SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

ITEM
2.25
(ID # 4147)

MEETING DATE:
Tuesday, May 2, 2017

FROM : EXECUTIVE OFFICE:

SUBJECT: EXECUTIVE OFFICE: Legislative Update - May 2, All Districts. [$0]

RECOMMENDED MOTION: That the Board of Supervisors:
1. Receive and File the Legislative Update for May 2, 2017.

ACTION: Consent

Brian Nestande 4/26/2017

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Ashley, seconded by Supervisor Jeffries and duly carried by unanimous vote, IT WAS ORDERED that the above matter is received and filed as recommended.

Ayes:	Jeffries, Tavaglione, Washington and Ashley
Nays:	None
Absent:	None
Date:	May 2, 2017
xc:	EO

Kecia Harper-Ihem
Clerk of the Board
By: _____
Deputy

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost
COST	$ 0	$ 0	$ 0	$ 0
NET COUNTY COST	$ 0	$ 0	$ 0	$ 0
SOURCE OF FUNDS: N/A			**Budget Adjustment:** N/A	
			For Fiscal Year: N/A	

C.E.O. RECOMMENDATION: APPROVE

BACKGROUND:

Summary

As per Board Policy A-27, the purpose of Riverside County's Legislative Program is to secure legislation that benefits the county and its residents, and to oppose/amend legislation that might adversely affect the county. Recognizing the need for consistency in conveying official positions on legislative matters, the county has instituted a coordinated process involving interaction between the Board of Supervisors, the County Executive Office, county agencies/departments, and the county's legislative advocates in Sacramento and Washington, D.C.

Letters of Support/Opposition

Since the last meeting of the Riverside County Board of Supervisors, the following letters were delivered to our legislative delegation and all pertinent parties in order to voice Riverside County's Support/Opposition.

Legislation/Policy: AB 205 (Wood) – Medi-Cal: Medi-Cal Managed Care Plans
Position: SUPPORT – Per Legislative Platform
Recipient: Assembly Member Wood
Summary: This bill ensures the continuation of supplemental funding to public hospitals, which is worth $1-1.5 billion statewide. As Riverside County currently operates a level 2 trauma center, Riverside County would qualify for the highest levels of supplemental payments available under this bill. Current state law establishes hearing procedures for an applicant or beneficiary of Medi-Cal who is dissatisfied with certain actions regarding health care services and medical assistance to request a hearing from the State Department of Social Services under specified circumstances, and requires a request for a hearing to be filed within 90 days after the order or action complained of. This bill would implement various provisions in regard to those federal regulations, as amended May 6, 2016, governing Medicaid managed care plans. The bill would authorize a person to request a hearing involving a Medi-Cal managed care plan within 120 calendar days after the order or action complained of, and would exclude a request from the 120-calendar day filing time if there is good cause, as defined, for filing the request beyond the 120-calendar day period.

Legislation/Policy: AB 227 (Mayes): CalWORKs: Education Incentives
Position: SUPPORT – Per Legislative Platform

Recipient: Assemblymember Chad Mayes
Summary: AB 227 would create the CalWORKs Educational Opportunity and Attainment Program to provide CalWORKs recipients with a monthly education incentive grant of $100 for attainment of a high school diploma or its equivalent, $200 for attainment of an associate's degree or career technical education program, or $300 for attainment of a bachelor's degree, if the educational program was completed while the recipient was receiving CalWORKs assistance. The bill would require the education incentive grant to be provided on an ongoing basis if the recipient meets certain eligibility criteria.

Legislation/Policy: SB 130 (Mitchell): Local Government Finance: Property Tax Revenue Allocations: Vehicle License Fee Adjustments
Position: SUPPORT – Per Legislative Platform
Recipient: Senator Holly Mitchell
Summary: This bill contains language similar to Senator Roth's SB 37 to provide a VLF adjustment to the four cities within Riverside County. Beginning with the 2004–05 fiscal year and for each fiscal year thereafter, current law requires that each city, county, and city and county receive additional property tax revenues in the form of a vehicle license fee adjustment amount, as defined, from a Vehicle License Fee Property Tax Compensation Fund that exists in each county treasury. Current law requires that these additional allocations be funded from ad valorem property tax revenues otherwise required to be allocated to educational entities. This bill would modify these reductions and transfer provisions for a city incorporating after January 1, 2004, and on or before January 1, 2012, for the 2017–18 fiscal year and for each fiscal year thereafter, by providing for a vehicle license fee adjustment amount calculated on the basis of changes in assessed valuation.

Legislation/Policy: SB 130 (Mitchell): Local Government Finance: Property Tax Revenue Allocations: Vehicle License Fee Adjustments
Position: SUPPORT – Per Legislative Platform
Recipient: Assemblymember Phil Ting
Summary: This bill contains language similar to Senator Roth's SB 37 to provide a VLF adjustment to the four cities within Riverside County. Beginning with the 2004–05 fiscal year and for each fiscal year thereafter, current law requires that each city, county, and city and county receive additional property tax revenues in the form of a vehicle license fee adjustment amount, as defined, from a Vehicle License Fee Property Tax Compensation Fund that exists in each county treasury. Current law requires that these additional allocations be funded from ad valorem property tax revenues otherwise required to be allocated to educational entities. This bill would modify these reductions and transfer provisions for a city incorporating after January 1, 2004, and on or before January 1, 2012, for the 2017–18 fiscal year and for each fiscal year thereafter, by providing for a vehicle license fee adjustment amount calculated on the basis of changes in assessed valuation.

Legislation/Policy: SB 132: Budget Act of 2016.

Position: SUPPORT – Per Legislative Platform
Recipient: Senator Holly Mitchell
Summary: This bill contains language regarding the proposed Riverside County transportation projects. The Budget Act of 2016 made appropriations for the support of state government for the 2016–17 fiscal year. This bill would amend the Budget Act of 2016 by amending and adding items of appropriation and making other changes. This bill would become operative only if SB 496 of the 2017–18 Regular Session is enacted and becomes operative. This bill would declare that it is to take effect immediately as a Budget Bill.

Legislation/Policy: SB 171 (Hernandez) – Medi-Cal: Medi-Cal Managed Care Plans
Position: SUPPORT – Per Legislative Platform
Recipient: Senator Hernandez
Summary: This bill ensures the continuation of supplemental funding to public hospitals, which is worth $1-1.5 billion statewide. As Riverside County currently operates a level 2 trauma center, Riverside County would qualify for the highest levels of supplemental payments available under this bill. Current state law establishes hearing procedures for an applicant for or beneficiary of Medi-Cal who is dissatisfied with certain actions regarding health care services and medical assistance to request a hearing from the State Department of Social Services under specified circumstances, and requires a request for a hearing to be filed within 90 days after the order or action complained of. This bill would implement various provisions in regard to those federal regulations, as amended May 6, 2016, governing Medicaid managed care plans. The bill would authorize a person to request a hearing involving a Medi-Cal managed care plan within 120 calendar days after the order or action complained of, and would exclude a request from the 120-calendar day filing time if there is good cause, as defined, for filing the request beyond the 120-calendar day period.

Legislation/Policy: SB 249 (Allen): Off-Highway Motor Vehicle Recreation
Position: OPPOSE – Per Board Action
Recipient: Senator Lara
Summary: Would revise and recast various provisions of the Off-Highway Motor Vehicle Recreation Act of 2003. The bill would expand the duties of the Division of Off-Highway Motor Vehicle Recreation. The bill would require the Director of Parks and Recreation to assemble a science advisory team to advise and assist the department and the division in meeting the natural and cultural resource conservation purposes of the act, as specified.

Legislation/Policy: SB 649 (Hueso): Wireless Telecommunications Facilities
Position: OPPOSE – Per Legislative Platform
Recipient: Senator Ben Hueso
Summary: Under current law, a wireless telecommunications collocation facility, as specified, is subject to a city or county discretionary permit and is required to comply with specified criteria, but a collocation facility, which is the placement or installation of wireless facilities, including antennas and related equipment, on or immediately adjacent to that wireless

telecommunications collocation facility, is a permitted use not subject to a city or county discretionary permit. This bill would provide that a small cell is a permitted use, not subject to a city or county discretionary permit, if the small cell meets specified requirements.

Legislation/Policy: 340B Drug Program
Position: OPPOSE – Per Legislative Platform
Recipient: Assembly Member Ting
Summary: Yet to be released language by the Governor seeks to change how 340B entities can bill Medi-Cal managed care plans for outpatient drugs, allowing the state to capture any savings public health care systems receive from purchasing 340B drugs. The Department of Health Care Services (DHCS) signaled their intent to clarify current law in the January budget; however, trailer bill language and a specific revenue estimate were not released at that time. More details are expected in May with the budget revisions.

Legislation/Policy: 340B Drug Program
Position: OPPOSE – Per Legislative Platform
Recipient: Senator Holly Mitchell
Summary: Yet to be released language by the Governor seeks to change how 340B entities can bill Medi-Cal managed care plans for outpatient drugs, allowing the state to capture any savings public health care systems receive from purchasing 340B drugs. The Department of Health Care Services (DHCS) signaled their intent to clarify current law in the January budget; however, trailer bill language and a specific revenue estimate were not released at that time. More details are expected in May with the budget revisions.

Impact on Residents and Businesses
The action presented should not affect residents or businesses within Riverside County.

ATTACHMENT A. Legislative Update – May 2

COUNTY OF RIVERSIDE

Board of Supervisors

District 1	**Kevin Jeffries** 951-955-1010
District 2 Chairman	**John F. Tavaglione** 951-955-1020
District 3	**Chuck Washington** 951-955-1030
District 4	**Vacant** 951-955-1040
District 5	**Marion Ashley** 951-955-1050

April 18, 2017

The Honorable Chad Mayes
Assembly Republican Leader
State Capitol Building, Room 3104
Sacramento, CA 95814

RE: AB 227 (Mayes): CalWORKs: Educational Opportunity & Attainment Program
As Introduced, January 26, 2017
Set for hearing April 25, 2017: Assembly Human Services Committee
County of Riverside: SUPPORT – Per Legislative Platform

Dear Assemblymember Mayes:

On behalf of the Riverside County Board of Supervisors, I write to express our support for your legislation, AB 227.

Existing law requires counties to provide cash assistance and other social services to struggling families through the California Work Opportunity and Responsibility to Kids (CalWORKs) program using federal, state, and county funds. Recipients of CalWORKs are required to participate in welfare-to-work activities for a specified number of hours each week as a condition of eligibility for aid and existing law authorizes certain welfare-to-work participants to engage in adult basic education in satisfaction of these work requirements.

AB 227 would create incentive bonuses for CalWORKs recipients if they reach an educational milestone, such as a high school diploma, associate or bachelor's degree while receiving CalWORKs. This legislation would provide a much needed support and incentive to help CalWORKs recipients achieve their educational goals and bolster their ability to better pursue long-term career goals and break out of poverty.

For these reasons, we strongly support AB 227. Should you have any questions about our position, please do not hesitate to contact Deputy County Executive Officer Brian Nestande at (951) 955-1110 or bnestande@rceo.org.

Sincerely,

John Tavaglione
Chairman, Riverside County Board of Supervisors

cc: County of Riverside Delegation
Assembly Human Services Committee, Members and Consultants

ASSEMBLY BILL No. 227

Introduced by Assembly Member Mayes
(Principal coauthor: Assembly Member Gipson)
(Principal coauthor: Senator Bates)
(Coauthors: Assembly Members Acosta, Baker, Bigelow, Brough, Chávez, Choi, Cunningham, Flora, Gallagher, Eduardo Garcia, Lackey, Mathis, Obernolte, Steinorth, Waldron, and Wood)
(Coauthors: Senators Anderson, Nguyen, and Vidak)

January 26, 2017

An act to add Article 3.7 (commencing with Section 11340) to Chapter 2 of Part 3 of Division 9 of the Welfare and Institutions Code, relating to CalWORKs, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 227, as introduced, Mayes. CalWORKs: education incentives.

Existing law requires each county to provide cash assistance and other social services to needy families through the California Work Opportunity and Responsibility to Kids (CalWORKs) program using federal, state, and county funds. Under existing law, a recipient of CalWORKs is required to participate in welfare-to-work activities for a specified number of hours each week as a condition of eligibility for aid. Existing law authorizes certain welfare-to-work participants to engage in adult basic education in satisfaction of these work requirements.

Existing law establishes the Cal-Learn Program, under which a recipient of CalWORKs aid who is under 19 years of age and who does not have a high school diploma or its equivalent is required to participate in the program as a student attending school on a full-time basis.

Existing law provides for a supplement to, or a reduction in, a Cal-Learn participant's aid grant based on his or her performance in school.

This bill would create the CalWORKs Educational Opportunity and Attainment Program to provide CalWORKs recipients with a monthly education incentive grant of $100 for attainment of a high school diploma or its equivalent, $200 for attainment of an associate's degree or career technical education program, or $300 for attainment of a bachelor's degree, if the educational program was completed while the recipient was receiving CalWORKs assistance. The bill would require the education incentive grant to be provided on an ongoing basis if the recipient meets certain eligibility criteria. The bill would require a recipient, when applying for an education bonus, to submit evidence of completion of the educational program to the county. The bill would require the county, upon verification of completion of the educational program, to certify that the recipient is eligible for an education incentive grant and ensure that the recipient's monthly cash grant is increased. By imposing additional administrative duties on counties, this bill would impose a state-mandated local program.

Existing law establishes the CalWORKs Recipients Education Program in the California Community Colleges. Existing law requires, to the extent that funding is provided in the annual Budget Act, a community college district to receive funding for purposes of providing special services for CalWORKs recipients, including job placement and workstudy.

This bill would appropriate $20,000,000 from the General Fund to the Board of Governors of the California Community Colleges to fund services provided under that 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: $\frac{2}{3}$. Appropriation: yes. Fiscal committee: yes. State-mandated local program: yes.

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

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

(a) In California's high-skill economy, it is very difficult to get a good, middle-class job without vocational education or a college degree, let alone a high school diploma.

(b) This is a significant barrier to socioeconomic mobility for California's highly vulnerable CalWORKs recipients, because as many as 65 percent of CalWORKs recipients do not have a high school education.

(c) Research has consistently shown that postsecondary education boosts social mobility, particularly for those at the bottom of the income distribution scale, and that a parent's level of education has positive effects on his or her child's level of success into middle adulthood.

(d) California has the seventh largest federal Temporary Assistance for Needy Families cash grant in the nation, and the second largest among the 10 largest states.

(e) Poverty remains a persistent problem.

(f) This act is intended to provide incentives for CalWORKs recipients to pursue education, thereby improving the opportunities and outcomes for adults and children in the CalWORKs program.

SEC. 2. Article 3.7 (commencing with Section 11340) is added to Chapter 2 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 3.7. CalWORKs Educational Opportunity and Attainment Program

11340. This article shall be known, and may be cited, as the CalWORKs Educational Opportunity and Attainment Program.

11341. (a) A CalWORKs recipient may apply to receive an education incentive grant in the following amounts:

(1) One hundred dollars ($100) per month for completion of a high school diploma or its equivalent.

(2) Two hundred dollars ($200) per month for completion of an associate's degree or career technical education program.

(3) Three hundred dollars ($300) per month for completion of a bachelor's degree.

(b) The amounts listed in subdivision (a) are not cumulative. A recipient shall receive, on an ongoing basis, the highest monthly bonus to which he or she is entitled.

(c) The amounts listed in subdivision (a) constitute ongoing adjustments to the recipient's monthly cash grant.

11342. (a) When applying for an education incentive grant, a recipient shall submit evidence of completion of the educational program to the county. A recipient is not eligible unless all of the following criteria are satisfied:

(1) The recipient completed an educational program included in the recipient's welfare-to-work plan approved by the county.

(2) The recipient completed an educational program offered by an accredited educational institution.

(3) The recipient completed the educational program while receiving CalWORKs assistance.

(b) Upon verification of completion of the educational program, the county shall certify that the recipient is eligible for an education incentive grant and shall ensure that the recipient's monthly cash grant is increased as prescribed in Section 11341.

11343. (a) A CalWORKs recipient who is receiving an education incentive grant and then ceases to receive CalWORKs assistance shall not be eligible for the same education incentive grant if he or she begins receiving CalWORKs assistance in the future. The recipient is eligible, however, to receive a different education incentive grant if he or she attains a higher level of education while receiving CalWORKs assistance.

(b) A CalWORKs recipient is permanently ineligible for an education incentive grant under either of the following circumstances:

(1) The recipient has exhausted his or her CalWORKs benefits.

(2) The recipient has committed public assistance fraud, as described in Article 7 (commencing with Section 11475.2).

(c) A CalWORKs recipient shall not receive an education incentive grant in any month during which he or she is sanctioned.

SEC. 3. The sum of twenty million dollars ($20,000,000) is hereby appropriated from the General Fund to the Board of Governors of the California Community Colleges to fund services provided under the CalWORKs Recipients Education Program (Article 5 (commencing with Section 79200) of Chapter 9 of Part 48 of Division 7 of Title 3 of the Education Code), including, but

not limited to, education and career counseling services, employment development services, including job development staff positions, and workstudy positions.

SEC. 4. 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.

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COUNTY OF RIVERSIDE

April 24, 2017

The Honorable Holly Mitchell, Chair
Senate Budget and Fiscal Review Committee
State Capitol, Room 5080
Sacramento, California 95814

Re: **SB 130 (Mitchell): Local Government Finance: Property Tax Revenue Allocations: Vehicle License Fee Adjustments**
As amended 4/19/2017
Awaiting Hearing – Assembly Budget Committee
County of Riverside: SUPPORT – Per Legislative Platform

Dear Senator Mitchell: Holly

On behalf of the Riverside County Board of Supervisors, I write to communicate our support for your Senate Bill 130. This bill would provide a "Vehicle License Fee Adjustment Amount" for cities incorporated between January 1, 2004 and January 1, 2012, which includes those that were impacted by SB 89 (2011). The Board strongly supports this measure, as it would provide immediate financial assistance to the four newly incorporated cities in Riverside County.

