AMENDED IN ASSEMBLY APRIL 26, 2021

AMENDED IN ASSEMBLY APRIL 12, 2021

AMENDED IN ASSEMBLY MARCH 18, 2021

CALIFORNIA LEGISLATURE—2021–22 REGULAR SESSION

ASSEMBLY BILL No. 369

Introduced by Assembly Member Kamlager
(Coauthors: Assembly Members Bauer-Kahan, *Burke,* Carrillo, Cristina Garcia, Gipson, Santiago, ~~and Stone~~) *Stone, Wood, and Lorena Gonzalez)*
(Coauthors: Senators Allen, Umberg, and Wiener)

February 1, 2021

An act to amend Section 15926 of, and to add Sections 14011.67, 14133.55, 14133.56, ~~and 14133.57~~ *14133.57, and 14301.12* to, the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 369, as amended, Kamlager. Medi-Cal services: persons experiencing homelessness.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department to provide presumptive Medi-Cal eligibility to pregnant women and children. Existing law authorizes a qualified hospital to make presumptive eligibility determinations if it complies with specified requirements. Existing law authorizes the department, on a regional pilot project basis, to issue an identification card to a person who is eligible for Medi-Cal program

benefits, but does not possess a valid California driver's license or identification card issued by the Department of Motor Vehicles. Existing law requires the department, in consultation with the board governing the California Health Benefit Exchange, to develop a single paper, electronic, and telephone application for insurance affordability programs, including Medi-Cal.

This bill would require the department to implement a program of presumptive eligibility for persons experiencing homelessness, under which a person would receive full-scope Medi-Cal benefits without a share of cost. The bill would require the department to authorize an enrolled Medi-Cal provider to issue a temporary Medi-Cal benefits identification card to a person experiencing homelessness, and would prohibit the department from requiring a person experiencing homelessness to present a valid California driver's license or identification card issued by the Department of Motor Vehicles to receive Medi-Cal services if the provider verifies the person's eligibility. The bill would require the insurance affordability program's paper application to include a check box, and electronic application to include a pull-down menu, for an applicant to indicate if they are experiencing homelessness at the time of application.

This bill would authorize an enrolled Medi-Cal provider to make a presumptive eligibility determination for a person experiencing homelessness. The bill would authorize an enrolled Medi-Cal provider to bill the Medi-Cal program for Medi-Cal services provided off the premises to a person experiencing homelessness, as specified. The bill would require a Medi-Cal managed care plan to allow a beneficiary to seek those services and allow a provider to provide those services, but would authorize a Medi-Cal managed care plan to establish reasonable requirements governing utilization protocols and network participation. *If Medi-Cal covered health care services covered by a Medi-Cal managed care plan are not provided within the first 60 calendar days of enrollment to a Medi-Cal beneficiary who has indicated that they are a person experiencing homelessness at the time of application, the bill would require the department to deduct the capitation payments made by the department to the plan from subsequent payments due to the plan for the time period from when the person was initially enrolled into a plan until the first receipt of plan-covered services.*

~~If a county determines a person experiencing homelessness is eligible for benefits under the Medi-Cal program, the bill would require the person to be enrolled in the Medi-Cal program's fee-for-service delivery~~

~~system until they elect to enroll in a Medi-Cal managed care plan. By creating new duties for counties, the bill would impose a state-mandated local program.~~

~~The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.~~

~~This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.~~

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: ~~yes~~ *no*.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) People experiencing homelessness have poorer health outcomes and increased mortality rates compared to the general population. This has been attributed to competing priorities, such as finding food and shelter and maintaining safety, which detract from prioritizing health care, independent of health care coverage status.

(b) People experiencing homelessness have poor access to primary care, with only 8 percent of people experiencing homelessness having a primary care provider versus 82 percent of the general population.

(c) People experiencing homelessness with Medi-Cal coverage rely on referrals from their primary care providers to access specialty care. Lack of access to primary care furthers lack of access to specialty care and necessitates at least two visits, each one difficult to accomplish, when only one might be necessary.

(d) Poor health outcomes have been attributed to institutional trauma in the traditional health care system, such as distrust of the health care system, institutional discrimination, and feeling unwelcome, leading to an unwillingness to seek medical care.

(e) Deaths in the homeless population in the County of Los Angeles have doubled in the last five years, according to a report from the State Department of Public Health.

(f) Homelessness and homeless deaths disproportionately affect people of color, accounting for 68 percent of deaths and demonstrating a gross health inequity.

(g) The COVID-19 pandemic has increased reliance on telemedicine, but people experiencing homelessness often lack access to telephones, furthering health inequities and increasing isolation.

