory tests, examinations or laboratory services to federally-qualified healthcare centers (FQHCs) from being considered as a basis for the reduction of payments below the reimbursement rate established pursuant to Welfare & Institutions (W&I) Code Section 14105.22. W&I Code Section 14105.22 affects payments for laboratory services in various ways, including prohibiting reimbursement from exceeding 80 percent of the lowest maximum allowance established by Medicare for the same or similar service. The bill also permanently removes the authority for DHCS to apply Title 22 of the California Code of Regulations, Section 51501(a), known as the “best price” regulation, to FQHCs.

SB 728 Negrete McLeod (Chapter 451)
MEDI-CAL: DURABLE MEDICAL EQUIPMENT REIMBURSEMENT

SB 728, sponsored by the California Association of Medical Products Suppliers, revises the requirement for determining manufacturer’s suggested retail purchase (MSRP) price for the reimbursement of durable medical equipment (DME) that has no specified maximum allowable rate known as “by report.” The bill changes the MSRP date specified in the DME “by report” reimbursement methodology from June 1, 2006, to a date on or prior to the date of service, and documented by a printed catalog or hard copy of an electronic catalog page.

SB 1228 Alquist (Chapter 671)
SMALL HOUSE SKILLED NURSING FACILITIES

SB 1228, sponsored by the NCB Capital Impact, creates a pilot program for a new class of Skilled Nursing Facilities known as "Small House Skilled Nursing Facilities" (small nursing homes), licensed by the California Department of Public Health (CDPH), through January 1, 2020.

LEGAL SERVICES

AB 2041 Swanson (Chapter 723)
REGULATIONS: ADOPTION: DISABILITY ACCESS

AB 2041, sponsored by the California Counsel of the Blind, requires specified state agencies promulgating regulations to include, within the notice of proposed action, a statement regarding the availability of a narrative description of the proposed regulatory changes for persons with visual or other disabilities.

AB 2492 Blumenfield (Chapter 647)
CALIFORNIA FALSE CLAIMS ACT

AB 2492, sponsored by the author, amends the California False Claims Act, (FCA), to bring it into conformity with Federal False Claims Act. Bringing the FCA into federal conformity will preserve California's eligibility to receive tens of millions of dollars each year in enhanced federal incentives when recovering funds through prosecutions under the FCA.

LEGISLATIVE AND GOVERNMENTAL AFFAIRS

AB 1467 Committee on Budget (Chapter 23)
HEALTH OMNIBUS TRAILER BILL

AB 1467, sponsored by the author implements the provisions of the Budget Act for fiscal year 2012-13, as it pertains to DHCS, CDPH, Department of Mental Health (DMH), the Office of Statewide Health Planning and Development (OSHPD), the California Health Facilities Financing Authority, and the California Office of Health Information Integrity. Specifically, AB 1467 provides:

SEC. 1, 2, 32, 33, 33.5, 34, 123: These sections amend and repeal provisions of the Government Code and Health and Safety (H&S) Code to require that when a child has an Individualized Education Program (IEP), all occupational and physical therapy services assessed and determined to be educationally necessary by the IEP team, and included in the IEP, shall be provided in accordance with the federal Individuals with Disabilities Education Act, and not paid for by the California Children's Services (CCS) Medical Therapy Program.

SEC. 3: This provision changes existing statute for Office of Systems Integration (OSI) and deletes language that prohibits additional information technology projects from being added to their docket without additional authorizing legislation. This allows new information technology projects to be added to their responsibilities without additional specific legislation.

SEC. 15-17: These sections establish the Long-Term Care Quality Assurance Fund effective August 1, 2013. Revenues from the AB 1629 nursing home quality assurance fee, Intermediate Care Facility/Developmental Disabilities quality assurance fee, and freestanding pediatric subacute facility quality assurance fee would be deposited into this fund.

SEC. 18-25, 35, 44-46, 116, 121-122, and 126: These sections transfer three direct service programs from CDPH to DHCS. The programs proposed for transfer, effective July 1, 2012, are: Every Woman Counts (EWC) Program, Prostate Cancer Treatment Program, and Family Planning, Access, Care, and Treatment (FPACT) Program, which are further described below. Specifically, these sections require changes to the enabling statutes in order to grant DHCS the legal authority to operate these programs, develop formal estimates for EWC, and prepare mandated and ad hoc reports to the Legislature.

SEC. 36-39: These sections amend and repeal specified provisions of the H&S Code to eliminate the Advisory Committee on Genetically Handicapped Persons Program.

SEC. 40: This section changes the deadline for qualified hospitals to submit an extension request from seismic deadlines to OSHPD from March 31, 2012 to September 21, 2012.

SEC. 47: This section adds a provision to require the DHCS Director or the Governor to appoint the Deputy Director of Mental Health and Substance Use Disorder Services, subject to Senate confirmation.

SEC. 48-54: As part of Fiscal Year (FY) 2012-13 Budget, the Governor proposed to eliminate funding for Caregiver Resource Centers (CRCs), for a reduction of $2.9 million GF. These sections implement the Legislature's proposal to retain the funding for CRCs and transfer the oversight of CRCs from DMH to DHCS.

SEC. 56: This section adds DHCS as an entity with which OSHPD shall work to secure appropriate staffing resources for the California Mental Health Planning Council (MHPC) to appropriately fulfill its duties with regards to Mental Health Services Act (MHSA) education and training policy development and oversight.

SEC. 58: This section establishes more detailed requirements for county MHSA Innovative Programs.

SEC. 59: This section transfers the MHSA Prevention and Early Intervention program to DHCS.

SEC. 60: This section specifies that DHCS provides assistance, including data and information, to the Mental Health Oversight and Accountability Commission (MHSOAC) to assist in its role of oversight, training and technical assistance, accountability, and evaluation of county MHSA programs and funds; and collaborate with the MHPC and California Mental Health Director Association (CMHDA) in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system.

SEC. 62: This section adds provisions that specify additional detail and requirements for counties' submission of their three year program and expenditure plans for MHSA funds. It would also require DHCS to inform CMHDA and the MHSOAC of the methodology used for revenue allocation to the counties for their three-year program and expenditure plans.

SEC. 63: This section adds provisions that DHCS and the MHSOAC, in collaboration with CMHDA, shall jointly establish performance outcomes for the three-year program and expenditure plans.