Prior to the passage of SB 89 (2011), the four newly incorporated cities in Riverside County relied on current state law in evaluating their fiscal viability through the LAFCO process. In each case, LAFCO considered the Vehicle License Fee (VLF) revenue special allocation in their evaluation of the new cities' revenue, which informed the eventual LAFCO vote to allow the local voters to consider incorporation. When SB 89 was approved and redirected those VLF revenues to 2011 realignment, these new cities were impacted in a significant way.

SB 130 provides a mechanism by which these newly incorporated cities resume receipt of revenues anticipated prior to their incorporations. By establishing a "Vehicle License Fee Adjustment Amount" and replacing the lost VLF revenues with property taxes from the schools' share (as currently exists for all other cities and counties in the state), AB 48 restores funds to those impacted by SB 89 and ensures their continued viability.

COUNTY OF RIVERSIDE

Board of Supervisors

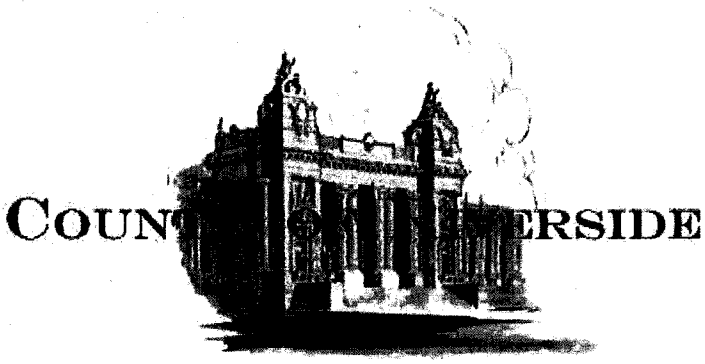
District 1	**Kevin Jeffries** 951-955-1010
District 2 Chairman	**John F. Tavaglione** 951-955-1020
District 3	**Chuck Washington** 951-955-1030
District 4	**Vacant** 951-955-1040
District 5	**Marion Ashley** 951-955-1050

For these reasons, we strongly support SB 130. Should you have any questions about our position, please do not hesitate to contact Deputy County Executive Officer Brian Nestande at (951) 955-1110 or bnestande@rceo.org.

Sincerely,

John F. Tavaglione
Chairman, Riverside County Board of Supervisors

Cc: Members and Consultants, Senate Budget and Fiscal Review Committee
County of Riverside Delegation



April 24, 2017

The Honorable Phil Ting, Chair
Assembly Budget Committee
State Capitol, Room 6026
Sacramento, California 95814

Re: **SB 130 (Mitchell): Local Government Finance: Property Tax Revenue Allocations: Vehicle License Fee Adjustments**
As amended 4/19/2017
Awaiting Hearing – Assembly Budget Committee
County of Riverside: SUPPORT – Per Legislative Platform

Dear Assembly Member Ting:

On behalf of the Riverside County Board of Supervisors, I write to communicate our support for Senate Bill 130. This bill would provide a "Vehicle License Fee Adjustment Amount" for cities incorporated between January 1, 2004 and January 1, 2012, which includes those that were impacted by SB 89 (2011). The Board strongly supports this measure, as it would provide immediate financial assistance to the four newly incorporated cities in Riverside County.

Prior to the passage of SB 89 (2011), the four newly incorporated cities in Riverside County relied on current state law in evaluating their fiscal viability through the LAFCO process. In each case, LAFCO considered the Vehicle License Fee (VLF) revenue special allocation in their evaluation of the new cities' revenue, which informed the eventual LAFCO vote to allow the local voters to consider incorporation. When SB 89 was approved and redirected those VLF revenues to 2011 realignment, these new cities were impacted in a significant way.

SB 130 provides a mechanism by which these newly incorporated cities resume receipt of revenues anticipated prior to their incorporations. By establishing a "Vehicle License Fee Adjustment Amount" and replacing the lost VLF revenues with property taxes from the schools' share (as currently exists for all other cities and counties in the state), AB 48 restores funds to those impacted by SB 89 and ensures their continued viability.

COUNTY OF RIVERSIDE

For these reasons, we strongly support SB 130. Should you have any questions about our position, please do not hesitate to contact Deputy County Executive Officer Brian Nestande at (951) 955-1110 or bnestande@rceo.org.

Sincerely,

John F. Tavaglione
Chairman, Riverside County Board of Supervisors

Cc: Members and Consultants, Senate Budget and Fiscal Review Committee
County of Riverside Delegation

AMENDED IN SENATE APRIL 19, 2017

SENATE BILL No. 130

Introduced by Committee on Budget and Fiscal Review

January 11, 2017

~~An act relating to the Budget Act of 2017.~~ *An act to amend Section 97.70 of the Revenue and Taxation Code, relating to local government finance, and making an appropriation therefor, to take effect immediately, bill related to the budget.*

LEGISLATIVE COUNSEL'S DIGEST

SB 130, as amended, Committee on Budget and Fiscal Review. ~~Budget Act of 2017.~~ *Local government finance: property tax revenue allocations: vehicle license fee adjustments.*

Existing property tax law requires the county auditor, in each fiscal year, to allocate property tax revenue to local jurisdictions in accordance with specified formulas and procedures, and generally provides that each jurisdiction be allocated an amount equal to the total of the amount of revenue allocated to that jurisdiction in the prior fiscal year, subject to certain modifications, and that jurisdiction's portion of the annual tax increment, as defined.

Existing property tax law also requires that, for purposes of determining property tax revenue allocations in each county for the 1992–93 and 1993–94 fiscal years, the amounts of property tax revenue deemed allocated in the prior fiscal year to the county, cities, and special districts be reduced in accordance with certain formulas. It requires that the revenues not allocated to the county, cities, and special districts as a result of these reductions be transferred to the Educational Revenue Augmentation Fund in that county for allocation to school districts, community college districts, and the county office of education.

Beginning with the 2004–05 fiscal year and for each fiscal year thereafter, existing law requires that each city, county, and city and county receive additional property tax revenues in the form of a vehicle license fee adjustment amount, as defined, from a Vehicle License Fee Property Tax Compensation Fund that exists in each county treasury. Existing law requires that these additional allocations be funded from ad valorem property tax revenues otherwise required to be allocated to educational entities.

This bill would modify these reduction and transfer provisions for a city incorporating after January 1, 2004, and on or before January 1, 2012, for the 2017–18 fiscal year and for each fiscal year thereafter, by providing for a vehicle license fee adjustment amount calculated on the basis of changes in assessed valuation.

By imposing additional duties upon local tax officials with respect to the allocation of ad valorem property tax revenues, this bill would impose a state-mandated local program.

This bill would appropriate $5,000 to the Department of Finance to prepare a report to the Legislature by a specified date regarding compliance by county auditors with respect to this measure.

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.

This bill would declare that it is to take effect immediately as a bill providing for appropriations related to the Budget Bill.

~~This bill would express the intent of the Legislature to enact statutory changes relating to the Budget Act of 2017.~~

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

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

SECTION 1. Section 97.70 of the Revenue and Taxation Code is amended to read:

97.70. Notwithstanding any other law, for the 2004–05 fiscal year and for each fiscal year thereafter, all of the following apply:

(a) (1) (A) The auditor shall reduce the total amount of ad valorem property tax revenue that is otherwise required to be allocated to a county's Educational Revenue Augmentation Fund by the countywide vehicle license fee adjustment amount.

(B) If, for the fiscal year, after complying with Section 97.68 there is not enough ad valorem property tax revenue that is otherwise required to be allocated to a county Educational Revenue Augmentation Fund for the auditor to complete the allocation reduction required by subparagraph (A), the auditor shall additionally reduce the total amount of ad valorem property tax revenue that is otherwise required to be allocated to all school districts and community college districts in the county for that fiscal year by an amount equal to the difference between the countywide vehicle license fee adjustment amount and the amount of ad valorem property tax revenue that is otherwise required to be allocated to the county Educational Revenue Augmentation Fund for that fiscal year. This reduction for each school district and community college district in the county shall be the percentage share of the total reduction that is equal to the proportion that the total amount of ad valorem property tax revenue that is otherwise required to be allocated to the school district or community college district bears to the total amount of ad valorem property tax revenue that is otherwise required to be allocated to all school districts and community college districts in a county. For purposes of this subparagraph, "school districts" and "community college districts" do not include any districts that are excess tax school entities, as defined in Section 95.

(2) The countywide vehicle license fee adjustment amount shall be allocated to the Vehicle License Fee Property Tax Compensation Fund that shall be established in the treasury of each county.

(b) (1) The auditor shall allocate moneys in the Vehicle License Fee Property Tax Compensation Fund according to the following:

(A) Each city in the county shall receive its vehicle license fee adjustment amount.

(B) Each county and city and county shall receive its vehicle license fee adjustment amount.

(2) The auditor shall allocate one-half of the amount specified in paragraph (1) on or before January 31 of each fiscal year, and the other one-half on or before May 31 of each fiscal year.

(c) For purposes of this section, all of the following apply:

(1) "Vehicle license fee adjustment amount" for a particular city, county, or a city and county means, subject to an adjustment under paragraph (2) and Section 97.71, all of the following:

(A) For the 2004–05 fiscal year, an amount equal to the difference between the following two amounts:

(i) The estimated total amount of revenue that would have been deposited to the credit of the Motor Vehicle License Fee Account in the Transportation Tax Fund, including any amounts that would have been certified to the Controller by the auditor of the County of Ventura under subdivision (j) of Section 98.02, as that section read on January 1, 2004, for distribution under the law as it read on January 1, 2004, to the county, city and county, or city for the 2004–05 fiscal year if the fee otherwise due under the Vehicle License Fee Law ~~(Pt.~~ *(Part* 5 (commencing with Section 10701) of ~~Div.~~ *Division* 2) was 2 percent of the market value of a vehicle, as specified in ~~Section~~ *Sections* 10752 and 10752.1 as those sections read on January 1, 2004.

(ii) The estimated total amount of revenue that is required to be distributed from the Motor Vehicle License Fee Account in the Transportation Tax Fund to the county, city and county, and each city in the county for the 2004–05 fiscal year under Section 11005, as that section read on the operative date of the act that amended this clause.

(B) (i) Subject to an adjustment under clause (ii), for the 2005–06 fiscal year, the sum of the following two amounts:

(I) The difference between the following two amounts:

~~(Ia)~~

(ia) The actual total amount of revenue that would have been deposited to the credit of the Motor Vehicle License Fee Account in the Transportation Tax Fund, including any amounts that would have been certified to the Controller by the auditor of the County of Ventura under subdivision (j) of Section 98.02, as that section read on January 1, 2004, for distribution under the law as it read on January 1, 2004, to the county, city and county, or city for the 2004–05 fiscal year if the fee otherwise due under the Vehicle License Fee Law (Part 5 (commencing with Section 10701) of Division 2) was 2 percent of the market value of a vehicle, as specified in Sections 10752 and 10752.1 as those sections read on January 1, 2004.

~~(Ib)~~

(ib) The actual total amount of revenue that was distributed from the Motor Vehicle License Fee Account in the Transportation Tax Fund to the county, city and county, and each city in the county for the 2004–05 fiscal year under Section 11005, as that section read on the operative date of the act that amended this ~~sub-subclause.~~ *subsubclause.*

(II) The product of the following two amounts:

~~(IIa)~~

(ia) The amount described in subclause (I).

~~(IIb)~~

(ib) The percentage change from the prior fiscal year to the current fiscal year in gross taxable assessed valuation within the jurisdiction of the entity, as reflected in the equalized assessment roll for those fiscal years. For the first fiscal year for which a change in a city's jurisdictional boundaries first applies, the percentage change in gross taxable assessed valuation from the prior fiscal year to the current fiscal year shall be calculated solely on the basis of the city's previous jurisdictional boundaries, without regard to the change in that city's jurisdictional boundaries. For each following fiscal year, the percentage change in gross taxable assessed valuation from the prior fiscal year to the current fiscal year shall be calculated on the basis of the city's current jurisdictional boundaries.

(ii) The amount described in clause (i) shall be adjusted as follows:

(I) If the amount described in subclause (I) of clause (i) for a particular city, county, or city and county is greater than the amount described in subparagraph (A) for that city, county, or city and county, the amount described in clause (i) shall be increased by an amount equal to this difference.

(II) If the amount described in subclause (I) of clause (i) for a particular city, county, or city and county is less than the amount described in subparagraph (A) for that city, county, or city and county, the amount described in clause (i) shall be decreased by an amount equal to this difference.

(C) For the 2006–07 fiscal year and for each fiscal year thereafter, the sum of the following two amounts:

(i) The vehicle license fee adjustment amount for the prior fiscal year, if Section 97.71 and clause (ii) of subparagraph (B) did not apply for that fiscal year, for that city, county, and city and county.

(ii) The product of the following two amounts:

(I) The amount described in clause (i).

(II) The percentage change from the prior fiscal year to the current fiscal year in gross taxable assessed valuation within the jurisdiction of the entity, as reflected in the equalized assessment roll for those fiscal years. For the first fiscal year for which a change in a city's jurisdictional boundaries first applies, the percentage change in gross taxable assessed valuation from the prior fiscal year to the current fiscal year shall be calculated solely on the basis of the city's previous jurisdictional boundaries, without regard to the change in that city's jurisdictional boundaries. For each following fiscal year, the percentage change in gross taxable assessed valuation from the prior fiscal year to the current fiscal year shall be calculated on the basis of the city's current jurisdictional boundaries.

(2) Notwithstanding paragraph (1), "vehicle license fee adjustment amount," for a city incorporating after January 1, 2004, and on or before January 1, 2012, means the following:

(A) For the 2017–18 fiscal year, the quotient derived from the following fraction:

(i) The numerator is the product of the following two amounts:

(I) The sum of the most recent vehicle license fee adjustment amounts determined for all cities in the county.

(II) The population of the incorporating city.

(ii) The denominator is the sum of the populations of all cities in the county.

(B) For the 2018–19 fiscal year, and for each fiscal year thereafter, the sum of the following two amounts:

(i) The vehicle license fee adjustment amount for the prior fiscal year.

(ii) The product of the following two amounts:

(I) The amount described in clause (i).

(II) The percentage change from the prior fiscal year to the current fiscal year in gross taxable assessed valuation within the jurisdiction of the entity, as reflected in the equalized assessment roll for those fiscal years.

~~(2)~~

(3) For the 2013–14 fiscal year, the vehicle license fee adjustment amount that is determined under subparagraph (C) of paragraph (1) for the County of Orange shall be increased by

fifty-three million dollars ($53,000,000). For the 2014–15 fiscal year and each fiscal year thereafter, the calculation of the vehicle license fee adjustment amount for the County of Orange under subparagraph (C) of paragraph (1) shall be based on a prior fiscal year amount that reflects the full amount of this one-time increase of fifty-three million dollars ($53,000,000).

~~(3)~~

(4) "Countywide vehicle license fee adjustment amount" means, for any fiscal year, the total sum of the amounts described in paragraphs ~~(1)~~ *(1), (2),* and ~~(2)~~ *(3)* for a county or city and county, and each city in the county.

~~(4)~~

(5) On or before June 30 of each fiscal year, the auditor shall report to the Controller the vehicle license fee adjustment amount for the county and each city in the county for that fiscal year.

(d) For the 2005–06 fiscal year and each fiscal year thereafter, the amounts determined under subdivision (a) of Section 96.1, or any successor to that provision, shall not reflect, for a preceding fiscal year, any portion of any allocation required by this section.

(e) For purposes of Section 15 of Article XI of the California Constitution, the allocations from a Vehicle License Fee Property Tax Compensation Fund constitute successor taxes that are otherwise required to be allocated to counties and cities, and as successor taxes, the obligation to make those transfers as required by this section shall not be extinguished nor disregarded in any manner that adversely affects the security of, or the ability of, a county or city to pay the principal and interest on any debts or obligations that were funded or secured by that city's or county's allocated share of motor vehicle license fee revenues.

(f) This section shall not be construed to do any of the following:

(1) Reduce any allocations of excess, additional, or remaining funds that would otherwise have been allocated to county superintendents of schools, cities, counties, and cities and counties pursuant to clause (i) of subparagraph (B) of paragraph (4) of subdivision (d) of Sections 97.2 and 97.3 or Article 4 (commencing with Section 98) had this section not been enacted. The allocations required by this section shall be adjusted to comply with this paragraph.

(2) Require an increased ad valorem property tax revenue allocation or increased tax increment allocation to a community redevelopment agency.

(3) Alter the manner in which ad valorem property tax revenue growth from fiscal year to fiscal year is otherwise determined or allocated in a county.

(4) Reduce ad valorem property tax revenue allocations required under Article 4 (commencing with Section 98).

(g) Tax exchange or revenue sharing agreements, entered into prior to the operative date of this section, between local agencies or between local agencies and nonlocal agencies are deemed to be modified to account for the reduced vehicle license fee revenues resulting from the act that added this section. These agreements are modified in that these reduced revenues are, in kind and in lieu thereof, replaced with ad valorem property tax revenue from a Vehicle License Fee Property Tax Compensation Fund or an Educational Revenue Augmentation Fund.

SEC. 2. The sum of five thousand dollars ($5,000) is hereby appropriated to the Department of Finance to prepare, by September 1, 2018, a report to the Legislature regarding the compliance by county auditors with paragraph (2) of subdivision (c) of Section 97.70 of the Revenue and Taxation Code.

SEC. 3. 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.

SEC. 4. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.

~~SECTION 1. It is the intent of the Legislature to enact statutory changes relating to the Budget Act of 2017.~~

O

COUNTY OF RIVERSIDE

April 18, 2017

The Honorable Holly Mitchell, Chair
Senate Budget and Fiscal Review Committee
State Capitol, Room 5080
Sacramento, CA 95814

Re: SB 132 (Committee on Budget and Fiscal Review): Budget Act of 2016
As amended 4/06/2017
County of Riverside: SUPPORT – Per Legislative Platform

Dear Senator Mitchell:

On behalf of the Riverside County Board of Supervisors, I write to inform you of our support for SB 132, a budget bill that includes funding priority transportation projects in the County of Riverside. SB 132, along with new revenues that will be generated from the recently approved SB 1 (Beall), will go a long way to ensure that necessary investments in transportation infrastructure in our region will be achieved.

