A History of Medi-Cal Physician Payment Rates

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I. Introduction

Physician payment rates in Medi-Cal, California’s Medicaid program, result from a complex web of federal and state regulations, political and economic pressures, and physician and patient needs. The advent of Medi-Cal managed care has recently focused the rates debate on the adequacy of health plan capitation payments. However, fee-for-service physician rates, which drive managed care payment levels, remain a critical issue.

In order to fully understand the issues surrounding Medi-Cal payment rates, one must understand the way in which the debate has been framed throughout the history of the Medi-Cal program. Decisions that were made twenty years ago about rate-setting methodologies continue to impact the way the system functions today. This report outlines the legislative and legal history of Medi-Cal’s fee-for-service physician rates and discusses their impact on managed care payments. This report does not analyze the adequacy of Medi-Cal rates, but rather provides the background and context for such an analysis.
II. 1965 to 1979: Medi-Cal’s Formative Years

Created in 1965, the Medi-Cal program provides health coverage to nearly five million low-income, aged, and disabled Californians. The program’s operations, including physician rate-setting methodologies, are largely determined by the California legislature and Department of Health Services (DHS), but the federal government establishes general guidelines and provides oversight via the Health Care Financing Administration (HCFA).

Since the program began, there has been considerable debate surrounding how and how much physicians are paid. Medi-Cal was originally intended to be a marginal cost program, meaning that physicians could maintain their normal practices and add a few Medi-Cal patients at little additional cost. Therefore the program was designed to cover only these small marginal costs, and not the full cost of maintaining a practice or the average cost of providing patient care. However, questions about Medi-Cal physician payment rates quickly arose. What level of payment would be sufficient to provide care to this population? Were the rates adequate to encourage physician participation? How should the state calculate and evaluate rates?

Establishing Medi-Cal Rates

In 1966 the Code of Federal Regulations laid out the first national Medicaid physician payment guidelines, instructing states that payment must be:

- consistent with efficiency, economy, and quality of care; and
- sufficient to enlist enough providers so that services under the plan are available to recipients, at least to the extent that those services are available to the general population (known as the “equal access” requirement).¹
Later that year the California Medical Association (CMA), the largest association of physicians in the state, published its first “California Relative Value Studies” (CRVS).

The CRVS assigned non-monetary “unit values” to a comprehensive list of medical and surgical procedures based on the presumed resource costs of providing each service. Physicians and/or health care payers could then apply a dollar conversion factor to the unit values to derive a price for any listed service (see textbox). The state subsequently adopted the CRVS as a means to calculate Medi-Cal physician rates.

In 1970 the state attempted to cut Medi-Cal physician fees, citing Section 14120 of the California Welfare and Institutions Code that allows a 10% cut in payments for services if Medi-Cal is running a budget deficit. The CMA sued the state to block the payment cut, and successfully argued that the program was under-funded and the cost overrun was not unexpected. This section of the state code is still in place, but has never been used to reduce Medi-Cal spending.

In 1976, Section 14079 of the California Welfare and Institutions Code was amended by passage of AB 4242 “to ensure the reasonable access” to services by requiring the director of DHS to compare annually Medi-Cal payment rates for physician services to various measures, including:

- physician costs as reflected by the Consumer Price Index (CPI);
- physician payments made through Medicare, Blue Shield, and other third-party payers;
- prevailing physician charges within the state and in various geographic areas;
- procedures reflected by the current Relative Value Studies (RVS); and
- characteristics of current Medi-Cal beneficiaries and their medical needs.²

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**Example: Calculating a Physician Payment Using CRVS**

CPT Code 70030 - Radiological eye exam

Unit Value (1969 CRVS) = 8.8

Dollar Conversion Factor (1999 CA Code of Regulations) = $3.82

Total 1999 Payment = 8.8 x $3.82

= $33.62

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<th>1965</th>
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<td>Social Security Act establishes Medicaid. California legislature enacts Medi-Cal.</td>
<td>Federal law says Medicaid payments must be sufficient to ensure beneficiaries “equal access” to physicians.</td>
<td>California Medical Association publishes the California Relative Value Studies (CRVS).</td>
<td>Federal judge blocks attempt to cut Medi-Cal rates by 10%.</td>
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AB 4242 originally required DHS to report the results of this rates review to the legislative fiscal committees annually; however, this reporting requirement was eliminated in 1992.