SEC. 64: This section makes clarifying changes to existing law regarding services to children.

SEC. 65: This section specifies that DHCS shall enter into performance contracts with counties for their county mental health programs.

SEC. 66: This section specifies that DHCS, rather than DMH, shall seek any applicable federal Medicaid approvals to maximize the availability of federal funds and beneficiary eligibility for MHSA services.

SEC. 67: This section adds a provision that DHCS provide to the State Controller's Office the methodology by which to distribute monthly allocations from the Mental Health Services Fund. It also specifies that counties are to base their expenditures on their three-year program and expenditure plans or annual updates to the plan.

SEC. 68: This section adds provisions that terminate the state's role in allocating percentages of MHSA funds for specific purposes and instead provides the full amount to the counties with the concordant responsibility of allocating funds for specific purposes. It also expands the list of specific state agencies that may use MHSA funds under an administrative cap of 3.5 percent to meet their MHSA obligations.

SEC. 69: This section, similar to Section 65, specifies that DHCS shall implement and oversee the county mental health performance contracts, which are inclusive of MHSA services.

SEC. 70: This section specifies that DHCS in consultation with the MHSOAC shall develop regulations for the MHSA program.

SEC. 71: This section adds provisions that specify that DHCS, in consultation with the MHSOAC and CMHDA, shall develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report.

SEC. 72: This section adds provisions to allow no more than $200,000 to be expended annually from the General Fund, for administration and oversight of the Medi-Cal Electronic Health Record Incentive Program.

SEC. 73-77: These sections add sunset dates for the following supplemental funds:

1. The Emergency Services and Supplemental Payments Fund–0693,
2. The Medi-Cal Medical Education Supplemental Payment Fund–0550,
3. The Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund–0549; and
4. The Small and Rural Hospital Supplemental Payments

SEC. 78: This section allows DHCS to expand the Medi-Cal managed care program into the following 28 counties that currently offer Medi-Cal services only on a fee-for-service basis: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Lake, Lassen, Mariposa, Modoc, Nevada, Mono, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba. The director has authority to enter into exclusive or nonexclusive contracts on a bid or negotiated basis with one or more Medi-Cal managed health care plans to provide a comprehensive program of health care services to Medi-Cal recipients residing in these counties.

SEC. 79-80, 112, 114-115, 124, 129: These sections make amendments to existing statute and add sections of law regarding Medi-Cal dental managed care services in Sacramento County and the use of performance metrics and benchmarks for contracted Medi-Cal dental managed care plans. Provisions include the ability for Sacramento County to establish a stakeholder advisory committee which may provide written input to the department on policies to improve the delivery of oral health and dental services in Sacramento and requires DHCS to meet with them on a quarterly basis; establishes a beneficiary exception process to opt out of dental managed care for individuals mandatorily enrolled in dental managed care in Sacramento County who are having difficulty accessing dental services in accordance with contractual time frames and to report monthly on the outcomes on the Denti-Cal website; the submission of a report by March 15, 2013, and annually thereafter, to the Legislature by DHCS on performance metrics and

service utilization of Sacramento dental managed care plans; and a report to the Legislature by the Department of Managed Health Care (DMHC) by January 1, 2013, on the non-routine surveys performed on the Sacramento dental managed care plans based the DHCS contract requirements.

SEC. 81: This section adds provisions to Section 14091.3 of the W&I Code related to the Rogers Rate Amendment. It allows the extension of the sunset date and validates payment amounts established under the statute up until the Diagnosis-Related Groups (DRG) payment methodology is implemented. It also specifies that upon implementation of the DRG payment methodology, which hospitals must accept as payment the amount determined under the DRG methodology.

SEC. 82: This section adds provisions to require the State to increase Medi-Cal reimbursement for certain primary care services to no less than 100 percent of the Medicare rate from January 1, 2013 to December 31, 2014, provided by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine. For services furnished during this period of time, the Centers for Medicare and Medicaid Services (CMS) shall provide full reimbursement for the incremental difference between the level of payment in effect on July 1, 2009, and 100 percent of Medicare.

SEC. 83: This section authorizes DHCS to develop a rate methodology that is based on the lowest amounts other payers are paying for similar clinical laboratory or other laboratory services. In addition, payments for clinical laboratory or laboratory services would be reduced by up to 10 percent, for dates of service on and after July 1, 2012, and will continue until the new methodology has been approved by CMS.

SEC. 84-86: These sections update definitions, add clarification, and provide technical clean-up to existing co-pay statutes as they relate to emergency and non-emergency services provided under the Medi-Cal program pursuant to W&I Code sections 14134 and 14134.1.

SEC. 87: This section amends Section 14154 of the W&I Code to not fund cost of living increases for county administrative activities for FY 2012-13 for the purposes of conducting Medi-Cal eligibility determinations and redeterminations. Under Assembly Bill 102 (Section 17, Chapter 29, Statutes of 2011), DHCS was to develop and implement, in consultation with county program and fiscal representatives, a new budgeting methodology to reimburse counties for eligibility determinations for applicants and beneficiaries, including one-time eligibility processing and ongoing case maintenance. Meetings were convened by the department with the county representatives and given the complexity of the issue, especially in light of the changes that will occur under the Affordable Care Act. Both parties have concluded additional time is necessary to develop the new budgeting methodology. In lieu of a new budgeting methodology, DHCS developed a temporary budget solution for the 2012-13 May Revision based upon current

standards and requirements including not providing a cost of living adjustment for FY 2012-13.

SEC. 88, 90, 91, 97 and 98: These sections redirect unpaid private and nondesignated public hospitals' (NDPH) stabilization funding for fiscal years 2005-06 through 2009-10 (including the extension period of the Medi-Cal Hospital/Uninsured Demonstration through October 31, 2010). Additionally, these sections provide the Director of DHCS the authority to utilize a portion of the redirected funding to make payments to hospitals that received Disproportionate Share Hospital Replacement underpayments in FYs 2005-06 and 2006-07, if a determination is made that such underpayments occurred. Also, these sections grant DHCS the ability to continue to exercise its powers received from California Medical Assistance Commission's (CMAC) dissolution for the years that have not yet been finalized even though the All Patient Refined DRG payment methodology has been implemented. These sections also represent the transition plan of CMAC staff to DHCS and upon implementation of the payment system based on DRG, the section details the transition of those staff into civil service positions within DHCS.