SB 132 provides funding for a number of key transportation projects in the region. These include the 91 Toll Connector to Interstate 15 North, Hamner Bridge widening, McKinley Grade Separation, Jurupa Avenue Grade Separation, and the Interstate 15/Limonite Interchange. We greatly appreciate the efforts of Senator Roth, Assembly Member Cervantes, Senate and Assembly leadership, and Governor Brown to ensure that these important transportation projects will move forward.

The County supports these efforts to invest in roads and highways, active transportation facilities, transit, and key freight corridors as a critical component to the economic well-being and quality of life in our region and in California. For these reasons, we strongly support SB 132. Should you have any questions about our position, please do not hesitate to contact Deputy County Executive Officer Brian Nestande at (951) 955-1110 or bnestande@rceo.org.

Sincerely,

John F. Tavaglione
Chairman, Riverside County Board of Supervisors

cc: Members and Consultants, Senate Budget and Fiscal Review Committee
County of Riverside Delegation

Senate Bill No. 132

Passed the Senate April 17, 2017

_____

Secretary of the Senate

Passed the Assembly April 24, 2017

_____

Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of _____, 2017, at _____ o'clock ___M.

_____

Private Secretary of the Governor

CHAPTER _____

An act to amend the Budget Act of 2016 (Chapter 23 of the Statutes of 2016) by amending Items 9800-001-0001, 9800-001-0494, and 9800-001-0988 of, and adding Items 2660-109-0042, 2660-109-0046, 2660-110-0042, and 3900-101-3291 to, Section 2.00 of, and amending Section 39.00 of, that act, relating to the state budget, and making an appropriation therefor, to take effect immediately, budget bill.

LEGISLATIVE COUNSEL'S DIGEST

SB 132, Committee on Budget and Fiscal Review. Budget Act of 2016.

The Budget Act of 2016 made appropriations for the support of state government for the 2016–17 fiscal year.

This bill would amend the Budget Act of 2016 by amending and adding items of appropriation and making other changes.

This bill would become operative only if SB 496 of the 2017–18 Regular Session is enacted and becomes operative.

This bill would declare that it is to take effect immediately as a Budget Bill.

Appropriation: yes.

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

SECTION 1. Item 2660-109-0042 is added to Section 2.00 of the Budget Act of 2016, to read:

2660-109-0042—For local assistance, Department of Transportation, payable from the State Highway Account, State Transportation Fund 100,000,000

Schedule:

(1) 1835020-Local Assistance..... 100,000,000

Provisions:

1. The funds appropriated in this item are for the University of California, Merced Campus Parkway Project and shall be available for encumbrance and liquidation until June 30, 2023.

SEC. 2. Item 2660-109-0046 is added to Section 2.00 of the Budget Act of 2016, to read:

2660-109-0046—For local assistance, Department of Transportation, payable from the Public Transportation Account, State Transportation Fund 400,000,000

Schedule:

(1) 1835020-Local Assistance..... 400,000,000

Provisions:

1. The funds appropriated in this item shall be used for the extension of the Altamont Corridor Express to Ceres and Merced, including associated system improvements.
2. Notwithstanding any other law restricting the allocation of program funds, this appropriation is for the Altamont Corridor Express from the Transit and Intercity Rail Capital Program and shall be available for encumbrance and liquidation until June 30, 2027.

SEC. 3. Item 2660-110-0042 is added to Section 2.00 of the Budget Act of 2016, to read:

2660-110-0042—For local assistance for the Riverside County Transportation Efficiency Corridor, Department of Transportation, payable from the State Highway Account, State Transportation Fund 427,172,000

Schedule:

(1) 91 Toll Connector to Interstate 15 North..... 180,000,000
(2) Hamner Bridge Widening..... 6,322,000
(3) McKinley Grade Separation..... 84,450,000
(4) Jurupa Avenue Grade Separation..... 108,400,000
(5) Interstate 15/Limonite Interchange..... 48,000,000

Provisions:

1. The funds appropriated in this item shall be available for encumbrance and liquidation until June 30, 2023.
2. The Secretary of Transportation shall convene a task force of state, local, and private sector experts to develop recommendations to accelerate the schedule of

delivery of these and other projects in the region. Any recommendations that require statutory changes should be included in the May Revision to the 2017–18 Governor's Budget.

SEC. 4. Item 3900-101-3291 is added to Section 2.00 of the Budget Act of 2016, to read:

3900-101-3291—For local assistance, State Air Resources Board, payable from the Trade Corridor Enhancement Account 50,000,000

Schedule:

(1) 3525-The Zero/Near-Zero Emission Warehouse Program..... 50,000,000

Provisions:

1. The funds appropriated in this item are available for encumbrance or expenditure until June 30, 2019.
2. The funds appropriated in this item are for a competitive funding program to advance implementation of zero/near zero emission warehouses and technology. The funds will be combined with a one-to-one match resulting in $100,000,000 for projects.

SEC. 5. Item 9800-001-0001 of Section 2.00 of the Budget Act of 2016, as amended by Section 1 of Chapter 2 of the Statutes of 2017, is amended to read:

9800-001-0001—For Augmentation for Employee Compensation..... 549,624,000

Schedule:

(1) 7800-Employee Compensation Program..... 549,624,000

Provisions:

1. The amount appropriated in this item shall not be construed to control or influence collective bargaining between the state employer and employee representatives.
2. The funds appropriated in this item are for compensation increases and increases in benefits related thereto of employees whose compensation, or portion thereof,

is chargeable to the General Fund, to be allocated by budget executive order by the Director of Finance to the several state offices, departments, boards, bureaus, commissions, and other state agencies, in augmentation of their respective appropriations or allocations, in accordance with approved memoranda of understanding or, for employees excluded from collective bargaining, in accordance with salary and benefit schedules established by the Department of Human Resources.

3. It is the intent of the Legislature that all proposed augmentations for increased employee compensation costs, including, but not limited to, base salary increases, pay increases to bring one group of employees into a pay equity position with another group of public employees, and recruitment and retention differentials, be budgeted and considered on a comprehensive, statewide basis. Therefore, the Legislature declares its intent to reject any proposed augmentations that are not included in Items 9800-001-0001, 9800-001-0494, and 9800-001-0988, given that these are the items where the funds to implement comprehensive statewide compensation policies, including those adopted pursuant to collective bargaining, are considered. This provision shall not apply to augmentations for increased employee compensation costs resulting from mandatory judicial orders to raise pay for any group of employees or augmentations for increased compensation costs, or approvals for departments to provide increased employee compensation levels, that are included in bills separate from the Budget Act.

4. This item contains funds estimated to be necessary to implement side letters, appendices, or other addenda to a memorandum of understanding (collectively referred to as "pending agreements") that have been determined by the Joint Legislative Budget Committee to require legislative approval prior to their implementation, but which may not have been approved in separate legislation as of the date of the passage of this act. In the event that the Legislature does not approve separate legislation to authorize implementation of

any of the pending agreements, the Director of Finance shall not allocate any funds related to those pending agreements pursuant to Provision 2, and the expenditure of funds for those pending agreements shall not be deemed to have been approved by the Legislature.

5. As of July 31, 2017, the unencumbered balances of the above appropriation shall revert to the General Fund.
6. The Director of Finance may adjust this item of appropriation to reflect the health benefit premiums approved by the Board of Administration of the Public Employees' Retirement System or dental benefit premiums approved by the Department of Human Resources for the 2017 calendar year. Within 30 days of making any adjustment pursuant to this provision, the Director of Finance shall report the adjustment in writing to the Chairperson of the Joint Legislative Budget Committee and the chairpersons of the committees in each house of the Legislature that consider appropriations.
7. Notwithstanding Sections 3517.6 and 3517.63 of the Government Code, the Department of Finance shall provide written notification to the Joint Legislative Budget Committee regarding any expenditure of funds resulting from any side letter, appendix, or other addendum to a properly ratified memorandum of understanding.
8. Notice provided pursuant to Provision 7 shall include a copy of the side letter, appendix, or other addendum (collectively addendum) and a fiscal summary of any expenditure of funds resulting from the agreement in the 2016–17 fiscal year and future fiscal years. The notice shall indicate whether the Department of Finance determines that an agreement does or does not require legislative action to ratify the addendum before implementation, pursuant to subdivision (a), (b), or (c) of this provision.
   (a) An addendum to a properly ratified memorandum of understanding may be implemented without legislative action not less than 30 calendar days

after notice has been provided to the Joint Legislative Budget Committee, or not sooner than whatever lesser time after that notification the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may in each instance determine, if all of the following apply:

(1) The agreement results in total net costs of less than $1,000,000 (all funds) during the 2016–17 fiscal year.

(2) Any cost resulting from the agreement can be absorbed within the 2016–17 fiscal year appropriation authority of impacted departments.

(3) The addendum does not present substantial additions that are reasonably outside the parameters of the original memorandum of understanding.

(b) An addendum to a properly ratified memorandum of understanding that results in any expenditure of funds may be implemented not less than 30 calendar days after notice has been provided to the Joint Legislative Budget Committee, or not sooner than whatever lesser time after that notification the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may in each instance determine, if, during the legislative consideration of the 2016–17 Governor's Budget, the Department of Finance identified to the Legislature both of the following:

(1) The administration anticipated that the addendum would be signed during the 2016–17 fiscal year.

(2) Any costs resulting from the addendum are included in the 2016–17 Governor's Budget or another piece of legislation.

(c) An addendum to a properly ratified memorandum of understanding that results in any expenditure of funds requires legislative action before implementation if any of the following apply:

(1) The agreement results in total net costs greater than $1,000,000 (all funds) during the 2016–17 fiscal year.
(2) The agreement results in costs that cannot be absorbed within the 2016–17 fiscal year appropriation authority of impacted departments.
(3) The addendum presents substantial additions that are not reasonably within the parameters of the original memorandum of understanding.

9. Notwithstanding Sections 3517.6 and 3517.63 of the Government Code, any addendum to a properly ratified memorandum of understanding that is implemented in the 2016–17 fiscal year, pursuant to subdivision (a) of Provision 8 and requires the expenditure of funds beyond the 2016–17 fiscal year that was not approved as part of the Budget Act of 2016, shall be approved by the Legislature as part of the Budget Act of 2017 or through another piece of legislation.
10. The Department of Human Resources shall promptly post on its public Internet Web site all signed addenda. Each addendum shall be posted in its entirety, including any attachments or schedules that are part of the agreement, along with the fiscal summary documents of the agreement.

SEC. 6. Item 9800-001-0494 of Section 2.00 of the Budget Act of 2016, as amended by Section 2 of Chapter 2 of the Statutes of 2017, is amended to read:

9800-001-0494—For Augmentation for Employee Compensation, payable from other unallocated special funds..... 313,108,000
Schedule:
(1) 7800-Employee Compensation Program..... 313,108,000
Provisions:
1. The amount appropriated in this item shall not be construed to control or influence collective bargaining

between the state employer and employee representatives.

2. The funds appropriated in this item are for compensation increases and increases in benefits related thereto of employees whose compensation, or portion thereof, is chargeable to special funds, to be allocated by budget executive order by the Director of Finance to the several state offices, departments, boards, bureaus, commissions, and other state agencies, in augmentation of their respective appropriations or allocations, in accordance with approved memoranda of understanding or, for employees excluded from collective bargaining, in accordance with salary and benefit schedules established by the Department of Human Resources.
3. Notwithstanding any other provision of law, upon approval of the Director of Finance, expenditure authority may be transferred between this item and Item 9800-001-0988 as necessary to fund costs for approved memoranda of understanding or, for employees excluded from collective bargaining, in accordance with salary and benefit schedules established by the Department of Human Resources.
4. It is the intent of the Legislature that all proposed augmentations for increased employee compensation costs, including, but not limited to, base salary increases, pay increases to bring one group of employees into a pay equity position with another group of public employees, and recruitment and retention differentials, be budgeted and considered on a comprehensive, statewide basis. Therefore, the Legislature declares its intent to reject any proposed augmentations that are not included in Items 9800-001-0001, 9800-001-0494, and 9800-001-0988, given that these are the items where the funds to implement comprehensive statewide compensation policies, including those adopted pursuant to collective bargaining, are considered. This provision does not apply to augmentations for increased employee compensation costs resulting from mandatory judicial orders to raise pay for any group of employees or augmentations for increased

compensation costs, or approvals for departments to provide increased employee compensation levels, that are included in bills separate from the Budget Act.

5. This item contains funds estimated to be necessary to implement side letters, appendices, or other addenda to a memorandum of understanding (collectively referred to as "pending agreements") that have been determined by the Joint Legislative Budget Committee to require legislative approval prior to their implementation, but which may not have been approved in separate legislation as of the date of the passage of this act. In the event that the Legislature does not approve separate legislation to authorize implementation of any of the pending agreements, the Director of Finance shall not allocate any funds related to those pending agreements pursuant to Provision 2, and the expenditure of funds for those pending agreements shall not be deemed to have been approved by the Legislature.
6. As of July 31, 2017, the unencumbered balances of the above appropriation shall no longer be available for expenditure.
7. The Director of Finance may adjust this item of appropriation to reflect the health benefit premiums approved by the Board of Administration of the Public Employees' Retirement System or dental benefit premiums approved by the Department of Human Resources for the 2017 calendar year. Within 30 days of making any adjustment pursuant to this provision, the Director of Finance shall report the adjustment in writing to the Chairperson of the Joint Legislative Budget Committee and the chairpersons of the committees in each house of the Legislature that consider appropriations.
8. Notwithstanding Sections 3517.6 and 3517.63 of the Government Code, the Department of Finance shall provide written notification to the Joint Legislative Budget Committee regarding any expenditure of funds resulting from any side letter, appendix, or other addendum to a properly ratified memorandum of understanding.

9. Notice provided pursuant to Provision 8 shall include a copy of the side letter, appendix, or other addendum (collectively addendum) and a fiscal summary of any expenditure of funds resulting from the agreement in the 2016–17 fiscal year and future fiscal years. The notice shall indicate whether the Department of Finance determines that an agreement does or does not require legislative action to ratify the addendum before implementation, pursuant to subdivision (a), (b), or (c) of this provision.
   (a) An addendum to a properly ratified memorandum of understanding may be implemented without legislative action not less than 30 calendar days after notice has been provided to the Joint Legislative Budget Committee, or not sooner than whatever lesser time after that notification the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may in each instance determine, if all of the following apply:
      (1) The agreement results in total net costs of less than $1,000,000 (all funds) during the 2016–17 fiscal year.
      (2) Any cost resulting from the agreement can be absorbed within the 2016–17 fiscal year appropriation authority of impacted departments.
      (3) The addendum does not present substantial additions that are reasonably outside the parameters of the original memorandum of understanding.
   (b) An addendum to a properly ratified memorandum of understanding that results in any expenditure of funds may be implemented not less than 30 calendar days after notice has been provided to the Joint Legislative Budget Committee, or not sooner than whatever lesser time after that notification the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may in each instance determine, if, during the legislative consideration of the 2016–17 Governor's

Budget, the Department of Finance identified to the Legislature both of the following:

(1) The administration anticipated that the addendum would be signed during the 2016–17 fiscal year.

(2) Any costs resulting from the addendum are included in the 2016–17 Governor's Budget or another piece of legislation.

(c) An addendum to a properly ratified memorandum of understanding that results in any expenditure of funds requires legislative action before implementation if any of the following apply:

(1) The agreement results in total net costs greater than $1,000,000 (all funds) during the 2016–17 fiscal year.

(2) The agreement results in costs that cannot be absorbed within the 2016–17 fiscal year appropriation authority of impacted departments.

(3) The addendum presents substantial additions that are not reasonably within the parameters of the original memorandum of understanding.

10. Notwithstanding Sections 3517.6 and 3517.63 of the Government Code, any addendum to a properly ratified memorandum of understanding that is implemented in the 2016–17 fiscal year, pursuant to subdivision (a) of Provision 9 and requires the expenditure of funds beyond the 2016–17 fiscal year that was not approved as part of the Budget Act of 2016, shall be approved by the Legislature as part of the Budget Act of 2017 or through another piece of legislation.

11. The Department of Human Resources shall promptly post on its public Internet Web site all signed addenda. Each addendum shall be posted in its entirety, including any attachments or schedules that are part of the agreement, along with the fiscal summary documents of the agreement.

SEC. 7. Item 9800-001-0988 of Section 2.00 of the Budget Act of 2016, as amended by Section 3 of Chapter 2 of the Statutes of 2017, is amended to read:

9800-001-0988—For Augmentation for Employee Compensation, payable from other unallocated nongovernmental cost funds 161,144,000

Schedule:

(1) 7800-Employee Compensation Program 161,144,000

Provisions:

1. The amount appropriated in this item shall not be construed to control or influence collective bargaining between the state employer and employee representatives.
2. The funds appropriated in this item are for employee compensation increases, and increases in benefits related thereto, whose compensation or portion thereof is chargeable to nongovernmental cost funds, to be allocated by budget executive order by the Director of Finance to the several state offices, departments, boards, bureaus, commissions, and other state agencies, in augmentation of their respective appropriations or allocations, in accordance with approved memoranda of understanding or, for employees excluded from collective bargaining, in accordance with salary and benefit schedules established by the Department of Human Resources.
3. Notwithstanding any other provision of law, upon approval of the Director of Finance, expenditure authority may be transferred between Item 9800-001-0494 and this item as necessary to fund costs for approved memoranda of understanding or, for employees excluded from collective bargaining, in accordance with salary and benefit schedules established by the Department of Human Resources.
4. It is the intent of the Legislature that all proposed augmentations for increased employee compensation costs, including, but not limited to, base salary increases, pay increases to bring one group of employees into

a pay equity position with another group of public employees, and recruitment and retention differentials, be budgeted and considered on a comprehensive, statewide basis. Therefore, the Legislature declares its intent to reject any proposed augmentations that are not included in Items 9800-001-0001, 9800-001-0494, and 9800-001-0988, given that these are the items where the funds to implement comprehensive statewide compensation policies, including those adopted pursuant to collective bargaining, are considered. This provision shall not apply to augmentations for increased employee compensation costs resulting from mandatory judicial orders to raise pay for any group of employees or augmentations for increased compensation costs, or approvals for departments to provide increased employee compensation levels, that are included in bills separate from the Budget Act.