**Medi-Cal Managed Care Begins**

In 1975 state legislation authorized health plans in California to enroll beneficiaries voluntarily in Medi-Cal managed care. Provisions were made to federal Medicaid law to regulate this new form of health care insurance, payment, and delivery. According to federal Medicaid regulations:

- Prepaid payments to Medicaid managed care plans must be “actuarially sound”;³ and
- These payments may not exceed the cost of providing the same services on a fee-for-service basis to an “actuarially equivalent,” non-enrolled population group.⁴

This second requirement, known as the Upper Payment Limit (UPL), dictates that the overall costs of a Medicaid managed care program be no more than the fee-for-service equivalent (FFSE) costs for a similar population. Consequently, Medi-Cal’s fee-for-service payment levels establish a ceiling for managed care capitation rates. The UPL requirement is twofold:

- **State UPL**: The state’s aggregate payments to all managed care plans, plus any associated administrative costs, cannot exceed the FFSE.
- **Plan UPL**: The state’s payments to individual managed care plans cannot exceed the FFSE.

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### Actuarially Sound

The federal requirement that Medi-Cal capitation rates be “actuarially sound” has been the source of great debate. Some stakeholders contend that Medi-Cal rates are based on state budgetary concerns rather than on a sound actuarial analysis of the cost of providing care. DHS currently uses its own actuaries to determine rates, although there has been a call to create an independent panel.

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<th>1975</th>
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<td>First Medi-Cal managed care plans are authorized to begin voluntary enrollment.</td>
<td>AB 4242 requires DHS to conduct annual reviews of Medi-Cal physician rates.</td>
<td>California Medical Association signs consent decree to stop publication of the CRVS.</td>
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California Relative Value Studies Repealed

In the early 1970s the Federal Trade Commission began an investigation of relative value studies amidst concerns about price fixing. Ultimately, the FTC found that use of the CRVS was in violation of federal law because it had the effect of establishing and influencing the fees which physicians charged for their services. In 1979, the CMA and its subsidiaries entered into a voluntary consent decree not to publish or disseminate new fee schedules related to physician compensation; however, payers were not prohibited from using the most recent CRVS to calculate rates. While DHS occasionally updates the conversion factor, current Medi-Cal fee-for-service rates are still largely based on values assigned in the 1969 CRVS (see textbox on page 4).
III. 1980 to 1989: Budget Crunch and Health Care Inflation

The national recession of the early 1980s created pressure for many states to introduce various cost containment strategies for Medicaid. In 1982, following several years of cost-of-living increases for Medi-Cal physician rates, the California legislature approved a temporary measure to reduce Medi-Cal fee-for-service rates for outpatient and dental services by 10% and for lab services by 25%. The following year Governor Deukmejian vetoed a 3% cost-of-living adjustment. Restorative rates increases of 7.7% in 1984 and 5.3% in 1985 were approved, but resulted in a net increase of only 3% over pre-1982 outpatient and dental rates.

Governor Deukmejian attempted to cut physician fees another 10% as part of an emergency mid-year budget change in 1987. A federal judge blocked the decision based on concerns about the impact of low rates on access to specialists and evidence that some Medi-Cal patients already seemed to be having trouble receiving the quality of care available to other Californians.