SEC. 89: This section adds a provision, beginning FY 2012-13, to require DPHs and their affiliated governmental entities that provide non-hospital clinic or other non-hospital services to the uninsured that are eligible for claiming under the Special Terms and Conditions of the Bridge to Reform Waiver (Waiver), to report and certify those expenditures.

SEC. 92-96: These sections add provisions that change the reimbursement methodology for NDPHs for fee-for-service (FFS) inpatient services for Medi-Cal beneficiaries, from a per diem or cost-based reimbursement to a certified public expenditure methodology. These sections also allow the NDPHs access to funds from the Safety Net Care Pool Uncompensated Care and Delivery System Reform Incentive Pool, subject to approval of an amendment to the 1115 Waiver from CMS. These sections implement these reimbursement methodology changes as a requirement for NDPHs through the end of calendar year 2013, and condition this new reimbursement methodology on voluntary certification of the participating hospitals as of January 1, 2014. Implementation is subject to obtaining federal approval of all applicable sections, and they are inclusive of each other.

SEC. 99: This provision redirects the amount allocated for direct grants to designated public hospitals in 2013-14 to provide additional funding for children's health coverage under Medi-Cal.

SEC. 100-103 and 105-107: These sections amend the provisions of the hospital quality assurance fee and related payment sections to allow the FFS payment component of the hospital free program to proceed absent federal approval for the managed care component.

SEC. 104: This provision increases the amount of funding allocated to children's health coverage under Medi-Cal for FY 12-13 and 13-14.

SEC. 108: This section entitles a provider who prevails in an appeal of a disallowed payment previously recovered by the DHCS, interest at the rate equal to the monthly average on investments in the Surplus Money Investment Fund, or simple interest at the rate of seven percent per annum, whichever is higher. This bill also allows DHCS to assess interest at the rate equal to the monthly average on investment in the Surplus Money Investment Fund, or simple interest at the rate or seven percent per year (annum), whichever is higher to any unrecovered overpayment due to DHCS.

SEC. 109-110: These sections establish the provisions for NDPH participation in the Delivery System Reform Incentive Program to the extent federal approval is obtained and sunsets the existing provision for the State to provide incentives to NDPHs for activities related to the transformation of the delivery system transformation, once federal approval has been obtained to implement the provisions of Section 92.

SEC. 111: This section allows DHCS to enter into an interagency agreement with DMHC to have DMHC, on behalf of DHCS, conduct financial audits, medical surveys, and a review of the provider networks of the managed care plans participating in the duals demonstration project and the Medi-Cal managed care expansion into rural counties as proposed under Section 78. The interagency agreement would also provide authority for DMHC to provide consumer assistance to beneficiaries in the expansion counties. The interagency agreement would be updated, as necessary, on an annual basis in order to maintain functional clarity regarding the roles and responsibilities of these core activities.

SEC. 113: This section indicates the intent of the Legislature to preserve the goal of supporting and strengthening the safety net and requires that if the department adds additional cost factors to the default Medi-Cal managed care algorithm that we do so in consultation with the stakeholder workgroup to ensure that any cost factor disregards specified payments to safety net providers.

SEC. 117: This section allows that notwithstanding the current statutory provision prohibiting that capitated rates for the Low Income Health Programs (LIHPs) cannot be retroactive beyond the first day of the fiscal year in which approval is obtained, for fiscal year 2011-12, the rates can be retroactive as early as July 1, 2011, regardless of when CMS approval of the rates is obtained.

SEC. 119: This section adds Section 15912.1 to W&I Code to require the DHCS in collaboration with CDPH, to develop policies and procedures and consult with stakeholders in the development process, on the transition of persons diagnosed with HIV/AIDS from the federal Ryan White Act programs to the LIHP.

SEC. 120: This section adds provisions to authorize the State to reallocate unspent Health Care Coverage Initiative federal funding to the Safety Net Care Pool (SNCP) uncompensated care component of the Waiver. The funding reallocated to the SNCP will be shared 50-50 between the State and the designated public hospitals to offset General Fund expenditures and provide additional funding for local uncompensated care costs and ensures that the state achieves its $400 million annually in general fund relief.

SEC. 125: This provision of the bill requires CDPH to report to the Joint Legislative Budget Committee by October 1, 2012, on whether the projections or assumptions used by CDPH to develop the AIDS Drug Assistance Program (ADAP) estimated budget for the Budget Act of 2012, result in an inability to provide services to individuals eligible for ADAP.

SEC. 127: This section adds a provision that clarifies that section 55-63, 66-68 and 70-71 clarify and support the intent of the MHSA.

SEC. 128: This section declares that a special law is necessary to implement Sections 78 and 111 to expand Medi-Cal managed care into counties that are currently FFS counties.

SEC. 130: This section is a technical provision to provide for appropriate implementation and operation of Section 123870 of the Health and Safety Code which is also being amended by this bill and either by AB 1494 or SB 1034.

AB 1468 Committee on Budget (Chapter 438)
HEALTH TRAILER BILL

AB 1468, sponsored by the author, proposes several clarifying and technical changes via several amendments to SB 1008 (Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2012), AB 1467 (Committee on Budget, Chapter 23, Statutes of 2012), and AB 1494 (Committee on Budget, Chapter 28, Statutes of 2012).

Sections 13-14: These sections amend sections 14005.26 and 14005.27 of the W&I Code to make several technical and clarifying changes with regard to the Healthy Families Program (HFP) and its transition to Medi-Cal. Specifically, these proposed changes eliminate an erroneous age limitation imposed on transitioning enrollees, clarify the premium amounts and discounts that would apply to transitioning enrollees with incomes over 150 percent of the federal poverty level, and provides new language exempting DHCS from specified contracting requirements.

SEC. 15 and 16: These sections exempt services provided to individuals not eligible for Medi-Cal or FPACT from the payment increases pursuant to Section 14105.196 of the W&I Code.

SEC. 18, 19, 23, 24, 26, 28: These sections provide clarification and technical cleanup related to the implementation of the Coordinated Care Initiative (CCI) established under SB 1008 (Chapter 33, Statutes of 2013), to serve individuals that are dually eligible for Medicare and Medi-Cal (Duals).