5. This item contains funds estimated to be necessary to implement side letters, appendices, or other addenda to a memorandum of understanding (collectively referred to as "pending agreements") that have been determined by the Joint Legislative Budget Committee to require legislative approval prior to their implementation, but which may not have been approved in separate legislation as of the date of the passage of this act. In the event that the Legislature does not approve separate legislation to authorize implementation of any of the pending agreements, the Director of Finance shall not allocate any funds related to those pending agreements pursuant to Provision 2, and the expenditure of funds for those pending agreements shall not be deemed to have been approved by the Legislature.
6. As of July 31, 2017, the unencumbered balances of the above appropriation shall no longer be available for expenditure.
7. The Director of Finance may adjust this item of appropriation to reflect the health benefit premiums approved by the Board of Administration of the Public Employees' Retirement System or dental benefit premiums approved by the Department of Human Re-

sources for the 2017 calendar year. Within 30 days of making any adjustment pursuant to this provision, the Director of Finance shall report the adjustment in writing to the Chairperson of the Joint Legislative Budget Committee and the chairpersons of the committees in each house of the Legislature that consider appropriations.

8. Notwithstanding Sections 3517.6 and 3517.63 of the Government Code, the Department of Finance shall provide written notification to the Joint Legislative Budget Committee regarding any expenditure of funds resulting from any side letter, appendix, or other addendum to a properly ratified memorandum of understanding.
9. Notice provided pursuant to Provision 8 shall include a copy of the side letter, appendix, or other addendum (collectively addendum) and a fiscal summary of any expenditure of funds resulting from the agreement in the 2016–17 fiscal year and future fiscal years. The notice shall indicate whether the Department of Finance determines that an agreement does or does not require legislative action to ratify the addendum before implementation, pursuant to subdivision (a), (b), or (c) of this provision.
   (a) An addendum to a properly ratified memorandum of understanding may be implemented without legislative action not less than 30 calendar days after notice has been provided to the Joint Legislative Budget Committee, or not sooner than whatever lesser time after that notification the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may in each instance determine, if all of the following apply:
      (1) The agreement results in total net costs of less than $1,000,000 (all funds) during the 2016–17 fiscal year.
      (2) Any cost resulting from the agreement can be absorbed within the 2016–17 fiscal year appropriation authority of impacted departments.

(3) The addendum does not present substantial additions that are reasonably outside the parameters of the original memorandum of understanding.

(b) An addendum to a properly ratified memorandum of understanding that results in any expenditure of funds may be implemented not less than 30 calendar days after notice has been provided to the Joint Legislative Budget Committee, or not sooner than whatever lesser time after that notification the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may in each instance determine, if, during the legislative consideration of the 2016–17 Governor's Budget, the Department of Finance identified to the Legislature both of the following:

(1) The administration anticipated that the addendum would be signed during the 2016–17 fiscal year.

(2) Any costs resulting from the addendum are included in the 2016–17 Governor's Budget or another piece of legislation.

(c) An addendum to a properly ratified memorandum of understanding that results in any expenditure of funds requires legislative action before implementation if any of the following apply:

(1) The agreement results in total net costs greater than $1,000,000 (all funds) during the 2016–17 fiscal year.

(2) The agreement results in costs that cannot be absorbed within the 2016–17 fiscal year appropriation authority of impacted departments.

(3) The addendum presents substantial additions that are not reasonably within the parameters of the original memorandum of understanding.

10. Notwithstanding Sections 3517.6 and 3517.63 of the Government Code, any addendum to a properly ratified memorandum of understanding that is implemented

in the 2016–17 fiscal year, pursuant to subdivision (a) of Provision 9, and requires the expenditure of funds beyond the 2016–17 fiscal year that was not approved as part of the Budget Act of 2016, shall be approved by the Legislature as part of the Budget Act of 2017 or through another piece of legislation.

11. The Department of Human Resources shall promptly post on its public Internet Web site all addenda. Each addendum shall be posted in its entirety, including any attachments or schedules that are part of the agreement, along with the fiscal summary documents of the agreement.

SEC. 8. Section 39.00 of the Budget Act of 2016, as amended by Section 4 of Chapter 2 of the Statutes of 2017, is amended to read:

SEC. 39.00. The Legislature hereby finds and declares that the following bills are other bills providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution: AB 1600, AB 1601, AB 1602, AB 1603, AB 1604, AB 1605, AB 1606, AB 1607, AB 1608, AB 1609, AB 1610, AB 1611, AB 1612, AB 1614, AB 1615, AB 1616, AB 1617, AB 1618, AB 1619, AB 1620, AB 1621, AB 1624, AB 1625, AB 1626, AB 1627, AB 1628, AB 1629, AB 1630, AB 1632, AB 1633, AB 1634, AB 1635, AB 1636, SB 828, SB 829, SB 831, SB 832, SB 833, SB 834, SB 835, SB 836, SB 837, SB 838, SB 839, SB 840, SB 841, SB 842, SB 843, SB 844, SB 845, SB 846, SB 847, SB 848, SB 849, SB 850, SB 851, SB 852, SB 854, SB 855, SB 856, SB 857, SB 858, SB 859, SB 860, SB 861, SB 862, SB 863, SB 864, and SB 865 of the 2015–16 Regular Session and AB 48, SB 28, SB 48, SB 49, SB 50, SB 51, SB 127, SB 128, SB 129, SB 130, and SB 131 of the 2017–18 Regular Session.

SEC. 9. This act shall become operative only if Senate Bill 496 of the 2017–18 Regular Session is enacted and becomes operative.

SEC. 10. This act is a Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution and shall take effect immediately.

Approved _____, 2017

_____

Governor

COUNTY OF RIVERSIDE

April 25, 2017

The Honorable Ben Hueso
California State Senate
State Capitol, Room 4035
Sacramento, California 95814

Re: SB 649 (Hueso): Wireless Telecommunications Facilities
As amended 3/28/2017
Set for hearing April 26, 2017 – Senate Governance and Finance Committee
County of Riverside: OPPOSE – Per Legislative Platform

Dear Senator Hueso:

On behalf of the Riverside County Board of Supervisors, I write to communicate our opposition to your SB 649, a measure that seeks to prohibit the local consideration of certain impacts of "small cell" wireless communications facilities during the permitting process. The County is opposed to efforts to limit local control of siting of these wireless communication facilities.

SB 649 would tie the hands of cities and counties by prohibiting discretionary review of "small cell" wireless communications facilities, regardless of whether they are collocated on existing structures or located on new structures, including those within the public right of way. Essentially this would allow such facilities in all zones as a use by-right.

The County is not opposed to the deployment of wireless communications facilities to ensure that our residents have access to telecommunications and improved technology services. However, we are mindful of our role to protect the safety and health of the public, as well as impacts to the environment and aesthetic view, that are inherent in the local planning process. SB 649 undermines those efforts unnecessarily. We respectfully suggest that telecommunications companies that wish to deploy small cells work with us to ensure our mutual goals of quick approvals that meet local public health and safety requirements are reached successfully.

COUNTY OF RIVERSIDE

For these reasons, we are opposed to SB 649. Should you have any questions about our position, please do not hesitate to contact Deputy County Executive Officer Brian Nestande at (951) 955-1110 or bnestande@rceo.org.

Sincerely,

John F. Tavaglione
Chairman, Riverside County Board of Supervisors

Cc: The Honorable Mike McGuire, Chair, Senate Governance and Finance Committee
Members and Consultants, Senate Governance and Finance Committee
County of Riverside Delegation

AMENDED IN SENATE MARCH 28, 2017

SENATE BILL No. 649

Introduced by Senator Hueso
(Principal coauthor: Assembly Member Quirk)
(Coauthor: Senator Dodd)

February 17, 2017

An act to amend ~~Sections 65850.6 and~~ *Section* 65964 ~~of~~ *of, and to add Section 65964.2 to,* the Government Code, relating to telecommunications.

LEGISLATIVE COUNSEL'S DIGEST

SB 649, as amended, Hueso. Wireless telecommunications facilities.

Under existing law, a wireless telecommunications collocation facility, as specified, is subject to a city or county discretionary permit and is required to comply with specified criteria, but a collocation facility, which is the placement or installation of wireless facilities, including antennas and related equipment, on or immediately adjacent to that wireless telecommunications collocation facility, is a permitted use not subject to a city or county discretionary permit. ~~Existing law defines various terms for these purposes.~~

This bill would *provide that a small cell is a permitted use, not subject to a city or county discretionary permit, if the small cell meets specified requirements. By imposing new duties on local agencies, this bill would impose a state-mandated local program. The bill would authorize a city or county to require an administrative permit for small cell, as specified. The bill would* define the term "small cell" ~~as a particular type of telecommunications facility~~ for these purposes.

Under existing law, a city or county, as a condition of approval of an application for a permit for construction or reconstruction of a

development project for a wireless telecommunications facility, may not require an escrow deposit for removal of a wireless telecommunications facility or any component thereof, unreasonably limit the duration of any permit for a wireless telecommunications facility, or require that all wireless telecommunications facilities be limited to sites owned by particular parties within the jurisdiction of the city or county, as specified.

This bill would ~~apply these prohibitions to the approval of small cell facilities as defined by this bill.~~ *require permits for these facilities to be renewed for equivalent durations, as specified.*

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 no reimbursement is required by this act for a specified reason.

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

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

SECTION 1. The Legislature finds and declares that, to ensure that communities across the state have access to the most advanced wireless communications technologies and the transformative solutions that robust wireless connectivity enables, such as Smart Communities and the Internet of Things, California should work in coordination with federal, state, and local officials to create a statewide framework for the deployment of advanced wireless communications infrastructure in California that does all of the following:

(a) Reaffirms local governments' historic role and authority with respect to wireless communications infrastructure siting and construction generally.

(b) Reaffirms that deployment of telecommunications facilities in the rights-of-way is a matter of statewide concern, subject to a statewide franchise, and that expeditious deployment of telecommunications networks generally is a matter of both statewide and national concern.

(c) Recognizes that the impact on local interests from individual small wireless facilities will be sufficiently minor and that such

deployments should be a permitted use statewide and should not be subject to discretionary zoning review.

(d) Requires expiring permits for these facilities to be renewed so long as the site maintains compliance with use conditions adopted at the time the site was originally approved.

(e) Requires providers to obtain all applicable building or encroachment permits and comply with all related health, safety, and objective aesthetic requirements for small wireless facility deployments on a ministerial basis.

(f) Grants providers fair, reasonable, nondiscriminatory, and nonexclusive access to locally owned utility poles, street lights, and other suitable host infrastructure located within the public right-of-way and in other local public places such as stadiums, parks, campuses, hospitals, transit stations, and public buildings consistent with all applicable health and safety requirements, including Public Utilities Commission General Order 95.

(g) Provides for full recovery by local governments of the costs of attaching small wireless facilities to utility poles, street lights, and other suitable host infrastructure in a manner that is consistent with existing federal and state laws governing utility pole attachments generally.

(h) Permits local governments to charge wireless permit fees that are fair, reasonable, nondiscriminatory, and cost based.

(i) Advances technological and competitive neutrality while not adding new requirements on competing providers that do not exist today.

~~SEC. 2. Section 65850.6 of the Government Code is amended to read:~~

~~65850.6. (a) A collocation facility shall be a permitted use not subject to a city or county discretionary permit if it satisfies the following requirements:~~

~~(1) The collocation facility is consistent with requirements for the wireless telecommunications collocation facility pursuant to subdivision (b) on which the collocation facility is proposed.~~

~~(2) The wireless telecommunications collocation facility on which the collocation facility is proposed was subject to a discretionary permit by the city or county and an environmental impact report was certified, or a negative declaration or mitigated negative declaration was adopted for the wireless telecommunications collocation facility in compliance with the~~

~~California Environmental Quality Act (Division 13 (commencing with Section 21000) of the Public Resources Code), the requirements of Section 21166 do not apply, and the collocation facility incorporates required mitigation measures specified in that environmental impact report, negative declaration, or mitigated negative declaration.~~

~~(b) A wireless telecommunications collocation facility, where a subsequent collocation facility is a permitted use not subject to a city or county discretionary permit pursuant to subdivision (a), shall be subject to a city or county discretionary permit issued on or after January 1, 2007, and shall comply with all of the following:~~

~~(1) City or county requirements for a wireless telecommunications collocation facility that specifies types of wireless telecommunications facilities that are allowed to include a collocation facility, or types of wireless telecommunications facilities that are allowed to include certain types of collocation facilities; height, location, bulk, and size of the wireless telecommunications collocation facility; percentage of the wireless telecommunications collocation facility that may be occupied by collocation facilities; and aesthetic or design requirements for the wireless telecommunications collocation facility.~~

~~(2) City or county requirements for a proposed collocation facility, including any types of collocation facilities that may be allowed on a wireless telecommunications collocation facility; height, location, bulk, and size of allowed collocation facilities; and aesthetic or design requirements for a collocation facility.~~

~~(3) State and local requirements, including the general plan, any applicable community plan or specific plan, and zoning ordinance.~~

~~(4) The California Environmental Quality Act (Division 13 (commencing with Section 21000) of the Public Resources Code) through certification of an environmental impact report, or adoption of a negative declaration or mitigated negative declaration.~~

~~(c) The city or county shall hold at least one public hearing on the discretionary permit required pursuant to subdivision (b) and notice shall be given pursuant to Section 65091, unless otherwise required by this division.~~

~~(d) For purposes of this section, the following definitions apply:~~

~~(1) "Collocation facility" means the placement or installation of wireless facilities, including antennas, and related equipment,~~

~~on, or immediately adjacent to, a wireless telecommunications collocation facility.~~

~~(2) "Small cell" means a wireless telecommunications facility within the volume limits established by the Federal Communications Commission for small wireless antennas and associated equipment in the First Amendment to Nationwide Programmatic Agreement for the Collocation of Wireless Antennas (47 C.F.R. Part 1 Appendix B).~~

~~(3) "Wireless telecommunications facility" means equipment and network components such as towers, utility poles, transmitters, base stations, and emergency power systems that are integral to providing wireless telecommunications services.~~

~~(4) "Wireless telecommunications collocation facility" means a wireless telecommunications facility that includes collocation facilities.~~

~~(e) The Legislature finds and declares that both small cell and collocation facilities, as defined in this section, have a significant economic impact in California and are not a municipal affair as that term is used in Section 5 of Article XI of the California Constitution, but are a matter of statewide concern.~~

~~(f) With respect to the consideration of the environmental effects of radio frequency emissions, the review by the city or county shall be limited to that authorized by Section 332(c)(7) of Title 47 of the United States Code, or as that section may be hereafter amended.~~

~~SEC. 3.~~

SEC. 2. Section 65964 of the Government Code is amended to read:

65964. As a condition of approval of an application for a permit for construction or reconstruction for a development project for a wireless telecommunications ~~facility or small cell,~~ *facility,* as defined in Section 65850.6, a city or county shall not do any of the following:

(a) Require an escrow deposit for removal of a wireless telecommunications facility or any component thereof. However, a performance bond or other surety or another form of security may be required, so long as the amount of the bond security is rationally related to the cost of removal. In establishing the amount of the security, the city or county shall take into consideration

information provided by the permit applicant regarding the cost of removal.

(b) Unreasonably limit the duration of any permit for a wireless telecommunications facility. Limits of less than 10 years are presumed to be unreasonable absent public safety reasons or substantial land use reasons. However, cities and counties may establish a build-out period for a site. *A permit shall be renewed for an equivalent duration unless the city or county makes a finding that the wireless telecommunications facility does not comply with the codes and permit conditions applicable at the time the permit was initially approved.*

(c) Require that all wireless telecommunications facilities be limited to sites owned by particular parties within the jurisdiction of the city or county.

SEC. 3. Section 65964.2 is added to the Government Code, to read:

65964.2. (a) A small cell shall be a permitted use not subject to a city or county discretionary permit if it satisfies the following requirements:

(1) The small cell is located in the public right-of-way in any zone or in any zone that includes a commercial or industrial use.

(2) The small cell complies with all applicable state and local health and safety regulations.

(3) The small cell is not located on a fire department facility.

(b) (1) A city or county may require that the small cell be approved pursuant to a single administrative permit provided that the permit is issued within the time frames required by state and federal law.

(2) An administrative permit may be subject to the following:

(A) The same administrative permit requirements as similar construction projects applied in a nondiscriminatory manner.

(B) The submission of additional information showing that the small cell complies the Federal Communications Commission's regulations concerning radio frequency emissions referenced in Section 332(c)(7)(B)(iv) of Title 47 of the United States Code.

(3) The administrative permit shall not be subject to:

(A) Requirements to provide additional services, directly or indirectly, including, but not limited to, in-kind contributions such as reserving fiber, conduit, or pole space.

(B) The submission of any additional information other than that required of similar construction projects, except as specifically provided in this section.

(C) Limitations on routine maintenance or the replacement of small cells with small cells that are substantially similar, the same size or smaller.

(D) The regulation of any antennas mounted on cable strands.

(c) A city or county shall not preclude the leasing or licensing of its vertical infrastructure located in public right-of-way or public utility easements under the terms set forth in this paragraph. Vertical infrastructure shall be made available under fair and reasonable fees, terms, and conditions and offered on a nondiscriminatory basis for small cells. Fees shall be cost-based, and shall not exceed the lesser of either of the following:

(1) The costs of ownership of the percentage of the volume of the capacity of the vertical infrastructure rendered unusable by a small cell.

(2) The rate produced by applying the formula adopted by the Federal Communications Commission for telecommunications pole attachments in Section 1.1409(e)(2) of Part 47 of the Code of Federal Regulations.

(d) A city or county shall not unreasonably discriminate in the leasing or licensing of property not located in the public right-of-way owned or operated by the city or county for installation of a small cell. A city or county shall authorize the installation of a small cell on property owned or controlled by the city or county not located within the public right-of-way to the same extent the city or county permits access to that property for commercial projects or uses. These installations shall be subject to reasonable and nondiscriminatory rates, terms, and conditions.