In the late 1980s DHS increased Medi-Cal payments significantly for obstetrical services amidst concerns about insufficient access to maternity services in some areas. Obstetrics rates grew by 85% between 1985 and 1989. Conversely, in 1992 physician rates for anesthesia, radiology, and surgery were cut by 9.5% to reduce overall Medi-Cal expenditures. Aside from these changes, however, nearly all other physician rates remained frozen at 1985 levels until the late 1990s.
Meanwhile the rest of the economy was experiencing rapid inflation. Between 1985 and 1990, the Consumer Price Index—one of the indicators against which DHS is required to compare Medi-Cal rates annually (see page 4)—increased by more than 21%. During the same period the CPI specific to physician services grew by nearly 42%. In contrast to these price increases, Medi-Cal’s overall physician payment growth rate was nearly flat.

**Cost-Based Reimbursement for Safety-Net Providers**

In 1989, the federal government passed provisions to protect certain “safety-net” providers from Medicaid rates adjustments. The Omnibus Budget Reconciliation Act (OBRA 1989) approved cost-based reimbursement for Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and “look-alikes,” allowing these organizations to bill Medicaid for the full cost of services rather than the discounted rates paid to other providers.

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<td>Outpatient rates cut by 10% and lab rates cut by 25%.</td>
<td>Legislature approves restorative rates increases of 7.7% for most physician services.</td>
<td>Physician rates are increased by 5.3%, resulting in a net increase of 3% over pre-1972 rates.</td>
<td>Obstetrics rates are increased by 26.5%. By 1989 these rates have increased by 85%.</td>
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Source: California Department of Health Services, May 1999.
OBRA 1989 also contained several other provisions pertaining to Medicaid rates including:

- Requiring states to submit annual plans and average Medicaid payments for obstetrical and pediatric care to the secretary of the U.S. Department of Health and Human Services in order to verify that Medicaid services were similar to those available to the general public. This requirement, however, was eliminated in the Balanced Budget Act of 1997.

- Commissioning the Physician Payment Review Commission to study physician payment under state Medicaid programs, particularly to examine the adequacy of physician fees, physician participation, and beneficiary access to care.¹³

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<td>Federal judge blocks another attempt to cut Medi-Cal rates by 10%.</td>
<td>Federal legislation allows FQHCs and RHCs to bill 100% of costs for certain services.</td>
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By 1990 physician groups were beginning to campaign for increases in Medi-Cal rates. They maintained that inadequate rates were driving physicians out of the program, endangering access to services and quality of care. That year a report by the Little Hoover Commission explored the reasons behind declining physician participation in Medi-Cal. The Commission found that Medi-Cal failed to provide quality medical care for those who needed it, and that low physician participation was a persistent problem. According to the report, physicians had two primary concerns about Medi-Cal: insufficient payment rates; and, perhaps more importantly, the complex and time-consuming process of claiming reimbursement and obtaining prior authorization for services.14

Courts Find Rates Insufficient

In the early 1990s two court cases involving Medi-Cal rates set important precedents for Medi-Cal physician rate-setting standards. In October 1990, Clark v. Kizer explored the meaning of the “equal access” requirement in regards to Medi-Cal’s fee-for-service dental program, Denti-Cal. The court found that the reimbursement levels for Denti-Cal were not sufficient to ensure that access to dental services for Medi-Cal beneficiaries was equal to access

| 1990 | The Little Hoover Commission reports that low physician participation is a problem in Medi-Cal. |
| 1990 | Clark v. Kizer examines the “equal access” requirement. |
in the general population. As a result, DHS was required to increase Denti-Cal rates from 55% to 80% of dentists’ customary charges.

In 1992, the U.S. District Court for California ruled in *Orthopaedic Hospital v. Kizer* that DHS had “acted arbitrarily and capriciously in setting six out of seven disputed rates” for reimbursing hospital outpatient services. DHS was ordered to conduct an inquiry into the adequacy of outpatient rates that considered “efficiency, economy, and quality of care” as required by federal law. The case was appealed, but the decision ultimately was upheld. This lawsuit directly impacted physicians who are hospital employees, but more significantly it created a standard that could be extended to all physician services in the future.