SEC. 21 and 22: These sections make technical changes to W&I Code Section 14166.12 and 14166.17 to ensure that the statutory language that sets eligibility for various hospital supplemental payments correctly references Article 2.6 of the W&I Code pertaining to the Selective Provider Contracting Program.

SEC. 25: This section requires DHCS to include in the interagency agreement with DMHC, the Medi-Cal managed care plans (MCPs) that will be part of the expansion of managed care into the 28 rural counties not currently served by MCPs.

Section 27: This section contains language carried over from AB 1467 regarding the default Medi-Cal managed care algorithm. The language is added to this section in order to avoid a chaptering out conflict between this bill and AB 1467.

Section 29: This section amends W&I Code section 15912.1, as added by Section 119 of SB 1008, to add subparagraph (c), which requires DHCS, in collaboration with CDPH, to share relevant data related to the beneficiary's enrollment in the Ryan White Act programs that may be eligible for the LIHP.

AB 1471 Committee on Budget (Chapter 439)
HUMAN SERVICES: IN-HOME SUPPORTIVE SERVICES CLEANUP TO SB 1036

AB 1471, sponsored by the author, proposes several clarifying and technical changes via several amendments to SB 1036 (Committee on Budget and Fiscal Review, Chapter 45, Statutes of 2012) related to the In-Home Support Services (IHSS) Program and CCI.

SEC. 35: This section amends W&I Code Section 12302.6 to make technical and clarifying changes to provisions recently enacted in SB 1036 relating to the managed care plan authority to contract for the provision of IHSS.

SEC 42: This section amends W&I Code Section 14186.35 to specify that a managed care health plan will not be the employer of record in terms of liability due to the negligence or intentional torts of providers.

AB 1489 Committee on Budget (Chapter 631)
NURSING FACILITIES: QUALITY ASSURANCE FEE

AB 1489, sponsored by the author, contains necessary statutory changes to implement the Budget Act of 2012 for DHCS with regard to the Nursing Home Quality Assurance Fee (QAF) and the Minimum Data Set Assessment Tool.

Sections 1, 2, 3, and 4: This section amends provisions of the Health and Safety Codes Section 1324.23, 1324.27, 1324.29 and 1324.30 to:

- Extend the AB1629 QAF rulemaking provider bulletin authority to July 31, 2015;
- Provide technical clean up by adding the word "Care" to the title of the Department in order to formally and accurately address the Department in statute; and
- End the assessment of the QAF and provide a sunset date for the QAF program on July 31, 2015.

Sections 5, 6, 8 and 9: This section amends provisions of W& I Codes Section 14126.022, 14126.027, 14126.033, and 14126.036 to:

- Provide technical clean up language changes to the programmatic rules governing the Quality and Accountability Special Fund, in terms of revenue sources and payments for the current rate year;
- Extend the AB 1629 (nursing home fee) program rulemaking provider bulletin authority to July 31, 2015;
- Provide rate setting policy changes and adjustments applicable to the 2012-13, 2013-14, and the 2014-15 rate years; and
- Extend the nursing home fee program sunset date to August 1, 2015.

SEC. 7: This Section adds Section 14126.028 to H&S Code to:

- Formalize efforts required to inform individuals residing in nursing facilities of opportunities, as appropriate, to receive long-term services and supports in community settings, through use of an existing assessment tool.
- Require DHCS, in collaboration with CDPH, to provide a report to the Legislature by April 1, 2013, on appropriate sections of the assessment tool.

AB 1494 Committee on Budget (Chapter 28)

HEALTHY FAMILIES PROGRAM: MEDI-CAL TRANSITION: EXPANSION

AB 1494, sponsored by the author implements portions of the 2012-12 Budget Act that relate to the transition of approximately 875,000 children from the Healthy Families Program to the Medi-Cal program. The bill would also authorize DHCS to establish a new payment methodology for clinical laboratory or laboratory services based on the lowest amount other payer pay for clinical laboratory services.

Sec. 1-7: These sections pertain to the CCS Program, and make minor technical corrections, include administrative efficiencies for the consumer relative to financial documentation requirements, and makes clear financial participation at the local county level for diagnostic and treatment services and administration of the CCS Program pursuant to W&I Code section 14005.26. These changes are necessary to ensure continued access to CCS program services for existing and potential Healthy Families enrollees who have a CCS eligible health condition.

Sec. 9: This section authorizes DHCS to develop a new payment rate methodology for clinical laboratory or laboratory services that is based on the

lowest amounts other payers are paying for similar clinical laboratory services. Until the new methodology is approved by CMS, payments for clinical laboratory or laboratory services would be reduced by up to an additional 10 percent, excluding the FPACT Program, effective July 1, 2012. This section also requires laboratory service providers to submit data reports within six months of enactment and annually thereafter, that reflect other state Medicaid programs and private insurance payment data, minus discounts and rebates.

Sec. 8-11: Section 8 amends Section 12694.1 of the Insurance Code, respectively, and Sections 10 and 11 add Sections 14005.26 and 14005.27 of the W&I Code. These sections would require the HFP to cease enrolling beneficiaries by January 1, 2013. All beneficiaries enrolled in the HFP by January 1, 2013, would be considered presumptively eligible for Medi-Cal and would move over to the Medi-Cal program in four phases. Section 11 also establishes the transition reporting to the Legislature as well as the dental plan reporting to DHCS.

Sec. 12-13: These sections appropriate $400,000 from the Managed Care Fund to DMHC for the administration of the call center to assist individuals with the HFP transition as well as other aspects of coordination and health plan readiness, and also establish legislative findings and declarations that a special law is necessary.

SB 71 Leno (Chapter 728)
STATE AGENCIES: BOARDS, COMMISSIONS, AND REPORTS

SB 71, sponsored by the author, eliminates 17 reporting requirements which are outdated or otherwise do not contribute information of value. For DHCS, this bill eliminates the following reporting requirements to the Legislature.