(e) For purposes of this section, the following terms have the following meanings:

(1) (A) "Small cell" means a wireless telecommunications facility, as defined in Section 65850.6, using licensed or unlicensed spectrum that meets the following qualifications:

(i) Any individual antenna, excluding the associated equipment, is individually no more than three cubic feet in volume, and all antennas on the structure total no more than six cubic feet in volume, whether in a single array or separate.

(ii) (I) The associated equipment on pole structures does not exceed 21 cubic feet for poles that can support fewer than three providers or 28 cubic feet for pole collocations that can support at least three providers, or the associated equipment on nonpole structures does not exceed 28 cubic feet for collocations that can support fewer than three providers or 35 cubic feet for collocations that can support at least three providers.

(II) The following types of associated ancillary equipment are not included in the calculation of equipment volume:

(ia) Electric meters and any required pedestal.

(ib) Concealment elements.

(ic) Any telecommunications demarcation box.

(id) Grounding equipment.

(ie) Power transfer switch.

(if) Cut-off switch.

(ig) Vertical cable runs for the connection of power and other services.

(B) "Small cell" does not include communications infrastructure extending beyond the telecommunications demarcation box.

(2) "Vertical infrastructure" means all poles or similar facilities owned or controlled by a city or county that are in the public right-of-way or public utility easements and meant for, or used in whole or in part for, communications service, electric service, lighting, traffic control, signage, or similar functions.

(f) The Legislature finds and declares that small cells, as defined in this section, have a significant economic impact in California and are not a municipal affair as that term is used in Section 5 of Article XI of the California Constitution, but are a matter of statewide concern.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because a local agency or school district has the authority to levy service charges, fees, or assessments sufficient to pay for the program or level of service mandated by this act, within the meaning of Section 17556 of the Government Code.

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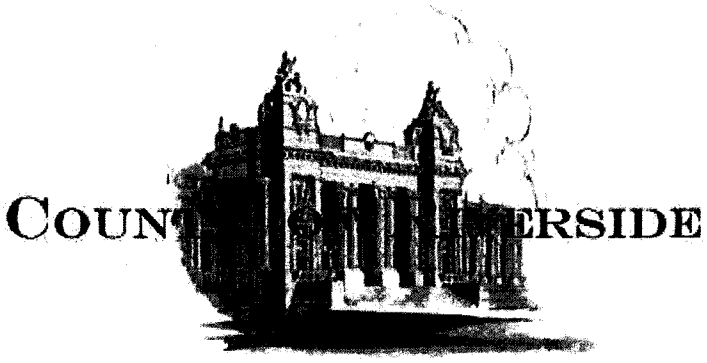

COUNTY OF RIVERSIDE

April 26, 2017

The Honorable Phil Ting
Chair, Assembly Budget Committee
State Capitol, Room 6026
Sacramento, CA 95814

Re: 340B Drug Pricing – OPPOSE – Per Legislative Platform

Dear Assembly Member Ting:

On behalf of the Riverside County Board of Supervisors, I write in opposition to the Governor's proposal to change statutory provisions related to the use of and reimbursement for drugs purchased under the 340B program in Medi-Cal. The Department of Health Care Services (DHCS) signaled their intent to clarify current law in the January budget; however, trailer bill language and a specific revenue estimate were not released at that time. More details are expected in May with the budget revisions.

The 340B program allows safety net providers to purchase discounted outpatient drugs and stretch federal resources to serve more eligible patients and provide more comprehensive services. The Governor's proposal would change how 340B entities can bill Medi-Cal managed care plans for outpatient drugs, allowing the state to capture any savings public health care systems receive from purchasing 340B drugs.

This proposal disproportionately impacts providers that serve the largest number of low-income vulnerable patients. Participation in the 340B program has allowed public health care systems, like the Riverside University Health System, to 1) provide drugs to the uninsured, regardless of ability to pay; 2) offer specific programs to the safety net population around Hepatitis C; 3) offset uncompensated care losses from uninsured and Medi-Cal patients; and 4) use program savings to fund a growing clinical pharmacy residency program, which trains pharmacists to act as physician extenders in a region that has severe shortages in family medicine and specialty practitioners.

COUNTY OF RIVERSIDE

With limited resources, these savings are important to Riverside University Health System. Because the proposed policy change would impact Medi-Cal managed care drug billing for 340B entities, safety-net systems that serve a disproportionate number of Medi-Cal patients would bear the largest financial risk. If this policy change is implemented, it may cause us to reevaluate closing or limiting high-cost drug programs, hospital retail pharmacies, and withdrawing from the 340B program if the administrative cost outweighs the savings.

Riverside County would like to see the state withdraw this budget proposal. If the state proceeds, we ask for your opposition. If you have any questions about the County's position, please do not hesitate to contact Deputy County Executive Officer, Brian Nestande at (951) 955-1110 or bnestande@rceo.org.

Sincerely,

John Tavaglione
Chairman, Riverside County Board of Supervisors

cc: Members, Assembly Budget Subcommittee No. 1
Andrea Margolis, Consultant, Assembly Budget Committee
Frank Prewoznik, Consultant, Assembly Republican Caucus
County of Riverside Legislative Delegation
Michael Cohen, Director, Department of Finance
Jennifer Kent, Director, Department of Health Care Services

COUNTY OF RIVERSIDE

April 26, 2017

The Honorable Holly Mitchell
Chair, Senate Budget & Fiscal Review Committee
State Capitol, Room 5080
Sacramento, CA 95814

Re: **340B Drug Pricing – OPPOSE – Per Legislative Platform**

Dear Senator Mitchell: Holly-

On behalf of the Riverside County Board of Supervisors, I write in opposition to the Governor's proposal to change statutory provisions related to the use of and reimbursement for drugs purchased under the 340B program in Medi-Cal. The Department of Health Care Services (DHCS) signaled their intent to clarify current law in the January budget; however, trailer bill language and a specific revenue estimate were not released at that time. More details are expected in May with the budget revisions.

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This proposal disproportionately impacts providers that serve the largest number of low-income vulnerable patients. Participation in the 340B program has allowed public health care systems, like the Riverside University Health System, to 1) provide drugs to the uninsured, regardless of ability to pay; 2) offer specific programs to the safety net population around Hepatitis C; 3) offset uncompensated care losses from uninsured and Medi-Cal patients; and 4) use program savings to fund a growing clinical pharmacy residency program, which trains pharmacists to act as physician extenders in a region that has severe shortages in family medicine and specialty practitioners.

COUNTY OF RIVERSIDE

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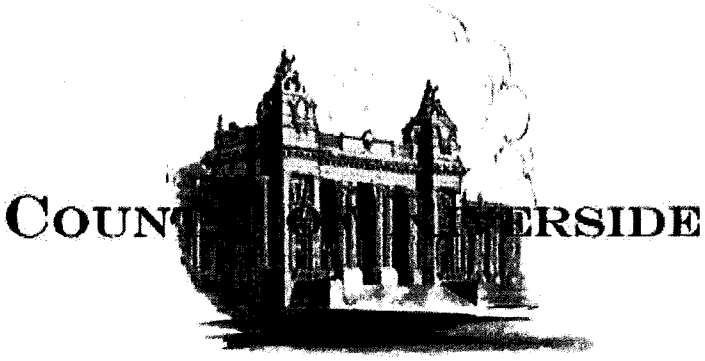
Riverside County would like to see the state withdraw this budget proposal. If the state proceeds, we ask for your opposition. If you have any questions about the County's position, please do not hesitate to contact Deputy County Executive Officer, Brian Nestande at (951) 955-1110 or bnestande@rceo.org.

Sincerely,

John Tavaglione
Chairman, Riverside County Board of Supervisors

cc: Members, Senate Budget & Fiscal Review Subcommittee No. 3
Scott Ogus, Consultant, Senate Budget & Fiscal Review Committee
Anthony Archie, Consultant, Senate Republican Caucus
County of Riverside Legislative Delegation
Michael Cohen, Director, Department of Finance
Jennifer Kent, Director, Department of Health Care Services



April 26, 2017

The Honorable Jim Wood
Chair, Assembly Health Committee
State Capitol, Room 6005
Sacramento, CA 95814

Re: AB 205 (Wood) – Medi-Cal: Medi-Cal Managed Care Plans
As Amended April 19, 2017
Set for Hearing April 25, 2017: Assembly Health Committee
County of Riverside: SUPPORT – Per Legislative Platform

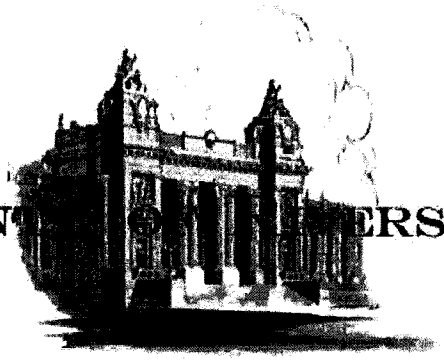
Dear Assembly Member Wood:

On behalf of the Riverside County Board of Supervisors, I write in support of your AB 205, a measure that addresses the Medicaid supplemental payments changes required by the federal Medicaid Managed Care Rule.

In 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to modernize Medicaid (Medi-Cal in California) managed care, given the significant growth in the use of managed care nationwide. The final rule was sweeping, impacting issues such as how plans' rates are determined, grievance and appeals processes, alignment of quality objectives, and most importantly for public health care systems, it placed new restrictions on the ability of the Department of Health Care Services (DHCS) to specify how managed care plans should pay certain essential providers. As a result, California must restructure an estimated $1-1.5 billion annually in Medi-Cal managed care payments to public health care systems. These payments are crucial to helping Riverside University Health System cover uncompensated costs associated with caring for the uninsured and underinsured.

Riverside University Health System relies on these supplemental payments for two important reasons:

1) We serve a large number of Medi-Cal beneficiaries, but receive extremely low provider rates that alone are unsustainable; and
2) We also put up the match (or non-federal share) for Medi-Cal services in many instances, and often do not receive any payments from the state for our services.



COUNTY OF RIVERSIDE

The federal Medicaid Managed Care Rule requires us to restructure these payments and we are working productively with the state, the California Association of Public Hospitals and Health Systems (CAPH) and the plans to come to an agreement. AB 205 contains important statutory changes to bring California into compliance with the Rule and enables supplemental payments to continue.

To continue supporting public health care systems at the same historical levels, payments that DHCS directs managed care plans to make to these essential hospitals must meet one of the exceptions allowed by the final rule, which include models that support value-based purchasing, minimum fee schedules, or uniform increases above base payments. AB 205 contains two key elements. The first is a uniform percentage increase above base rates. The method would be applied uniformly within various "classes" of providers, which for public health care systems will include 3 classes, with the percentage increase varying by class: (1) Level I or II trauma centers, (2) University of California Medical Centers, and (3) all other public health care systems. Riverside University Health System Medical Center is a Level II adult and pediatric trauma center.

In addition, AB 205 includes a quality incentive program designed to align with national quality programs and managed care plan quality objectives, supporting the critical goals of promoting access and value-based payment in the managed care context while increasing the amount of funding tied to quality outcomes. All of the funding for the quality program will be based on the achievement of clinical metrics.

For these reasons, the Riverside County Board of Supervisors supports AB 205 and urges your 'aye' vote. If you have any questions about the County's position, please do not hesitate to contact our Deputy County Executive Officer, Brian Nestande at (951) 955-1110, bnestande@rceo.org.

Sincerely,

John Tavaglione
Chairman, Riverside County Board of Supervisors

cc: County of Riverside Delegation
Members, Assembly Health Committee
Rosielyn Pulmano, Consultant, Assembly Health Committee
Peter Anderson, Consultant, Assembly Republican Caucus

AMENDED IN ASSEMBLY APRIL 19, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 205

Introduced by Assembly Member Wood
(Coauthor: Senator Hernandez)

January 23, 2017

An act to amend Section 10951~~of~~ *of, and to add Article 6.3 (commencing with Section 14197) to Chapter 7 of Part 3 of Division 9 of,* the Welfare and Institutions Code, relating to ~~Medi-Cal.~~ *Medi-Cal, and making an appropriation therefor.*

LEGISLATIVE COUNSEL'S DIGEST

AB 205, as amended, Wood. Medi-Cal: ~~state fair hearing.~~ *Medi-Cal managed care plans.*

~~Existing~~

(1) Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which health care services are provided to qualified, low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans. Existing federal regulations, published on May 6, 2016, revise regulations governing Medicaid managed care plans to, among other things, align, where feasible, those rules with those of other major sources of coverage, including coverage through qualified health plans offered through an American Health Benefit Exchange, such as the *California Health Benefit* Exchange, and promote quality of care and strengthen efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. These federal ~~regulations~~ *regulations,*

among other things, authorize an enrollee to request a state fair hearing only after receiving notice that the Medicaid managed care plan is upholding an adverse benefit determination, and requires the enrollee to request a state fair hearing no later than 120 calendar days from the date of the Medicaid managed care plans notice of resolution.

Existing *state* law establishes hearing procedures for an applicant for or beneficiary of Medi-Cal who is dissatisfied with certain actions regarding health care services and medical assistance to request a hearing from the State Department of ~~Health Care~~ *Social* Services under specified circumstances, and requires a request for a hearing to be filed within 90 days after the order or action complained of.

This bill would *implement various provisions in regard to those federal regulations, as amended May 6, 2016, governing Medicaid managed care plans. The bill would* authorize a person to request a hearing involving a Medi-Cal managed care plan within 120 calendar days after the order or action complained of, and would exclude a request from the 120-calendar day filing time if there is good cause, as defined, for filing the request beyond the 120-calendar day period.

(2) These federal regulations require a state that contracts with specified Medicaid managed care plans to develop and enforce network adequacy standards and requires each state to ensure that all services covered under the Medicaid state plan are available and accessible to enrollees of specified Medicaid managed care plans in a timely manner. These regulations also require specified Medicaid managed care plans to calculate and report a medical loss ratio (MLR) for the rating period that begins in 2017. If a state elects to mandate a minimum MLR for its Medicaid managed care plans, these regulations require that minimum MLR to be equal to or higher than 85% and authorizes the state to impose a remittance requirement consistent with the minimum standards established in these federal regulations for the failure to meet the minimum ratio standard imposed by the state.

The bill would require the State Department of Health Care Services, in consultation with the Department of Managed Health Care, to develop time and distance standards for specified provider types to ensure medically necessary covered services are accessible to enrollees of Medi-Cal managed care plans, as defined, to develop, for those Medi-Cal managed care plans that cover long-term services and supports (LTSS), time and distance standards for LTSS providers and network adequacy standards other than time and distance standards, and to develop timeliness standards to ensure that all services are

available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as specified. The bill would require these standards to meet or exceed specified existing standards for timeliness of access to care established by the Department of Managed Health Care or those set forth in existing Medi-Cal managed care plan contracts. The bill would authorize the State Department of Health Care Services, upon the request of a Medi-Cal managed care plan, to allow alternative access standards, including the use of telecommunications technology, if the applying Medi-Cal managed care plan has exhausted all other reasonable options to obtain providers to meet either the time and distance or timely access standards. The bill would require, on at least an annual basis, a Medi-Cal managed care plan, as defined, to demonstrate to the department its compliance with the standards developed under this provision.

The bill would require a Medi-Cal managed care plan, as defined, to comply with the MLR reporting requirements imposed under those federal regulations, and would require a Medi-Cal managed care plan to comply with a minimum 85% MLR and to provide a remittance to the state if the ratio does not meet the minimum ratio of 85% for that reporting year consistent with those federal regulations.

The bill would require the department to adopt regulations by July 1, 2019, and, commencing July 1, 2018, would require the department to provide a status report to the Legislature on a semiannual basis until regulations are adopted.

(3) Existing law requires specified percentages of newly eligible beneficiaries, such as childless adults under 65 years of age, to be assigned to public hospital health systems in an eligible county, if applicable, until the county public hospital health system meets its enrollment target, as defined. Existing law also requires, subject to specified criteria, Medi-Cal managed care plans serving newly eligible beneficiaries to pay county public hospital health systems for providing and making available services to newly eligible beneficiaries of the Medi-Cal managed care plan in amounts that are no less than the cost of providing those services, and requires the capitation rates paid to Medi-Cal managed care plans for newly eligible beneficiaries to be determined based on its obligations to provide supplemental payments to those county public hospital health systems providing services to newly eligible beneficiaries. Existing law requires the department to pay Medi-Cal managed care plans specified rate range increases, and requires those Medi-Cal managed care plans to pay all of the rate range

increases as additional payments to county public hospital health systems, as specified. Existing law authorizes a designated public hospital system or affiliated governmental entity to voluntarily provide intergovernmental transfers to provide support for the nonfederal share of risk-based payments to managed care health plans to enable those plans to compensate designated public hospital systems in an amount to preserve and strengthen the availability and quality of services provided by those hospitals.

These federal regulations generally prohibit states from directing managed care plans' expenditures under a managed care contract. The federal regulations authorize states to direct managed care plans' expenditures for provider payment through the managed care contracts in a manner based on the delivery of services, utilization, and the outcomes and quality of the delivered services.

This bill, commencing with the 2017–18 state fiscal year, would require the department to require each Medi-Cal managed care plan, as defined, to enhance contract services payments to designated public hospital systems, as defined, by a uniform percentage applied uniformly across specified classes of designated public hospital systems in accordance with a prescribed methodology. The bill would require a Medi-Cal managed care plan to annually provide to the department an accounting of the amount paid or payable to a designated public hospital system to demonstrate its compliance with the directed payment requirements. The bill would authorize the department to reduce the default assignment into a Medi-Cal managed care plan by up to 25%, as specified, if the Medi-Cal managed care plan is not in compliance with the directed payment requirements.

The bill, commencing with the 2017–18 state fiscal year, would require the department, in consultation with the designated public hospital systems and each Medi-cal managed care plans, to establish a program under which a designated public hospital system may earn performance-based quality incentive payments from Medi-Cal managed care plans, as specified, and would require payments to be earned by each designated public hospital system based on its performance in achieving identified targets for quality of care. The bill would require the department to establish uniform performance measures and parameters for the designated public hospital systems to select the applicable measures, and would require these performance measures to advance at least one goal identified in the state's Medicaid quality strategy.