### Managed Care Rates Challenged

Watts Health Foundation filed a lawsuit against DHS in 1996 challenging the legality of Medi-Cal capitation rates. The suit asked the court to either:

- Eliminate the UPL and increase capitation rates to levels that were “actuarially sound”;
- Maintain the UPL but raise fee-for-service rates.

Although the case was eventually dismissed, it raised important questions about managed care rates that HCFA, Medi-Cal, and other state Medicaid programs are still grappling with today.

### Phaseout of Cost-Based Reimbursement

The federal Balanced Budget Act of 1997 (BBA ’97) approved provisions to phase out the cost-based reimbursements for FQHCs and RHCs introduced in 1989. The phaseout, beginning in October 1999, would allow states to decrease payments from 100% of costs to 70% of costs by fiscal year 2003. Consumer advocates and safety-net providers voiced concern that this would threaten the solvency of safety-net clinics and ultimately compromise patient care. California, however, indicated that it would keep in place a state mandate authorizing 100% cost-based reimbursement despite the federal phaseout.
V. 1998 to Present: Legislative Action

By 1998 the public debate over the impact of Medi-Cal physician rates was in full force. Several reports released by provider and consumer advocates concluded that low Medi-Cal rates were having a negative impact on physician participation and patient care. For example, a March 1998 report by the Institute for Research on Women and Families cited low reimbursement as one of the key reasons that physicians do not accept foster children on Medi-Cal.20 Studies by the CMA, the American Academy of Pediatrics, and the Senate Select Committee on Developmental Disabilities and Mental Health drew similar conclusions.21,22,23

The controversy over Medi-Cal rates was highlighted further through news stories about physicians charging Medi-Cal recipients for services. The Los Angeles Times reported on the practice of some physicians and hospitals illegally forcing Medi-Cal beneficiaries to pay cash for epidural anesthesia during childbirth. The physicians named in the story maintained that they had to demand payment from the patients to cover their costs because Medi-Cal payments were insufficient.24

Rates Increases Legislated

In September 1998, the California legislature undertook significant action regarding Medi-Cal rates. The 1998-99 California Budget Act included the first substantial increases to Medi-Cal physician rates in 12 years. Rates were increased by 10% for adult primary care services and by 20% for pediatric preventive and primary care, marking some of the largest increases to Medi-Cal rates in the history of the program.25 Although these increases were favorably received by physicians, concern remained that Medi-Cal rates were still well below rates paid through Medicare and the private sector.
The reporting of Medi-Cal physician rates was also debated in the 1998-99 legislative session. AB 2516 would have required the director of DHS to report physician rates in five comparable states to the legislature annually and would have reinstated the reporting requirement originally included in Section 14079 of the *Welfare and Institutions Code* (see page 5). This bill was approved by the legislature but was ultimately vetoed by the Governor Wilson.

**Increasing Payments in Managed Care**

Following the 1998-99 Medi-Cal fee-for-service rates increases, questions arose about whether or not it was appropriate to incorporate those increases into Medi-Cal managed care capitation rates. Many stakeholders argued that health plan contracts had already been determined for the year, and that any form of mandated increases would be contrary to the competitive model of managed care. However, in April 1999, after several months of debate, DHS and the California Medical Assistance Commission agreed to incorporate the fee-for-service increases into Medi-Cal managed care rates (see textbox).

Ultimately, capitation rates rose by approximately 1% and this increase was integrated into all plan contracts retroactively to August 1998. While there is no guarantee that physicians themselves will receive any increased payments, several health plans have reported that they passed on increases of 1% to 5% to their physicians in early 1999.26

**Legislative Action Continues**

Governor Davis and the legislature continued action on Medi-Cal rates in 1999. Through the 1999-2000 state budget, they approved the following increases for specialty services:

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<td>Several reports discuss negative impact of Medi-Cal rates on provider participation.</td>
<td>Los Angeles Times reports that physicians are illegally asking Medi-Cal patients to pay cash for epidurals during childbirth.</td>
<td>Adult primary care rates are increased by 10% and pediatric rates are increased by 20%.</td>
<td>AB 2516, requiring DHS to report annually to the Assembly on the adequacy of physician rates, is vetoed by Governor Wilson.</td>
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</tbody>
</table>
- 5% increase for California Children Services (CCS) physician services;
- 9.5% rate restoration for surgery, anesthesiology, and radiology services;
- 20% increase in obstetrical anesthesiology rates;
- 22% increase in rates paid to optometrists;
- correction of cardiac catheterization physician rates to resolve coding errors; and
- increase for multiple surgical procedures performed during the same operation.27

Although these are notable changes to specialist payment rates, physician groups had lobbied for significantly larger increases. Some physician groups contend that these changes are merely corrections, and that little progress has been made to actually increase specialist rates.

The California legislature also considered several other Medi-Cal rates bills in 1999:

- AB 461, a reintroduction of AB 2516 (see page 14), again raised the issue of DHS reporting its rates comparisons to the legislature. This bill was vetoed by Governor Davis in September, who said that the “bill is not necessary since the DHS annually surveys payment rates and this information is readily available to the legislature when requested.”28

- AB 1068 would require increases in fee-for-service rates to be incorporated into managed care payments within 60 days and passed on directly to physicians. The bill was introduced in 1999, and will be considered by the Senate Appropriations Committee in early 2000.

- AB 715 would require DHS to continue to provide reimbursement based on 100% of the reasonable cost for all RHCs and FQHCs after the phaseout of the federal requirement. (Funds to temporarily maintain cost-based reimbursement until June 30, 2000 were included in the 1999-2000 state budget.) This bill was approved by the Assembly and will be considered on the Senate floor in 2000.
VI. Looking Forward: Unanswered Questions

Many questions remain unanswered for the Medi-Cal program. Are Medi-Cal’s rates negatively impacting access to care? How much below prevailing costs and commercial rates can Medi-Cal rates fall without compromising quality? How price-sensitive are Medi-Cal physicians? Are rates increases necessary? If so, how much of an increase is needed, and for what types of services? Will increases result in concrete improvements in access, quality, and physician participation? How might these improvements be measured?

Are Current Rates Adequate?

Medi-Cal’s payment rates are among the lowest of any Medicaid program in the country.29 In addition, according to a study of 1998 rates by PricewaterhouseCoopers, Medi-Cal fee-for-service payments for office visits are typically only 40% of payments from other California payers, including Medicare and several large commercial plans.30 But what does this mean? It could mean that Medi-Cal rates are too low to be sustainable, or it could mean that other states’ Medicaid programs are run less efficiently. How these variations affect physician participation, access to services, and quality of care has yet to be documented, but some analysis of Medicaid rates nationally suggests that utilization of and access to services may be compromised when rates are set too low.31,32

Physicians in California point out that when the Medi-Cal program began, commercial and private payers were able to offset the financial losses caused by low Medi-Cal rates. Today, the rise of managed care, intensifying cost competition, and an increase in the supply of physicians has reduced commercial payments substantially. The tightening health care market potentially threatens the solvency of physicians whose practices are comprised largely of Medi-Cal beneficiaries. However, much of the evidence on the impact of rates is anecdotal, and there is a
strong need for better data exploring the adequacy of Medi-Cal rates and documenting the effect of rates on quality and access.

**How Should FFS Rates Be Calculated?**

Medi-Cal rates are still based on the antiquated CRVS guidelines from 1969. As standard medical practices and medical coding continue to change, these guidelines are becoming increasingly obsolete. One option is the adoption of a newer national scale to calculate physician rates: the Resource Based Relative Value Scale (RBRVS). The RBRVS, developed at Harvard University for the federal Medicare program, emphasizes the benefits of primary and preventive care. It is considered comprehensive and is updated annually. Many commercial health plans and state Medicaid programs – including New York, Arizona, Oregon, Washington, and Massachusetts – base their payments on this scale.