(h) Rates of COVID-19 have been increasing substantially for people experiencing homelessness. They are largely unable to follow the Governor's safer at home orders, wash hands regularly, and keep face masks clean.

(i) Barriers to care prevent COVID-19 diagnosis and treatment, increasing morbidity and mortality, increasing rates of community transmission, and ultimately putting the general population at increased risk.

(j) There are effective, evidence-based models for delivering health care to persons experiencing homelessness, including street medicine, shelter-based care, and care provided in transitional housing. These models were developed specifically to address the unique needs and circumstances of persons experiencing homelessness onsite where they reside.

(k) Through shelter-based care, street medicine, mobile clinics and related delivery models, providers remove access barriers for persons experiencing homelessness in order to deliver patient-centered care. Services provided include medical care for acute and chronic health conditions, behavioral health care treatment, and treatment for substance use disorders, dispensing common medications, and drawing blood work.

(*l*) Less than 30 percent of people experiencing homelessness who are insured have ever seen their primary care physician, versus 70 percent of those treated by street medicine teams, who are actively engaged in primary care within one week of referral.

(m) Providing medical care to persons experiencing homelessness outside of traditional medical settings has demonstrated a decrease in hospital admissions by two-thirds with a hospital-based consult service.

(n) Persons experiencing homelessness have twice the length of stay while hospitalized compared to the housed population, and spend 740 percent more days in the hospital at a 170-percent greater cost per day than people who are housed.

(o) Providing health care and social services on the street or outside traditional medical facilities improves housing placement compared to only providing nonmedical outreach services. In the City of Los Angeles, street medicine teams have successfully transitioned 42 percent of their homeless patients into permanent housing, compared to 4 percent when the Los Angeles Homeless Services Authority is the responsible party.

(p) Direct care delivery to people experiencing homelessness has taken an important role during the COVID-19 response in shelters and encampments across the state, but has been limited due to small existing infrastructure before the pandemic.

(q) The COVID-19 pandemic has forced direct care providers to ration resources, either choosing to provide COVID-19 surveillance and testing, or needed ongoing primary care. Lack of infrastructure has made it impossible to do both well.

SEC. 2. Section 14011.67 is added to the Welfare and Institutions Code, to read:

14011.67. (a) ~~To the extent federal financial participation is available, the~~ *The* department shall implement a program of presumptive eligibility for persons experiencing homelessness.

(b) The presumptive eligibility benefits provided under this section shall be full-scope Medi-Cal benefits without a share of cost.

(c) Upon implementation of the presumptive eligibility program for persons experiencing homelessness, the department shall issue a declaration, which shall be retained by the director, stating that implementation of the program has commenced.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. Thereafter, the department shall adopt any necessary regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(e) An enrolled Medi-Cal provider, including a health facility, such as a hospital or clinic, may make a presumptive eligibility determination for a person experiencing homelessness.

~~(f) If the county determines that the person experiencing homelessness is eligible for benefits under the Medi-Cal program, the person shall be enrolled in the Medi-Cal program's fee-for-service delivery system until they elect, by providing informed consent, to enroll in a Medi-Cal managed care plan. If they elect to enroll in a Medi-Cal managed care plan, they shall complete a Medi-Cal choice form with their chosen primary care provider who is present for purposes of completing that form. The department shall not assign a person experiencing homelessness to a primary care provider without the person's informed consent under any circumstances, including any time beyond the 60-day choice period.~~

~~(g)~~

(f) For purposes of this section, a "person experiencing homelessness" means a person who is "homeless" as defined in Section 91.5 of Title 24 of the Code of Federal Regulations.

(g) (1) The department shall seek any federal approvals necessary to implement this section.

(2) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

SEC. 3. Section 14133.55 is added to the Welfare and Institutions Code, to read:

14133.55. (a) The department shall authorize an enrolled Medi-Cal provider to bill the Medi-Cal program for covered services that are otherwise reimbursable to the Medi-Cal provider, but that are provided off the premises of the Medi-Cal provider's office, to a person who is experiencing homelessness and meets one of the following criteria:

(1) Is a Medi-Cal beneficiary who is eligible pursuant to Section 14011.67.

(2) Is exempt from mandatory enrollment in a Medi-Cal managed care plan.

(3) Receives services through fee-for-service Medi-Cal before Medi-Cal managed care plan enrollment.

(b) For purposes of this section:

(1) A "person experiencing homelessness" means a person who is "homeless" as defined in Section 91.5 of Title 24 of the Code of Federal Regulations.

(2) "Premises" means a site located at an address other than the address listed either on the provider's license or in the provider master file.