The bill would authorize a designated public hospital system and their affiliated governmental entities, or other public entities, to voluntarily provide the nonfederal share of the portion of the capitation rates associated with the directed payments and for the quality incentive payments through an intergovernmental transfer. The bill would authorize the department to accept these elective funds and, in its discretion, to deposit the transfer in the Medi-Cal Inpatient Payment Adjustment Fund, a continuously appropriated fund, thereby making an appropriation.

The bill would prohibit the department from making any payment to a Medi-Cal managed care plan pursuant to the provisions described in (3) for any state fiscal year in which these provisions are implemented, as specified.

The bill would authorize the department to implement, interpret, or make specific these provisions by means of all-county letters, plan letters, provider bulletins, or other similar instructions without taking regulatory action.

The bill would require these provisions to be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized, and would require the department to seek any necessary federal approvals.

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

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

SECTION 1. It is the intent of the Legislature to implement the revisions to federal regulations governing Medicaid managed care plans at Parts 431, 433, 438, 440, 457, and 495 of Title 42 of the Code of Federal Regulations, as amended May 6, 2016, as published in the Federal Register (81 Fed. Reg. 27498).

SEC. 2. Section 10951 of the Welfare and Institutions Code is amended to read:

10951. (a) (1) A person is not entitled to a hearing pursuant to this chapter unless he or she files his or her request for the same within 90 days after the order or action complained of.

(2) Notwithstanding paragraph (1), a person shall be entitled to a hearing pursuant to this chapter if he or she files the request more than 90 days after the order or action complained of and there is

good cause for filing the request beyond the 90-day period. The director may determine whether good cause exists.

(b) (1) Notwithstanding subdivision (a), a person may request a hearing pursuant to this chapter involving a Medi-Cal managed care plan within 120 calendar days after the order or action complained of.

(2) Notwithstanding paragraph (1), a person shall be entitled to a hearing pursuant to this chapter if he or she files the request more than 120 calendar days after the order or action complained of and there is good cause for filing the request beyond the 120-calendar day period. The director may determine whether good cause exists.

(c) For purposes of this section, "good cause" means a substantial and compelling reason beyond the party's control, considering the length of the delay, the diligence of the party making the request, and the potential prejudice to the other party. The inability of a person to understand an adequate and language-compliant notice, in and of itself, shall not constitute good cause. The department shall not grant a request for a hearing for good cause if the request is filed more than 180 days after the order or action complained of.

(d) This section shall not preclude the application of the principles of equity jurisdiction as otherwise provided by law.

(e) Notwithstanding the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department shall implement this section through an all-county information notice. The department may also provide further instructions through training notes.

SEC. 3. Article 6.3 (commencing with Section 14197) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 6.3. Medi-Cal Managed Care Plans

14197. (a) It is the intent of the Legislature that the department implement the time and distance requirements set forth in Section 438.68, 438.206, and 438.207 of Title 42 of the Code of Federal Regulations, to ensure that all services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as those standards were enacted in May 2016.

(b) The department, in consultation with the Department of Managed Health Care, shall develop all of the following:

(1) Time and distance standards for the following provider types, as specified in Section 438.68(b)(1) of Title 42 of the Code of Federal Regulations, to ensure that medically necessary covered services are accessible to enrollees of Medi-Cal managed care plans.

(A) Primary care, adult and pediatric.

(B) Obstetrics and gynecology.

(C) Behavioral health, including mental health and substance use disorder, adult and pediatric.

(D) Specialist, adult and pediatric.

(E) Hospital.

(F) Pharmacy.

(G) Pediatric dental.

(H) Additional provider types when it promotes the objectives of the Medicaid program, as determined by the federal Centers for Medicare and Medicaid Services, for the provider type to be subject to time and distance access standards.

(2) For those Medi-Cal managed care plans that cover long-term services and supports (LTSS), both of the following:

(A) Time and distance standards for LTSS provider types in which an enrollee must travel to the provider to receive services.

(B) Network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services.

(3) Standards to ensure that all services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner.

(c) The standards developed by the department pursuant to this section shall, at a minimum, do both of the following:

(1) Meet or exceed existing time and distance standards developed pursuant to Section 1367.03 of the Health and Safety Code and the standards set forth in Medi-Cal managed care contracts entered into with the department as of January 1, 2016.

(2) Meet or exceed the appointment time standards developed pursuant to Section 1367.03 of the Health and Safety Code and the standards set forth in contracts entered into between the department and Medi-Cal managed care plans.

(d) In developing the time and distance standards, if the department elects a county standard for time and distance, the department shall categorize counties in to at least five or more county categories.

(e) The department may have varying standards for the same provider type based on geographic areas, subject to the requirements of this section.

(f) (1) The department, upon request of a Medi-Cal managed care plan, may allow alternative access standards if the requesting Medi-Cal managed care plan has exhausted all other reasonable options to obtain providers to meet either time and distance or timely access standards, and, if the Medi-Cal managed care plan is licensed as a health care service plan under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), has obtained approval from the Department of Managed Health Care. The department shall post any approved alternative access standards on its Internet Web site.

(2) The department may allow for the use of telecommunications technology as a means of alternative access to care, including telemedicine, e-visits, or other evolving and innovative technological solutions that are used to provide care from a distance.

(g) The department may permit standards other than time and distance if the health care provider travels to the beneficiary or to a community-based setting to deliver services.

(h) A Medi-Cal managed care plan shall, on at least an annual basis, demonstrate to the department its compliance with the time and distance and timeliness standards developed pursuant to this section.

(i) (1) For purposes of this section, "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(A) Article 2.7 (commencing with Section 14087.3), including dental managed care programs developed pursuant to Section 14087.46 .

(B) Article 2.8 (commencing with Section 14087.5).

(C) Article 2.81 (commencing with Section 14087.96).

(D) Article 2.9 (commencing with Section 14088).

(E) Article 2.91 (commencing with Section 14089).

(F) Chapter 8 (commencing with Section 14200), including dental managed care plans.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall 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 regulations are adopted. The department shall adopt regulations by July 1, 2019, 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. Commencing July 1, 2018, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations are adopted.

14197.1. (a) This section implements the state option in subdivision (j) of Section 438.8 of Title 42 of the Code of Federal Regulations.

(b) A Medi-Cal managed care plan shall comply with a minimum 85 percent medical loss ratio (MLR) consistent with Section 438.8 of Title 42 of the Code of Federal Regulations. The ratio shall be calculated and reported for each MLR reporting year by the Medi-Cal managed care plan consistent with Section 438.8 of Title 42 of the Code of Federal Regulations.

(c) A Medi-Cal managed care plan shall provide a remittance for an MLR reporting year if the ratio for that MLR reporting year does not meet the minimum MLR standard of 85 percent.

(d) For purposes of this section, the following definitions apply:

(1) "Medical loss ratio (MLR) reporting year" shall have the same meaning as that term is defined in Section 438.8 of Title 42 of the Code of Federal Regulations.

(2) (A) "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(i) Article 2.7 (commencing with Section 14087.3).

(ii) Article 2.8 (commencing with Section 14087.5).

(iii) Article 2.81 (commencing with Section 14087.96).

(iv) Article 2.9 (commencing with Section 14088).

(v) Article 2.91 (commencing with Section 14089).

(vi) Article 1 (commencing with Section 14200) of Chapter 8.

(vii) Article 7 (commencing with Section 14490) of Chapter 8.

(B) "Medi-Cal managed care plan" does not include dental managed care plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200).

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall 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 regulations are adopted. The department shall adopt regulations by July 1, 2019, 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. Commencing July 1, 2018, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations are adopted.

14197.2. (a) The Legislature finds and declares all of the following:

(1) Designated public hospitals systems play an essential role in the Medi-Cal program, providing high-quality care to a disproportionate number of low-income Medi-Cal and uninsured populations in the state. Because Medi-Cal covers approximately one-third of the state's population, the strength of these essential public health care systems is of critical importance to the health and welfare of the people of California.

(2) Designated public hospital systems provide comprehensive health care services to low-income patients and life-saving trauma, burn, and disaster-response services for entire communities, and train the next generation of doctors and other health care professionals, such as nurses and paramedical professionals, who are critical to new team-based care models that achieve more efficient and patient-centered care.

(3) The Legislature intends to continue to provide levels of support for designated public hospital systems in light of their reliance on Medi-Cal funding to provide quality care to everyone, regardless of insurance status, ability to pay, or other circumstance, the significant proportion of Medi-Cal services

provided under managed care by these public hospital systems, and new federal requirements related to Medicaid managed care.

(4) It is the intent of the Legislature that Medi-Cal managed care plans and designated public hospital systems shall in good faith negotiate for, and implement, contract rates, the provision and arrangement of services and member assignment that are sufficient to ensure continued participation by designated public hospital systems and to maintain access to services for Medi-Cal managed care beneficiaries and other low-income patients.

(b) Commencing with the 2017–18 state fiscal year, and for each state fiscal year thereafter, and notwithstanding any other law, the department shall require each Medi-Cal managed care plan to enhance contract services payments to the designated public hospital systems by a uniform percentage as described in this subdivision.

(1) The applicable percentage for purposes of the directed payments shall be uniformly applied across all of the following classes of designated public hospital systems:

(A) Designated public hospital systems owned and operated by the University of California.

(B) Designated public hospital systems not identified in subparagraph (A) that include a designated public hospital with a level 1 or level 2 trauma designation.

(C) Designated public hospital systems not identified in subparagraph (A) or (B).

(2) The department, in consultation with the designated public hospital systems, shall annually determine the applicable uniform percentages for each class identified in paragraph (1) and the classification of each designated public hospital system. Once the department determines the classification for each designated public hospital system for a particular state fiscal year, that classification shall not be eligible to change until no sooner than the subsequent state fiscal year. To the extent necessary to meet the objectives identified in subdivisions (a) and (d) or to comply with federal requirements, the department may, in consultation with the designated public hospital systems, adjust or modify the applicable percentages or the classifications. The department shall consult with the designated public hospital systems and each affected Medi-Cal managed care plan with regard to the implementation

of the directed payment requirements once these payment levels have been established.

(3) The required directed payment amounts shall be determined by multiplying the applicable percentage developed pursuant to paragraph (2) by the total amount of contract services payments. Performance-based incentive payments, amounts earned pursuant to the quality incentive program described in subdivision (c), and amounts paid pursuant to Sections 14301.4 and 14301.5 shall not be subject to the required directed payments. Nothing in this subdivision shall prevent a Medi-Cal managed care plan from making additional payments to a designated public hospital system in amounts exceeding the directed payment amounts required under this subdivision, or, at the sole option and request of a designated public hospital system, from working with the designated public hospital system to develop risk-sharing arrangements consistent with the intent and purposes of this subdivision.

(4) The directed payments required under this subdivision shall be implemented and documented by each Medi-Cal managed care plan and designated public hospital system in accordance with all of the following parameters and any guidance issued by the department:

(A) A Medi-Cal managed care plan and the designated public hospital systems shall determine the manner, timing, and amount of payment for contracted services, including through fee-for-service, capitation, or other permissible manner. The rates of payment for contracted services agreed upon by the Medi-Cal managed care plan and the designated public hospital system shall be established and documented without regard to the directed payments and quality incentive payments required by this section.

(B) A Medi-Cal managed care plan and a designated public hospital system shall, for the directed payment amounts determined pursuant to paragraph (3), determine the manner of their distribution, including the frequency and amount of each distribution through arrangements that may include, but are not limited to, a per-claim enhancement, per-capitation enhancement, monthly or quarterly lump-sum enhancement, or other permissible arrangement.

(C) The required directed payment enhancements provided pursuant to this subdivision shall not supplant amounts that would

otherwise be payable by a Medi-Cal managed care plan to a designated public hospital system for an applicable state fiscal year.

(D) A Medi-Cal managed care plan shall not terminate a contract with a designated public hospital system for the purpose of circumventing the directed payment obligations under this subdivision.

(E) In the event a Medi-Cal managed care plan subcontracts or otherwise delegates responsibility to a separate entity for either or both the arrangement or payment of services, the Medi-Cal managed care plan shall ensure that the designated public hospital system receives the directed payment enhancements described in this subdivision with respect to the services it provides that are covered by that arrangement, regardless of whether the Medi-Cal managed care plan subcontracted or delegated responsibility for payment of the directed payment amounts to the subcontracted or delegated entity, and shall be liable for any unpaid amounts. A Medi-Cal managed care plan shall require reporting of amounts paid or payable pursuant to that subcontracted or delegated arrangements as necessary to calculate the amount of those directed payment enhancements.

(5) Each year, a Medi-Cal managed care plan shall provide to the department, at the times and in the form and manner specified by the department, an accounting of amounts paid or payable to the designated public hospital systems it contracts with, including both contracted rates and the directed payments, to demonstrate compliance with this subdivision. To the extent the department determines, in its sole discretion, that a Medi-Cal managed care plan is not in compliance with the requirements of this subdivision, or is otherwise circumventing the purposes thereof, to the material detriment of an applicable designated public hospital system , and, independent of any remedy available to the designated public hospital system, the department may reduce the default assignment into the Medi-Cal managed care plan with respect to all Medi-Cal managed care beneficiaries by up to 25 percent, so long as the other Medi-Cal managed care plan or Medi-Cal managed care plans in the applicable county have the capacity to receive the additional default membership. The department's determination, whether to exercise discretion under this paragraph, shall not be subject to judicial review. Nothing in this paragraph shall be

construed to preclude or otherwise limit the right of any designated public hospital system to pursue a breach of contract action in connection with the requirements of this subdivision.

(6) Capitation rates paid by the department to a Medi-Cal managed care plan shall account for the Medi-Cal managed care plan's obligation to pay the directed payments to designated public hospital systems in accordance with this subdivision. The department may require Medi-Cal managed care plans and the designated public hospital systems to submit information regarding contract rates and expected utilization of services, at the times and in the form and manner specified by the department. To the extent consistent with federal law and actuarial standards of practice, the department shall utilize the most recently available data, as determined by the department, when accounting for the directed payments required under this subdivision, and may account for material adjustments, as appropriate and as determined by the department, to contracts entered into between a Medi-Cal managed care plan and a designated public hospital system.

(c) Commencing with the 2017–18 state fiscal year, and for each state fiscal year thereafter, the department, in consultation with the designated public hospital systems and each Medi-Cal managed care plan, shall establish a program under which a designated public hospital system may earn performance-based quality incentive payments from the Medi-Cal managed care plan they contract with in accordance with this subdivision.

(1) Payments shall be earned by each designated public hospital system based on its performance in achieving identified targets for quality of care.

(A) The department, in consultation with the designated public hospital systems and each Medi-Cal managed care plan, shall establish and provide a method for updating uniform performance measures for the performance-based quality incentive payment program and parameters for the designated public hospital systems to select the applicable measures. The performance measures shall advance at least one goal identified in the state's Medicaid quality strategy. Measures shall not duplicate measures utilized in the PRIME program established pursuant to Section 14184.50.

(B) Each designated public hospital system shall submit reports to the department containing information required to evaluate its performance on all applicable performance measures, at the times

and in the form and manner specified by the department. A Medi-Cal managed care plan shall assist a designated public hospital system in collecting information necessary for these reports.

(2) The department, in consultation with each designated public hospital system, shall determine a maximum amount that each class may earn in quality incentive payments for the state fiscal year.

(3) The department shall calculate the amount earned by each designated public hospital system based on its performance score established pursuant to paragraph (1).

(A) This amount shall be paid to the designated public hospital system by each of its contracted Medi-Cal managed care plan. If a designated public hospital system contracts with multiple Medi-Cal managed care plans, the department shall identify each Medi-Cal managed care plan's proportionate amount of the designated public hospital system's payment. The timing and amount of the distributions and any related reporting requirements for interim payments shall be established and agreed to by the designated public hospital system and each of the applicable Medi-Cal managed care plans.

(B) A Medi-Cal managed care plan shall not terminate a contract with a designated public hospital system for the purpose of circumventing the payment obligations under this subdivision.

(C) Each Medi-Cal managed care plan shall be responsible for payment of the quality incentive payments described in this subdivision.

(4) Nothing in this subdivision shall be construed to replace or otherwise prevent the continuation of prior quality incentive or pay-for-performance payment mechanisms or the establishment of new payment programs by any Medi-Cal managed care plan and their contracted designated public hospital systems.

(5) The department shall provide appropriate funding to each Medi-Cal managed care plan, to account for and to enable them to make the quality incentive payments described in this subdivision, through the incorporation into actuarially sound capitation rates or any other federally permissible method. The amounts designated by the department for the quality incentive payments made pursuant to this subdivision shall be reserved for

the purposes of the performance-based quality incentive payment program.

(d) In determining the uniform percentages described in paragraph (2) of subdivision (b), and the aggregate size of the quality incentive payment program described in paragraph (2) of subdivision (c), the department shall consult with designated public hospital systems to establish levels for these payments that, in combination with one another, are projected to result in aggregate payments that will advance the quality and access objectives reflected in prior payment enhancement mechanisms for designated public hospital systems. To the extent necessary to meet these objectives or to comply with any federal requirements, the department may, in consultation with the designated public hospital systems, adjust or modify either or both the applicable percentages or quality incentive payment program.

(e) The provisions of paragraphs (3) and (4) of subdivision (a), and of subdivisions (b) and (c) shall be deemed incorporated into each contract between a designated public hospital system and a Medi-Cal managed care plan, and its subcontractor or designee, as applicable, and any claim for breach of those provisions may be brought directly in a court of competent jurisdiction.

(f) (1) The nonfederal share of the portion of the capitation rates specifically associated with directed payments to designated public hospital systems required under subdivision (b) and for the quality incentive payments established pursuant to subdivision (c) may consist of voluntary intergovernmental transfers of funds provided by designated public hospitals and their affiliated governmental entities, or other public entities, pursuant to Section 14164. Upon providing any intergovernmental transfer of funds, each transferring entity shall certify that the transferred funds qualify for federal financial participation pursuant to applicable federal Medicaid laws, and in the form and manner specified by the department. Any intergovernmental transfer of funds made pursuant to this section shall be considered voluntary for purposes of all federal laws. Notwithstanding any other law, the department shall not assess the fee described in subdivision (d) of Section 14301.4 or any other similar fee.