There are some concerns with the RBRVS: Primarily, that it was originally developed for older Medicare patients, not the young women and children that make up the majority of the Medi-Cal population. Further, the adoption of a new payment scale could be extremely costly if it called for across the board increases in rates. Nonetheless, DHS supports the system and has recommended several plans for a cost-neutral conversion to the RBRVS that would require reductions in some rates to offset increases for other services. Another option would be to increase overall appropriations to Medi-Cal in combination with a conversion to the RBRVS.

**How Should Managed Care Rates Be Calculated?**

Medi-Cal managed care costs are currently calculated using 1985 utilization data from Santa Barbara County, and are limited by a UPL that is based on historical Medi-Cal fee-for-service data. The adequacy of this methodology is widely debated. Some stakeholders contend that:

- The 1985 data from Santa Barbara is out of date and does not reflect current patient behavior or medical practice.
- Fee-for-service data is becoming biased and unrepresentative of typical costs as more eligible beneficiaries enter managed care plans. Recently the state began requiring encounter/utilization data from all Medi-Cal managed care health plans, but many reporting systems are still new and DHS has not yet been able to use the information to determine payment rates.
- The UPL does not include sufficient adjustments for the administrative and quality assurance services required of health plans. For example, managed care plans are required to provide 24-hour access to interpretive services, but fee-for-service providers are not.
Finally, managed care rates are currently set at 94% of the UPL, and plans argue that at a minimum the state could raise rates up to 100% of the UPL.

In an effort to address some of the concerns with UPL restrictions, HCFA convened the Upper Payment Limit Work Group in June 1999 to re-evaluate the relevance and application of the UPL. The group includes representatives from Medi-Cal and several other state Medicaid agencies, federal agencies, and health plans.

Further Research

There are a number of areas where further research is needed to clarify the issues surrounding Medi-Cal physician rates:

- Are there problems of access to physicians in the Medi-Cal program? Are there geographic regions and physician specialties where access is a particular concern? Are the tools currently being used to measure access adequate?
- Are access and quality correlated with differences in Medi-Cal managed care payment and contracting structures? What best practices have emerged in plans, counties, and other states?
- How do other states balance the competing interests of cost containment and quality?
- Have conversions to the Resource Based Relative Value Scale in other states been successful?
- How do the quality and rates divisions at the Department of Health Services share information? Over time, has there been a correlation between quality of care data and payment levels?
- As the state considers moving other populations (i.e., elderly or disabled) into Medi-Cal managed care, will it begin to consider risk-adjusted rates? Are the methods used for risk adjustment adequate to predict costs for the Medi-Cal program?
VII. Conclusion

California provides more services to more Medicaid beneficiaries at a lower per-recipient cost than any other state. It does so in part by paying physicians rates that are far below Medicare and commercial rates. Debate has begun to focus on the economic disadvantage facing physicians who choose to treat Medi-Cal patients. However, policymakers must consider whether a rates increase will be effective in achieving real improvements in quality and access. Further, some policymakers are concerned that a rates increase might result in spiraling program costs when the booming economy turns and Medi-Cal enrollment begins to grow. As the Medi-Cal program approaches a new century, it will continue to grapple with these questions and with balancing the competing goals of cost-containment, the provision of effective and efficient care, and the need to attract and retain the physicians required to treat beneficiaries in the future.
Notes

1 42USC Sec.1396a(a)(30)(A).
2 California Welfare and Institutions Code, Sec.14079.
3 42USC Sec. 1396b(m)(2)(A)(iii).
4 2CFR447.361.
6 CCR Title 22, Div.3, Sub.1, Ch.3, Art.7, Sec.51503(b).
12 Omnibus Budget Reconciliation Act of 1989 §6404.

Senate Select Committee on Developmental Disabilities and Mental Health. *Improving the Quality of Community-Based Services and Supports in California for Persons with Developmental Disabilities.* February 1998.