(c) (1) The department shall seek any federal ~~waivers~~ *approvals* necessary to implement this section.

(2) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

SEC. 4. Section 14133.56 is added to the Welfare and Institutions Code, to read:

14133.56. (a) A Medi-Cal managed care plan shall allow a Medi-Cal beneficiary described in subdivision (b) to seek Medi-Cal covered services directly from a participating Medi-Cal provider, pursuant to this section.

(b) A Medi-Cal managed care plan shall authorize an enrolled Medi-Cal provider to provide covered services that are otherwise reimbursable to the Medi-Cal provider, but that are provided off the premises of the Medi-Cal provider's office, to a Medi-Cal beneficiary who is experiencing homelessness.

(c) In implementing this section, a Medi-Cal managed care plan may establish reasonable requirements governing utilization protocols and participation in the plan network, if protocols and network participation requirements are consistent with the goal of authorizing services to beneficiaries pursuant to this section.

(d) A Medi-Cal provider providing services pursuant to this section shall not be required to obtain prior approval from another physician, another provider, a medical group or independent practice association, a clinic, or the Medi-Cal managed care plan before providing services, including specialist services and laboratory services.

(e) (1) A Medi-Cal managed care plan shall provide a Medi-Cal beneficiary the ability to inform the plan online, in person, or via telephone that they are experiencing homelessness.

(2) The department shall inform the Medi-Cal managed care plan if a Medi-Cal beneficiary has indicated they are experiencing homelessness based on information furnished on the Medi-Cal application.

(f) For purposes of this section:

(1) A "person experiencing homelessness" means a person who is "homeless" as defined in Section 91.5 of Title 24 of the Code of Federal Regulations.

(2) "Premises" means a site located at an address other than the address listed either on the provider's license or in the provider master file.

(g) (1) The department shall seek any federal ~~waivers~~ *approvals* necessary to implement this section.

(2) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

SEC. 5. Section 14133.57 is added to the Welfare and Institutions Code, to read:

14133.57. (a) (1) Notwithstanding Sections 14017 and 14017.5, the department shall authorize an enrolled Medi-Cal provider, including a health facility, such as a hospital or clinic, to issue a temporary, provider-issued Medi-Cal benefits identification card to a person experiencing homelessness who is a Medi-Cal beneficiary or receives full-scope Medi-Cal benefits pursuant to Section 14011.67. The department shall not require a person experiencing homelessness to present a valid California driver's license or identification card issued by the Department of Motor Vehicles in order to receive services under the Medi-Cal program if the Medi-Cal provider verifies Medi-Cal eligibility through telephone or electronic means.

(2) The department shall not require a provider to match the name and signature on any Medi-Cal benefits identification card, including the initially issued temporary card, as described under paragraph (1), issued by the department or provider to a person experiencing homelessness or that individual's valid California driver's license or California identification card against a signature executed at the time of service, or require a provider to visually verify the likeness of a person experiencing homelessness to the photograph on the identification card or driver's license, if the person does not possess a benefits identification card, temporary benefits identification card, California driver's license, or California identification card.

(3) If a provider is unable to verify eligibility based on a Medi-Cal benefits identification card, including the initially issued temporary card, the provider may verify eligibility through any

other system, including the Medi-Cal Eligibility Data System or the Homeless Management Information System, as defined in subdivision (i) of Section 50216 of the Health and Safety Code.

(b) For purposes of this section, a "person experiencing homelessness" means a person who is "homeless" as defined in Section 91.5 of Title 24 of the Code of Federal Regulations.

(c) (1) The department shall seek any federal ~~waivers~~ *approvals* necessary to implement this section.

(2) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

SEC. 6. Section 14301.12 is added to the Welfare and Institutions Code, to read:

14301.12. (a) If Medi-Cal covered health care services covered by a Medi-Cal managed care plan are not provided within the first 60 calendar days of enrollment to a Medi-Cal beneficiary who has indicated that they are a person experiencing homelessness at the time of application, the department shall deduct the capitation payments made by the department to the plan from subsequent payments due to the plan for the time period from when the person was initially enrolled into a Medi-Cal managed care plan until the first receipt of plan-covered services.

(b) For purposes of this section, a "person experiencing homelessness" means a person who is "homeless" as defined in Section 91.5 of Title 24 of the Code of Federal Regulations.

(c) "Medi-Cal managed care plan" means an individual, organization, or entity that enters into a comprehensive risk contract with the department to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries pursuant to Chapter 7 (commencing with Section 14000) or this chapter.