(2) When applicable for voluntary intergovernmental transfers, the department, in consultation with the designated public hospital systems, shall develop and maintain a protocol to determine each

public entity's intergovernmental transfer amount in an applicable state fiscal year for purposes of funding the nonfederal share associated with payments pursuant to this section. The protocol developed and maintained pursuant to this paragraph shall account for any applicable contributions made by public entities to the nonfederal share of Medi-Cal managed care expenditures, including, but not limited to, contributions previously made pursuant to Section 14182.15 or 14199.2. Nothing in this section shall be construed to limit or otherwise alter any existing authority of the department to accept intergovernmental transfers for purposes of funding the nonfederal share of Medi-Cal managed care expenditures.

(g) (1) 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.

(2) For any state fiscal year in which this section is implemented, in whole or in part, and notwithstanding any other law, the department shall not be required to make any payment to a Medi-Cal managed care plan pursuant to Section 14182.15, 14199.2, or 14301.5.

(h) (1) The department shall seek any necessary federal approvals for the directed payments and the quality incentive payments set forth in this section.

(2) The department shall consult with the designated public hospital systems with regard to the development and implementation of the directed payment levels and the quality incentive payments established pursuant to this section.

(3) The director, after consultation with the designated public hospital systems, may modify the requirements set forth in this section to the extent necessary to meet federal requirements or to maximize available federal financial participation. In the event federal approval is only available with significant limitations or modifications, or in the event of changes to the federal Medicaid program that result in a loss of funding currently available to the designated public hospital systems, the department shall consult with the designated public hospitals to consider alternative methodologies.

(i) 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, provider bulletins, or other similar instructions, without taking regulatory action. The department shall make use of appropriate processes to ensure that affected designated public hospital systems and Medi-Cal managed care plans are timely informed of, and have access to, applicable guidance issued pursuant to this authority, and that this guidance remains publicly available until all payments made pursuant to this section are finalized.

(j) For purposes of this section, the following definitions apply:

(1) "Contract services payments" means the amount paid or payable to a designated public hospital system, including amounts paid or payable under fee-for-service, capitation, prior to any adjustments for service payment withholds or deductions, or other basis, under a contract with a Medi-Cal managed care plan for services, drugs, supplies or other items provided to a Medi-Cal beneficiary enrolled in the Medi-Cal managed care plan. Contract services includes all services, drugs, supplies, or other items the designated public hospital system provides, or is responsible for providing, or arranging or paying for, pursuant to a contract entered into with a Medi-Cal managed care plan. In the event a Medi-Cal managed care plan subcontracts or otherwise delegates responsibility to a separate entity for either or both the arrangement or payment of services, "contracted services payments" also include amounts paid or payable for the services provided by, or otherwise the responsibility of, the designated public hospital system that are within the scope of services of the subcontracted or delegated arrangement so long as the designated public hospital system holds a contract with the primary Medi-Cal managed care plan.

(2) "Designated public hospital" shall have the meaning set forth in subdivision (f) of Section 14184.10.

(3) "Designated public hospital system" means a designated public hospital and its affiliated government entity clinics, practices, and other health care providers, including the respective affiliated hospital authority and county government entities described in Chapter 5 (commencing with Section 101850) and Chapter 5.5 (commencing with Section 101852), of Part 4 of Division 101 of the Health and Safety Code.

(4) (A) "Medi-Cal managed care plan" means an applicable organization or entity that enters into a contract with the department pursuant to any of the following:

(i) Article 2.7 (commencing with Section 14087.3).

(ii) Article 2.8 (commencing with Section 14087.5).

(iii) Article 2.81 (commencing with Section 14087.96).

(iv) Article 2.91 (commencing with Section 14089).

(v) Chapter 8 (commencing with Section 14200).

(B) "Medi-cal managed care plan" does not include any of the following:

(i) A mental health plan contracting to provide mental health care for Medi-Cal beneficiaries pursuant to Chapter 8.9 (commencing with Section 14700).

(ii) A plan not covering inpatient services, such as primary care case management plans, operating pursuant to Section 14088.85.

(iii) A Program of All-Inclusive Care for the Elderly organization operating pursuant to Chapter 8.75 (commencing with Section 14591).

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April 26, 2017

The Honorable Ed Hernandez, OD
Chair, Senate Health Committee
State Capitol, Room 4070
Sacramento, CA 95814

Re: SB 171 (Hernandez) – Medi-Cal: Medi-Cal Managed Care Plans
As Amended April 19, 2017
Set for Hearing: April 26, 2017: Senate Health Committee
County of Riverside: SUPPORT – Per Legislative Platform

Dear Senator Hernandez:

On behalf of the Riverside County Board of Supervisors, I write in support of your SB 171, a measure that addresses the Medicaid supplemental payments changes required by the federal Medicaid Managed Care Rule.

In 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to modernize Medicaid (Medi-Cal in California) managed care, given the significant growth in the use of managed care nationwide. The final rule was sweeping, impacting issues such as how plans' rates are determined, grievance and appeals processes, alignment of quality objectives, and most importantly for public health care systems, it placed new restrictions on the ability of the Department of Health Care Services (DHCS) to specify how managed care plans should pay certain essential providers. As a result, California must restructure an estimated $1-1.5 billion annually in Medi-Cal managed care payments to public health care systems. These payments are crucial to helping Riverside University Health System cover uncompensated costs associated with caring for the uninsured and underinsured.

Riverside University Health System relies on these supplemental payments for two important reasons:

1) We serve a large number of Medi-Cal beneficiaries, but receive extremely low provider rates that alone are unsustainable; and
2) We also put up the match (or non-federal share) for Medi-Cal services in many instances, and often do not receive any payments from the state for our services.

COUNTY OF RIVERSIDE

The federal Medicaid Managed Care Rule requires us to restructure these payments and we are working productively with the state, the California Association of Public Hospitals and Health Systems (CAPH) and the plans to come to an agreement. SB 171 contains important statutory changes to bring California into compliance with the Rule and enables supplemental payments to continue.

To continue supporting public health care systems at the same historical levels, payments that DHCS directs managed care plans to make to these essential hospitals must meet one of the exceptions allowed by the final rule, which include models that support value-based purchasing, minimum fee schedules, or uniform increases above base payments. SB 171 contains two key elements. The first is a uniform percentage increase above base rates. The method would be applied uniformly within various "classes" of providers, which for public health care systems will include 3 classes, with the percentage increase varying by class: (1) Level I or II trauma centers, (2) University of California Medical Centers, and (3) all other public health care systems. Riverside University Health System Medical Center is a Level II adult and pediatric trauma center.

In addition, SB 171 includes a quality incentive program designed to align with national quality programs and managed care plan quality objectives, supporting the critical goals of promoting access and value-based payment in the managed care context while increasing the amount of funding tied to quality outcomes. All of the funding for the quality program will be based on the achievement of clinical metrics.

For these reasons, the Riverside County Board of Supervisors supports SB 171 and urges your 'aye' vote. If you have any questions about the County's position, please do not hesitate to contact our Deputy County Executive Officer, Brian Nestande at (951) 955-1110, bnestande@rceo.org.

Sincerely,

John Tavaglione
Chairman, Riverside County Board of Supervisors

cc: County of Riverside Delegation
Members, Senate Health Committee
Scott Bain, Consultant, Senate Health Committee
Joe Parra, Consultant, Senate Republican Caucus

AMENDED IN SENATE APRIL 19, 2017

SENATE BILL No. 171

Introduced by Senator Hernandez
(Coauthor: Assembly Member Wood)

January 23, 2017

An act to amend Section 10951 ~~of~~ *of, and to add Article 6.3 (commencing with Section 14197) to Chapter 7 of Part 3 of Division 9 of,* the Welfare and Institutions Code, relating to ~~Medi-Cal.~~ *Medi-Cal, and making an appropriation therefor.*

LEGISLATIVE COUNSEL'S DIGEST

SB 171, as amended, Hernandez. Medi-Cal: ~~state fair hearing.~~ *Medi-Cal managed care plans.*

~~Existing~~

(1) Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which health care services are provided to qualified, low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans. Existing federal regulations, published on May 6, 2016, revise regulations governing Medicaid managed care plans to, among other things, align, where feasible, those rules with those of other major sources of coverage, including coverage through qualified health plans offered through an American Health Benefit Exchange, such as the *California Health Benefit* Exchange, and promote quality of care and strengthen efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. These federal ~~regulations~~ *regulations, among other things,* authorize an enrollee to request a state fair hearing

only after receiving notice that the Medicaid managed care plan is upholding an adverse benefit determination, and requires the enrollee to request a state fair hearing no later than 120 calendar days from the date of the Medicaid managed care plans notice of resolution.

Existing *state* law establishes hearing procedures for an applicant for or beneficiary of Medi-Cal who is dissatisfied with certain actions regarding health care services and medical assistance to request a hearing from the State Department of ~~Health Care~~ *Social* Services under specified circumstances, and requires a request for a hearing to be filed within 90 days after the order or action complained of.

This bill would *implement various provisions in regard to those federal regulations, as amended May 6, 2016, governing Medicaid managed care plans. The bill would* authorize a person to request a hearing involving a Medi-Cal managed care plan within 120 calendar days after the order or action complained of, and would exclude a request from the 120-calendar day filing time if there is good cause, as defined, for filing the request beyond the 120-calendar day period.

(2) These federal regulations require a state that contracts with specified Medicaid managed care plans to develop and enforce network adequacy standards and requires each state to ensure that all services covered under the Medicaid state plan are available and accessible to enrollees of specified Medicaid managed care plans in a timely manner. These regulations also require specified Medicaid managed care plans to calculate and report a medical loss ratio (MLR) for the rating period that begins in 2017. If a state elects to mandate a minimum MLR for its Medicaid managed care plans, these regulations require that minimum MLR to be equal to or higher than 85% and authorizes the state to impose a remittance requirement consistent with the minimum standards established in these federal regulations for the failure to meet the minimum ratio standard imposed by the state.

The bill would require the State Department of Health Care Services, in consultation with the Department of Managed Health Care, to develop time and distance standards for specified provider types to ensure medically necessary covered services are accessible to enrollees of Medi-Cal managed care plans, as defined, to develop, for those Medi-Cal managed care plans that cover long-term services and supports (LTSS), time and distance standards for LTSS providers and network adequacy standards other than time and distance standards, and to develop timeliness standards to ensure that all services are available and accessible to enrollees of Medi-Cal managed care plans

in a timely manner, as specified. The bill would require these standards to meet or exceed specified existing standards for timeliness of access to care established by the Department of Managed Health Care or those set forth in existing Medi-Cal managed care plan contracts. The bill would authorize the State Department of Health Care Services, upon the request of a Medi-Cal managed care plan, to allow alternative access standards, including the use of telecommunications technology, if the applying Medi-Cal managed care plan has exhausted all other reasonable options to obtain providers to meet either the time and distance or timely access standards. The bill would require, on at least an annual basis, a Medi-Cal managed care plan, as defined, to demonstrate to the department its compliance with the standards developed under this provision.

The bill would require a Medi-Cal managed care plan, as defined, to comply with the MLR reporting requirements imposed under those federal regulations, and would require a Medi-Cal managed care plan to comply with a minimum 85% MLR and to provide a remittance to the state if the ratio does not meet the minimum ratio of 85% for that reporting year consistent with those federal regulations.

The bill would require the department to adopt regulations by July 1, 2019, and, commencing July 1, 2018, would require the department to provide a status report to the Legislature on a semiannual basis until regulations are adopted.

(3) Existing law requires specified percentages of newly eligible beneficiaries, such as childless adults under 65 years of age, to be assigned to public hospital health systems in an eligible county, if applicable, until the county public hospital health system meets its enrollment target, as defined. Existing law also requires, subject to specified criteria, Medi-Cal managed care plans serving newly eligible beneficiaries to pay county public hospital health systems for providing and making available services to newly eligible beneficiaries of the Medi-Cal managed care plan in amounts that are no less than the cost of providing those services, and requires the capitation rates paid to Medi-Cal managed care plans for newly eligible beneficiaries to be determined based on its obligations to provide supplemental payments to those county public hospital health systems providing services to newly eligible beneficiaries. Existing law requires the department to pay Medi-Cal managed care plans specified rate range increases, and requires those Medi-Cal managed care plans to pay all of the rate range increases as additional payments to county public hospital health

systems, as specified. Existing law authorizes a designated public hospital system or affiliated governmental entity to voluntarily provide intergovernmental transfers to provide support for the nonfederal share of risk-based payments to managed care health plans to enable those plans to compensate designated public hospital systems in an amount to preserve and strengthen the availability and quality of services provided by those hospitals.

These federal regulations generally prohibit states from directing managed care plans' expenditures under a managed care contract. The federal regulations authorize states to direct managed care plans' expenditures for provider payment through the managed care contracts in a manner based on the delivery of services, utilization, and the outcomes and quality of the delivered services.

This bill, commencing with the 2017–18 state fiscal year, would require the department to require each Medi-Cal managed care plan, as defined, to enhance contract services payments to designated public hospital systems, as defined, by a uniform percentage applied uniformly across specified classes of designated public hospital systems in accordance with a prescribed methodology. The bill would require a Medi-Cal managed care plan to annually provide to the department an accounting of the amount paid or payable to a designated public hospital system to demonstrate its compliance with the directed payment requirements. The bill would authorize the department to reduce the default assignment into a Medi-Cal managed care plan by up to 25%, as specified, if the Medi-Cal managed care plan is not in compliance with the directed payment requirements.

The bill, commencing with the 2017–18 state fiscal year, would require the department, in consultation with the designated public hospital systems and each Medi-cal managed care plans, to establish a program under which a designated public hospital system may earn performance-based quality incentive payments from Medi-Cal managed care plans, as specified, and would require payments to be earned by each designated public hospital system based on its performance in achieving identified targets for quality of care. The bill would require the department to establish uniform performance measures and parameters for the designated public hospital systems to select the applicable measures, and would require these performance measures to advance at least one goal identified in the state's Medicaid quality strategy.

The bill would authorize a designated public hospital system and their affiliated governmental entities, or other public entities, to voluntarily provide the nonfederal share of the portion of the capitation rates associated with the directed payments and for the quality incentive payments through an intergovernmental transfer. The bill would authorize the department to accept these elective funds and, in its discretion, to deposit the transfer in the Medi-Cal Inpatient Payment Adjustment Fund, a continuously appropriated fund, thereby making an appropriation.

The bill would prohibit the department from making any payment to a Medi-Cal managed care plan pursuant to the provisions described in (3) for any state fiscal year in which these provisions are implemented, as specified.

The bill would authorize the department to implement, interpret, or make specific these provisions by means of all-county letters, plan letters, provider bulletins, or other similar instructions without taking regulatory action.

The bill would require these provisions to be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized, and would require the department to seek any necessary federal approvals.

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

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

SECTION 1. It is the intent of the Legislature to implement the revisions to federal regulations governing Medicaid managed care plans at Parts 431, 433, 438, 440, 457, and 495 of Title 42 of the Code of Federal Regulations, as amended May 6, 2016, as published in the Federal Register (81 Fed. Reg. 27498).

SEC. 2. Section 10951 of the Welfare and Institutions Code is amended to read:

10951. (a) (1) A person is not entitled to a hearing pursuant to this chapter unless he or she files his or her request for the same within 90 days after the order or action complained of.

(2) Notwithstanding paragraph (1), a person shall be entitled to a hearing pursuant to this chapter if he or she files the request more than 90 days after the order or action complained of and there is

good cause for filing the request beyond the 90-day period. The director may determine whether good cause exists.

(b) (1) Notwithstanding subdivision (a), a person may request a hearing pursuant to this chapter involving a Medi-Cal managed care plan within 120 calendar days after the order or action complained of.

(2) Notwithstanding paragraph (1), a person shall be entitled to a hearing pursuant to this chapter if he or she files the request more than 120 calendar days after the order or action complained of and there is good cause for filing the request beyond the 120-calendar day period. The director may determine whether good cause exists.

(c) For purposes of this section, "good cause" means a substantial and compelling reason beyond the party's control, considering the length of the delay, the diligence of the party making the request, and the potential prejudice to the other party. The inability of a person to understand an adequate and language-compliant notice, in and of itself, shall not constitute good cause. The department shall not grant a request for a hearing for good cause if the request is filed more than 180 days after the order or action complained of.

(d) This section shall not preclude the application of the principles of equity jurisdiction as otherwise provided by law.

(e) Notwithstanding the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department shall implement this section through an all-county information notice. The department may also provide further instructions through training notes.

SEC. 3. Article 6.3 (commencing with Section 14197) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 6.3. Medi-Cal Managed Care Plans

14197. (a) It is the intent of the Legislature that the department implement the time and distance requirements set forth in Section 438.68, 438.206, and 438.207 of Title 42 of the Code of Federal Regulations, to ensure that all services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as those standards were enacted in May 2016.

(b) The department, in consultation with the Department of Managed Health Care, shall develop all of the following:

(1) Time and distance standards for the following provider types, as specified in Section 438.68(b)(1) of Title 42 of the Code of Federal Regulations, to ensure that medically necessary covered services are accessible to enrollees of Medi-Cal managed care plans.

(A) Primary care, adult and pediatric.

(B) Obstetrics and gynecology.

(C) Behavioral health, including mental health and substance use disorder, adult and pediatric.

(D) Specialist, adult and pediatric.

(E) Hospital.

(F) Pharmacy.

(G) Pediatric dental.

(H) Additional provider types when it promotes the objectives of the Medicaid program, as determined by the federal Centers for Medicare and Medicaid Services, for the provider type to be subject to time and distance access standards.

(2) For those Medi-Cal managed care plans that cover long-term services and supports (LTSS), both of the following:

(A) Time and distance standards for LTSS provider types in which an enrollee must travel to the provider to receive services.

(B) Network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services.

(3) Standards to ensure that all services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner.

(c) The standards developed by the department pursuant to this section shall, at a minimum, do both of the following:

(1) Meet or exceed existing time and distance standards developed pursuant to Section 1367.03 of the Health and Safety Code and the standards set forth in Medi-Cal managed care contracts entered into with the department as of January 1, 2016.