- **Section 111** - Health status of American Indians.
- **Section 112** - Activities related to primary care services.
- **Section 196** - Status report regarding income and resource eligibility standards due on a semi-annual basis until regulations have been adopted for less restrictive standards.
- **Section 197** - Transition plan on transfer of Drug Medi-Cal program to DHCS. Additionally, the requirement to provide updates to the Legislature during budget subcommittee hearings, as necessary, would be eliminated.
- **Section 198** - Notification of any occurrence which renders inoperative the prohibition on a nursing facility for the developmentally disabled to voluntarily withdraw from the Medi-Cal program.
- **Section 199** - Annual community outreach plan for both the Medi-Cal and Healthy Families Program.
- **Section 201** - Evaluation of the personalized provider directory pilot project and its impact on the Medi-Cal managed care program.
- **Section 202** - Report on implementation of a multi-plan project in the county of San Diego in which a number of Knox-Keene licensed health

plans shall be the only Medi-Cal managed care plans authorized to operate within San Diego County.

- **Section 203** - Status reports and final evaluation report on Roger's Amendment impact on Hospital Contracting, Beneficiary Access, Rates Paid for Inpatient Hospitalization, and Costs to the State.
- **Section 204** - Evaluation of the CCS pilot project.
- **Section 205** - Status reports for the FPACT program required on a semiannual basis until regulations have been adopted for the program.
- **Section 206** - Status reports every three months on treatment authorization requests.
- **Section 207** - Annual report setting forth a fiscal accounting of expenditures and an evaluation of the relative effectiveness of various plans.
- **Section 208** - Annual report on the implementation of changes made to the Adult Day Health Care program.
- **Section 209** - Transition plan on transfer of Department of Mental Health to DHCS.
- **Section 225** - Home and Community Based Waiver Assessment required by Section 51 of AB 430, (Cardenas, Chapter 171, Statutes of 2001).
- **Section 237** - Semi-annual report regarding active Medi-Cal waivers.

SB 1008 Committee on Budget and Fiscal Review (Chapter 33)

COORDINATED CARE INITIATIVE

SB 1008, sponsored by the author, enacts the CCI which promotes coordinated care models in which seniors and disabled Medi-Cal beneficiaries receive all their benefits in an organized delivery system, including medical services, long-term services and supports (LTSS), and behavioral health services. Specifically, SB 1008 establishes demonstration projects in up to eight counties to provide coordinated health care through Medi-Cal managed care plans (MC Plans) for beneficiaries eligible for both Medicare and Medi-Cal (dual eligible) in selected counties; require mandatory enrollment of dual eligible beneficiaries into a participating MC Plan in counties participating in the demonstration; and integrate LTSS as a managed care benefit.

SEC. 1: This section allows DHCS to contract with CMS to establish a demonstration project in eight California counties, to be overseen by the State.

SEC. 2: This section requires that Demonstration sites follow certain requirements regarding provider payments for services provided under the Demonstration in skilled nursing facilities. This section will require clean-up language that provides that the above requirements only apply to the extent they are allowed by the federal government under the Demonstration.

SEC. 3: This section augments the continuity of care provisions as they relate to medical exemption requests applying to seniors and persons with disabilities under the federal 1115 Waiver.

SEC. 4: This section requires mandatory enrollment of duals beneficiaries into a participating MC Plan in counties participating in the demonstration.

SEC. 5: This section establishes continuity of care elements in duals demonstration projects and MC Plans.

SEC. 6: This section amends Section 14183.6 of the W&I Code to require DMHC to provide consumer assistance to MC Plans and their providers who are subject by existing statute to financial audits, medical surveys, and review of provider networks performed by Managed Health Care.

SEC. 7: This section adds Section 14186 to the W&I Code to define the integration into the duals demonstration projects of LTSS that improve care coordination and system efficiency, reduce unnecessary use of emergency rooms and hospitals, and improve the effectiveness of communication between provider types and MC Plans.

SEC. 8: This section amends Section 14301.1 of the W&I Code to authorize DHCS to establish capitated rates of payment for any managed care organization licensed under the Knox-Keene Act, including those serving persons with HIV/AIDS.

SEC. 9: This section adds Section 14301.2 to the W&I Code to authorize the Director to defer payments made to DHCS' contracts managed care organizations during the final month of State fiscal year 2012-13.

SEC. 10: This section establishes DHCS' option to discontinue the duals demonstration projects if federal approval for rate-setting and cost-sharing methods has not been received, or is imminent, by February 1, 2013.

SEC. 11-14: These sections declare legislative intent for the duals demonstration to expand statewide within three years of its initiation, contingent upon statutory authorization and budget appropriation; it makes this bill's enactment contingent upon the enactment of SB 1036 which implements the IHSS portions of the CCI; implements the provide administrative facilitation for DHCS to implement this bill, providing $1,000 to DHCS to administer this bill; and that state appropriations related to this bill shall take effect immediately.

SB 1009 Committee on Budget and Fiscal Review (Chapter 34)
MENTAL HEALTH REALIGNMENT

SB 1009, sponsored by the author, statutorily enacts the transfer of DMH's oversight of: 1) Medi-Cal specialty mental health services (SMHS) managed care; 2) Medi-Cal Early and Periodic Screening, Diagnostic and Treatment, SMHS; and iii) non Medi-Cal community mental health services from DMH to other state departments effective July 1, 2012. This is as the result of elimination of DMH as a state department effective July 1, 2012. DHCS only addresses the Medi-Cal portions of this bill, while the California Department of Social Services (CDSS) will analyze those portions pertaining to licensing.

SB 1014 Committee on Budget and Fiscal Review (Chapter 36)
ALCOHOL AND DRUG PROGRAMS: REALIGNMENT

SB 1014, sponsored by the author, transfers sections: 63, 72, 73, 74, 75, 76, 77, 78, 79, and 80 commencing July 1, 2012, the administrative functions of the Drug Medi-Cal Program performed by the State Department of Alcohol and Drug Programs to DHCS in accordance with an administrative and programmatic transition plan as authorized by AB 106 (Committee on Budget, Chapter 32, Statutes of 2011). SB 1014 makes various changes to the statutory provisions regulating to the Drug Medi-Cal program to conform these provisions to the above-described transfer requirement.

SB 1014 deletes the county plan and negotiated net amount contract requirements and instead require counties that apply for funds to submit to the department a contract for federal funding from the state to provide alcohol and other drug prevention, treatment, and recovery services. It would declare that the state has an interest in a specified women and children's residential treatment services program, funded by federal grants, and state the Legislature's intent for the department to work with counties under the 2011 realignment to develop reporting requirements. The bill would generally remove references to state involvement and funding in reference to alcohol and drug abuse prevention, treatment, and recovery services in a county.