~~SEC. 6.~~

SEC. 7. Section 15926 of the Welfare and Institutions Code is amended to read:

15926. (a) The following definitions apply for purposes of this part:

(1) "Accessible" means in compliance with Section 11135 of the Government Code, Section 1557 of the PPACA, and regulations or guidance adopted pursuant to these statutes.

(2) "Limited-English-proficient" means not speaking English as one's primary language and having a limited ability to read, speak, write, or understand English.

(3) "Insurance affordability program" means a program that is one of the following:

(A) The Medi-Cal program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(B) The state's children's health insurance program (CHIP) under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(C) A program that makes available to qualified individuals coverage in a qualified health plan through the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code with advance payment of the premium tax credit established under Section 36B of the Internal Revenue Code.

(4) A program that makes available coverage in a qualified health plan through the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code with cost-sharing reductions established under Section 1402 of PPACA and any subsequent amendments to that act.

(b) An individual shall have the option to apply for insurance affordability programs in person, by mail, online, by telephone, or by other commonly available electronic means.

(c) (1) A single, accessible, standardized paper, electronic, and telephone application for insurance affordability programs shall be developed by the department, in consultation with the board governing the Exchange, as part of the stakeholder process described in subdivision (b) of Section 15925. The application shall be used by all entities authorized to make an eligibility determination for any of the insurance affordability programs and by their agents. The paper application shall include a check box, and the electronic application shall include a pull-down menu, for the applicant to indicate if the applicant is homeless at the time of application. For purposes of this section, "homeless" has the same meaning as in Section 91.5 of Title 24 of the Code of Federal Regulations.

(2) The department may develop and require the use of supplemental forms to collect additional information needed to

determine eligibility on a basis other than the financial methodologies described in Section 1396a(e)(14) of Title 42 of the United States Code, as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148), and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments, as provided under Section 435.907(c) of Title 42 of the Code of Federal Regulations.

(3) The application shall be tested and operational by the date as required by the federal Secretary of Health and Human Services.

(4) The application form shall, to the extent not inconsistent with federal statutes, regulations, and guidance, satisfy all of the following criteria:

(A) The form shall include simple, user-friendly language and instructions.

(B) The form may not ask for information related to a nonapplicant that is not necessary to determine eligibility in the applicant's particular circumstances.

(C) The form may require only information necessary to support the eligibility and enrollment processes for insurance affordability programs.

(D) The form may be used for, but shall not be limited to, screening.

(E) The form may ask, or be used otherwise to identify, if the mother of an infant applicant under one year of age had coverage through an insurance affordability program for the infant's birth, for the purpose of automatically enrolling the infant into the applicable program without the family having to complete the application process for the infant.

(F) The form may include questions that are voluntary for applicants to answer regarding demographic data categories, including race, ethnicity, primary language, disability status, and other categories recognized by the federal Secretary of Health and Human Services under Section 4302 of the PPACA.

(G) Until January 1, 2016, the department shall 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. The department shall work with

counties and consumer advocates to develop the supplemental questions.

(d) Nothing in this section shall preclude the use of a provider-based application form or enrollment procedures for insurance affordability programs or other health programs that differs from the application form described in subdivision (c), and related enrollment procedures. Nothing in this section shall preclude the use of a joint application, developed by the department and the State Department of Social Services, that allows for an application to be made for multiple programs, including, but not limited to, CalWORKs, CalFresh, and insurance affordability programs.

(e) The entity making the eligibility determination shall grant eligibility immediately whenever possible and with the consent of the applicant in accordance with the state and federal rules governing insurance affordability programs.

(f) (1) If the eligibility, enrollment, and retention system has the ability to prepopulate an application form for insurance affordability programs with personal information from available electronic databases, an applicant shall be given the option, with their informed consent, to have the application form prepopulated. Before a prepopulated application is submitted to the entity authorized to make eligibility determinations, the individual shall be given the opportunity to provide additional eligibility information and to correct any information retrieved from a database.

(2) All insurance affordability programs may accept self-attestation, instead of requiring an individual to produce a document, for age, date of birth, family size, household income, state residence, pregnancy, and any other applicable criteria needed to determine the eligibility of an applicant or recipient, to the extent permitted by state and federal law.

(3) An applicant or recipient shall have their information electronically verified in the manner required by the PPACA and implementing federal regulations and guidance and state law.

(4) Before an eligibility determination is made, the individual shall be given the opportunity to provide additional eligibility information and to correct information.

(5) The eligibility of an applicant shall not be delayed beyond the timeliness standards as provided in Section 435.912 of Title

42 of the Code of Federal Regulations or denied for any insurance affordability program unless the applicant is given a reasonable opportunity, of at least the kind provided for under the Medi-Cal program pursuant to Section 14007.5 and paragraph (7) of subdivision (e) of Section 14011.2, to resolve discrepancies concerning any information provided by a verifying entity.