(2) Meet or exceed the appointment time standards developed pursuant to Section 1367.03 of the Health and Safety Code and the standards set forth in contracts entered into between the department and Medi-Cal managed care plans.

(d) In developing the time and distance standards, if the department elects a county standard for time and distance, the department shall categorize counties in to at least five or more county categories.

(e) The department may have varying standards for the same provider type based on geographic areas, subject to the requirements of this section.

(f) (1) The department, upon request of a Medi-Cal managed care plan, may allow alternative access standards if the requesting Medi-Cal managed care plan has exhausted all other reasonable options to obtain providers to meet either time and distance or timely access standards, and, if the Medi-Cal managed care plan is licensed as a health care service plan under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), has obtained approval from the Department of Managed Health Care. The department shall post any approved alternative access standards on its Internet Web site.

(2) The department may allow for the use of telecommunications technology as a means of alternative access to care, including telemedicine, e-visits, or other evolving and innovative technological solutions that are used to provide care from a distance.

(g) The department may permit standards other than time and distance if the health care provider travels to the beneficiary or to a community-based setting to deliver services.

(h) A Medi-Cal managed care plan shall, on at least an annual basis, demonstrate to the department its compliance with the time and distance and timeliness standards developed pursuant to this section.

(i) (1) For purposes of this section, "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(A) Article 2.7 (commencing with Section 14087.3), including dental managed care programs developed pursuant to Section 14087.46 .

(B) Article 2.8 (commencing with Section 14087.5).

(C) Article 2.81 (commencing with Section 14087.96).

(D) Article 2.9 (commencing with Section 14088).

(E) Article 2.91 (commencing with Section 14089).

(F) Chapter 8 (commencing with Section 14200), including dental managed care plans.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall 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 regulations are adopted. The department shall adopt regulations by July 1, 2019, 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. Commencing July 1, 2018, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations are adopted.

14197.1. (a) This section implements the state option in subdivision (j) of Section 438.8 of Title 42 of the Code of Federal Regulations.

(b) A Medi-Cal managed care plan shall comply with a minimum 85 percent medical loss ratio (MLR) consistent with Section 438.8 of Title 42 of the Code of Federal Regulations. The ratio shall be calculated and reported for each MLR reporting year by the Medi-Cal managed care plan consistent with Section 438.8 of Title 42 of the Code of Federal Regulations.

(c) A Medi-Cal managed care plan shall provide a remittance for an MLR reporting year if the ratio for that MLR reporting year does not meet the minimum MLR standard of 85 percent.

(d) For purposes of this section, the following definitions apply:

(1) "Medical loss ratio (MLR) reporting year" shall have the same meaning as that term is defined in Section 438.8 of Title 42 of the Code of Federal Regulations.

(2) (A) "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(i) Article 2.7 (commencing with Section 14087.3).

(ii) Article 2.8 (commencing with Section 14087.5).

(iii) Article 2.81 (commencing with Section 14087.96).

(iv) Article 2.9 (commencing with Section 14088).

(v) Article 2.91 (commencing with Section 14089).

(vi) Article 1 (commencing with Section 14200) of Chapter 8.

(vii) Article 7 (commencing with Section 14490) of Chapter 8.

(B) "Medi-Cal managed care plan" does not include dental managed care plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200).

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall 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 regulations are adopted. The department shall adopt regulations by July 1, 2019, 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. Commencing July 1, 2018, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations are adopted.

14197.2. (a) The Legislature finds and declares all of the following:

(1) Designated public hospitals systems play an essential role in the Medi-Cal program, providing high-quality care to a disproportionate number of low-income Medi-Cal and uninsured populations in the state. Because Medi-Cal covers approximately one-third of the state's population, the strength of these essential public health care systems is of critical importance to the health and welfare of the people of California.

(2) Designated public hospital systems provide comprehensive health care services to low-income patients and life-saving trauma, burn, and disaster-response services for entire communities, and train the next generation of doctors and other health care professionals, such as nurses and paramedical professionals, who are critical to new team-based care models that achieve more efficient and patient-centered care.

(3) The Legislature intends to continue to provide levels of support for designated public hospital systems in light of their reliance on Medi-Cal funding to provide quality care to everyone, regardless of insurance status, ability to pay, or other circumstance, the significant proportion of Medi-Cal services

provided under managed care by these public hospital systems, and new federal requirements related to Medicaid managed care.

(4) It is the intent of the Legislature that Medi-Cal managed care plans and designated public hospital systems shall in good faith negotiate for, and implement, contract rates, the provision and arrangement of services and member assignment that are sufficient to ensure continued participation by designated public hospital systems and to maintain access to services for Medi-Cal managed care beneficiaries and other low-income patients.

(b) Commencing with the 2017–18 state fiscal year, and for each state fiscal year thereafter, and notwithstanding any other law, the department shall require each Medi-Cal managed care plan to enhance contract services payments to the designated public hospital systems by a uniform percentage as described in this subdivision.

(1) The applicable percentage for purposes of the directed payments shall be uniformly applied across all of the following classes of designated public hospital systems:

(A) Designated public hospital systems owned and operated by the University of California.

(B) Designated public hospital systems not identified in subparagraph (A) that include a designated public hospital with a level 1 or level 2 trauma designation.

(C) Designated public hospital systems not identified in subparagraph (A) or (B).

(2) The department, in consultation with the designated public hospital systems, shall annually determine the applicable uniform percentages for each class identified in paragraph (1) and the classification of each designated public hospital system. Once the department determines the classification for each designated public hospital system for a particular state fiscal year, that classification shall not be eligible to change until no sooner than the subsequent state fiscal year. To the extent necessary to meet the objectives identified in subdivisions (a) and (d) or to comply with federal requirements, the department may, in consultation with the designated public hospital systems, adjust or modify the applicable percentages or the classifications. The department shall consult with the designated public hospital systems and each affected Medi-Cal managed care plan with regard to the implementation

of the directed payment requirements once these payment levels have been established.

(3) The required directed payment amounts shall be determined by multiplying the applicable percentage developed pursuant to paragraph (2) by the total amount of contract services payments. Performance-based incentive payments, amounts earned pursuant to the quality incentive program described in subdivision (c), and amounts paid pursuant to Sections 14301.4 and 14301.5 shall not be subject to the required directed payments. Nothing in this subdivision shall prevent a Medi-Cal managed care plan from making additional payments to a designated public hospital system in amounts exceeding the directed payment amounts required under this subdivision, or, at the sole option and request of a designated public hospital system, from working with the designated public hospital system to develop risk-sharing arrangements consistent with the intent and purposes of this subdivision.

(4) The directed payments required under this subdivision shall be implemented and documented by each Medi-Cal managed care plan and designated public hospital system in accordance with all of the following parameters and any guidance issued by the department:

(A) A Medi-Cal managed care plan and the designated public hospital systems shall determine the manner, timing, and amount of payment for contracted services, including through fee-for-service, capitation, or other permissible manner. The rates of payment for contracted services agreed upon by the Medi-Cal managed care plan and the designated public hospital system shall be established and documented without regard to the directed payments and quality incentive payments required by this section.

(B) A Medi-Cal managed care plan and a designated public hospital system shall, for the directed payment amounts determined pursuant to paragraph (3), determine the manner of their distribution, including the frequency and amount of each distribution through arrangements that may include, but are not limited to, a per-claim enhancement, per-capitation enhancement, monthly or quarterly lump-sum enhancement, or other permissible arrangement.

(C) The required directed payment enhancements provided pursuant to this subdivision shall not supplant amounts that would

otherwise be payable by a Medi-Cal managed care plan to a designated public hospital system for an applicable state fiscal year.

(D) A Medi-Cal managed care plan shall not terminate a contract with a designated public hospital system for the purpose of circumventing the directed payment obligations under this subdivision.

(E) In the event a Medi-Cal managed care plan subcontracts or otherwise delegates responsibility to a separate entity for either or both the arrangement or payment of services, the Medi-Cal managed care plan shall ensure that the designated public hospital system receives the directed payment enhancements described in this subdivision with respect to the services it provides that are covered by that arrangement, regardless of whether the Medi-Cal managed care plan subcontracted or delegated responsibility for payment of the directed payment amounts to the subcontracted or delegated entity, and shall be liable for any unpaid amounts. A Medi-Cal managed care plan shall require reporting of amounts paid or payable pursuant to that subcontracted or delegated arrangements as necessary to calculate the amount of those directed payment enhancements.

(5) Each year, a Medi-Cal managed care plan shall provide to the department, at the times and in the form and manner specified by the department, an accounting of amounts paid or payable to the designated public hospital systems it contracts with, including both contracted rates and the directed payments, to demonstrate compliance with this subdivision. To the extent the department determines, in its sole discretion, that a Medi-Cal managed care plan is not in compliance with the requirements of this subdivision, or is otherwise circumventing the purposes thereof, to the material detriment of an applicable designated public hospital system , and, independent of any remedy available to the designated public hospital system, the department may reduce the default assignment into the Medi-Cal managed care plan with respect to all Medi-Cal managed care beneficiaries by up to 25 percent, so long as the other Medi-Cal managed care plan or Medi-Cal managed care plans in the applicable county have the capacity to receive the additional default membership. The department's determination, whether to exercise discretion under this paragraph, shall not be subject to judicial review. Nothing in this paragraph shall be

construed to preclude or otherwise limit the right of any designated public hospital system to pursue a breach of contract action in connection with the requirements of this subdivision.

(6) Capitation rates paid by the department to a Medi-Cal managed care plan shall account for the Medi-Cal managed care plan's obligation to pay the directed payments to designated public hospital systems in accordance with this subdivision. The department may require Medi-Cal managed care plans and the designated public hospital systems to submit information regarding contract rates and expected utilization of services, at the times and in the form and manner specified by the department. To the extent consistent with federal law and actuarial standards of practice, the department shall utilize the most recently available data, as determined by the department, when accounting for the directed payments required under this subdivision, and may account for material adjustments, as appropriate and as determined by the department, to contracts entered into between a Medi-Cal managed care plan and a designated public hospital system.

(c) Commencing with the 2017–18 state fiscal year, and for each state fiscal year thereafter, the department, in consultation with the designated public hospital systems and each Medi-Cal managed care plan, shall establish a program under which a designated public hospital system may earn performance-based quality incentive payments from the Medi-Cal managed care plan they contract with in accordance with this subdivision.

(1) Payments shall be earned by each designated public hospital system based on its performance in achieving identified targets for quality of care.

(A) The department, in consultation with the designated public hospital systems and each Medi-Cal managed care plan, shall establish and provide a method for updating uniform performance measures for the performance-based quality incentive payment program and parameters for the designated public hospital systems to select the applicable measures. The performance measures shall advance at least one goal identified in the state's Medicaid quality strategy. Measures shall not duplicate measures utilized in the PRIME program established pursuant to Section 14184.50.

(B) Each designated public hospital system shall submit reports to the department containing information required to evaluate its performance on all applicable performance measures, at the times

and in the form and manner specified by the department. A Medi-Cal managed care plan shall assist a designated public hospital system in collecting information necessary for these reports.

(2) The department, in consultation with each designated public hospital system, shall determine a maximum amount that each class may earn in quality incentive payments for the state fiscal year.

(3) The department shall calculate the amount earned by each designated public hospital system based on its performance score established pursuant to paragraph (1).

(A) This amount shall be paid to the designated public hospital system by each of its contracted Medi-Cal managed care plan. If a designated public hospital system contracts with multiple Medi-Cal managed care plans, the department shall identify each Medi-Cal managed care plan's proportionate amount of the designated public hospital system's payment. The timing and amount of the distributions and any related reporting requirements for interim payments shall be established and agreed to by the designated public hospital system and each of the applicable Medi-Cal managed care plans.

(B) A Medi-Cal managed care plan shall not terminate a contract with a designated public hospital system for the purpose of circumventing the payment obligations under this subdivision.

(C) Each Medi-Cal managed care plan shall be responsible for payment of the quality incentive payments described in this subdivision.

(4) Nothing in this subdivision shall be construed to replace or otherwise prevent the continuation of prior quality incentive or pay-for-performance payment mechanisms or the establishment of new payment programs by any Medi-Cal managed care plan and their contracted designated public hospital systems.

(5) The department shall provide appropriate funding to each Medi-Cal managed care plan, to account for and to enable them to make the quality incentive payments described in this subdivision, through the incorporation into actuarially sound capitation rates or any other federally permissible method. The amounts designated by the department for the quality incentive payments made pursuant to this subdivision shall be reserved for

the purposes of the performance-based quality incentive payment program.

(d) In determining the uniform percentages described in paragraph (2) of subdivision (b), and the aggregate size of the quality incentive payment program described in paragraph (2) of subdivision (c), the department shall consult with designated public hospital systems to establish levels for these payments that, in combination with one another, are projected to result in aggregate payments that will advance the quality and access objectives reflected in prior payment enhancement mechanisms for designated public hospital systems. To the extent necessary to meet these objectives or to comply with any federal requirements, the department may, in consultation with the designated public hospital systems, adjust or modify either or both the applicable percentages or quality incentive payment program.

(e) The provisions of paragraphs (3) and (4) of subdivision (a), and of subdivisions (b) and (c) shall be deemed incorporated into each contract between a designated public hospital system and a Medi-Cal managed care plan, and its subcontractor or designee, as applicable, and any claim for breach of those provisions may be brought directly in a court of competent jurisdiction.

(f) (1) The nonfederal share of the portion of the capitation rates specifically associated with directed payments to designated public hospital systems required under subdivision (b) and for the quality incentive payments established pursuant to subdivision (c) may consist of voluntary intergovernmental transfers of funds provided by designated public hospitals and their affiliated governmental entities, or other public entities, pursuant to Section 14164. Upon providing any intergovernmental transfer of funds, each transferring entity shall certify that the transferred funds qualify for federal financial participation pursuant to applicable federal Medicaid laws, and in the form and manner specified by the department. Any intergovernmental transfer of funds made pursuant to this section shall be considered voluntary for purposes of all federal laws. Notwithstanding any other law, the department shall not assess the fee described in subdivision (d) of Section 14301.4 or any other similar fee.

(2) When applicable for voluntary intergovernmental transfers, the department, in consultation with the designated public hospital systems, shall develop and maintain a protocol to determine each

public entity's intergovernmental transfer amount in an applicable state fiscal year for purposes of funding the nonfederal share associated with payments pursuant to this section. The protocol developed and maintained pursuant to this paragraph shall account for any applicable contributions made by public entities to the nonfederal share of Medi-Cal managed care expenditures, including, but not limited to, contributions previously made pursuant to Section 14182.15 or 14199.2. Nothing in this section shall be construed to limit or otherwise alter any existing authority of the department to accept intergovernmental transfers for purposes of funding the nonfederal share of Medi-Cal managed care expenditures.

(g) (1) 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.

(2) For any state fiscal year in which this section is implemented, in whole or in part, and notwithstanding any other law, the department shall not be required to make any payment to a Medi-Cal managed care plan pursuant to Section 14182.15, 14199.2, or 14301.5.

(h) (1) The department shall seek any necessary federal approvals for the directed payments and the quality incentive payments set forth in this section.

(2) The department shall consult with the designated public hospital systems with regard to the development and implementation of the directed payment levels and the quality incentive payments established pursuant to this section.

(3) The director, after consultation with the designated public hospital systems, may modify the requirements set forth in this section to the extent necessary to meet federal requirements or to maximize available federal financial participation. In the event federal approval is only available with significant limitations or modifications, or in the event of changes to the federal Medicaid program that result in a loss of funding currently available to the designated public hospital systems, the department shall consult with the designated public hospitals to consider alternative methodologies.

(i) 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, provider bulletins, or other similar instructions, without taking regulatory action. The department shall make use of appropriate processes to ensure that affected designated public hospital systems and Medi-Cal managed care plans are timely informed of, and have access to, applicable guidance issued pursuant to this authority, and that this guidance remains publicly available until all payments made pursuant to this section are finalized.

(j) For purposes of this section, the following definitions apply:

(1) "Contract services payments" means the amount paid or payable to a designated public hospital system, including amounts paid or payable under fee-for-service, capitation, prior to any adjustments for service payment withholds or deductions, or other basis, under a contract with a Medi-Cal managed care plan for services, drugs, supplies or other items provided to a Medi-Cal beneficiary enrolled in the Medi-Cal managed care plan. Contract services includes all services, drugs, supplies, or other items the designated public hospital system provides, or is responsible for providing, or arranging or paying for, pursuant to a contract entered into with a Medi-Cal managed care plan. In the event a Medi-Cal managed care plan subcontracts or otherwise delegates responsibility to a separate entity for either or both the arrangement or payment of services, "contracted services payments" also include amounts paid or payable for the services provided by, or otherwise the responsibility of, the designated public hospital system that are within the scope of services of the subcontracted or delegated arrangement so long as the designated public hospital system holds a contract with the primary Medi-Cal managed care plan.

(2) "Designated public hospital" shall have the meaning set forth in subdivision (f) of Section 14184.10.

(3) "Designated public hospital system" means a designated public hospital and its affiliated government entity clinics, practices, and other health care providers, including the respective affiliated hospital authority and county government entities described in Chapter 5 (commencing with Section 101850) and Chapter 5.5 (commencing with Section 101852), of Part 4 of Division 101 of the Health and Safety Code.

(4) (A) "Medi-Cal managed care plan" means an applicable organization or entity that enters into a contract with the department pursuant to any of the following:

(i) Article 2.7 (commencing with Section 14087.3).

(ii) Article 2.8 (commencing with Section 14087.5).

(iii) Article 2.81 (commencing with Section 14087.96).

(iv) Article 2.91 (commencing with Section 14089).

(v) Chapter 8 (commencing with Section 14200).

(B) "Medi-cal managed care plan" does not include any of the following:

(i) A mental health plan contracting to provide mental health care for Medi-Cal beneficiaries pursuant to Chapter 8.9 (commencing with Section 14700).

(ii) A plan not covering inpatient services, such as primary care case management plans, operating pursuant to Section 14088.85.

(iii) A Program of All-Inclusive Care for the Elderly organization operating pursuant to Chapter 8.75 (commencing with Section 14591).

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