SB 1036 Committee on Budget and Fiscal Review (Chapter 45)
COORDINATED CARE INITIATIVE: IN-HOME SUPPORTIVE SERVICES

SB 1036, sponsored by the author, implements the provisions of the Budget Act for FY 2012-13, pertaining to the IHSS portions of the CCI.

SECTIONS 8, 12, 13 AND 14: These sections allow IHSS to become a managed care benefit in the 8 counties that are approved as dual demonstration counties pursuant to AB 1468 (Committee on Budget, Chapter 438, Statutes of 2012): San Diego, Los Angeles, Orange, San Mateo, San Bernardino, Riverside, Santa Clara and Alameda. Managed care plans would be permitted to contract with IHSS agencies, for no more than 5 percent of the total IHSS hours in the demonstration counties, to provide services and to enter into agreements with the counties, CDSS, and the local public authorities or consortia to arrange for IHSS services that are authorized by the counties social service workers.

LONG TERM CARE

AB 1733 Logue (Chapter 782)
TELEHEALTH

AB 1733, sponsored by the California State Rural Health Association, expands existing law regarding the use of telehealth to all health care service plan contracts with DHCS and the Program of All-Inclusive Care for the

Elderly. Further, the bill updates various sections of existing law by replacing the term “telemedicine” with “telehealth.”

LOW-INCOME HEALTH PROGRAM

SB 1081 Fuller (Chapter 453)
PUBLIC HEALTH CARE: MEDI-CAL: DEMONSTRATION PROJECTS

SB 1081, sponsored by the District Hospital Leadership Forum, is an urgency measure that allows an NDPH, or the entity with which it is affiliated, to operate a LIHP in a county that does not have a designated public hospital, and does not intend to operate a LIHP.

MEDI-CAL BENEFITS

AB 1803 Mitchell (Chapter 442)
MEDI-CAL: EMERGENCY MEDICAL CONDITIONS

AB 1803, sponsored by the California Chapter of American College of Emergency Physician, codifies emergency services and care as a Medi-Cal benefit for FFS beneficiaries. The bill also references definitions for “emergency services and care” and “emergency medical condition” found in statutes applicable to health facilities and health plans.

SB 1538 Simitian (Chapter 458)
HEALTH CARE: MAMMOGRAMS

SB 1538, sponsored by the author, requires health facilities that perform mammograms to include a written notice to patients, who are categorized as having either heterogeneously dense breasts or extremely dense breasts. This notice raises awareness and informs these patients that dense breast tissue is common and is not abnormal, but may be associated with an increased risk of breast cancer. The notice must not be inconsistent with federal mammography quality standards. This requirement becomes operative April 1, 2013, and remains effective until January 1, 2019.

MEDI-CAL ELIGIBILITY

AB 174 Monning (Chapter 815)
OFFICE OF SYSTEMS INTEGRATION: CALIFORNIA HEALTH AND HUMAN SERVICE AGENCY (CHHSA) AUTOMATION FUND

AB 174, sponsored by the author, allows for the exchange of information between the Franchise Tax Board, Employment Development Department, DHCS, Managed Risk Medical Insurance Board, and the California Health Benefit Exchange (HBEX) Board (also known as Covered California) necessary to make certain Medi-Cal and health subsidy eligibility determinations and establishes the infrastructure to support these data

exchanges. AB 174 also establishes the OSI within the CHHSA and establishes a fund to allow OSI to manage various technology projects.

AB 1580 Bonilla (Chapter 856)
HEALTH CARE: ELIGIBILITY: ENROLLMENT

AB 1580, sponsored by the Western Center on Law and Poverty, makes technical and clarifying changes to AB 1296 (Bonilla, Chapter 641, Statutes of 2011), which implemented the Health Care Reform Eligibility, Enrollment, and Retention Planning Act, a major starting point in California's efforts to implement the federal Affordable Care Act (ACA).

AB 1580 also allows an individual to apply for state health subsidy programs by other commonly available electronic means. This bill conforms state statute to federal regulations, which replaced "facsimile" with "other commonly available electronic means."

AB 1640 Mitchell (Chapter 778)
CALWORKs BENEFITS: PREGNANT MOTHERS

AB 1640, sponsored by the California Black Women's Health Project and the Western Center on Law and Poverty, provides expanded eligibility for the California Work Opportunity and Responsibility for Kids (CalWORKs) Program to a pregnant mother who is 18-years-old or younger, any time after verification of pregnancy, regardless of whether she is eligible for the Cal-Learn Program and only if the Cal-Learn Program is operative.

SB 35 Padilla (Chapter 505)
VOTER REGISTRATION AGENCIES

SB 35, sponsored by the American Civil Liberties Union of California, establishes the HBEX as a new voter registration agency and codifies into state law the National Voter Registration Act (NVRA), relating to voter registration services. The Office of the Secretary of State (SOS) is responsible for implementing and coordinating NVRA. This bill requires a voter registration agency, which allows a person to apply online for services or assistance, or to submit a recertification, renewal, or change of address form, to implement a process and infrastructure that allows an applicant to electronically submit a voter preference form to the voter registration agency, and to submit an affidavit of voter registration electronically on the SOS Internet Website.

SB 1462 Leno (Chapter 837)
MEDICAL PROBATION FOR COUNTY INMATES

SB 1462, sponsored by the Los Angeles County Sheriff's Department and the California State Sheriffs' Association, authorizes a county sheriff, or his or her designee, to release certain prisoners from a county correctional facility on compassionate release or medical probation, if the prisoner does not pose a

threat to public safety, and has a life expectancy of six months or less, is physically incapacitated, or needs long term care. Prior to compassionate release or medical probation, a placement option for the prisoner must be secured and county welfare departments or other applicable county agencies must examine the prisoner's eligibility for Medi-Cal or other medical coverage that might assist in funding the prisoner's medical treatment while on compassionate release or medical probation. Counties will be required to pay the non-federal share of Medi-Cal expenditures associated with the bill's implementation for the period of time the offender would have otherwise been incarcerated.