(6) To the extent federal financial participation is available, an applicant shall be provided benefits in accordance with the rules of the insurance affordability program, as implemented in federal regulations and guidance, for which the applicant otherwise qualifies until a determination is made that the applicant is not eligible and all applicable notices have been provided. Nothing in this section shall be interpreted to grant presumptive eligibility if it is not otherwise required by state law, and, if so required, then only to the extent permitted by federal law.

(g) The eligibility, enrollment, and retention system shall offer an applicant and recipient assistance with their application or renewal for an insurance affordability program in person, over the telephone, by mail, online, or through other commonly available electronic means and in a manner that is accessible to individuals with disabilities and those who are limited-English proficient.

(h) (1) During the processing of an application, renewal, or a transition due to a change in circumstances, an entity making eligibility determinations for an insurance affordability program shall ensure that an eligible applicant and recipient of insurance affordability programs that meets all program eligibility requirements and complies with all necessary requests for information moves between programs without any breaks in coverage and without being required to provide any forms, documents, or other information or undergo verification that is duplicative or otherwise unnecessary. The individual shall be informed about how to obtain information about the status of their application, renewal, or transfer to another program at any time, and the information shall be promptly provided when requested.

(2) The application or case of an individual screened as not eligible for Medi-Cal on the basis of Modified Adjusted Gross Income (MAGI) household income but who may be eligible on the basis of being 65 years of age or older, or on the basis of blindness or disability, shall be forwarded to the Medi-Cal program for an eligibility determination. During the period this application

or case is processed for a non-MAGI Medi-Cal eligibility determination, if the applicant or recipient is otherwise eligible for an insurance affordability program, the applicant or recipient shall be determined eligible for that program.

(3) Renewal procedures shall include all available methods for reporting renewal information, including, but not limited to, face-to-face, telephone, mail, and online renewal or renewal through other commonly available electronic means.

(4) An applicant who is not eligible for an insurance affordability program for a reason other than income eligibility, or for any reason in the case of applicants and recipients residing in a county that offers a health coverage program for individuals with income above the maximum allowed for the Exchange premium tax credits, shall be referred to the county health coverage program in their county of residence.

(i) Notwithstanding subdivisions (e), (f), and (j), before an online applicant who appears to be eligible for the Exchange with a premium tax credit or reduction in cost sharing, or both, may be enrolled in the Exchange, both of the following shall occur:

(1) The applicant shall be informed of the overpayment penalties under the federal Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (Public Law 112-9), if the individual's annual family income increases by a specified amount or more, calculated on the basis of the individual's current family size and current income, and that penalties are avoided by prompt reporting of income increases throughout the year.

(2) The applicant shall be informed of the penalty for failure to have minimum essential health coverage.

(j) The department shall, in coordination with the Exchange board, streamline and coordinate all eligibility rules and requirements among insurance affordability programs using the least restrictive rules and requirements permitted by federal and state law. This process shall include the consideration of methodologies for determining income levels, assets, rules for household size, citizenship and immigration status, and self-attestation and verification requirements.

(k) (1) Forms and notices developed pursuant to this section shall be accessible and standardized, as appropriate, and shall

comply with federal and state laws, regulations, and guidance prohibiting discrimination.

(2) Forms and notices developed pursuant to this section shall be developed using plain language and shall be provided in a manner that affords meaningful access to limited-English-proficient individuals, in accordance with applicable state and federal law, and at a minimum, provided in the same threshold languages as required for Medi-Cal managed care plans.

(*l*) The department, the California Health and Human Services Agency, and the Exchange board shall establish a process for receiving and acting on stakeholder suggestions regarding the functionality of the eligibility systems supporting the Exchange, including the activities of all entities providing eligibility screening to ensure the correct eligibility rules and requirements are being used. This process shall include consumers and their advocates, be conducted no less than quarterly, and include the recording, review, and analysis of potential defects or enhancements of the eligibility systems. The process shall also include regular updates on the work to analyze, prioritize, and implement corrections to confirmed defects and proposed enhancements, and to monitor screening.

(m) In designing and implementing the eligibility, enrollment, and retention system, the department and the Exchange board shall ensure that all privacy and confidentiality rights under the PPACA and other federal and state laws are incorporated and followed, including responses to security breaches.

(n) Except as otherwise specified, this section shall be operative on January 1, 2014.

~~SEC. 7. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.~~

REVISIONS:

Heading—Line 3.

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