PRIMARY AND RURAL HEALTH

AB 1896 Chesbro (Chapter 119)
TRIBAL HEALTH PROGRAMS: HEALTH CARE PRACTITIONERS

AB 1896, sponsored by the California Rural Indian Health Board, codifies into state statute existing federal law to provide an exemption from state licensure for health care practitioners employed by a tribal health program. The federal ACA of 2010, Section 10221, Subsection 134, allows for the exemption of health care practitioners employed by tribally operated health programs from state licensing requirements, if the practitioner is licensed in another state.

SB 1575 Committee on Business, Professions & Economic Development (Ch. 799)
PROFESSIONS AND VOCATIONS

SB 1575, sponsored by the author, makes several non-controversial minor, non-substantive or technical changes to various provisions pertaining to the health-related regulatory Boards of the Department of Consumer Affairs, provides clean-up language for AB 1896 (Chesbro, Chapter 119, Statutes of 2012). This bill requires a health care practitioner, who is exempt from California licensure because s/he is employed by a tribal health program, to possess a current, valid license in another state.

PROVIDER ENROLLMENT

SB 1529 Alquist (Chapter 797)
MEDI-CAL: PROVIDERS: FRAUD

SB 1529, sponsored by DHCS, expands state Medi-Cal screening and anti-fraud law to conform to the federal ACA and the Title 42 Code of Federal Regulations. By conforming state law to federal law in the areas of screening, enrollment, and sanctions of Medi-Cal providers, DHCS will have more tools to address and curb Medi-Cal fraud. The purpose of this bill is to comply with federal regulations and ensure California continues to receive valuable federal financial participation funds.

SAFETY NET FINANCING

AB 2608 Bonilla (Chapter 755)
MEDI-CAL: LOCAL EDUCATIONAL AGENCY BILLING OPTION

AB 2608, sponsored by the Los Angeles Unified School District, eliminates the sunset date for the Local Educational Agency (LEA) Medi-Cal billing option, and aligns state and federal regulations for transportation for students with disabilities reimbursable to school districts. The bill requires equitable and proportional payments to LEAs, and also requires DHCS to make a publicly accessible annual accounting of funds collected by DHCS from Medicaid payments to LEAs.

SB 920 Hernandez, E. (Chapter 452)
MEDI-CAL: HOSPITALS

SB 920, sponsored by the California Hospital Association, is an urgency measure, and a technical clean-up bill intended to align the final hospital QAF program with federal approvals. In addition, other minor changes were made to align with final policy negotiations between the hospitals.

SYSTEMS OF CARE

AB 1731 Block (Chapter 336)
NEWBORN SCREENING PROGRAM: CRITICAL CONGENITAL HEART DISEASE

AB 1731, sponsored by the American Heart Association and the March of Dimes, requires, beginning July 1, 2013, that all general acute care hospitals with licensed perinatal services offer parents of newborns, prior to discharge, a pulse oximetry (PO) test to identify critical congenital heart disease (CCHD). DHCS is required to issue guidance stating that all such hospitals must perform a PO test in a manner consistent with guidelines by the federal Centers for Disease Control and Prevention for CCHD screening.

2012 ENROLLED BILLS

BILL NUMBER	AUTHOR	FINAL STATUS	CHAPTER	PROGRAM*	PAGE NUMBER
AB 174	Monning	Sign	815	ME	16
AB 369	Huffman	Veto	---	MC	---
AB 540	Beall	Veto	---	MB	---
AB 969	Atkins	Sign	738	FR	1
AB 1223	Committee on Veterans Affairs	Veto	---	ME	---
AB 1467	Committee on Budget	Sign	23	LA	2
AB 1468	Committee on Budget	Sign	438	LA	9
AB 1471	Committee on Budget	Sign	439	LA	10
AB 1489	Committee on Budget	Sign	631	LA	10
AB 1494	Committee on Budget	Sign	28	LA	11
AB 1580	Bonilla	Sign	856	ME	17
AB 1640	Mitchell	Sign	778	ME	17
AB 1731	Block	Sign	336	SC	19
AB 1733	Logue	Sign	782	LT	15
AB 1803	Mitchell	Sign	442	MB	16
AB 1896	Chesbro	Sign	119	RH	18
AB 2034	Fuentes	Veto	---	SC	---
AB 2041	Swanson	Sign	723	LG	2
AB 2206	Atkins	Veto	---	LT	---
AB 2492	Blumenfield	Sign	647	LG	2
AB 2508	Bonilla	Sign	824	AD	1
AB 2608	Bonilla	Sign	755	SF	19
SB 35	Padilla	Sign	505	ME	17
SB 71	Leno	Sign	728	LA	12
SB 393	Hernandez, E.	Veto	---	HP	---
SB 447	DeSaulnier	Veto	---	LG	---
SB 728	Negrete McLeod	Sign	451	FR	1
SB 920	Hernandez, E.	Sign	452	SF	19
SB 970	De León	Veto	---	ME	---
SB 1008	Committee on Budget and Fiscal Review	Sign	33	LA	13
SB 1009	Committee on Budget and Fiscal Review	Sign	34	LA	14
SB 1014	Committee on Budget and Fiscal Review	Sign	36	LA	15
SB 1036	Committee on Budget and Fiscal Review	Sign	45	LA	15
SB 1081	Fuller	Sign	453	LH	16
SB 1228	Alquist	Sign	671	FR	2
SB 1462	Leno	Sign	837	ME	17
SB 1529	Alquist	Sign	797	PE	18
SB 1538	Simitian	Sign	458	MB	16

SB 1575	Committee on Business, Professions & Economic Development	Sign	799	RH	18

PROGRAM ASSIGNMENTS AND ACRONYMS

PROGRAM	CODE
Administration	AD
Audits and Investigations	AI
Budget Office	BO
California Medicaid Management Information System (CA-MMIS)	CM
Civil Rights, Office of	CR
Drug Medi-Cal	DM
Fiscal Forecasting & Data Management	FF
Family Planning, Office of	FP
Fee-for-Service Rate Development	FR
HIPAA Compliance, Office of	HC
Health Care Policy	HP
Health Information Technology	HT
Information Technology	IT
Legislative and Governmental Affairs, Office of	LA
Legal Services, Office of	LG
Low Income Health Program	LH
Long-Term Care	LT
Medi-Cal Benefits	MB
Medi-Cal Managed Care	MC
Medi-Cal Dental Services	MD
Medi-Cal Eligibility	ME
Mental Health Services	MH
Medi-Cal Procurement, Office of	MP
Pharmacy Benefits	PB
Provider Enrollment	PE
Capitated Rates Development	RD
Primary & Rural Health	RH
Systems of Care	SC
Safety Net Financing	SF
Third Party Liability & Recovery	TR
Utilization Management	UM

SIGN MESSAGES

(No Sign messages recorded.)

VETO MESSAGES

BILL#	AUTHOR	SUBJECT	DIV
AB 369	Huffman	Health Care Coverage: Prescription Drugs	MC
AB 540	Beall	Medi-Cal: Alcohol and Drug Screening and Brief Intervention Services	MB
AB 1223	Committee on Veterans Affairs	Medi-Cal: Public Assistance Reporting Information	ME
AB 2034	Fuentes	Medical Care: Genetically Handicapping Conditions	SC
AB 2206	Atkins	Medi-Cal: Dual Eligible: Pilot Projects	LT
SB 393	Hernandez, E.	Patient-Centered Medical Homes	HP
SB 447	DeSaulnier	State Agencies: Communications: Social Security Numbers	LG
SB 970	De Leon	Health Care Reform Eligibility, Enrollment, and Retention Planning Act: Coordination with Other Programs	ME

(Sign and Veto messages are also available on www.leginfo.ca.gov)

OFFICE OF THE GOVERNOR

SEP 30 2012

To the Members of the California State Assembly:

I am returning Assembly Bill 369 without my signature.

This bill would prohibit a health plan or insurer from requiring a patient to try and "fail" more than two medications before allowing a patient to have the pain medication prescribed by his or her doctor.

While I sympathize with the author's good intentions, I am not convinced that this bill strikes the right balance between physician discretion and health plan or insurer oversight. A doctor's judgment and a health plan's clinical protocols both have a role in ensuring the prudent prescribing of pain medications. Independent medical reviews are available to resolve differences in clinical judgment when they occur, even on an expedited basis.

If current law does not suffice – and I am not certain that it doesn't, any limitations on the practice of "step-therapy" should better reflect a health plan or insurer's legitimate role in determining the allowable steps.

Sincerely,

Edmund G. Brown Jr.

GOVERNOR EDMUND G. BROWN JR. • SACRAMENTO, CALIFORNIA 95814 • (916) 445-2841

OFFICE OF THE GOVERNOR

SEP 29 2012

To the Members of the California State Assembly:

I am returning Assembly Bill 540 without my signature.

I commend the author for his efforts to mitigate the risks of alcohol and drug use for pregnant women and women of childbearing age in the Medi-Cal program.

The federal Patient Protection and Affordable Care Act requires comprehensive health care coverage to be provided in the private market and through public programs. Rather than embarking on this piecemeal effort, my administration will consider whether a more comprehensive approach to screening – for all Medi-Cal beneficiaries, including pregnant women and women of childbearing age – is possible, as we implement the changes that are necessary to comply with the Affordable Care Act.

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OFFICE OF THE GOVERNOR

SEP 22 2012

To the Members of the California State Assembly:

I am returning Assembly Bill 1223 without my signature. While I support efforts to inform veterans about the health care options that best meet their needs, current law already requires screening of Medi-Cal beneficiaries for veteran status and allows for expansion of the Public Assistance Reporting Information System (PARIS) data match project beyond the current pilot counties.

Rather than requiring the PARIS pilot project to be implemented statewide, more effort should go into understanding which health care benefits work best for veterans, and how that outreach can be most effective before expending additional resources statewide.

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SEP 29 2012

To the Members of the California State Assembly:

I am returning Assembly Bill 2034 without my signature.

The future of the Genetically Handicapped Persons Program and the health coverage of people with amyotrophic lateral sclerosis will be taken up as California implements the federal Patient Protection and Affordable Care Act.

A separate legislative report is unnecessary.

Sincerely,

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OFFICE OF THE GOVERNOR

SEP 22 2012

To the Members of the California State Assembly:

I am returning AB 2206 without my signature.

The Program of All-Inclusive Care for the Elderly (PACE) provides fully integrated care to people age 55 and older who need skilled nursing home type care, but can live in a community setting. California was the pioneer for PACE programs in the nation, having started the first one of its kind in the early 1970's.

Last year, I signed AB 574 to expand PACE, so that more providers could use this model and give aging Californians the benefits of fully integrated care. Since that time, my administration has embarked on a large scale effort to coordinate care for people who qualify for both the Medi-Cal and Medicare programs. The Coordinated Care Initiative, enacted through SB 1008 of 2012, will similarly build on the integrated care concept, using managed care plans to break down the silos that currently exist between medical and long-term care.

Within this effort, there will be ample opportunity for PACE to continue its mission and thrive as a model of care. I will direct my administration to involve PACE providers as the initiative rolls out. Enacting special provisions for PACE eligibility and referral is not necessary at this time.

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OFFICE OF THE GOVERNOR

SEP 30 2012

To the Members of the California State Senate:

I am returning Senate Bill 393 without my signature.

I commend the author for trying to improve the delivery of health care by encouraging the greater use of "patient-centered medical homes." While this concept is not new, it is still evolving.

For this reason, I think more work is needed before we codify the definition contained in this bill.

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Many state agencies already use a unique number, and not an individual's social security number, for identification purposes. But sometimes a social security number is used to determine eligibility for programs such as unemployment and disability benefits. On these occasions, federal and state laws provide numerous protections against identity theft and fraud, including how and when a document listing a person's social security number can be sent.

While I understand the author's intent to prevent identity theft, the additional prohibition in this bill would hinder the ability of state agencies to promptly and accurately provide information to run essential programs.

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SEP 30 2012

To the Members of the California State Senate:

I am returning Senate Bill 970 without my signature.

This bill is well-intentioned but overly prescriptive in its requirements. Codifying another workgroup and requiring another report are not necessary.

My administration has worked and will continue to work with the Legislature and stakeholders in transparent and cooperative ways to implement the requirements of the federal Patient Protection and Affordable Care Act.

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My administration has worked and will continue to work with the Legislature and stakeholders in transparent and cooperative ways to implement the requirements of the federal Patient Protection and Affordable Care Act.

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